Safeguarding Adults Executive Board

MCA Multi-Agency Audit Report

Evaluating Staff Compliance with the Mental Capacity Act (2005) and Code of Practice

Background

The Safeguarding Adults Executive Board (SAEB) published a Safeguarding Adults Review (SAR) in November 2022 in respect of 'Joan'. This Safeguarding Adult Review titled **'Joan's Legacy'** highlighted there was little recorded evidence of Joan's wishes and feelings within records across the organisations. Documentation frequently referred to 'best interests' decisions being made, but without decision-specific mental capacity assessments being completed.

In response to SAR Joan, The Learning & Development (L&D) Subgroup conducted a multi-agency audit to evaluate the practical application of the Mental Capacity Act (2005) and identify areas for improvement across the partnership

Safeguarding Adults Executive Board

MCA Multi-Agency Audit:
Assessing Staff Compliance Across All Partner Agencies

The Audit Team:

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- **Lynn Tan**, Mental Capacity Act Lead, Bi-Borough, Adult Social Care
- **Trish McMahon**, Business Manager, Bi-Borough, Safeguarding Adults Executive Board

The audit group included representatives from:

- Royal Brompton Hospital, Harefield Hospital, Guy's and St Thomas' NHS Foundation Trust
- Central London Community Healthcare NHS Foundation Trust
- Central and Northwest London NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Northwest London ICB
- Bi-Borough, Adult Social Care, Royal Borough of Kensington & Chelsea & Westminster City Council,
- Metropolitan Police
- Westminster Housing
- Imperial College Healthcare NHS Trust

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Mental Capacity Act 2005 - Overview

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The Mental Capacity Act 2005 (the Act) 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 capacity must have regard to the Mental Capacity Act.

- **The following statutory principles underpin this practice guidance and its procedures.**
- **Statutory principles of the Mental Capacity Act 2005** The core principles of the MCA 2005 are set out in s.1. They are:
- 1. A person must be **assumed** to have capacity unless it is established that they lack capacity.
- 2. A person is not to be treated as unable to make a decision unless **all practicable steps** to help him to do so have been taken without success.
- 3. A person is not to be treated as unable to make a decision merely because he makes an **unwise** decision.
- 4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**.
- 5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive** of the person's rights and freedom of action

Mental Capacity Act 2005 - Overview

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Capacity - The 3 questions

The Assessment: Stage 1 – is the person able to make the decision?

to **understand** the information relevant to the decision; or

➢ to **retain** that information; or

➢ to **use or weigh** that information as part of the process of making the decision; or

➢ to **communicate** his decision (whether by talking, using sign language or any other means).

The Assessment: Stage 2 – is there an impairment or disturbance in the functioning of the person's mind or brain?

The Assessment: Stage 3 – is the person's inability to make the decision because of the identified impairment or disturbance?

Mental Capacity Act 2005 -Overview

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Context of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- **The MCA** applies to all individuals working with or caring for adults who may lack the capacity to make specific decisions for themselves. Professionals must be aware of and act in accordance with the Act when making decisions or providing care.
- **Under Section 44 of the MCA,** a criminal offence was introduced for wilful neglect or ill-treatment of individuals who lack capacity. The Act also established the role of Independent Mental Capacity Advocates (IMCAs) to support individuals who lack capacity.
- The Act reformed previous statutory schemes, including Enduring Powers of Attorney and Court of Protection Receivers, and created the **Office of the Public Guardian (OPG)**. It set up a legal framework for Powers of Attorney and Court Deputies for decisions related to Property & Affairs and Personal Welfare. Additionally, the Act legally recognised Advance Decisions (living wills) and formalized the use of written statements.
- **The Deprivation of Liberty Safeguards (DoLS**), which came into force on 1st April 2009, provide a lawful framework for depriving an individual of their liberty in situations where they lack the capacity to consent to care or treatment. This may be necessary in care homes or hospitals, but only where it is deemed to be in the person's best interests and to protect them from harm.

Purpose and Aims

Safeguarding Adults Executive Board

This report outlines the key findings from five safeguarding cases involving mental capacity issues.

Its primary aim is to assess how effectively staff across agencies adhere to the Mental Capacity Act (MCA) and its Code of Practice when assessing mental capacity and making best interests decisions.

