Mental Capacity Act 2005
Policy and Procedure

Policy Number	Safeguard003
Target Audience	NHS Bolton CCG NHS Bolton CCG CHC Team / NHS nursing Funded Care
Approving Committee	Safeguarding Assurance Group (SAG) NHS Bolton CCG Executive
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Policy Author	Kaleel Khan, MCA lead
Version Number	

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Version Control Sheet

Version	Date	Reviewed By	Job Role	Comment
0.1	28.07.2017	Kaleel Khan	NHS Bolton CCG MCA Lead	Policy update
0.2	31.07.2017	Christine Dixon	Designated Nurse for Children Looked After	Comments received
0.3	01.08.2017	CHC/Nurse Funded Care Team	Nurse Assessors	Comments received
0.3	01.08.2017	Diane Sankey	Governance, Risk & Complaints Manager	Comments received
0.4	01.08.2017	Melissa Laskey	NHS Bolton CCG Commissioners	No comments
0.5	31.08.2017	Caroline Gardner	Equality and Policy Manager- OPG	Comments on safeguarding, OPG

Analysis of Effect completed:	By:	Date:

Contents

1. Policy Statement

NHS Bolton Clinical Commissioning Group (CCG) aspires 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. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

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 Bolton CCG has 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 NHS CCG's contract management.

Fundamentally NHS Bolton CCG will want to ensure;

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

2. Introduction

NHS Bolton Clinical Commissioning Group, (henceforth referred to as "the CCG"), as with all other NHS bodies has a statutory duty to ensure that it makes 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 CCG fulfils its 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.

[1] http://www.legislation.gov.uk/ukpga/2005/9/contents

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

- Deprivation of Liberty Safeguards (2009) (See NHS Bolton CCG DoLS Policy)
- Care Act 2014
- Care and Support Statutory Guidance (DH, 2014)
- Prevent Duty Guidance 2015
- Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (NHS England, 2015)
- Working Together to Safeguard Children (HM Government, 2015)
- The policies and procedures of Bolton Safeguarding Children Board (BSCB) and Bolton Safeguarding Adults Board (BSAB).

3. Aims

The policy aims to ensure that no act of commission or omission on behalf of the CCG as a commissioning organisation or by a service it commissions 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 NHS Greater Manchester Safeguarding Collaborative 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 all service users are protected from abuse and the risk of abuse.

4. Principles

This policy demonstrates that the CCG recognises that safeguarding young people and adults at risk 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 senior managers and board members to seek continuous improvement with regards to safeguarding and MCA 2005 both within the work of the CCG and of services commissioned.

- Clear lines of accountability within the CCG 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 in relation to safeguarding practice and the MCA 2005.
- Effective interagency working including effective information sharing.

5. Definition

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

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 (refer to NHS Bolton CCG DoLS policy).

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 (see NHS Bolton CCG's DoLS policy).

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 Bolton CCG employees who have responsibility for delivering direct patient care meet their statutory responsibilities for those who lack capacity to consent to care and treatment.

The Deprivation of Liberty Safeguards (DoLS, 2009) is an amendment to the Mental Capacity Act 2005 (Refer to NHS Bolton CCG DoLS policy).

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)[2]

6. Roles and Responsibilities of the CCG

Chief Officer

The ultimate accountability for safeguarding and the MCA 2005 sits with the Chief Officer for the CCG. 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 CCG 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.

[2] www.gov.uk/government//...mental-capacity-act-code-of-practice

- Seeking assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year 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 Bolton Safeguarding Children Board (BSCB), Bolton Safeguarding Adult Board (SAB), and Bolton Health and Wellbeing Board.
- 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.
- Working with the local authority to enable access to community resources that can reduce social and physical isolation for adults.
- 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 CCG has management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding young people and adults at risk 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 at risk under MCA 2005.
- 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 CCG meet the requirements of the Mental Capacity Act (MCA), including Deprivation of Liberty Safeguards (DoLS).
- To ensure that safeguarding young people children and adults at risk 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 at risk; including, ensuring the CCG operates 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 CCG 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 Local

Safeguarding 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 the 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 NHS Bolton CCG safeguarding policy). If no member is available to speak to a referral should be made to the Local Authority, for Bolton this is the Multi Agency Safeguarding Screening Service (MASSS) as per local policies and procedures or Bolton Safeguarding Adult Team. Refer to the NHS Bolton CCG safeguarding 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 quarterly to the NHS Bolton CCG Safeguarding Assurance Group (SAG) which is a sub-group to the CCG Quality and Safety 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 CCG on learning from reviews and audits that are aimed at driving improvements to safeguard young people and adults at risk.

The Quality and Safety Committee will oversee the implementation of any action plans stemming from the local review and audits.

