Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act (2005)

Department/ Service:	Corporate
Originator:	Head of Safeguarding
Accountable Director:	Chief Nursing Officer
Approved by:	Integrated Safeguarding Committee 29th July 2025 (Chair approval) Improving Safety Action Group (ISAG) 2nd September 2025
Date of approval:	2nd September 2025
Revision due: **This is the most current document and should be used until a revised version is in place**	2nd September 2028
Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Trustwide
Target Staff Categories:	All staff

Policy Overview:
The Mental Capacity Act (MCA), 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters. This Policy outlines the requirements of staff working within Worcestershire Acute Hospitals NHS Trust to ensure that care delivered is in accordance with the law and principles of consent to healthcare treatment requirements.

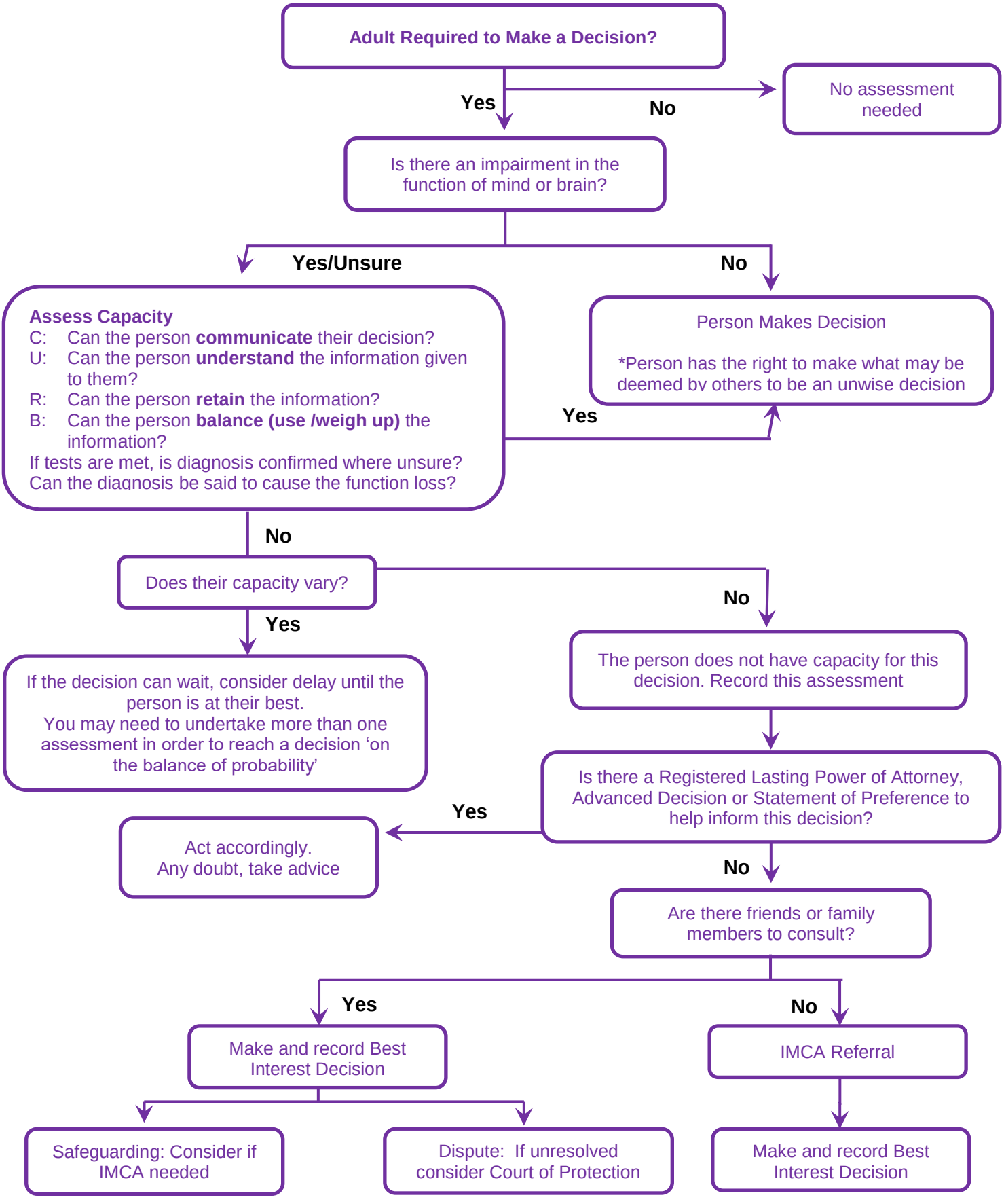
Key Amendments to this Document

Date	Amendment	Approved by:
10.06.2025	New Trust Policy to replace previously adopted Worcestershire Safeguarding Adults Board (WSAB) Policy.	Integrated Safeguarding Committee ISAG
1st June 2018	Full adoption of the Worcestershire Safeguarding Adult Board Policy /Procedure – Mental Capacity Act 2005 - Guidance and Policy for Staff	Safeguarding Committee
May 2021	Revision and update by Worcestershire Safeguarding Adults Board	CGG

Contents page:

Quick Reference Guide

Quick Reference Guide



1. Introduction

Regulation 11 of the Health and Social Care Act 2008 requires that care and treatment of people using services must only be provided with the consent of the relevant person. When a person is asked for their consent, information about the proposed care and treatment must be provided in a way that the person can understand.

It is also a legal duty under section 20 of the Equality Act 2010 to make reasonable adjustments to enable a disabled person who requires them to access healthcare. This includes making reasonable adjustments to help a person when their capacity is assessed.

If care or treatment is provided to someone without valid consent, both the staff member and the NHS trust are at risk of legal action. This could include accusations of assault, violating the person's human rights (specifically their right to respect for a private and family life under Article 8 of the European Convention on Human Rights) or being sued for battery (similar to assault). Staff could face criminal charges and the trust could face a civil claim demanding compensation (damages).

