Blackpool Clinical Commissioning Group
Fylde and Wyre Clinical Commissioning Group

FYLDE COAST CLINICAL COMMISSIONING GROUPS

MENTAL CAPACITY ACT 2005

POLICY

DOCUMENT CONTROL

Policy Title:		Mental Capacity Act 2005 Policy
Purpose:		The purpose of the Mental Capacity Act 2005 (MCA)[1] for CCGs is in relation to a commissioner's duties to ensure provider services are delivered in accordance with the MCA 2005 framework and that the rights of those who use services are promoted and protected. NHS Fylde and Wyre and Blackpool CCGs have responsibility for commissioning high quality care and treatment and needs to ensure commissioners and providers understand the legal framework and its supporting Code of Practice to ensure this is embedded through its commissioning arrangements whilst monitoring compliance through the safeguarding standards and the CCG's contract management process.
Supersedes:		
This policy applies to:		All employees within FWCCG and BCCG including employees on temporary or fixed terms contracts. It does not apply to contractors or self-employed consultants.
Circulation:		All employees
Policy Area:		Corporate
Version No:		1
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FWCCG	**Date approved / by:**	8/10/19 - Quality Improvement and Engagement Committee
	Date ratified / by:	5/11/19 - Governing Body
	Effective Date:	November 2019
BCCG	**Date approved / by:**	8/10/19 - Quality Improvement and Engagement Committee
	Date ratified / by	5/11/19 - Governing Body
	Effective Date:	November 2019
Review Date:		November 2020

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1. POLICY STATEMENT

NHS Fylde and Wyre and Blackpool Clinical Commissioning Groups (CCGs) aspire to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources.

The purpose of the Mental Capacity Act 2005 (MCA) for CCGs is in relation to a commissioner's duties to ensure provider services are delivered in accordance with the MCA 2005 framework and that the rights of those who use services are promoted and protected. NHS Fylde and Wyre and Blackpool CCGs have responsibility for commissioning high quality care and treatment and needs to ensure commissioners and providers understand the legal framework and it's supporting Code of Practice to ensure this is embedded through its commissioning arrangements whilst monitoring compliance through the safeguarding standards and the CCG's contract management process.

NHS Fylde and Wyre and Blackpool CCGs will ensure:

- The MCA 2005 is given a high profile and priority within the NHS Fylde and Wyre CCG and Blackpool CCG.
- Compliance with the Act. How this will be achieved is a key part of the tendering process through the commissioning and procurement cycle by working with NHS Fylde and Wyre and Blackpool CCG children and adult commissioners.
- Ongoing compliance is monitored through the safeguarding standards, audits and assurance visits to provider organisations.

2. INTRODUCTION

NHS Fylde and Wyre and Blackpool Clinical Commissioning Groups, (henceforth referred to as "the CCGs"), as with all other NHS bodies, have a statutory duty to ensure that they make arrangements to safeguard and promote the welfare of young people and vulnerable adults as the MCA legal framework applies to people aged 16 years and over. This policy details the safeguarding arrangements that must be in place to ensure the CCGs fulfil their statutory duties and responsibilities. The MCA (2005) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves, or have the capacity and want to make decisions for a time when they may lack capacity in the future. The Act covers a wide range of decisions made and actions taken on behalf of people who may lack capacity to make specific decisions for themselves.

In discharging these statutory duties/responsibilities account must be taken of:

- HM Government (2014) The Care Act
- The Children Act (1989 and 2004)

- DH (2017) Care and Support Statutory Guidance
- NHS England (July 2019) Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework
- HM Government (2018) Working Together to Safeguard Children
- DH, DfE (March 2015) Statutory Guidance on Promoting the Health and Well-being of Looked After Children
- Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice
- DH 2011 Safeguarding Adults: The Role of Health Services
- The policies and procedures of the Childrens Safeguarding Assurance Partnership and Lancashire Safeguarding Adults Board (LSAB) and Blackpool Safeguarding Adults Board (BSAB).
- HM Government (2011) Prevent Strategy
- Mental Capacity Act (2005) including 2011 amendments
- Royal College Paediatrics and Child Health et al (2019) Intercollegiate Document for safeguarding adults supported by the Department of Health Adult Safeguarding: Roles and Competencies for Health Care Staff