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 CCG is committed to have arrangements in place to ensure effective training of relevant staff. The CCG expects relevant clinical staff to be trained in MCA level 1

and 2. Further levels of training will be determined by the responsibilities set out in job descriptions/role functions.

Line managers will agree the level of MCA training required for each employee depending on their role and responsibilities, in line with the CCG Safeguarding Training Framework. The framework can be found on the CCGs website under the safeguarding section.

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

Recording of Best Interest Decisions on Broadcare

The CCG require CHC/Funded Care Team nurse assessors / commissioners to record best interest decisions on Broadcare. This is to ensure all decisions are properly recorded.

Young People 16-17 Years old

The CCG is committed to have arrangements in place through the commissioning and compliance processes in ensuring young people are safeguarded under the MCA 2005. This also includes young people who may not be able to consent but are cared for at home.

Looked After Children and Mental Capacity

The CCG will take into account young people aged 16 -17 years old who are outside the zone of parental responsibility. 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 (refer to NHS CCG DoLS policy).

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.

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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[3].

8. Five Statutory Principles of the Mental Capacity Act

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).

[3] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

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. Mental Capacity Assessment

NHS Bolton CCG commissioners (CHC nurse assessors) where appropriate and relevant will ensure when assessing mental capacity the correct assessment form needs to be completed (a flow chart of the MCA process is attached at appendix 2) to assess where or not a person has mental capacity to make certain clinical decisions.

11. Type of Clinical Mental Capacity Decisions

NHS Bolton 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 arrangements

12. 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.

Definitions of the types of restraint are outlined below.

Physical Restraint: any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Prone Restraint: (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.

Chemical Restraint: (this brief guide does not cover the use of chemical restraint. Refer to brief guide on psychoactive medicines for people with learning disabilities): the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behavior, where it is not prescribed for the treatment of a formally identified physical or mental illness.

Mechanical Restraint: the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioral control.

Principles: Positive and Proactive Care states that: "The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles". These are:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent?
- Restrictive interventions should only ever be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.

13. 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. (See best interest template).

14. 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" as locally agreed 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.

15. 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. 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)

16. 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 Advances Decision to Refuse Treatment (ADRT)[4].

17. 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 your 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.

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[5] https://www.gov.uk/power-of-attorney/overview

[6] https://www.gov.uk/government/organisations/office-of-the-public-guardian

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 at Risk

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

E: opg.safeguardingunit@publicguardian.gsi.gov.uk Telephone: 0115 934 2777, Text phone: 0115 934 2778

Monday to Friday, 9am to 5pm Wednesday, 10am to 5pm

18. 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.

NHS Bolton CCG, as a responsible commissioner, 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 (Funded Care Team – FCT) will discuss / formally request an application to the Court of Protection with the senior manager of the FCT. The commissioner will liaise with NHS Bolton CCG MCA lead for advice, support and guidance.
- Where appropriate the senior manager will explore the case with the NHS Bolton CCG 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.
- If clinically appropriate the senior manager of the FCT will discuss application with the NHS Bolton Chief Nurse. The Chief Nurse may need to seek permission from the NHS Bolton Chief Officer to consider whether or not to instruct a solicitor on behalf of NHS Bolton CCG to act in the best interest of the person.

NHS Bolton CCG 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.

[7] https://www.gov.uk/become-deputy/overview

Court of Protection Contact Details

T: 0300 456 4600

19. 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**

20. Contacts Details

IMCA Referral	**Postal Address:** Rethink Mental Illness, The Wesley Centre, Royce Road, Manchester M15 5BP **Email Address:** boltonadvocacyservice@rethink.org (please password encrypt) **Telephone:** 0161 226 3332
CCG MCA Lead	Kaleel Khan, T: 01204 462204 E: kaleelhan@nhs.net
Richard Leigh	Programme Manager - NHS Funded Care Team T: 01204 462296 E: Richard.leigh2@nhs.net
Caroline Gee	Modern Matron, NHS Funded Care Team T: 01204 462204 E: caroline.gee3@nhs.net
Diane Sankey	Governance, Risk & Complaints Manager T: 01204 462023 E:dianesankey@nhs.net
Office of Public Guidance Safeguarding Team	E: opg.safeguardingunit@publicguardian.gsi.gov.uk Telephone: 0115 934 2777 Text phone: 0115 934 2778
Court of Protection	T:0300 456 4600

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365629/making-decisions-opg606-1207.pdf

