NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Decision making and mental capacity

NICE quality standard

Draft for consultation

November 2019

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| **This quality standard covers** decision making for people aged 16 and over, using health and social care services who may lack capacity to make their own decisions (now or in the future). It aims to support implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice. It is not a substitute for these.**It is for** commissioners, service providers, social care, health and public health practitioners, and the public.This is the draft quality standard for consultation (from 6 November to 4 December 2019). The final quality standard is expected to publish in March 2020. |

# Quality statements

[Statement 1](#_Quality_statement_1:_1) People aged 16 and over who may lack capacity to make decisions receive support for decision making that reﬂects their individual circumstances and meets their particular needs.

[Statement 2](#_Quality_statement_2:) People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health and social care review.

[Statement 3](#_Quality_statement_3:_1) People aged 16 and over who are assessed as lacking capacity to make a decision have a clear record of the practicable steps taken to support them and the reasons why they lack capacity.

[Statement 4](#_Quality_statement_4:_1) People aged 16 and over who lack capacity to make a decision have their wishes and feelings reflected in best interest decisions made on their behalf.

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| NICE has developed guidance and a quality standard on people’s experiences using social care services, patient experience in adult NHS services and service user experience in adult mental health services (see the NICE pathway on [people’s experiences using social care service](https://pathways.nice.org.uk/pathways/peoples-experience-in-adult-social-care-services), [patient experience in adult NHS services](http://pathways.nice.org.uk/pathways/patient-experience-in-adult-nhs-services) and [service user experience in adult mental health services](http://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-services)) which should be considered alongside these quality statements.Other quality standards that should be considered when commissioning or providing services for people aged over 16 who may lack capacity to make decisions include:* [Learning disability: care and support of people growing older](https://www.nice.org.uk/guidance/qs187) (2019) NICE quality standard 187
* [Dementia](https://www.nice.org.uk/guidance/QS184) (2019) NICE quality standard 184.
* [Violent and aggressive behaviours in people with mental health problems](https://www.nice.org.uk/guidance/qs154) (2017) NICE quality standard 154
* [Transition from children’s to adults’ services](https://www.nice.org.uk/guidance/qs140) (2016) NICE quality standard 140
* [Learning disability: behaviour that challenges](https://www.nice.org.uk/guidance/qs101) (2015) NICE quality standard 101
* [Medicines management in care homes](https://www.nice.org.uk/guidance/qs85) (2015) NICE quality standard 85

A full list of NICE quality standards is available from the [quality standards topic library](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library).  |

# Quality statement 1: Supporting decision making

## Quality statement

People aged 16 and over who may lack capacity to make decisions receive support for decision making that reﬂects their individual circumstances and meets their particular needs.

## Rationale

People may need support with a range of decisions, including decisions about their care and treatment, financial matters and day-to-day living. To approach decision making in a way that is suitable to the person’s circumstances, the practitioner needs to understand what is involved in a particular decision, and which aspects of decision making the person may need support with and why. Support may include helping the person to communicate or remember information, giving them information in an accessible format, or helping them to understand and weigh up the information. It may also include involving significant and trusted people, independent advocates or specialist services, in line with the person’s needs and wishes.

## Quality measures

### Structure

a) Evidence of local policy and guidance about which interventions, tools and approaches should be used to support decision making for people aged 16 and over who may lack capacity to make decisions.

***Data source:*** Local data collection, for example evidence of providers implementing the tools and approaches in local practice.

b) Evidence of local arrangements to ensure that people aged 16 and over who may lack capacity to make decisions are supported to do so in a way that reﬂects their individual circumstances and meets their particular needs.

***Data source:*** Local data collection, for example evidence of an advocacy service or clinical specialists such as occupational therapists, psychologists or speech and language therapists being involved in supporting the decision-making process.

c) Evidence of local protocols to record practicable steps taken, to support people aged 16 and over who may lack capacity, during the decision-making process

***Data source:*** Local data collection, for example, from local protocols or recording templates.

### Process

Principles of supported decision making should be applied to all decisions made by people who may lack capacity. However, recording of the decision-making process should be proportionate to the decision being made. For measurement purposes, commissioners may wish to focus on decisions that have significant consequences.