All organisations registered with the Care Quality Commission (CQC) are required to fulfil their responsibilities around the MCA, including monitoring practice within the organisation to ensure people's rights and associated legal requirements are being recognised and met. The CQC can prosecute an organisation for a breach of Regulation 11 of the Health and Social Care Act 2008 and may also take other regulatory action.

The Mental Capacity Act (MCA), 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act's starting point is to confirm in legislation that it should be assumed that an adult (**aged 16yrs or over**) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But, the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out some core principles and methods for making decisions and carrying out actions in relation to personal welfare,

healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.
(MCA Code of Practice, 1.1- 1.5)

1.1 Mental Capacity Act (2005) Code of Practice

The legal framework provided by the MCA 2005 is supported by a statutory **Code of Practice** which provides guidance and information about how the Act works in practice. All staff working within Worcestershire Acute Hospitals NHS Trust have a legal duty to have due regard to the Code when working with, or caring for, adults who may lack capacity to make decisions for themselves.

Key Information for Staff:

MCA Code of Practice 2005

Mental Capacity Act Code of Practice - GOV.UK

1.2 Is having due regard to the MCA Code of Practice important?

A failure to comply with the Code of Practice can be used in evidence before a court or tribunal in any civil or criminal proceedings, if the court or tribunal considers it to be relevant to those proceedings. For example, if a court or tribunal believes that anyone making decisions for someone who lacks capacity has not acted in the best interests of the person they care for, the court can use the person's failure to comply with the Code as evidence. That's why it's important that anyone working with or caring for a person who lacks capacity to make specific decisions should become familiar with the MCA Code of Practice.

People working within Worcestershire Acute Hospitals NHS Trust are legally required to 'have regard to' the MCA Code of Practice. This means you must be aware of the Code when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and able to explain how you have had regard to the Code when acting or making decisions.

1.3 Presumption of Capacity

The MCA Code of Practice states that the starting assumption must always be that the individual has mental capacity, until there is proof that they do not (MCA Code of Practice 2.4).
Where staff believe the individual lacks the mental capacity to make the specific decision at the time the decision needs to be made, then the onus is on staff to undertake a formal assessment of mental capacity. In cases where mental capacity appears to be fluctuating, then it is recommended the assessment is repeated in order to ascertain mental capacity 'on the balance of probability'.

1.4 What does the term 'lacking mental capacity' mean?

Whenever the term '**a person who lacks capacity** 'is used, it means **a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.**

1.5 Unwise decisions

'a person is not to be treated as unable to make a decision merely because he makes an unwise decision' (MCA Code of Practice, Principle 3).

Everyone has their own beliefs, values, preferences and attitudes. A person should not be deemed to lack the capacity to make a decision just because other people think their decision is unwise (MCA Code of Practice 2.10).

There may be cause for concern if somebody:

- Repeatedly makes unwise decisions that put them at significant risk of harm, exploitation, or
- Makes a particular unwise decision that is obviously irrational or out of character.

This may lead to further investigation by the professional but does not necessarily mean that somebody lacks capacity (MCA Code of Practice 2.11).

1.6 MCA Exclusions

The MCA makes reference to certain decisions which can never be made on behalf of a person who lacks capacity to make those specific decisions (MCA Code of Practice 1.10):

Decisions concerning family relationships:

- Consenting to marriage or a civil partnership
- Consenting to have sexual relations
- Consenting to a decree of divorce on the basis of two years' separation
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property, or
- Giving consent under the Human Fertilisation and Embryology Act 1990

Mental Health Act matters:

Where a person who lacks capacity to consent is currently detained and being treated under part 4 of the Mental Health Act 1983, nothing in the Act authorises anyone to:

- Give the person treatment for mental disorder, or
- Consent to the person being given treatment for mental disorder

Voting Rights:

Nothing in the Act permits a decision on voting to be made on behalf of a person who lacks capacity to vote.

Unlawful killing or assisting suicide:

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter, or assisting suicide.

2. Scope of this Document

The MCA applies to people aged **16yrs and over**.

Those who are involved in providing care, support or treatment to a person who lacks capacity are legally obliged to implement the MCA and to have regard to the Code of Practice.

Worcestershire Acute Hospitals NHS Trust expect that the practice of their employees (paid, voluntary, or contractual) will be in keeping with the Act and the guidance contained within the Code of Practice.

3. Definitions

Definition	Description
Advance Decision to Refuse Treatment (ADRT)	A decision to refuse specific treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when the person lacks capacity to consent to, or refuse the specified treatment. NB: specific rules apply to advance decisions to refuse life sustaining treatment.
Attorney	Someone either appointed under a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA), who has the legal right to make decisions within the scope of their authority on behalf of the person (donor) who made the Power of Attorney.
Best Interests	Any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out what is in a person's best interests such as the person's views, wishes, lifestyle, culture and beliefs. Any best interest decision made should be the least restrictive.
Capacity	The ability to make a decision regarding a particular matter at the time the decision needs to be made.
Children	The Code of Practice refers to children as being people aged below 16. This differs from the Children Act 1989 and the law more generally where the term 'child' is used to refer to people aged under 18.
Court of Protection	The specialist Court for all issues relating to people who lack capacity to make specific decisions.
Court of Protection visitors	Are appointed by the Court to investigate with the Local Authority suspected abuse or to check on the welfare of a person who lacks capacity.