3. AIMS

The policy aims to ensure that no act of commission or omission on behalf of the CCGs as commissioning organisations or by a service they commission puts a service user at risk of abuse or neglect and that robust systems are in place to safeguard and promote the welfare of young people and adults at risk under the MCA 2005. The policy reinforces the organisational philosophy that safeguarding and mental capacity is everybody's business and that all staff should respond and act to raise safeguarding awareness and address emerging issues.

The policy details the roles and responsibilities of the CCG as a commissioning organisation and of its employees, directly or indirectly employed.

To support the implementation of this policy a set of contractual safeguarding standards have been developed by the CCGs which includes safeguarding standards around MCA 2005 arrangements. These standards form part of the contractual arrangements with all commissioned services and are audited at a minimum annually to ensure that service users are protected from abuse and the risk of abuse.

4. PRINCIPLES

This policy demonstrates that the CCGs recognise that safeguarding young people and adults with care and support needs is a shared responsibility with the need for effective joint working between agencies and professionals that have different roles and expertise if those vulnerable groups in society are to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- A commitment of chief officers, senior managers and board members to seek continuous improvement with regards to safeguarding and MCA 2005 both within the work of the CCGs and of services commissioned.
- Clear lines of accountability within the CCGs for work on safeguarding and the MCA 2005.
- Clear policies setting out their commitment and approach to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with young people and adults as appropriate where they lack capacity to keep themselves safe from harm and exploitation.
- Service developments that take account of the need to safeguard all service users, and are informed, where appropriate, by the views of service users.
- Staff training and continuing professional development including appropriate supervision and support for staff so that staff have an understanding of their roles and responsibilities in relation to implementing MCA 2005.
- Effective interagency working including effective information sharing.

5. DEFINITIONS

Abbreviation	Acronym
Mental Capacity Act	MCA
Mental Health Act	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	CoP
Lasting Power of Attorney	LPA
Deprivation of Liberty Safeguards	DoLS
Liberty Protection Safeguards	LPS

The **Mental Capacity Act 2005 (MCA)** is the statutory framework for acting and making decisions on behalf of individuals over 16 years old who lack the capacity to make particular decisions for themselves or who have the capacity and want to make preparations for a time when they may lack capacity in the future.

Deprivation of Liberty Safeguards (DoLS) is an amendment to the MCA 2005. They apply in England and Wales only. The MCA framework allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS).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 be asked if a person can be deprived of their liberty.

Consent is the voluntary and continuing permission of the person to the intervention or decision in question. It is based on adequate knowledge and understanding of the purpose, nature, likely effects and risk of that intervention or decision, including the likelihood of success of that intervention and any alternative to it. Permission given under any unfair or undue pressure is not consent.

Decision Maker is anyone who is making welfare or health decisions on behalf of another person. This can be a carer or a relative who makes decisions about everyday matters. More serious decisions should be made by people in more senior roles. Decisions regarding a change of accommodation should be made by the multi- disciplinary team.

Independent Mental Capacity Advocate (IMCA) this is a type of advocacy introduced by the MCA 2005.The IMCA helps vulnerable people to make important decisions about serious medical treatment and changes in accommodation and who have no family or friends that would be appropriate to consult about these decisions**.**

Restraint is the use of threat or force and may be disproportionate or unlawful. This will also apply to people who are deprived of their liberty.

Enduring Power of Attorney (EPA) is the legal authorisation to act on someone else's behalf. This has now been replaced by the LPA but if in place before 2007 is still legally viable.

Lasting Power of Attorney (LPA) enables an individual to grant authority to one or more persons to make decisions on their behalf in relation to health, welfare, property or financial matters specified in the LPA document. These powers can include giving or refusing consent to medical examination and/or treatment as specified in the LPA.

Covert Medication involves the administration of medication in a disguised form for example in food or drink when a person is refusing treatment necessary for their physical or mental health. The patient lacks capacity in relation to the planned intervention.