1. Proportion of decisions made by a person aged 16 and over who may lack capacity where the decision-making process took into account their communication needs.

Numerator – the number in the denominator where communication needs of the person were taken into account.

Denominator – the number of decisions made by people aged 16 and over who may lack capacity.

***Data source:*** Local data collection, for example, local audit of patient records or care plans.

1. Proportion of decisions made by a person aged 16 and over who may lack capacity where the decision-making process involved their significant and trusted people in line with the person’s preferences.

Numerator – the number in the denominator where the decision-making process involved their significant and trusted people.

Denominator – the number of decisions made by a person aged 16 years and over who may lack capacity whose preference was to involve their significant and trusted people in the decision-making process.

***Data source:*** Local data collection, for example, local audit of patient records or care plans.

c) Proportion of decisions made by a person aged 16 and over who may lack capacity and had no significant or trusted people, that involved an advocate in line with the person’s preferences.

Numerator – the number in the denominator that involved an advocate in line with the person’s preferences.

Denominator – the number of decisions made by a person aged 16 and over who may lack capacity whose preference was to involve an advocate in the decision-making process.

***Data source:*** Local data collection, for example, local audit of patient records or care plans.

### Outcome

Proportion of people aged 16 and over who may lack capacity to make decisions, who feel supported to make their own decisions.

Numerator – the number in the denominator who feel supported to make their own decisions.

Denominator - the number of people aged 16 and over who may lack capacity to make decisions.

***Data source:***Local data collection, for example surveys for people aged 16 and over who may lack capacity to make decisions on their experiences of decision making in health and social care.

## What the quality statement means for different audiences

**Service providers** (such as community services, local authorities, private care providers, GPs and hospitals) develop local policy and guidance about which interventions, tools and approaches should be used to support decision making. They provide guidance on when to consult or instruct independent advocates and ensure that practitioners undergo training to help them apply the Mental Capacity Act 2005 and its Code of Practice. Training should be tailored to the role and responsibilities of the practitioner and cover new staff, pre-registration, and continuing development and practice supervision for existing staff.

**Health and social care practitioners** (such as social workers, care staff, GPs, doctors, nurses, allied health professionals and practitioners) take a personalised approach, accounting for any reasonable adjustments and the wide range of factors that can affect a person's ability to make a decision. They support effective communication using a range of tools such as inclusive communication, visual materials, visual aids, communication aids and hearing aids to enable people to take an active part in decision making. They also include significant and trusted people in supporting decision making, in line with the person’s preferences, and involve an advocate when needed.

**Commissioners** (such as local authorities, clinical commissioning groups and NHS England) commission services and training that require practitioners to apply the Mental Capacity Act 2005 and its Code of Practice. Specifically, they commission services that have arrangements for competency-based training and assessment of relevant communication skills as well as advocacy services that are available to people in need of support.

**People aged 16 and over who may need help with making decisions** are given support that is tailored to their own needs and circumstances. This might be helping them to communicate, or to understand information and what the different choices might mean for them. They may be given information in an ‘easy read’ or visual format. They may also have help from their family members or advocates when they need to make a decision.

## Source guidance

[Decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108) (2018) NICE guideline NG108, recommendations 1.2.4 and 1.2.11

## Definitions of terms used in this quality statement

### Reflecting individual circumstances and meeting particular needs

This should include understanding and taking account of:

* the person's physical and mental health condition
* the person's communication needs
* the person's previous experience (or lack of experience) in making decisions
* the involvement of others and being aware of the possibility that the person may be subject to undue influence, duress or coercion regarding the decision
* situational, social and relational factors
* cultural, ethnic and religious factors
* cognitive (including the person's awareness of their ability to make decisions), emotional and behavioural factors, or those related to symptoms
* the effects of prescribed drugs or other substances.

This knowledge should be used to develop a shared and personalised understanding of the factors that may help or hinder a person's decision-making, which can be used to identify ways in which the person's decision-making can be supported.

[NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), recommendation 1.2.4]

### Independent advocacy

Independent advocates can have a role in promoting social inclusion, equality and social justice and can provide a safeguard against the abuse of vulnerable people. Independent advocates take action to act to help people say what they want, secure their rights, represent their interests and obtain the services they need. Together with their provider organisations they work in partnership with the people they support and speak out on their behalf.

Independent advocates most likely to be involved in decision-making are independent mental capacity advocates (IMCAs) and independent mental health advocates (IMHAs).

[Adapted from NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), terms used in this guideline]

# Quality statement 2: Reviewing advance care plans

## Quality statement

People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health and social care review.

## Rationale

Advance care planning for people who are at risk of losing decision-making capacity or have fluctuating capacity enables them to exercise their autonomy as much as possible. It involves helping people to plan for their future care and support needs while they have capacity to make decisions. Reviewing advance care plans regularly enhances their utility and quality and ensures that the recorded wishes of the person stay valid, applicable and up to date.

## Quality measures

### Structure

Evidence of local arrangements to ensure that people aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, have ongoing opportunities to discuss their advance care plans while they have capacity.

***Data source:*** Local data collection, for example, from local protocols or recording templates.

### Process

a) Proportion of people aged16 and over who are at risk of losing capacity to make decisions, or have fluctuating capacity, who have an advance care plan.

Numerator – the number in the denominator who have an advance care plan.

Denominator – the number of people aged 16 and over who are at risk of losing capacity to make decisions or have fluctuating capacity.

***Data source:*** Local data collection, for example, local audit of individual care plans.

b) Proportion of people aged 16 and over who are at risk of losing capacity to make decisions, or have fluctuating capacity, having a health or social care review who have a documented discussion about advance care planning.

Numerator – the number in the denominator who have a documented discussion about advance care planning at their health or social care review.

Denominator – the number of people aged 16 and over who are at risk of losing capacity to make decisions or have fluctuating capacity having a health or social care review.

***Data source:*** Local data collection, for example, local audit of individual care plans.

### Outcome

Proportion of people aged 16 and over at risk of losing capacity to make decisions, or with fluctuating capacity, who feel supported to make decisions about their future care.

Numerator – the number in the denominator who feel supported to make decisions about their future care.

Denominator – the number of people aged 16 and over at risk of losing capacity to make decisions or with fluctuating capacity.

***Data source:*** Local data collection, for example, a survey of people with progressive illness such as dementia or mental health problems.

## What the quality statement means for different audiences

**Service providers** (such as community services, local authorities, private care providers, GPs and hospitals) ensure that systems are in place to support people to review their advance care plans regularly if they are at risk of losing their capacity to make decisions. Service providers also develop standard protocols and plans for joint working and sharing of information on advance care plans between practitioners, advocates, people and families and ensure that protocols and plans reflect the optional nature of advance care planning.

**Health and social care practitioners** (such as social workers, care staff, GPs, doctors, nurses, allied health professionals and practitioners) help people who are at risk of losing capacity to make decisions to continually review the decisions they have made about their future care and support. They provide the person with clear and accessible information to help them make these decisions. With the person’s consent, they involve carers, family, friends or advocates in regular reviews of advance care plans.

**Commissioners** (such as local authorities, clinical commissioning groups, NHS England) develop standard protocols and plans for joint working and sharing of information on advance care plans between practitioners, advocates, people and families. They ensure that protocols and plans reflect the fact that people have a choice about whether and how to participate in advance care planning. They commission training on advance care planning, including advance decisions to refuse treatment and lasting power of attorney. They also demonstrate that protocols are in place and training is available by including advance care planning in their performance monitoring frameworks.

**People aged 16 and over who may not be able to make decisions in the future** are helped to develop a plan that sets out their preferences for their future care, called an ‘advance care plan’. They can update their advance care plan every time their treatment or support is reviewed.