This audit examines the quality of decision-making within a multi-agency context, identifying strengths and areas for improvement to enhance practice.

The audit objectives :

- Evaluate the application of MCA principles in assessing mental capacity and making best interests' decisions across relevant agencies.
- Assess the effectiveness of decision-making in a multi-agency context.
- Identify strengths and areas where development and improvement are needed.
- Support further development and training needs across agencies.

Methodology and Audit Approach

Methodology

The group carefully selected 5 cases identified from safeguarding referrals concluded at the s42(2) stage between 1st April 2022 and 30th September 2023. These cases involved MCA components and multiple agencies and originated from mental health and acute Trusts

Audit Approach

Part 1 – Agencies/partners will be asked to complete audit tool in respect of each case they had involvement with.

Part 2 – from 12/01/2024, Agencies/Partners to take part in task and finish audit group for identified case (to run fortnightly until each case has been audited).

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MCA Multi-Agency Audit Tool Overview

Audit Tool designed to facilitate the auditing of cases involving the Mental Capacity Act (MCA) across multiple agencies, ensure that the principles of the Mental Capacity Act are upheld and that decisions made are in the best interest of the individuals involved.

- **Scoring System**: The toolkit used a scoring system to evaluate various aspects of the case, such as the quality of the mental capacity assessment and the best interest decision.
- **Mental Capacity Assessment**: Checks for evidence explaining why the MCA was carried out, whether the decision needed was clearly defined, and if the adult was supported to make decisions.
- **Best Interest Decision**: It ensures that the assessor made appropriate efforts to consider the person's wishes, consulted with others, involved the person, and considered less restrictive options.
- **Case Review**: It includes sections for recording the course of action, evidence used to make key decisions, multi-agency work, and the impact of the intervention.
- **Audit Findings and Recommendations**: The toolkit provides space for auditors to summaries their findings, identify areas of good practice, and suggest areas for development.

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Timeline

Ensuring Compliance and improving how we safeguard individuals and promote continuous quality improvement across the partnership through Time-Intensive but Essential Audits.

January to September 2024

The Audit

8 x individual case audit meetings

8 x panel meetings

October 2024

MCA Audit completed

Analysis and drafting of report / Learning Briefing by Audit Team & SAEB Team

November 2024

Final report to:

*Learning and Development Subgroup

*SAEB Chairs Group

for comment/feedback

***Finalisation of Report**

Dec 2024

Presentation to SAEB for review and agreement (Recommendations & Proposed Action)

Next Steps

*Plan webinar in Spring 2025 to share Learning

Objectives of the Audit

Assess the extent to which staff in all relevant agencies apply the principles of the Mental Capacity Act when assessing mental capacity and making best interests' decisions.

Establish the extent to which decision making is facilitated in a multi-agency context.

Establish the extent to which leadership responsibility is clear when making decisions in people's best interests.

Identify strengths and areas where development and improvement may be needed

Support further development and training needs

Share learning across agencies to improve practice and develop local activities.

Safeguarding Adults Executive Board

Overview of Selected Cases 1–5

1. **Domestic Abuse/Neglect**: Ms. A, an elderly woman with dementia, faced multiple safeguarding concerns after being discharged from the hospital. Her son frequently changed care agencies and refused temporary relocation for treatment. After a fall and further health issues, new safeguarding concerns emerged, including alleged neglect and abuse by her son.
2. **Psychological or Emotional Abuse**: Ms. B, living in a care home due to dementia and Parkinson's, experienced verbal and emotional abuse from her husband during a visit. The husband expressed hatred, made threats of physical harm, and verbally degraded her, leading to safeguarding procedures under Section 42.
3. **Cuckooing and Financial Abuse**: Mr. C, an elderly man with dementia, was financially exploited by local youths who coerced him into giving them money. His Lasting Power of Attorney arranged for his temporary relocation while long-term care arrangements were evaluated.
4. **Self-Neglect**: Mr. D, living in unsanitary conditions, repeatedly refused external support, leading to significant health risks. Social services initiated a safeguarding process and assigned a social worker to build rapport and reduce the risk of self-neglect.
5. **Self-Neglect**: Ms. E, a bariatric patient with complex healthcare needs, faced multiple safety concerns after a fall left her unable to move. Despite discussions, she continued using risky emollient creams, further complicating her health risks.