Mental Health Act (MHA) was first introduced in 1983 (further amendment in 2007) and sets out how you can be treated if you have a mental disorder. It affects those over 18 years old.

The Mental Capacity Act (2005) Code of Practice defines mental capacity as:

'A person who lacks capacity to make a particular decision or take a particular action for themselves at a time the decision or action needs to be taken'.

The policy endeavours to ensure that NHS Fylde and Wyre and Blackpool CCGs employees who have responsibility for delivering direct patient care meet their statutory responsibilities under the care Act

The Deprivation of Liberty Safeguards (DoLS, 2009) is an amendment to the Mental Capacity Act 2005 and only applies to those over the age of 18. (Please note that Royal Assent has been given to the DoLS replacement bill which will replace this legislation – the new Liberty Protection safeguards will apply to 16 and 17 year olds as well as those 18 and over).

Code of Practice

There is a code which provides practitioners with guidance in relation to decisions made under the MCA. This is Mental Capacity Act Code of Practice (2007).

(NB In light of changes in interpretation of MCA through Case Law, and lessons learned through practical use of the Code of practice over the past years, revision of the Code of Practice is underway. Practitioners are advised to use the current code with caution).

6. ROLES AND RESPONSIBILITIES OF THE CCG

The MCA is particularly relevant for the work of CCG in the following areas;

- CCG commissioned services
- CCG primary funder responsibilities for individually funded care contracts (for example, Continuing Healthcare or MHA Section 117 aftercare)
- Community partner responsibilities as a key statutory body

Refer to National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (revised) Para 320 – 322. The document incorporates the NHS Continuing Healthcare Practice Guidance.

Commissioned services

The CCGs have a responsibility in ensuring services they commission are MCA compliant through the commissioning cycle. As a basis, all commissioned services need to demonstrate that they have in place a

- Mental Capacity Act Lead
- Mental Capacity Act Policy
- Staff trained in principles sets out in Mental Capacity Act 2005 at level commensurate to their roles and responsibilities.

The NHS England MCA Guide for CCG's (2014) sets out in more detail what assurance CCG's should reasonably expect to see from hospitals and other services providing care to people aged over 16, and who lack capacity to consent to some or all of their care and treatment.

Chief Officer

The ultimate accountability for safeguarding and the MCA 2005 sits with the Chief Officer for the CCGs. Any failure to have systems and processes in place to protect young people and adults at risk in the commissioning process, or by the providers of

commissioned services would result in failure to meet statutory and non-statutory constitutional and governance requirements.

The CCGs must ensure that robust arrangements are in place to demonstrate compliance with safeguarding responsibilities. This includes:-

- A clear line of accountability for safeguarding reflected in governance arrangements.
- Establishing and maintaining good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commissioning services ensuring that all service users are protected from abuse and neglect.
- Having in place clear policies setting out the commitment and approach to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with young people and adults as appropriate.
- Supporting improvements in the quality of safeguarding practice across primary medical care.
- Ensuring the MCA 2005 plays an integral role in all parts of the commissioning cycle, from procurement to quality assurance.
- Seeking assurance from all commissioned services, both NHS and independent healthcare providers, to ensure continuous improvement and to demonstrate compliance with statutory MCA 2005 duties.
- Ensuring staff are trained in recognising and reporting MCA 2005 issues, have access to appropriate supervision, and are competent to carry out their roles and responsibilities.
  Effective inter-agency working with the local authority, the police and third sector organisations which includes appropriate arrangements to co-operate with the local authority in the operation of Lancashire Children's Safeguarding Assurance Partnership, Lancashire Safeguarding Adult Board (LSAB) and Blackpool Safeguarding Adults Board (BSAB).
- Having an Adult Safeguarding Lead and Mental Capacity Act Lead; supported by relevant policies and training.
- Effective systems for responding to abuse and neglect.
- Effective arrangements for information sharing.
- Supporting the development of a positive learning culture across partners for safeguarding adults to ensure that organisations are not unduly risk adverse.