## Source guidance

[Decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108) (2018) NICE guideline NG108, recommendation 1.3.15

## Definitions of terms used in this quality statement

### Advance care planning

Advance care planning with people who may lack mental capacity in the future is a voluntary process of discussion about future care between the person and their care providers. If the person wishes, their family, friends, legal representative or advocate may be included in the discussion. With the person's agreement this discussion is documented, regularly reviewed and communicated to key persons involved in their care.

[NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), terms used in the guideline].

# Quality statement 3: Assessing capacity

## Quality statement

People aged 16 and over who are assessed as lacking capacity to make a decision have a clear record of the practicable steps taken to support them and the reasons why they lack capacity.

## Rationale

Having mental capacity involves being able to make a particular decision at the time it needs to be made. To lack capacity within the meaning of the Mental Capacity Act 2005, a person must be unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. The assessment of capacity must show how this impairment or disturbance prevents the person from being able to understand the relevant information, retain it for long enough to make the decision, weigh up the important information or communicate their decision. Lack of capacity can only be established if everything practicable has been done to support the person to have capacity.

## Quality measures

### Structure

a) Evidence of local protocols to ensure mental capacity assessments are collaborative, person centred, thorough and aligned with the Mental Capacity Act 2005 and its Code of Practice.

***Data source:*** Local data collection, for example an audit of the quality of mental capacity assessments.

b) Evidence of local arrangements to ensure that assessors can seek advice from people with specialist knowledge to help them assess whether there is evidence that the person lacks mental capacity.

***Data source:*** Local data collection, for example, service level agreements and partnership arrangements between services.

### Process

a) Proportion of mental capacity assessments of people aged 16 and over that state the person lacks capacity to make a decision with a record of the practicable steps taken to support them with decision making.

Numerator – the number in the denominator with a record of the practicable steps taken to support the person with decision making.

Denominator – the number of mental capacity assessments of people aged 16 and over that state the person lacks capacity to make a decision.

***Data source:*** Local data collection, for example local audit of patient records or individual care plans.

b) Proportion of mental capacity assessments of people aged 16 and over that state the person lacks capacity with a record of the reasons why they lack capacity to make a decision.

Numerator – the number in the denominator with a record of the reasons why the person lacks capacity to make a decision.

Denominator - the number of mental capacity assessments of people aged 16 and over that state the person lacks capacity to make a decision.

***Data source:*** Local data collection, for example, local audit of patient records or individual care plans.

## What the quality statement means for different audiences

**Service providers** (such as community services, local authorities, private care providers, GPs and hospitals) monitor and audit the quality of mental capacity assessments, taking into account the degree to which they are collaborative, person centred, thorough and aligned with the Mental Capacity Act 2005 and its Code of Practice. They include people's views and experiences in data collected for monitoring an organisation's mental capacity assessment activity.

**Health and social care practitioners** (such as social workers, care staff, GPs, doctors, nurses, allied health professionals and practitioners) take a collaborative approach to assessing capacity when possible, working with the person to produce a shared understanding of what may help or hinder their communication and decision making. They also record the practicable steps they or other parties have taken to help the person make a decision for themselves, whether the person has capacity to make the decision and, if the person is assessed as lacking capacity, why the practitioner considers the decision they have made to be incapacitous as opposed to unwise. They record what impairment or disturbance of the mind or brain has been identified and the reasons why the person is unable to make a decision.

**Commissioners** (such as local authorities, clinical commissioning groups, NHS England) ensure that they commission services that follow the principles and requirements of the Mental Capacity Act 2005 and assume capacity unless it is established that the person lacks capacity. They commission necessary training to facilitate person-centred capacity assessments aligned with the Mental Capacity Act. They also ensure that people have access to advocacy services and that assessors have access to people with specialist condition-specific knowledge, such as clinical psychologists or speech and language therapists, to help them assess the person’s mental capacity.

**People aged 16 and over who have an assessment of their mental capacity to make a decision** havean assessor who knows them well enough to talk to them easily. The assessor can explain what is involved in the decision and find out what the person’s preferences are. If the assessor decides that the person is not able to make this decision, they write down why they decided that. They also write down the person’s preferences so that these can be taken into account when the decision is made.