Case 1: Ms. A

Synopsis (Domestic Abuse/Neglect

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Background: Ms A, diagnosed with Dementia and CNS Lymphoma, had limited mobility and was bedbound. Her son, who did not live with her, was involved in managing her care.

Safeguarding Concern: Concerns were raised due to multiple care agency changes, failure to respond to skin breakdown notifications, son refused entry, missed visits, and bruising observed during a hospital admission.

Proposed Actions: A Mental Capacity Assessment was conducted, and due to safeguarding risks, an interim nursing home placement was proposed.

Interventions: Care plans were adjusted following hospital discharge. When access to Ms A was denied by her son, joint visits by GP and DN led to hospital admission and a safeguarding referral.

Challenges: Her son frequently disagreed with clinical advice, declined equipment and temporary relocation, and tried to remove Ms A from hospital against advice.

Outcome: Ms A was placed in a nursing home on 12 October 2022, where she remained.

Conclusion: This case emphasises the importance of coordinated safeguarding, capacity assessments, and professional boundaries when family members resist essential care.

Case 2: Ms. B

Synopsis (Psychological or Emotional Abuse)

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Background: Ms B was subject to domestic abuse by her partner, disclosed during contact with emergency services. She was hospitalised and later moved into care.

Safeguarding Concern: Risk of harm from her partner led to extensive safeguarding work and multiple Mental Capacity Act and DoLS processes related to contact and accommodation decisions.

Proposed Actions: A multi-agency plan was initiated to protect Ms B while respecting family dynamics. An IMCA was appointed to support her.

Interventions: Ms B underwent nine MCA assessments. She moved through various care homes, which impacted advocacy continuity due to jurisdictional changes.

Challenges: Frequent transitions disrupted advocacy and required repeated assessments. Balancing family rights with safety was complex.

Outcome: Ms B was placed in a long-term care home with controlled visitation by her partner. The safeguarding enquiry was concluded in March 2023.

Conclusion: The case illustrates how safeguarding against domestic abuse requires persistent, cross-agency collaboration and consistent application of the MCA and DoLS frameworks.

Case 3: Mr. C

Synopsis

(Cuckooing and Financial Abuse)

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Background: Mr C, an older adult with dementia, was exploited by local youths in a suspected case of cuckooing. AGE UK and police involvement prompted safeguarding action.

Safeguarding Concern: Mr C was subject to financial exploitation and repeated intrusions, with concerns that he could not protect himself or understand the risks involved.

Proposed Actions: A Section 42.2 enquiry was initiated, including collaboration with police, housing, and his Lasting Power of Attorney (LPA). Interim accommodation was arranged.

Interventions: A Care Act assessment and MCA were conducted. Case notes reflected Mr C's views, and person-centred engagement was documented.

Challenges: Mental capacity assessments were not clearly recorded for key decisions, and Best Interests decisions were missing from records.

Outcome: LPA organised and arrangements for private funded move to an interim placement until a decision was made about Mr. C's long-term residence and care and support.

Conclusion: The case demonstrates the value of joint working and a person-centred approach. However, it highlights the need for consistent documentation of capacity and Best Interests decisions.

Case 4: Mr. D

Synopsis (Self-Neglect)

Safeguarding Adults Executive Board

Background: Mr D lived in unsanitary conditions, resisted care, and was at high risk due to malnutrition, self-neglect, and falls. His LPAs were active in supporting him.

Safeguarding Concern: His living conditions, combined with physical deterioration and medication mismanagement, posed significant safeguarding concerns.

Proposed Actions: Interventions aimed to support Mr D at home, but a care home placement and possible Court of Protection involvement were considered if risks remained unmanaged.

Interventions: A Care Act assessment was completed. LPAs arranged for a deep clean and private care. Eventually, they facilitated a move to a care home, supported by ASC.

Challenges: Mr D repeatedly declined support, refused hygiene care, and rejected safety interventions like fall alarms.

Outcome: Mr D moved to a care home, and professionals supported his transition, including medication collection and clothing provision.