Chief Nurse / Executive Board Lead with responsibility for safeguarding

- Ensures that the CCGs have management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding young people and adults with care and support needs under MCA 2005.
- Ensures that service plans/specifications/contracts/invitations to tender etc. include reference to the standards expected for safeguarding young people and adults with

care and support needs under MCA 2005 and Deprivation of Liberty Safeguards.

- Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding and MCA 2005 responsibilities are reflected in all job descriptions.
- Ensures that staff in contact with children and or adults in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

The CCG Safeguarding Team (Designated and Professional Leads for Safeguarding and Mental Capacity Act)

Designated leads will work across the local health system to support other professionals in their agencies on all aspects of safeguarding:

- To ensure the CCGs meet the requirements of the Mental Capacity Act (MCA), including Deprivation of Liberty Safeguards (DoLS).
- To ensure that safeguarding young people children and adults with care and support needs is an integral part of the CCG's clinical governance framework.
- To promote, influence and develop safeguarding training – on a single and inter-agency basis - to meet the training needs of staff.
- To provide clinical advice on the development and monitoring of the safeguarding aspects contracts/service specifications under MCA 2005.
- To provide a health perspective into single and multi-agency learning reviews.
- To fulfil the role of the Nominated Senior Officer where there is an allegation against a person who works with young people/adults with care and support needs; including, ensuring the CCGs operate within Local Safeguarding Boards policies and procedures; to provide a coordinating role in these instances, resolving any interagency issues that may arise and liaising with the Safeguarding Boards as necessary.
- To provide advanced expert knowledge and advice on safeguarding young people and adults under the MCA 2005 to a wide range of professional groups and organisations/agencies and where necessary taking responsibility for the oversight of complex cases.
- To undertake designated safeguarding functions as outlined in the accountability and assurance framework for safeguarding adults and MCA 2005.

Line Managers

- To understand the MCA 2005 policy and the commitment of the CCGs to ensure all staff are supported to maintain training and awareness.
- To conduct regular reviews of the standards required for each role. A full re-assessment will be required if changes are made to the duties of the role which warrant a new and different level of employment check or training requirement (e.g. if the post holder takes on new duties involving children or adults at risk of harm or abuse).

Individual Staff Members

- To be alert to the potential indicators of abuse or neglect for young people and adults where they lack mental capacity to keep themselves safe and know how to act on those concerns in line with local guidance.
- To undertake training in accordance with their roles and responsibilities as outlined by the CCG safeguarding training framework and those of the Childrens Safeguarding Assurance Partnership and Adult Boards so that they maintain their skills and are familiar with procedures aimed at safeguarding young people and adults at risk under the MCA 2005.
- Understand the principles of confidentiality and information sharing in line with local and government guidance.
- To contribute, when requested to do so, to the multi-agency meetings established to safeguard young people and adults at risk.

Managing Safeguarding Concerns under the Mental Capacity Act

If an employee of either CCG has concerns that a young person aged 16 year and above or adult is at risk of harm they should notify their line manager and or a member of the CCG Safeguarding Team (See Fylde Coast CCGs Safeguarding Childrens and Adults policy). If no member is available to speak to a referral should be made to the Local Authority, for Lancashire or Blackpool as per local policies and procedures. Refer to the Fylde Coast CCGs safeguarding Children and Adults Policy for further reference and contact details.

Governance Arrangements/ CCG Quality and Safety Committee

To ensure that safeguarding is integral to the governance arrangements of the CCG the Safeguarding Team will report bi-monthly to Safeguarding Assurance Group (SAG) which is a sub-group to the CCGs joint Quality Improvement and Engagement Committee. The purpose of the report is to provide assurance on the effectiveness of the safeguarding and MCA arrangements in place across the organisation and within commissioned services; to ensure that the CCG is kept informed of national and local initiatives for safeguarding and MCA; and to brief the CCGs on learning from reviews and audits that are aimed at driving improvements to safeguard young people and adults with care and support needs.

In addition to the reporting arrangements above an annual safeguarding report will be submitted to the Governing Body with exception reporting on issues of significance e.g. Serious Case Review and Safeguarding Adult Reviews reports, inspections' findings and learning lessons.