## Source guidance

[Decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108) (2018) NICE guideline NG108, recommendations 1.4.27 and 1.4.28

## Definitions of terms used in this quality statement

### Mental capacity

The concept of capacity under the Mental Capacity Act 2005 is relevant to many decisions including care, support and treatment, financial matters and day-to-day living. Capacity is decision-specific, and an individual is assumed to have capacity unless, on the balance of probabilities, proven otherwise. To lack capacity within the meaning of the Mental Capacity Act 2005, a person must be unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. The inability to make a decision must not be due to other factors, for example because of undue influence, coercion or pressure, or feeling overwhelmed by the suddenness and seriousness of a decision.

A lack of capacity can only be established if the condition prevents the person from understanding or retaining information about the decision, using or weighing it or communicating their decision. It cannot be established unless everything practicable has been done to support the person to have capacity, and it should never be based on the perceived wisdom of the decision the person wishes to make.

[NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), section 1.4 on assessment of mental capacity]

### Practicable steps

'Practicable steps' links to principle 2 of the Mental Capacity Act (and Chapter 3 of the Code of Practice), which states that 'all practicable steps' should be taken to help a person make a decision before being treated as though they are unable to make the decision. There are obvious steps a person might take, proportionate to the urgency, type and importance of the decision including the use of specific types of communication equipment or types of languages such as Makaton or the use of specialist services, such as a speech and language therapist or clinical psychologist. Practicable steps could also involve ensuring the best environment in which people are expected to make often life-changing decisions – for example giving them privacy and peace and quiet, or ensuring they have a family member or other trusted person to provide support during decision-making, if this is their wish.

[NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), terms used in this guideline]

# Quality statement 4: Best interests decision making

## Quality statement

People aged 16 and over who lack capacity to make a decision have their wishes and feelings reflected in best interest decisions made on their behalf.

## Rationale

When a person lacks capacity to make a decision, all actions and decisions taken by practitioners must be in the person’s best interests. The person should be placed at the heart of the decision-making process. Wherever possible this means talking to the person about their wishes and feelings and supporting them to be involved in the decision-making process. It also means using information included within the advance care plans, consulting with the person’s family, carers and advocates and seeking to establish the person’s wishes, preferences and values.

## Quality measures

### Structure

a) Evidence of local protocols to ensure that best interests decisions are being made in line with the Mental Capacity Act 2005.

***Data source:*** Local data collection, for example an audit of the best interest decision-making processes.

b) Evidence of systems and protocols that support practitioners to identify and locate any relevant written statement made by the person when they had capacity, at the earliest possible time.

***Data source:*** Local data collection, for example service level agreements and partnership arrangements between services.

### Process

a) Proportion of best interest decisions made on behalf of people aged 16 and over that involved the person in the best interest decision-making process where it was appropriate.

Numerator – the number in the denominator that involved the person in the best interest decision-making process where it was appropriate.

Denominator – the number of best interest decisions made on behalf of people aged 16 and over where it was appropriate to involve them.

***Data source:*** Local data collection, for example audit of notes from health and social care best interest decision meetings.

b) Proportion of best interest decisions made on behalf of people aged 16 and over that involved carers, family, friends or advocates in the best interest decision-making process where it was appropriate.

Numerator – the number in the denominator that involved carers, family, friends or advocates in the best interest decision-making process where it was appropriate.

Denominator – the number of best interest decisions made on behalf of people aged 16 and over where it was appropriate to involve them.

***Data source:*** Local data collection, for example audit of best interest decisions taken on behalf of people using health and social care services.

### Outcome

Proportion of best interest decisions made on behalf of people aged 16 and over who lack mental capacity to make a decision that reflect wishes, values and preferences recorded in advance care plans.

Numerator – the number in the denominator that reflect wishes, values and preferences recorded in advance care plans.

Denominator - the number of best interest decisions made on behalf of people aged 16 and over who lack mental capacity to make a decision.