Conclusion: This case illustrates effective multi-agency and LPA-led safeguarding, while also identifying the need for clear MCA assessments, Best Interests documentation, and appropriate DoLS referrals.

5: Ms. E

Synopsis (Self-Neglect)

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Background: Ms E, a 55-year-old woman with complex health conditions and mobility limitations, lived alone in a third-floor flat. She received CHC funding for privately sourced care.

Safeguarding Concern: Due to her refusal of care and repeated termination of services by agencies (31 in total), she was at ongoing risk. Concerns were raised about her executive capacity and understanding of risk.

Proposed Actions: During a crisis, a hospital admission was planned. Despite being assessed as having capacity, concerns arose about her ability to weigh and use relevant information.

Interventions: Healthcare teams coordinated a complex hospital transfer due to environmental constraints. Ms E requested the move occur at night due to feelings of shame.

Challenges: Her behaviour towards staff was challenging, she consistently refused care, and the flat's location complicated emergency response.

Outcome: Ms E was hospitalised on 2 June 2023 following a fall. She went into cardiac arrest during evacuation and died two days later.

Conclusion: The case highlights the complexities of supporting adults with fluctuating or executive capacity issues. It calls for a review of MCA use, including assessing ability to use and weigh information in high-risk contexts.

Case Summaries

The tables below provide detailed insights into the audit findings and recommendations for each of the five selected cases.

Each table highlights

‘what was done well’ and

‘what could be improved’.

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Case 1: Domestic Abuse/Neglect -Ms. A, diagnosed with dementia

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What was done well	What could be improved
There was evidence of good joint working between the district nursing team and the GP, with clear awareness of roles and responsibilities.	Clear guidance and support are needed for staff when faced with situations where it is unclear whether they are addressing issues related to executive functioning or eccentric/unwise decisions. Distinguishing between the two is essential for ensuring that appropriate actions are taken under the Mental Capacity Act (MCA).
	Clarity is required regarding the legal threshold for involving external agencies and determining which agency should seek intervention from the Court of Protection.
Best interest decision-making meetings included all relevant professionals, ensuring an inclusive process.	Greater involvement from other agencies, such as housing, could have been beneficial in this case to ensure a holistic approach to the individual's needs.
	The presence of a General Practitioner (GP) at Multi-Disciplinary Team (MDT) meetings and Best Interest meetings should be emphasised, as GPs are likely to be the most consistently involved professionals in the individual's care and treatment.
Managerial oversight was evident, which was key in providing guidance to relatively new clinicians.	There was no evidence that staff used appropriate resources or materials to support the decision-making process. Alternative approaches and tools could have been explored to assist the individual in making decisions.
	Clear guidance on how to escalate concerns when a patient refuses to engage in the MCA process is necessary. This would help ensure that staff can appropriately address instances where individuals are unwilling to participate in decision-making about their care.
	Executive capacity was discussed at MDT meetings and with legal departments; however, the guidance provided was not adequately reflected in the case notes, indicating a need for clearer documentation and consistent application of legal principles.

Case 1: Domestic Abuse/Neglect
Ms. A, diagnosed with dementia

Finding 1 - Benefits of using MCA & BI templates: While most partner agencies have templates for MCA assessments and Best Interest decisions, there are inconsistencies in how these templates are used and documented. Some records merely state a lack of capacity without evidence of applying the five principles of the MCA or linking decisions to specific impairments affecting capacity (known as the Causative Nexus). This can result in defensive record-keeping practices, rather than a robust, evidence-based approach that considers the individual's ability to use or weigh relevant information in their decision-making process.

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Case 2: Psychological or Emotional Abuse—Ms B, living in a care home due to dementia	
What was done well	**What could be improved**
MCA assessments were decision-specific and consistently considered capacity on multiple occasions, not just as a one-off.	The terms used to clarify the decision on MCA assessment forms could have been clearer.
Advocates were sought from each Local Authority the individual moved to, ensuring their wishes and views were represented.	Advocacy services were inconsistent due to involvement from multiple Local Authorities
A Deprivation of Liberty (DoLS) was identified early, with a timely application for DoLS.	There was no routine check to determine whether the individual had registered a Lasting Power of Attorney (LPA).
A person-centred approach was maintained, with staff providing legally informed support.	
Strong MCA assessments and best interests' decisions were well-considered, evidence-based, and legally compliant.	