Mental Capacity Act Training

The CCGs are committed to have arrangements in place to ensure effective training of relevant staff to ensure that all CCG employees have MCA training and competencies appropriate to their role and responsibly.

Support, supervision and mentorship will be provided for safeguarding leads within the CCGs as appropriate and identified through personal development needs and appraisal.

The CCGs have responsibility to ensure that any system and process that includes decision making around individual patient activity (e.g. funding panel) clearly demonstrates compliance with the MCA. This includes ensuring that assessment of capacity is documented relating to the specific decision and any following decision is documented in line with the best interest process.

Mental Capacity and young people

Many aspects of the Mental Capacity Act apply to people aged 16 and over who may lack capacity to make a specific decision (for more information see chapter 12 MCA Code of Practice). However the legislative framework for those cared for under The Children's Act (1989) will continue to apply until they are discharged from such care proceedings.

There are two elements of the act than can be applied to young people under the age of 16:

- Decisions about property or finance made by the Court of Protection
- Offences of ill treatment and wilful neglect

For young people aged 16 and 17 the capacity assessment must be used to determine whether the healthcare decision should be subject to the processes and provisions outlined within the Act. The Supreme Court has decided parental authority cannot be used to authorise the deprivation of liberty of 16 and 17 years olds who lack capacity to consent to arrangements that amount to a deprivation of liberty. Deprivations of liberty of 16 and 17 year olds without the capacity to provide their own consent will now have to be authorised by some means other than the exercise of parental responsibility (Re Child D September 19).

If valid consent is not provided by the young person, any confinement which would amount to deprivation of liberty will need to be authorised by the state. In such cases this will mean that a public authority including the CCGs will need to apply to the Court of Protection to rule on the lawfulness of the deprivation.

For those services working with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families in becoming familiar with the powers and provisions within the Act is an essential part of transition work. Families may choose to approach the Court to become Court Appointed Deputy for welfare decisions or property and finance decisions. Information should be provided to assist with such applications.

Looked After Children and Mental Capacity

For young people who are Looked After, commissioners and provider must ensure themselves that people's rights are protected under the MCA 2005 or where they lack mental capacity around their accommodation arrangements.

7. CARE AND TREATMENT OF PEOPLE WHO HAVE A MENTAL DISORDER

The Mental Health Act (MHA, 1983, amendment 2007) the Mental Health Act Code of Practice (2015) and the Mental Capacity Act (2005) have different purposes but should be considered in parallel where appropriate.

The **MCA (2005)** has a broad scope and provides a legal framework for acting and decision making which applies in many situations where adults are unable to make decisions themselves.

The **MHA (1983 amendment 2007)** provides a much narrower legal authority for the admission to hospital and treatment (where appropriate, without consent) of people with a mental disorder because of the risk posed to themselves or others.

The **MCA (2005)** does not apply to Mental Health treatment for people detained under the Mental Health Act but may still apply to decisions around their physical health treatment.

Note: The Mental Health Code of Practice 1983 (2015) should be read together with the Mental Capacity Code Practice 2007.

8. FIVE STATUTORY PRINCIPLES OF THE MENTAL CAPACITY ACT WHEN ASSESSING CAPACITY

The Mental Capacity Act sets out 5 statutory principles, the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives.

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.
2. A person must not be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision because he/she makes an unwise decision.
4. An act done or a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
5. 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 effectively achieved in a way that is less

restrictive of the person's rights and freedom of action.

9. TESTING FOR CAPACITY: TIME AND DECISION SPECIFIC

Stage one: Functional Test consider if the individual is able:

- To **understand** the information relevant to the decision
- To **retain** that information (for long enough - this is professional judgement)
- To use or **weigh that information** as part of the process making the decision
- To **communicate the decision** (whether by talking, using sign language or any other means).

Stage two: **Diagnostic Test:**

- Does the individual have the signs, symptoms or behaviours that indicate an impairment or disturbance in the functioning of their mind or brain (either permanent or temporary)

For some people, their ability to meet some or all of these criteria will fluctuate over time and it is therefore important that abilities to make decisions are reviewed regularly.