Decision Maker	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 throughout the Code, as the decision maker. It is the decision maker's responsibility to determine what would be in the best interests of the person who lacks capacity.
Deputy	The Court of Protection will appoint and direct Deputies to make ongoing specific property/financial affairs and/or health and welfare decisions in the 'best interests' of people after they become incapacitated. Deputies will be CRB checked, and will be supervised by the Public Guardian, including existing Receivers. The Court defines their powers and limitations. They are required to submit reports and to keep records. They have a right to be consulted as appropriate, and their 'best interest' view should be agreed or the matter will be brought to the Court. Deputies cannot: • Prohibit contact with named persons • Direct healthcare providers to allow another to take over • Settle property or execute wills • Override a decision within the scope of a LPA • Refuse consent to a life sustaining intervention
Deprivation of Liberty Safeguards (DoLS)	These were introduced in 2007 and are an additional safeguard to those contained within the original Mental Capacity Act 2005. A DoL can occur where, for their own safety and in their best interests, a person needs to be accommodated under a care regime that has the effect of removing their liberty. That person must lack the capacity to consent to be subject to a DoLS.
Donee	Is an individual named by a person when they have capacity; to represent them at times when they lack capacity.
Donor	An individual who at the time has capacity to delegate decisions regarding their

	welfare or property and finance to a nominated person known as a Lasting Power of Attorney
Enduring Power of Attorney (EPA)	A power of attorney created under the Enduring Powers of Attorney Act (1985) appointing an attorney to deal with the donor's property and financial affairs. Existing EPA's will continue to operate under Schedule 4 of the Act, which replaces the EPA Act 1985.
Independent Mental Capacity Advocate (IMCA)	IMCAs are instructed by designated decision makers as per the IMCA Engagement Protocol for unbefriended people where there are serious medical treatment and accommodation move decisions. They can request information, copies of records, a meeting, and a second opinion; can challenge decisions and seek a Court decision. They can also work alongside an existing advocate.
Lasting Power of Attorney (LPA)	A Power of Attorney created under the Act who is over the age of 18, registered with the Public Guardian, who is nominated to manage finances/property and / or to manage health / welfare decisions when an individual loses capacity. Their powers may enable full decision-making, including life-sustaining decisions, or they may be limited to specific decisions and circumstances by an adult when they have capacity. Those actions under LPA's must abide by Code of Practice standards, Court Directions and provide any requested court reports. Relevant professionals must be consulted when necessary.
MCA 1	Form to record assessment of capacity.
MCA 2	Form to record rationale for Best Interest Decision.
Office of the Public Guardian (OPG)	The Public Guardian is an Officer established under Section 57 of the Act. The Public Guardian will be supported by the Office of Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Power of Attorney and Enduring Power of Attorney, check on what the attorneys are doing, and investigate any complaints about attorneys or deputies.
Protection from Liability	Legal protection, granted to anyone who has acted or made decisions in line with the Acts principles
Receivers	An individual appointed by the former Court of Protection to manage the property and affairs of a person lacking capacity to manage their own affairs. Existing receivers

	continue as deputies with legal authority to deal with the person's property and affairs
Restraint	The use or threat of force to help do an act which the person resists, or the restriction of someone's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
Serious health/medical treatment	Includes invasive assessment and treatment; and involves providing new treatment, or withholding or stopping treatment that has already started. Some examples of medical treatments that might be considered serious include: • Chemotherapy and surgery for cancer • Electro-convulsive therapy • Therapeutic sterilisation • Major surgery (such as open-heart or brain/ neuro-surgery) • Major amputations (e.g. loss of arm or leg) • Treatments that will result in permanent loss of sight or hearing • Withholding or stopping artificial nutrition and hydration • Termination of pregnancy These are illustrative examples only, and whether these or other procedures are considered serious medical treatment in any given case will depend on the circumstances and the consequences for the person.
Unbefriended	The person has no friend, family, nominee or legal representative in effective contact with them, or who is willing or appropriate to represent their best interests.
Young People	The Act refers to young people as being aged 16-17 years.

4. Responsibilities

All Staff
All staff involved in the care of patients, including volunteers:

- Must follow the guidance set out in the MCA Code of Practice.
- Must follow the Trust Policy and Procedure in respect of consent to treatment
- Have an obligation to act in accordance with the principles of the Mental Capacity Act and in the best interests of a person deemed to be lacking capacity.

- Must seek advice from their line manager or clinical team if there is any doubt about the capacity of a person within our care. This should also include whether the person is being deprived of their liberty.
- Have a contractual obligation to ensure they are up to date with mandatory training requirements in respect of MCA and DoLS at the level assigned to their job role
- Must have a lawful basis upon which to deliver care and treatment e.g. with informed consent or best interest decision principles as laid out in the Code of Practice
- Where restriction or restraint is used should ensure a Datix incident is reported in accordance with incident reporting procedures
- To ensure record keeping is in accordance with Trust requirements and professional standards

Chief Nursing Officer
Is the Executive Accountable Officer on behalf of the Trust Board for Safeguarding activity, including MCA and DoLS.

Head of Safeguarding (MCA & DoLS Lead)
Has a responsibility to ensure that the MCA Policy and Procedure is fit for purpose and disseminated throughout Worcestershire Acute Hospitals NHS Trust to inform clinical practice.
As MCA & DoLS lead, they will also provide advice and support to staff where required.
Will support Divisional Governance teams in post incident reviews where restriction or restraint has been used to ensure restraint reduction principles for good practice are in effect within clinical practice.

Named Nurse Safeguarding Adults
Is responsible for the delivery of mandatory training for MCA & DoLS.
The Named Nurse will also provide clinical advice and support to practitioners.

Clinical Operational Managers
Are responsible for ensuring that staff within their areas of responsibility implement and comply with the requirements of the Act and Code of Practice.

Clinical Staff E.g. Doctor, Nurse, Therapists, Psychologists, Specialist Nurses
Have a duty to ensure the process for obtaining consent, the assessment of mental capacity and where required, best interest decision making is followed in accordance with the law.
Have a duty to ensure referral for statutory advocacy services where required.

Doctors and Psychiatrists
Determine the validity of an advance directive, and arrange second opinions on request. Certain decisions require Court directions, and formal / certifying mental capacity assessments by specialists, e.g. Doctors, Psychiatrists, Psychologists, and counter signatories. These staff can be part of a multi-disciplinary team designated by their organisation to make best interest decisions.

Governance Teams /Patient Safety
Have a responsibility to review and co-ordinate investigation into any reported incidents involving the MCA or DoLS in accordance with the Trust Incident Reporting Policy & Procedure. This includes ensuring the requirements of Duty of Candour (where applicable) are met.

Legal Services
Provides a legal service to staff for complex cases requiring legal advice / support, including where cases may need to be referred to the Court of Protection.