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Case 2: Psychological or Emotional Abuse
Ms B, living in a care home due to dementia

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Finding 2: To ensure effective implementation of the Mental Capacity Act (MCA), the following improvements are needed:

- Multi-agency collaboration is essential to manage shared risks effectively and ensure that all agencies involved are aligned in their approach to safeguarding and decision-making.
- Consistent advocacy services should be provided across all Local Authorities, ensuring individuals' wishes and preferences are consistently represented.
- Early identification of Deprivation of Liberty (DoLS) cases is critical to ensuring that individuals' rights are protected in line with the law.
- Person-centred approaches should be maintained to promote positive outcomes and ensure decisions are made in the best interests of the individual.
- Clear and defensible record-keeping must be practiced, ensuring that decisions are linked to impairments affecting capacity (Causative Nexus).
- MCA assessments should always be decision-specific and include careful consideration of whether individuals can use or weigh relevant information as part of the decision-making process.

These steps will help strengthen adherence to the MCA and ensure that safeguarding practices are both legally compliant and effective.

Case 3: Cuckooing and Financial Abuse: Mr. C, an elderly man with dementia	
What was done well	**What could be improved**
A Person-Centred approach was evidenced in the case notes and S42.2, with clear documentation of conversations with Mr. B and his wishes being central to decision-making. Good management oversight was provided throughout the process.	If there is reason to believe an individual may lack capacity to consent to safeguarding concerns, care, support, or a change of accommodation, a mental capacity assessment must always be conducted, and if necessary, a Best Interests decision should be made. No decision should be based on the assumption that a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) holds authority without verifying the documentation. The Office of the Public Guardian (OPG) provides a free service to confirm the validity of these powers and should be contacted for verification. Despite evidence presented, SA's friend continued to be treated as LPA without having the appropriate authority. There was no evidence of a Deprivation of Liberty Safeguard (DoLS) referral, which should have been considered. In cases involving a move to a care home or hospital, even for a short-term placement, a Standard Authorisation should have been sought before the move, regardless of whether the placement is interim.

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Case 3: Cuckooing and Financial Abuse
Mr. C, an elderly man with dementia

Finding 3: Verification of LPA and EPA Authority: To ensure compliance with legal safeguards, it is crucial to:

- Verify Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) claims through the Office of the Public Guardian (OPG) to confirm that only authorised individuals are making decisions, particularly regarding Best Interests decisions.
- Always seek a Deprivation of Liberty Safeguards (DoLS) Standard Authorisation before any planned moves to care settings, including short-term placements, to ensure that the person's rights are protected.
- Mental capacity assessments should be conducted whenever there is reason to believe that an individual may lack capacity to consent to decisions related to safeguarding, care, support, or accommodation changes.

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Case 4: Self-Neglect: Mr. D, living in unsanitary conditions, repeatedly refused external support, leading to significant health risks.

What was done well	What could be improved
A strong person-centred approach was evident; all agencies agreed on the least restrictive option, prioritising Mr. L's autonomy, dignity, and wishes. The principles of Making Safeguarding Personal were well applied. Mr. L, his advocates, and his family were actively involved in the process, ensuring decisions reflected his values and preferences while upholding his dignity and respect. There was clear evidence of multi-agency collaboration, with decision-making effectively coordinated between health professionals, GPs, and those with Lasting Power of Attorney (LPA) where verified	• When there is reason to believe a person may lack capacity to consent to safeguarding, care and support, or accommodation changes, a decision-specific mental capacity assessment should always be undertaken. Where capacity is lacking, a Best Interests decision should be made in line with the Mental Capacity Act (MCA). • There was no evidence that a Deprivation of Liberty Safeguards (DoLS) referral was made. In any situation involving a move to a care home or hospital—even for short-term or respite care—a Standard Authorisation must be sought in advance where the person lacks capacity and is deprived of their liberty.

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Case 4: Self-Neglect: Mr. D, living in unsanitary conditions, repeatedly refused external support, leading to significant health risks.