An individual may be competent to make certain decisions, but at the same time not have the capacity to make other, more complex decisions.

10. TYPE OF CLINICAL MENTAL CAPACITY DECISIONS

The CCG commissioners (CHC Nurse Assessors) may come across different type of clinical decisions that need to be made. This may include:

- Complex clinical placements / accommodation arrangements
- Covert medication (liquid or tablet form including injections)
- All types of Medical issues such as pressure ulcers / treatment/s
- Consent to nurse assessment / clinical referrals to specialist services
- Where or not a person is able to keep themselves safe from harm or exploitation
- Physical Restraint (see content 12)
- Changes to care and treatment
- Dispute with family / friends where there is a clinical need/accommodation arrangement.

11. PHYSICAL RESTRAINT AND MENTAL CAPACITY

The MCA 2005 defines restraint as when someone "uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person's liberty whether

or not they are resisting". Section 6 of the MCA states that restraining people who lack capacity will only be permitted if, in addition to it being in their best interests, the person taking action reasonably believes that it is necessary to prevent harm to the person. In addition, the amount or type of restraint used, as well as the amount of time it lasts, needs to be proportionate to the likelihood and seriousness of potential harm.

12. ACTING IN BEST INTEREST DECISION

Principle 5 of the Mental Capacity Act is that any action undertaken or decision made on behalf of someone who lacks mental capacity (see flowchart at appendix 1) must be undertaken or made in the individual's best interest.

The only exception may be when an individual who lacks capacity has made an Advanced Decision to refuse specified treatment.

13. WHO CAN MAKE THE DECISIONS?

A range of people may act as the 'decision maker' on behalf of the individual who lacks the capacity to decide on an issue for themselves. The decision maker will depend on the type of decision to be made e.g. in the context of healthcare decisions, the decision maker is most likely to be a doctor or healthcare member of staff responsible for carrying out the treatment/ procedure.

Once the 'decision maker' has been determined, they must work through the best interest "checklist" and come to a determination of what is in the individual's best interest.

The MCA requires the decision maker to consult with anyone who knows the person who may lack capacity and every effort must be made to encourage and enable the individual who lacks capacity to take part in the decision making.

14. ADVANCE DECISIONS

If a person (who lacks capacity) made an advanced decision to refuse medical treatment at a time when he/she had capacity. This will prevent a healthcare professional from giving him/her the same treatment in his/her best interest as long as the advanced decision remains **valid** and **applicable** to present circumstances.

Advanced care planning is a process by which people can plan ahead to make decisions and express preferences about what they wish to happen with their care and treatment if they lost capacity to make decisions for themselves and other people to make decisions for them. They can:

- Appoint someone to make decisions for them regarding health and welfare via a Lasting Power of Attorney authorisation (See section 16).
- Refuse specific treatments in advance if they want to by making an advanced decision to refuse treatment.

- They can nominate people they would like to be consulted when decisions are being made about them.

Individuals can write down a statement containing their wishes and preferences for their future care but may also have made a verbal decision. A decision to refuse treatment that is not life sustaining does not need to be in writing but the person must ensure relevant professionals know what treatment is being refused. A decision refusing advance life sustaining treatment must be in writing, signed and witnessed with a clear statement of which treatments are being refused. Practitioners must assure themselves that such decisions (written or verbal) are valid and applicable.

NB For further detail around advanced decisions, see Chapter 9 of the MCA Code of Practice (2007)

15. END OF LIFE DECISIONS

It is useful to have information around the person's preferences for care at the end of life as this can inform decision making if the person loses capacity and may influence when a DOLS is required.

Seek advice if further support is needed from your local MCA / DoLS lead in your local authority.