5. Policy Detail

5.1 What are the 5 Statutory Principles of the MCA?

The MCA is underpinned by 5 key principles that put the person at the centre of decision making and provides a framework for staff when providing care and treatment:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person must not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- Any action taken, or any decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before any action is taken, or any decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

If there is no trusted person who can support them, people should be provided with an independent advocate. The advocate will support them to make decisions in certain situations, such as serious treatment or where the person might have significant restrictions placed on their freedom and rights in their best interests.

5.2 Who may be deemed to lack mental capacity?

Examples of people who may lack capacity include those with:

- Neurological diseases e.g. dementia
- a severe learning disability
- a brain injury (traumatic or surgical)
- a mental health condition
- a stroke
- delirium
- effects of medication or anaesthesia
- unconsciousness caused by an anaesthetic or a sudden accident

But, just because a person has one of these health conditions does not necessarily mean they lack the capacity to make a specific decision.

Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop).

*Remember, the impairment or disturbance in the functioning of the mind or brain could be ***temporary*** e.g. infection, or it could be ***permanent*** e.g. severe learning disability

5.3 Helping people make their own decisions

Before deciding a person lacks capacity, it's important to take steps to enable them to try to make the decision themselves e.g.

- does the person have all the relevant information they need?
- have they been given information on any alternatives?
- could information be explained or presented in a way that's easier for them to understand (for example, by using simple language or visual aids)?
- have different methods of communication been explored, such as non-verbal communication?
- could anyone else help with communication, such as a family member, carer or advocate?
- are there particular times of day when the person's understanding is better?
- are there particular locations where the person may feel more at ease?
- could the decision be delayed until they might be better able to make the decision?

5.4 Mental Capacity and Consent

There are a number of health conditions which may affect an individual's mental capacity to consent to a proposed intervention or treatment. An impairment in the functioning of the mind or brain does not necessarily indicate a lack of capacity. It is only when the resulting impairment of brain function affects the individual's ability to make decisions that the level of cognitive ability should be assessed and any incapacity recorded (The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care – www.ncpqsw.com).

Staff of Worcestershire Acute Hospitals NHS Trust are required to understand their individual responsibilities and the legal requirements of the MCA (2005), where treatment or care is required for those individuals unable to provide informed consent; and to ensure any treatment decision made is lawful.

This Policy should be used in conjunction with the Trust Consent Policy available via the Trust SharePoint Key Documents page.

5.5 Who is responsible for assessing mental capacity to consent to treatment or care?

The assessment of mental capacity should be undertaken by:

- General healthcare or treatment – capacity to consent should be assessed by the most relevant health professional involved in such care
- Serious medical treatment – capacity assessment should be undertaken by a senior medical practitioner (BMA, 2018).

In settings such as a hospital, mental capacity assessments will likely involve the multi-disciplinary team. But, ultimately it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed (MCA Code of Practice 4.40).

5.6 The purpose of the Mental Capacity Assessment

The Mental Capacity Assessment is a legal test, and not a medical test, and is set down in s2(1) of the MCA 2005.

The purpose of the assessment is to determine whether a person aged 16 or over is able to make a particular decision at the time it needs to be made.

5.7 How to Assess Mental Capacity

An assessment of a person's capacity must be based upon their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general (MCA Code of Practice, 4.4).

The MCA sets out a 2-stage test of capacity:

1. Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?
2. Does the impairment mean the person is unable to make a specific decision when they need to? People can lack capacity to make some decisions, but have capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time, but may be able to make the same decision at a later point in time.

*Remember, the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- The loss of capacity is partial
- The loss of capacity is temporary
- Their capacity changes over time.

A person may also lack capacity to make a decision about one issue but not about others.

Where appropriate, people should be allowed the time to make a decision themselves.

Under Section 3 of the Act, a person is unable to make a decision for themselves if they are unable to do **one or more** of the following:

- **understand** the information relevant to the decision
- **retain** that information for long enough to make the decision
- **use or weigh up** that information as part of the process of making the decision
- **communicate** their decision in any way

5.7.1 Assessing Mental Capacity for those with a Learning Disability

NHSE Guidance to support implementation of the Mental Capacity Act in Acute Trusts for adults with a learning disability

A Health Services Safety Investigations Body report in 2023 on the care of acute hospital inpatients with a learning disability in England, found variation in staff understanding and application of the MCA in the care of people with a learning disability. NHS England guidance was published 28 May, 2025 providing practitioners with:

- Advice on how to undertake the 2 stage test of capacity
- Checklist for preparing to assess the mental capacity of someone with a learning disability
- Flowchart
- Practical tools and resources
- Template forms including balance tables

Key information for staff:

NHS England » Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

5.7.2 Executive Capacity / Function

Executive functioning has been described as “the ability to think, act, and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we’ve learned in the past, and use this information to solve problems of everyday life.”

It relates to the ability to put into practice knowledge and information about a decision in the moment or at the time that a decision or action is required. It is a clinical term and relates to a set of cognitive skills pertaining to working memory, planning, attention focus, remembering instructions, self-control and juggling multiple tasks.

These issues sometimes come to the fore in relation to mental capacity assessments when there is a disconnect between rational verbal answers the adult may give when talking about risk situations and what decisions they would make to stay safe, and in the moment functioning. For example, an individual may be able to verbally detail the risks of a decision and that they would make a ‘wise’ decision but when in the moment, they take an alternative risky decision, or are unable to enact the decision they previously said they would make.

When working within the Mental Capacity Act, we need to be mindful of the third principle and not treating the individual as lacking mental capacity because they have made an unwise decision/s, but repeated unwise decisions within a context of verbal reports to the contrary may be an indication of difficulties with executive function. In an assessment this would typically be considered as part of the ‘sufficiently weigh up and use information to make a decision’ assessment criteria.
The terms executive functioning and executive capacity are not referenced in the Mental Capacity Act or the MCA Code of Practice, but there is recognition of these concepts in case law. (*West Midlands Adult Safeguarding Policy & Procedures*)

In order to check out an individual's Executive capacity there should be repeated assessment of capacity, supported by collateral information and real-life functional assessment.