Finding 4: Record Keeping & Training needs: There is a need to improve the quality and consistency of documentation across all agencies, particularly in relation to Mental Capacity Act assessments, Best Interests decisions, and safeguarding procedures. In some cases, records lacked evidence that individuals' capacity was assessed in a decision-specific manner, including their ability to use and weigh relevant information. Additionally, DoLS processes were not always appropriately followed when required.

To address these gaps:

- Agencies should strengthen internal procedures for recording MCA decisions, especially where individuals are unable to make decisions about care, accommodation, or safeguarding.
- Ongoing multi-agency training is essential to reinforce legal duties under the MCA, DoLS, and safeguarding frameworks.
- All decisions must be clearly documented, legally defensible, and show how individuals' rights and freedoms have been respected through least restrictive and person-centred approaches.

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Case 5: Self-Neglect—Ms E, a bariatric patient with complex healthcare needs, faced multiple safety concerns in her flat

What was done well	What could be improved
• The MDT (Multi-Disciplinary Team) effectively came together during a crisis when there was a change in circumstances or capacity, showing responsiveness to changes in presentation. • A patient advocate was in place to ensure the patient's voice was heard, and no conversations happened without their involvement. • There was good evidence of joint assessment between District Nurses (DNs) with the GP in attendance, showing collaborative multi-agency working. • Capacity was considered and referenced whenever the patient declined interventions, indicating that mental capacity was factored into management plans. • Agencies sought early legal advice when concerned about the person's ability to understand and manage risks, ensuring lawful and proportionate responses.	• Staff require clearer guidance and support to distinguish between behaviours linked to executive dysfunction (i.e. inability to use or weigh information or follow through with decisions) and unwise or eccentric decisions made with capacity. This is critical to ensure decisions are not inappropriately dismissed or overlooked. • Clarity is required on the legal involvement threshold and which agency should approach the court of protection. • Other agencies, such as housing, could have been more involved in the case. • The presence of GPs at MDT and Best Interests meetings should be prioritised, as they are often the most consistently involved professionals in a person's ongoing care and can provide valuable clinical insights. • There was no evidence of materials or resources used by staff to support decision-making, and different ways could have been explored. • Clear escalation procedures are needed for situations where an individual refuses to engage with the Mental Capacity Act (MCA) assessment process, particularly in safeguarding contexts. • Although executive capacity was discussed at MDT and legal meetings, there was no documented evidence of how these discussions informed decision-making or outcomes, indicating a gap in record-keeping and application of guidance.

Case 5: Self-Neglect
Ms E, a bariatric patient with complex healthcare needs, faced multiple safety concerns in her flat

Finding 5 – Executive Capacity: Professionals must assess not only whether a person can understand, retain, and communicate a decision, but also whether they can use and weigh information and act upon their decision – this is critical when assessing executive capacity.

There is a risk of superficial assessments where individuals are deemed to have capacity based only on verbal interactions, without sufficient exploration of their ability to implement decisions or manage risks. To ensure lawful and person-centred practice:

- Staff should consult with others who know the person well,
- Review previous patterns of behaviour and documented risks,
- Document all assessments and rationale clearly, including any concerns around executive dysfunction.

This will support robust safeguarding, appropriate use of Deprivation of Liberty Safeguards (DoLS) where necessary and improved multi-agency working in complex cases.

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Case	Case Synopsis and Key Findings
1	**What was done well**: Strong collaboration between district nursing team and GP, Inclusive best interest decision-making meetings with managerial oversight. **What could be improved**: Clarify Executive Function vs. Mental Capacity: There is a need for clear, accessible guidance to support staff in distinguishing between issues of executive dysfunction (inability to act on a decision) and capacitous but unwise decisions. This distinction is critical for lawful and proportionate application of the Mental Capacity Act (MCA).
2	**What was done well**: Clear, decision-specific MCA assessments, early identification of Deprivation of Liberty Safeguards (DoLS) and evident person-centred approach. **What could be improved**: Improve clarity of MCA assessment forms, ensure consistent use of advocacy services and establish routine checks for lasting power of attorney (LPA).
3	**What was done well**: Demonstrated person-centred approach and good managerial oversight. **What could be improved**: Ensure consistency in mental capacity assessments, verify LPA/EPA (Lasting Power of Attorney/Enduring Power of Attorney) authority, make timely referrals for DoLS.
4	**What was done well**: Effective multi-agency collaboration and active involvement of advocates and families. Good example of person-centred approach and partnership working. **What could be improved**: Standardise mental capacity assessments and address gaps in referrals for DoLS.
5	**What was done well**: Robust multi-disciplinary team (MDT) collaboration. timely patient advocacy and early legal advice. **What could be improved**: Provide clear guidance on executive function and mental capacity, define thresholds for legal involvement e.g. Court of Protect (CoP), improved consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed and promote multi-agency approach