Do Not Resuscitate (DNAR) / Cardiopulmonary Resuscitation (CPR)

- DNACPR decisions should only be made for an individual who does not have capacity, if the decision is believed to be in their best interests (as defined by the MCA).
- DNACPR decisions must never be motivated by a desire to bring about the patient's death. Professionals should seek to establish the incapable person's wishes, preferences, beliefs and values by talking to those closest to the individual and/or the person with LPA or an Independent Mental Capacity Advocate (IMCA) before making a DNACPR decision.
- Input of the family or others close to the patient lacking capacity should be based on what they believe the patient would have wanted – not their own wishes.
- Decisions should reflect current circumstances i.e. what the individual would have wanted at that time given the circumstances they faced.
- Every effort should be made to involve and enable the individual in the decision making.
- Practitioners should tell the people closest to the individual lacking capacity if they reach a DNACPR decision and explain the reasons to them.

If there is a dispute as to an incapacitated patient's best interests when CPR is to be withheld or withdrawn then the patient or those close to them should be offered a second opinion. In the relatively rare circumstances where the patient or those close to them continue to fundamentally disagree with the clinical team, legal advice should be sought and the courts can be asked to intervene where there is time to do so. The decision whether or not to attempt CPR involves far more than the factual matter of probabilities of success. It must take account of what the person wants or what he or she considers being in their future best interests. A consideration of best interests must include not only clinical issues, but also the advantages and disadvantages of the options in relation to the patient's welfare, family life and social, recreational and daily living activities. It should also take into account the patient's religious or spiritual beliefs and views which may be relevant and significant to the patient.

How a patient in these situations decides whether CPR is in their best interests is unique to them. A patient with capacity has the right to make a decision that appears irrational or eccentric or unwise. Indeed, such a decision, if made with capacity, will be binding if it is recorded as an Advanced Decision to Refuse Treatment (ADRT).

16. LASTING POWER OF ATTORNEY (LPA)

Enduring Power of Attorney has been replaced following the introduction of the MCA 2005, by a Lasting Power of Attorney (LPA, whilst they have capacity). There are two type of LPA.[5]

- Health and welfare lasting power of attorney
- Property and financial affairs lasting power of attorney

Health and Welfare Lasting Power Of Attorney

This LPA is used to give an attorney the power to make decisions about things like: the person's daily routine, for example washing, dressing and eating

- medical care
- moving into a care home
- life-sustaining treatment

Property and Financial Affairs Lasting Power Of Attorney

This LPA is used to give an attorney the power to make decisions about money and property for a person, for example:

- managing a bank or building society account
- paying bills
- collecting benefits or a pension
- selling your home

It can be used as soon as it's registered, with the person's permission. It can only be used when the person is unable to make their own decisions

The LPA must be registered with the Office of the Public Guardian (OPG)[6] for it to be valid. If the LPA is not registered with the OPG it cannot be used until it is registered.

An LPA can only be applied for person whilst he/she has mental capacity over the age of 18 years old and above they must have given consent for someone to act as their attorney when they lack capacity on certain decisions. Further advice should be obtained from the CCG's MCA Lead if unsure.

Office of Public Guidance (OPG) Safeguarding Responsibilities

The OPG's clients are adults. Allegations of abuse of vulnerable children (or young people aged up to 21 in some circumstances) will usually be dealt with by local authority children's services. Where allegations of abuse relate to a child or young person, OPG will raise the issue with the police and/or the local authority children's services department.

OPG's Role in Safeguarding Adults

The OPG work to prevent abuse. This may include:

- Making people aware of legal safeguards such as lasting powers of attorney and the services of OPG and the Court of Protection. OPG promote safeguarding through talks, training, presentations, publicity and work with our key stakeholders and partners.

- Supervising deputies appointed by the Court of Protection to make decisions on behalf of someone who lacks mental capacity.

- Developing and reviewing strategies and policies about protecting clients, both within the Ministry of Justice and in partnership with other government departments and external partners.
- Making sure systems are in place to prevent or reduce the possibility of a member of OPG staff abusing an adult at risk
- Working with other agencies, including adult social services and the police.