5.8 People with Fluctuating or Temporary Capacity

Things to consider:

- Location - choose a location where the person feels most at ease, quiet, uninterrupted
- Timing – time of day when the person is most alert, is the person likely to regain capacity, medication and side effects e.g. sedatives
- Take one decision at a time, don't rush
- Support from other people – relative or friend (remember right to confidentiality)
- Can you delay the decision?
- What materials do you have available to support people to make their own decisions?
- Use of technology

Further information can be found in Chapter 3 of the MCA Code of Practice 3.12-3.16.

5.9 Balance of Probability – is it more likely than not that the person lacks capacity?

Making a decision on the balance of probabilities means deciding whether it is more likely than not that a person has (or lacks) capacity based on all of the available evidence. (mca-adults.trixonline.co.uk)

In such cases, it is advised several capacity assessments for the same decision are undertaken in order to reach a decision on **'the balance of probability'.** This may also involve seeking a second opinion from another clinician.

5.10 Best Interest Decision Making

Principle 4 of the MCA states that if a person has been assessed as lacking capacity, then any decision taken, or any decision made for, or on behalf of that person, must be made in their best interests.

The MCA provides a non-exhaustive checklist of factors that decision makers must work through in deciding what is in a person's best interests.

Form MCA 2 (record of best interest decision) provides guidance for staff in this regard.

If staff are faced with a particularly difficult or contentious decision, it is recommended that practitioners use a 'balance sheet' approach e.g. benefit v burden.

5.11 Recording an Assessment of Mental Capacity / Best Interests

Whenever possible, formal capacity assessments should be recorded on the relevant Trust forms:

MCA 1 – Assessment of Mental Capacity

MCA 2 – Record of Best Interest Decision

In the event access to the forms is not available then the above principles should be applied to record keeping. It is suggested staff utilise the headings detailed in order to cover all of the necessary elements.

Factors to remember

- Capacity is decision specific
- Capacity is person specific
- Capacity is time specific
- Individuals should be given appropriate information
- Individuals should be given all practicable help and support to make the decision

Key information for staff:

Worcestershire Safeguarding Adults Board (WSAB): Best Interest Decision Meeting Guidance

Policies, Procedures & Guidance - Worcestershire Safeguarding Boards

5.12 What else do I need to consider when the patient has been deemed to lack mental capacity?

5.12.1 Safeguarding

The presumption is that adults have the mental capacity to make informed decisions about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in Safeguarding Adults. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability:

- to understand the implications of their situation
- to take action themselves to prevent abuse
- to participate to the fullest extent possible in decision-making about interventions.

The MCA 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act.

The impact of controlling and coercive behaviours, and application of undue influence, is a factor that needs active consideration for those both with or without mental capacity. Local Safeguarding Policy and Procedure should be followed in addition to the principles of the MCA and Code of Practice.

Key information for staff:

The Care Act: safeguarding adults - SCIE

Worcestershire Safeguarding Adults Board (WSAB): Mental Capacity and Best Interest Decision resources

Policies, Procedures & Guidance - Worcestershire Safeguarding Boards

5.12.2 Children & Young People

See Section 12 of the Mental Capacity Act 2005 Code of Practice for full guidance. It is important that everyone is clear which safeguarding procedures should be implemented in situations involving 16-17 year olds.

Children – aged under 16 years

The Act does not generally apply to people under the age of 16. There are 2 exceptions:

- The Court of Protection can make decisions about a child's property or finances if the child lacks capacity to make such decisions and is still likely to lack capacity to make financial decisions when they reach the age of 18
- Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

Young People – aged 16-17 years

Most of the Act applies to young people aged 16-17 years of age. There may be an overlap with The Children's Act 1989. For the Mental Capacity Act 2005 to apply to a young person they must lack capacity to make specific decisions as set out above. There are 3 exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney
- Only people aged 18 and over can make an Advance Decision to Refuse Medical Treatment
- The Court of Protection may only make a statutory will for a person aged 18 and over

Care and treatment of young people aged 16 or 17

The Family Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. This also applies to any associated procedure i.e. investigations, anaesthesia or nursing care.

As with adults, decision-makers should assess the young person's capacity to consent to the proposed treatment or care. If the young person lacks capacity to consent because of an impairment or disturbance of the brain, then the MCA will apply in the same way as it does for those who are 18yrs and over.

If they lack capacity for any other reason, for example because they are overwhelmed by the implications of the decision, the Act will not apply to them and the legality of any treatment should be assessed under common law principles.

The Act does not apply to some rare types of procedure for example organ donation or research. In these cases, anyone under 18 is presumed to lack legal capacity, subject to the test of 'Gillick competence'.

5.13 Status of Next of Kin and decision making

It is important to remember that the individual considered to be the person's 'next of kin' does not have automatic legal decision making powers about treatment unless they hold a Lasting Power of Attorney for health & wellbeing decisions. In practice, next of kin are often consulted by professionals to provide *advice and guidance* on the persons known wishes.

5.14 Who can be the 'decision maker'

Decision making by the individual: Advance Care Planning

5.14.1 Advance Decisions to Refuse Treatments (ADRT)

An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a **legally binding decision** that allows someone aged 18 or over, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

An advance decision must:

- **be valid** (the person must not have withdrawn it)
- **and applicable**: clearly refer to the relevant type of treatment and explain the circumstances where the person would want to refuse the treatment

If these conditions are met, it has the same effect as a decision made by a person with capacity – healthcare professionals must follow the decision.

An ADRT can be altered or ended at any time providing the person has the capacity to do so. It is a good idea to regularly review and update any ADRT to ensure it accurately meets the person's needs.

Treatment which has been commenced in advance of the discovery of an ADRT should be discontinued once the clinician is satisfied that the ADRT is 'valid and applicable'.

If the advance decision refuses life-sustaining treatment, it must:

- be in writing, signed and witnessed by a third party
- state clearly that the decision applies even if life is at risk

What is validity?

There are 3 reasons why an ADRT may not be valid:

1. the person has withdrawn it whilst they had the capacity to do so, or
2. since making an ADRT the person has also made a Lasting Power of Attorney (LPA) for health & welfare and has given the attorney power to make relevant treatment decisions, although the LPA will need to show that the ADRT is not valid because of this or they should follow the ADRT, or
3. the person has acted in an inconsistent way since making the ADRT.