Audit Findings

1. **Benefits of using MCA & BI templates**: While most partner agencies have access to MCA and BI templates, documentation practices remain inconsistent. Some capacity assessments lack evidence of the five core principles of the MCA (2005), resulting in defensive rather than person-centred record-keeping. There is often insufficient demonstration of the causative nexus—i.e. the link between the individual's impairment and their inability to make a specific decision.

2. **Benefits of MCA having been accurately followed**: Effective implementation requires early identification of potential Deprivation of Liberty, consistent use of advocacy services, coordinated multi-agency input, and high-quality, legally sound documentation. Person-centred approaches improve outcomes and help safeguard individual rights.

3. **Verification of LPA and EPA Authority**: Where individuals claim to hold Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA), agencies must verify this through the Office of the Public Guardian (OPG) before any best interest decisions are made. In all cases involving moves to care settings (including respite), a Standard Authorisation under the Deprivation of Liberty Safeguards (DoLS) should be obtained prior to placement.

Audit Findings

4. **Record Keeping & Training**: There are significant gaps in documentation relating to MCA assessments and best interest decisions, particularly in relation to consent to care, safeguarding, changes in accommodation, and financial matters. All partner agencies would benefit from targeted training on the MCA, DoLS, executive capacity, and safeguarding responsibilities to improve lawful and effective practice.

5. **Executive Capacity**: Frontline staff require confidence and support to assess executive capacity – i.e. whether a person can not only make a decision but also act on it. There are risks associated with superficial assessments where capacity is presumed based only on verbal reasoning, without evaluating the person's ability to follow through. It is essential to consult those who know the individual well and to consider previous risk history and behaviour patterns when assessing executive function.

Key Recommendations for all SAEB Organisations

1. Mental Capacity Act 2005 (MCA) and Best Interests Templates

• Review and update all agency templates to ensure full integration of the five statutory principles of the MCA. Improve the quality of documentation by ensuring decisions are clearly linked to functional impairments affecting capacity (causative nexus).

2. Staff Adherence to the MCA 2005, Code of Practice, and Relevant Case Law

- Promote multi-agency identification of Deprivation of Liberty Safeguards (DoLS) cases and encourage early legal consideration.
- Embed person-centred planning, improve documentation, and align decision-making with legal duties under the MCA and DoLS framework.

3. Verification of Lasting Power of Attorney (LPA) and Enduring Power of Attorney (EPA) Authority

•Implement standard procedures for verifying LPA and EPA status via the Office of the Public Guardian (OPG). Ensure that no decisions are taken under assumed authority without formal verification, especially when making best interest decisions.

By adopting these measures, SAEB organisations can support person-centred approaches, uphold the principles of the MCA, and enhance the quality of practice across all agencies.

Safeguarding Adults Executive Board

Actions being taken forward by the SAEB Learning and Development Subgroup

Development of guidance on the Mental Capacity Act (MCA) in the form of either bite-size workshops or e-learning modules on:

1. Understanding Executive Capacity & Self Neglect
2. Enhancement of MCA Assessment and Best Interest decisions documentation.

Following implementation and evaluation of training and documentation improvements, all SAEB partner agencies will participate in an annual MCA Temperature Check to review compliance, identify gaps, and share learning.

Additional Guidance/Resources

The Social Care Institute for Excellence (SCIE) 'At a Glance Summary' presents a full overview of the Mental Capacity Act (MCA) 2005:

MCA 2005 At a Glance (SCIE)

Office of Public Guardian (OPG),

Mental Capacity Act 2005