OPG Safeguarding Contact Details

Email: opg.safeguardingunit@publicguardian.gsi.gov.uk Telephone: 0115 934 2777 Text phone: 0115 934 2778 Monday to Friday, 9am to 5pm and Wednesday, 10am to 5pm

17. COURT OF PROTECTION AND COURT APPOINTED DEPUTIES

If there is a significant disagreement on the outcome of the capacity test or the "best interests" decision, or concern about the conduct of a person acting under an LPA, an application to the Court of Protection (CoP) may be appropriate[7]. The court itself can make a decision, or it can appoint a "deputy" to oversee relevant aspects of the case. Relatives, local authorities or other people may apply to the court to be appointed as a deputy to enable them to make decisions on behalf of a person who already lacks mental capacity and are unable to appoint an LPA.

The LPA and Court appointed deputies updated information needs to be recorded in the patient's medical records.

The CCGs, as a responsible commissioners, will consider the appropriate pathway where there is a clinical decision to be made in respect of the application of the MCA that cannot be resolved locally. An application to the CoP can be made by instructing a solicitor. The current process must be followed:

- A representative of the commissioner CHC/IPA team will discuss/ formally request an application to the Court of Protection with the senior manager of the CCG. The commissioner will liaise with NHS Fylde and Wyre and Blackpool CCGs MCA lead for advice, support and guidance.
- Where appropriate the senior manager will explore the case with the NHS Fylde and Wyre and Blackpool CCGs MCA lead for further advice, support and guidance who will advise on alternative options or deem it clinically appropriate for an application to the CoP.

NHS Fylde and Wyre and Blackpool CCGs can make an application to the CoP for the following clinical decisions.

- Complex decisions that need to be made by the CoP regardless of if a person has mental capacity or not.
- Where there is a dispute between the CCG, the provider, a relative or an advocate where all options have been exhausted during the best interest meeting including mediation between the CCG, the provider, a relative or an advocate.

Court of Protection Contact Details

Telephone: 0300 456 4600

18. INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

The MCA (2005) establishes an Independent Mental Capacity advocacy[8] service to provide safeguards for people who:

- Lack capacity to make a decision at the time it needs to be made and are unfriended and there are significant safeguarding concerns.
- Moving the individual to a different care setting.
- Representing the views of the patient in adult safeguarding cases in relation to **serious medical treatment**

The decision maker must consider the views of the IMCA but is not bound by them.

19. CONTACTS DETAILS

IMCA Referral	Lancashire Advocacy Focus - Telephone: 0300 323 0965 Blackpool Advocacy Encompass - Telephone: 0300 323 2100
CCG MCA Lead	Fiona O'Donoghue - Telephone: 01253 956555
CCG Executive Lead for Safeguarding	Claire Lewis - Telephone: 01253 957183
Office of Public Guidance Safeguarding Team	Email: opg.safeguardingunit@publicguardian.gsi.gov.uk Telephone: 0115 934 2777 Text phone: 0115 934 2778
Court of Protection	Telephone:0300 456 4600

20. REFERENCES

- HM Government (2014) The Care Act
- The Children Act (1989 and 2004)
- DH (2017) Care and Support Statutory Guidance
- NHS England (July 2019) Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework
- HM Government (2018) Working Together to Safeguard Children
- DH, DfE (March 2015) Statutory Guidance on Promoting the Health and Well-being of Looked After Children
- Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice
- DH 2011 Safeguarding Adults: The Role of Health Services
- Childrens Safeguarding Assurance Partnership and Lancashire Safeguarding Adults Board (LSAB) and Blackpool Safeguarding Adults Board (BSAB) Policies Procedures and Practice Guidance.
- HM Government (2011) Prevent Strategy
- https://www.supremecourt.uk/cases/uksc-2018-0064.html
- Mental Capacity Act (2005) including 2011 amendments
- Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005, London TSO
- Ministry of Justice, Department of Health (2014) Mental Capacity Act: government response to the House of Lords Select Committee report
- Royal College Paediatrics and Child Health et al (2019) Intercollegiate Document for safeguarding children supported by the Department of Health. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing
- Royal College Paediatrics and Child Health et al (2019) Intercollegiate Document for safeguarding adults supported by the Department of Health Adult Safeguarding: Roles and Competencies for Health Care Staff

APPENDIX 1: MCA HIGH LEVEL PROCESS