If none of these 3 things are evident then anyone providing the person with treatment would need to act as per the ADRT and to do otherwise would be deemed unlawful (www.ncpqsw.com).

What is Applicability?

There are 3 reasons why an ADRT may not be applicable:

1. the treatment being offered may not be the treatment specified in the ADRT, or
2. the circumstances specified in the ADRT may not be relevant to the situation, or
3. there may be reasons for believing that there are now circumstances which the person could not have possibly anticipated at the time they made the decision, and if they had known may have altered their decision (www.ncpqsw.com).

What ADRT cannot do

ADRT cannot:

- be used to demand treatment or certain types of treatment
- used to confer decision making power on someone else
- refuse interventions designed to keep them clean and comfortable, nor the offer of food and fluids by mouth
- demand something illegal e.g. assisted death

Key information for staff:

NHS - Advance decision to refuse treatment (living will)

Advance decision (living will) - NHS

5.14.2 Advance statements and decisions

An advance statement is a written statement that sets down a person's preferences, wishes, beliefs and values regarding their future care. **It's not legally binding**.

The **aim is to provide a guide for anyone who might have to make decisions in a person's best interests** if that person has lost the capacity to make decisions or communicate their decision.

An advance statement can cover any aspect of a person's future health or social care.

This could include:

- how they want any religious or spiritual beliefs they hold to be reflected in their care
- where they would like to be cared for – for example, at home or in a hospital, nursing home or hospice
- how they like to do things – for example, if they prefer a shower instead of a bath, or like to sleep with the light on
- concerns about practical issues – for example, who will look after their pet if they become ill

Key information for staff:

Advance statement about your wishes - NHS

5.14.3 Lasting Powers of Attorney

You can grant a Lasting Power of Attorney (LPA) to another person (or people) to enable them to make decisions about your health and welfare, including consent to medical treatment, or decisions about your property and financial affairs.

Separate legal documents are made for each of these decisions, appointing one or more attorneys for each.

An Enduring Power of Attorney (EPA) under the previous law was restricted to making decisions over property and affairs, which includes financial affairs and accessing the person's information.

An EPA made before the Mental Capacity Act came into force on 1 October 2007 remains valid.

Powers of attorney can be made at any time when the person making it has the mental capacity to do so, provided they're 18 or over.

Both an EPA and LPA must be registered. An LPA can be registered at any time, but **a personal welfare LPA will only be effective once the person has lost the capacity to make their own decisions.**

When acting under an LPA, an attorney (the appointed person) must:

- make sure the MCA's statutory principles are followed
- check whether the person has the capacity to make that particular decision for themselves – if they do, a personal welfare LPA cannot be used and the person must make the decision

In addition, the Court of Protection will be able to appoint deputies who can also take decisions on health and welfare and financial matters if the person concerned lacks the capacity to make a decision.

They'll come into action when the court needs to delegate an ongoing series of decisions rather than one decision.

If the person concerned already has an LPA appointed, they will not normally need a deputy as well.

The Office of the Public Guardian registers LPAs and EPAs, and supervises court-appointed deputies.

It provides evidence to the Court of Protection and information and guidance to the public.

The Public Guardian works with a range of agencies, such as the financial sector, police and social services, to investigate concerns.

5.15 Office of the Public Guardian (OPG)

The Public Guardian is an Officer established under Section 57 of the Act. The Public Guardian will be supported by the Office of Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Power of Attorney and Enduring Power of Attorney, check on what the attorneys are doing, and investigate any complaints about attorneys or deputies.

5.16 Treatment Decisions without any Advance Care Planning in place

Where there is a need to make decisions about a person's care and treatment, professionals (often clinical staff) will consult with advocacy, family and those closest to the patient to see if an agreement about what should happen, in the person's best interests, can be reached.

Where no agreement can be reached then an application to the Court of Protection may be necessary.

In such cases, advice should be sought from the Trust Legal Team.

5.17 Decision Making by the Court of Protection

The Court of Protection oversees the operation of the Mental Capacity Act and deals with all issues, including financial and serious healthcare matters, concerning people who lack the mental capacity to make their own decisions.

The court also tries to resolve all disputes when the person's carer, healthcare worker or social worker disagree about what's in the person's best interests, or when the views of the attorneys conflict in relation to property and welfare.

The court hears important cases, such as whether the NHS should withdraw treatment, whether a serious medical treatment decision is in a person's best interests, or whether it's in a person's best interests to be deprived of their liberty.

Cases can be brought to the court by family members, as well as advocates and professionals involved in decisions.

Any cases that may require a Court of Protection application should be discussed with the Trust Legal Services team.

Key information for staff:

Court of Protection

Legal Services Team: via switchboard

5.18 Independent Mental Capacity Advocates (IMCA)

The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.

IMCAs must be independent.

5.18.1 Instructing and consulting an IMCA

An IMCA must be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or – they will stay in the care home for more than eight weeks.

An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved

5.18.2 Ensuring an IMCA's views are taken into consideration

The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to see relevant healthcare and social care records. Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person's best interests.

In adult protection cases, an IMCA may be appointed even where family members or others are available to be consulted (10.2).

The information the IMCA provides must be taken into account by decision-makers whenever they are working out what is in a person's best interests.

The IMCA will meet with the individual, clinical team and other relevant people and provide an independent and objective view of the persons wishes, beliefs, and former decisions in order to work with professionals to protect the person's rights and agree the Best Interests for specific clinical decisions. The role of the IMCA is also to raise questions or challenge decisions which appear not to be in the best interests of the person (10.4)

Key information for staff:

Onside Advocacy – referral information is available on the Sharepoint Safeguarding Hub page of the Trust intranet.

5.19 Best Interest Decision Making – role of the professional as 'decision maker'

If someone lacks the capacity to make a decision and the decision needs to be made for them, the MCA states the decision must be made in their best interests.