***Data source:*** Local data collection, for example local audit of patient records or individual care plans.

## What the quality statement means for different audiences

**Service providers** (such as local authorities, private care providers, GPs, hospitals and community services) ensure that best interests decisions are being made in line with the Mental Capacity Act 2005. They implement processes and protocols, and provide toolkits, to support staff to carry out and record best interests decisions. They also have clear systems in place to support practitioners to identify and locate any relevant written statement or advance care plan made by the person when they had capacity.

**Health and social care practitioners** (such as social workers, care staff, GPs, nurses, allied health professionals and practitioners) are responsible for deciding what course of action would be in the person's best interests. They ensure that any best interests decision made reflects the person’s wishes, values and preferences unless it is not possible or appropriate to do so, such as in an emergency. They use a range of approaches to gather information about the person informally as well as through formal meetings. They work with carers, family and friends, advocates, attorneys and deputies, to find out the person's values, beliefs, wishes and preferences in relation to the specific decision and to understand the person's decision-making history.

**Commissioners** (such as local authorities, clinical commissioning groups, NHS England) ensure that they commission services in which decisions are being made in line with the Mental Capacity Act 2005. They ensure that people aged 16 and over who lack capacity remain involved in the decision-making process and seek to establish the person’s wishes, preferences and values.

**People aged 16 and over who are not able to make decisions** are involved as much as possible when decisions are made about their care and support. Health and social care staff use the information they have about the person’s wishes and feelings to make sure that decisions made on the person’s behalf are what they would want.

## Source guidance

[Decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108) (2018) NICE guideline NG108, recommendations 1.5.6 and 1.5.14

## Definitions of terms used in this quality statement

### Best interest decision

When a person does not have capacity to make a decision, all actions and decisions taken by practitioners, or their attorney or court appointed deputy must be done or made in the person's best interests. Any advance statements expressing the individual's views about the decision in question should be taken into account and given appropriate weight. Health and social care organisations should provide toolkits to support staff to carry out and record best interests decisions. These toolkits should include:

* how to identify any decision-making instruments that would have an impact on best interests decision making occurring (for example a lasting power of attorney, advance decisions to refuse treatment, court orders)
* when to instruct an independent mental capacity advocate
* a prompt to consult interested parties (for example families, friends, advocates and relevant professionals) and a record of who they are
* guidance about recording the best interests process and decision. This may include, for example, a balance sheet, which may assist in documenting the risks and benefits of a particular decision
* instructions on what information to record, ensuring this covers:
	+ a clear explanation of the decision to be made
	+ the steps that have been taken to help the person make the decision themselves
	+ a current assessment concluding that the person lacks the capacity to make this decision, evidencing each element of the assessment
	+ a clear record of the person's wishes, feelings, cultural preferences, values and beliefs, including any advance statements
	+ the concrete choices that have been put to the person
	+ the salient details the person needs to understand
	+ the best interests decision made, with reasons.

[NICE’s guideline on [decision-making and mental capacity](https://www.nice.org.uk/guidance/ng108), section 1.5 on best interests decision making]

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See [quality standard advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard’s webpage](https://www.nice.org.uk/guidance/indevelopment/gid-qs10127).

This quality standard will be included in the NICE Pathway on [decision making and mental capacity](https://pathways.nice.org.uk/pathways/decision-making-and-mental-capacity), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

* people being enabled to make decisions about their own lives
* people being enabled to participate as fully and effectively as possible in a decision made in their best interests
* dignity, human rights and rights under the Mental Capacity Act 2005
* independence and social inclusion.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

* [Adult social care outcomes framework](https://digital.nhs.uk/data-and-information/publications/ci-hub/social-care)
* [NHS outcomes framework](https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework)
* [Public health outcomes framework for England](https://www.gov.uk/government/collections/public-health-outcomes-framework).

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact statement](https://www.nice.org.uk/guidance/ng108/resources) for the source guidance to help estimate local costs.

## Diversity, equality and language

During the development of this quality standard, equality issues were considered and [equality assessments](https://www.nice.org.uk/guidance/indevelopment/gid-qs10127/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN:

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