The MCA (2005) is clear that a person should be given support and practicle help to make any decision regarding care and treatment themselves. Even if the person is unable to make the decision themselves, they should be encouraged and supported to be actively involved and included in the decisions (Brown et al. 2015).

Decisions made for care and treatment for an individual who lacks mental capacity to consent, should follow the Best Interest Principles as laid out in the MCA Code of Practice.

The MCA sets out a checklist to consider when deciding what's in a person's best interests.

It says you should:

- encourage participation – do whatever's possible to permit or encourage the person to take part
- identify all relevant circumstances – try to identify the things the person lacking capacity would take into account if they were making the decision themselves

- find out the person's views – including their past and present wishes and feelings, and any beliefs or values
- avoid discrimination – do not make assumptions on the basis of age, appearance, condition or behaviour
- assess whether the person might regain capacity – if they might, could the decision be postponed?

It's vital to consult with others for their views about the person's best interests.
In particular, try to consult:

- anyone previously named by the person
- anyone engaged in caring for them
- close relatives and friends
- any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney
- any deputy appointed by the Court of Protection to make decisions for the person

5.20 Confidentiality and the Duty to Consult with others

Decision makers must balance the duty to consult with other people with the right to confidentiality of the person who lacks mental capacity. If confidential information is to be discussed then information sharing principles should be applied e.g. need to know, necessary, proportionate etc. Trust Policy and Procedure and professional guidance should be followed in such instances.

In complex cases, advice can be sought from the Trust Caldecott Guardian (Chief Medical Officer).

5.21 Best Interest Decision Making – Emergency Situations

The Best Interest checklist provides a guide for good practice to ensure care and treatment remains lawful and person centred.

In cases where urgent care and treatment need prompt decision making, with no time to consult others, explore known wishes, or refer for an IMCA, then the clinical team should still ensure that:

- Treatments and care are the least restrictive and least invasive as possible
- Clinical decisions are not made based on assumptions and discrimination
- The individual's family are informed and involved at the earliest opportunity
- Clinical decisions are made to provide the optimal outcomes for the individual
- Clinical decisions involve relevant health & social care practitioners available at the time of urgent treatment or rapidly declining condition
- Ongoing and further discussions are made following Best Interest principles

5.22 Finding the least restrictive option

Before you make a decision or act on behalf of someone who lacks capacity, always question if you can do something else that would interfere less with their basic rights and freedoms.

This is called finding the "least restrictive alternative". It includes considering whether there's a need to act or make a decision at all.

Where there's more than one option, it's important to explore ways that would be less restrictive or allow the most freedom for a person who lacks capacity.

But the final decision must always allow the original purpose of the decision or act to be achieved.

Any decision or action must still be in the best interests of the person who lacks capacity.

So sometimes it may be necessary to choose an option that is not the least restrictive alternative if that option is in the person's best interests.

5.23 Use of Restraint

Section 6 (4) of the Act states that someone is using restraint if they:

- 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.

Protection from Liability

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is ***necessary to prevent harm to the person*** who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

Key information for staff:

Restrictive Interventions – Adults Policy & Procedure: Available on the Sharepoint Safeguarding Hub and Key Documents page of the Trust intranet.

MCA Code of Practice – Section 6.40

5.24 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.

The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

DoLS in the hospital setting **only apply to adults over the age of 18years** whom are **deemed to lack the mental capacity to consent to the arrangements made for their care and treatment** in order to keep them safe from harm.

In certain cases, the restrictions (either singularly or in combination) placed upon a person who lacks capacity may amount to a "deprivation of liberty". This must be judged on a case-by-case basis.

Where it appears a deprivation of liberty might happen, the provider of care (usually a hospital or a care home) has to apply to their local authority.

They'll then arrange assessments of the person's care and treatment to decide if the deprivation of liberty is in the best interests of the individual concerned.

If it is, the local authority will grant a legal authorisation. If it is not, the care and treatment package must be changed and the person cannot be deprived of their liberty – otherwise, an unlawful deprivation of liberty will occur. This system is known as the Deprivation of Liberty Safeguards.

Where you have belief that the person is being deprived of their liberty then the Trust Policy & Procedure should be followed.

Key information for staff:

Deprivation of Liberty Safeguards Policy & Procedure

Available via Sharepoint Key Documents page of the Trust intranet.

*any application for a DoLS must be made to the Local Authority where the person is ordinarily resident.

MCA 2005 - Deprivation of Liberty Safeguards Code of Practice

https://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf

6. Implementation

6.1. Plan for Implementation

The latest version of this Policy can be found on the Trust Sharepoint intranet site Key Document and Safeguarding pages.

6.2. Dissemination

Staff will be advised of the updated Policy via dissemination by attendees of the Trust Integrated Safeguarding Committee and associated Governance Forums.

6.3. Training and Awareness

All staff receive mandatory training in respect of the Mental Capacity Act and Deprivation of Liberty Safeguards at a level in accordance with their job role. This level of training is assigned in the staff members Electronic Staff Record (ESR).

Training compliance is reported on a monthly basis via the Trust Divisional Compliance Dashboard.

7. Monitoring and Compliance

The NHSLA requirements are:

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.
Monitoring demonstrates whether the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process. The table below should help to detail the 'Who, What, Where and How' for the monitoring of this policy.

Section / page no:	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out?	Responsible for carrying out the check:	Results of the check reported to: *(Responsible for also ensuring actions are developed to address areas of non-compliance)*	Frequency of reporting:
No.	**WHAT?**	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
CQC notifications and conditions attached	DoLS Granted /not granted outcomes	Sent to generic safeguarding inbox	Upon receipt	Named Nurse Safeguarding Adults /Safeguarding Officer	Records kept on Integrated Safeguarding team shared drive	IST Annual Report
Applications made for DoLS by WAHT	Receipt of notifications made to Worcestershire / other areas as received	Sent to generic safeguarding inbox	Upon receipt	Named Nurse Safeguarding Adults /Safeguarding Officer	Records kept on Integrated Safeguarding team shared drive	IST Annual Report
Referrals for Advocacy	Monitored via the P&QA sub group of the Worcestershire Safeguarding Adults Board	Need for advocacy is one of the standard assessments	In accordance with P&QA reporting schedule	P&QA on behalf of WSAB	P&QA and reported back to WSAB and agency representatives	In accordance with P&QA reporting schedule

8. Policy Review

This Policy will be reviewed every 3 years in accordance with WAHT Key Document review process or in the event of any significant change to legislation or procedure.

9. References

Advance statement about your wishes - NHS

Advance Care Planning www.ncpqsw.com

Advance Decisions to Refuse Treatment www.ncpqsw.com

Brown et al. 2015, The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care. www.ncpqsw.com

BMA, 2018 cited in The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care. www.ncpqsw.com

Consent to Examination or Treatment WAHT-CG-075

Court of Protection

Children's Act 1989

Deprivation of Liberty Safeguards Code of Practice 2008

Deprivation of Liberty Safeguards Policy & Procedure WAHT-KD-026

European Convention of Human Rights – Article 8

Equality Act 2010

Family Reform Act 1969

Human Fertilisation and Embryology Act 1990

Health & Social Care Act 2008 – Regulation 11

Mental Capacity Act 2005

Mental Capacity Act 2005 Code of Practice
Mental Capacity Act Code of Practice - GOV.UK

Mental Capacity Act - Social care and support guide - NHS

Mental Capacity (Amendment) Act 2019

Mental Health Act 1983

The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care – www.ncpqsw.com

The Mental Capacity Act requirements for clinical decisions regarding treatment and care – www.ncpqsw.com

Mental Capacity Act 2005 Resource and Practice Toolkit trixonline.co.uk
Mental Capacity Act 2005 Resource and Practice Toolkit

NHSE Guidance to support implementation of the Mental Capacity Act in Acute Trusts for adults with a learning disability (March 2025)
NHS England » Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

NHS - Advance decision to refuse treatment (living will)
Advance decision (living will) - NHS

Social Care Institute for Excellence The Care Act: safeguarding adults - SCIE

West Midlands Adult Safeguarding Policy & Procedures WM Adult Docs

Worcestershire Safeguarding Adults Board (WSAB): Best Interest Decision Meeting Guidance

Policies, Procedures & Guidance - Worcestershire Safeguarding Boards

Worcestershire Safeguarding Adults Board (WSAB): Mental Capacity and Best Interest Decision resources

Policies, Procedures & Guidance - Worcestershire Safeguarding Boards

10. Background

10.1. Equality requirements

Refer to equality assessment Supporting Document 1

10.2. Financial risk assessment

Refer to financial risk assessment Supporting Document 2

10.3. Consultation

Contribution List This key document has been circulated to the following individuals for consultation:	
Name	**Designation**
Integrated Safeguarding Committee representatives	Divisional representatives ICB representative Non-Executive Director
J Walton	Caldecott Guardian, Chief Medical Officer
Ed Mitchell	Deputy Chief Medical Officer
Julie Webber	Learning Disability Lead
Karen Apps	Patient Safety Team
Legal Services – Rebecca Ollivere - Solicitor	Herefordshire & Worcestershire Combined Legal Services
Rachael Hayter	Director of AHP

Kate Haddigan	LGBTQ+ Network Vice Chair on behalf of Bec Harris LGBTQ+ Network Chair
Reena Rane	EmbRACE network (Chair)
Donna Scarrott	DAWN Network
Susan Smith	Deputy Chief Nursing Officer
This key document has been circulated to the chair(s) of the following committees / groups for comments:	
Integrated Safeguarding Committee	
Improving Safety Action Group (ISAG)	

10.4. Approval Process

Approval of this Policy will be via the Integrated Safeguarding Committee and Improving Safety Action Group (ISAG).

10.5. Version Control

Date	Amendment	Approved by:
10.06.2025	Full Policy rewrite and update. Inclusion of NHSE Guidance to support implementation of the Mental Capacity Act in Acute Trusts for adults with a learning disability.	Integrated Safeguarding Committee 29.07.2025 Chair Approval ISAG 02.09.2025

11. Supporting Document 1 – Equality Impact Assessment Form

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Deborah Narburgh

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	D Narburgh	Head of Safeguarding	deborah.narburgh@nhs.net
Date assessment completed	11.06.2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005
What is the aim, purpose and/or intended outcomes of this Activity?	The Mental Capacity Act (MCA), 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same

	rules apply whether the decisions are life-changing events or everyday matters. This Policy outlines the requirements of staff working within Worcestershire Acute Hospitals NHS Trust to ensure that care delivered is in accordance with the law and principles of consent to healthcare treatment requirements.			
Who will be affected by the development & implementation of this activity?	√ Service User √ Patient √ Carers Visitors		√ Staff ❑ Communities ❑ Other _____ ❑	
Is this:	√ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Detailed within reference list of Policy			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Detailed within Consultation			
Summary of relevant findings	Legal requirements supported by the MCA Code of Practice			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		Age applicable to clearly defined in law – 16yrs and above
Disability		x		Specific NHSE guidance for patients with a Learning Disability incorporated into the Policy as best practice guidance
Gender Reassignment		x		Policy applicable to all irrespective of gender reassignment. Process to be undertaken is person centred
Marriage & Civil Partnerships		x		Policy applicable to all post 16yrs. Decision making process clearly laid out

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		x		Policy applicable to all post 16yrs. Foetus remains classed as a limb of the mother until birth.
Race including Traveling Communities		x		Policy applicable to all post 16yrs
Religion & Belief		x		Policy applicable to all post 16yrs. Right to make what others may deem an unwise decision and exclusions clearly articulated within the legal framework.
Sex		x		Policy applicable to all post 16yrs
Sexual Orientation		x		Policy applicable to all post 16yrs
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Process for 16-17 years clearly defined within the Policy and supporting legal frameworks. Legal advice and support available. Where required, best interest guidance is provided to guide practice and conform to legal requirements. Deprivation of Liberty incorporated into Policy.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		Policy applicable to all persons 16yrs and above.

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		

How will you monitor these actions?	
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D Narburgh
Date signed	11.06.2025
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

12. Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
Other comments:		
[Insert comments here]		