21. Relevant Case Law

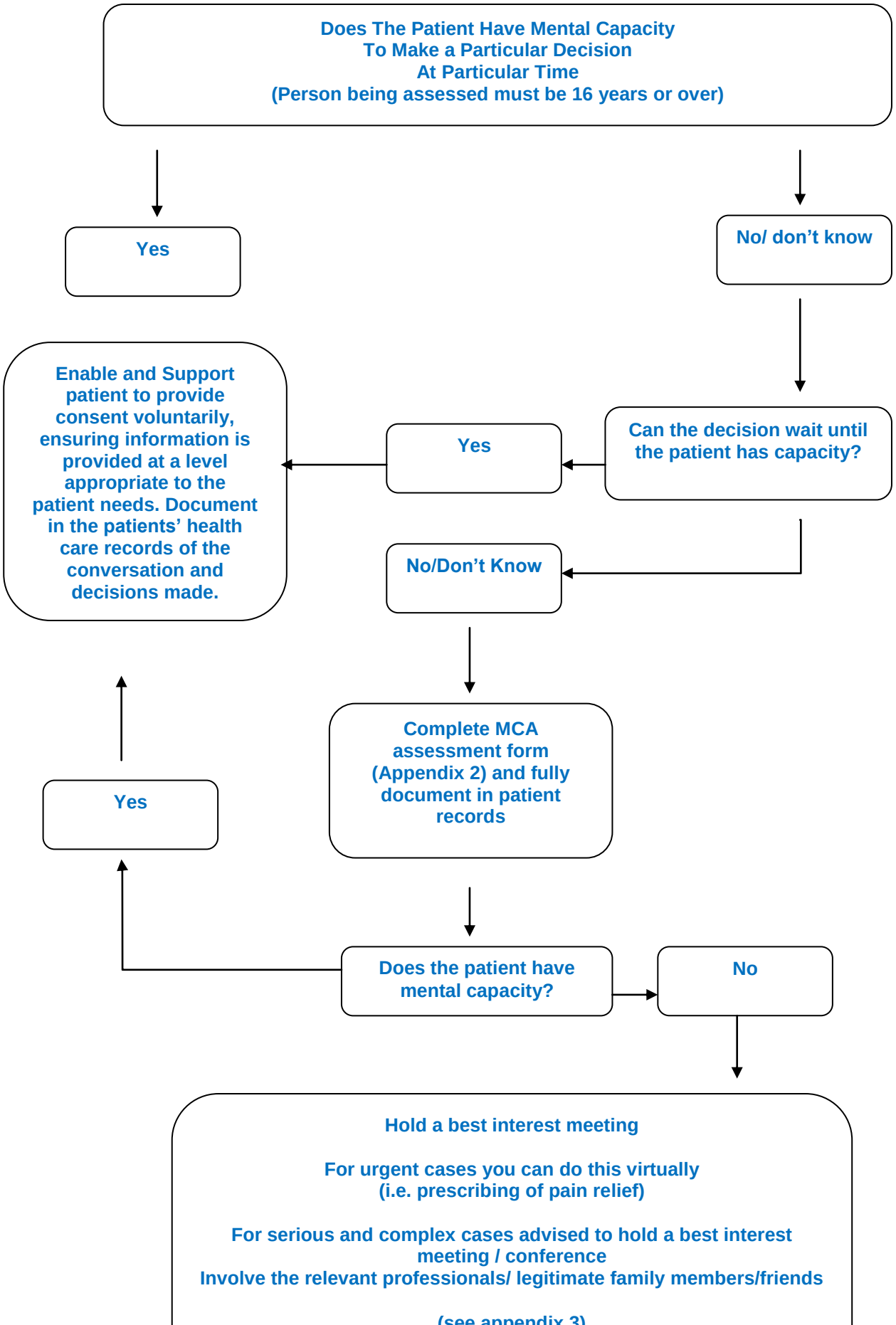
- Re: IH (Observation of Muslim Practice)
- PC and NC v City of York Council [2013] EWCA Civ 478 at paragraph 58 and Kings College NHS Foundation Trust v C and V [2015] EWCOP 80 at paragraph 35.
- Covert Medication - AG v BMBC and SNH (2016)
- Re AK (Adult Patient) (Medical Treatment: Consent) [2001] 1 FLR 129, Hughes J
- HE v A Hospital NHS Trust,1 Munby J
- Local Authority v E;14 X Primary Care Trust v XB15 and An NHS Trust v D,1
- Gorjat v Gorjat [2010] EWHC 1537(Ch)
- A Healthcare NHS Trust v P and Q [2015] EWCOP 15, [2015] MHLO 23
- N v A CCG
- Ferreira v HM Senior Coroner for Inner South London
- Re: CH (by his Litigation Friend, The Official Solicitor) Part 8 Claimant And A Metropolitan Council

22. References

(see foot notes)

- Mental Capacity Code of Practice 2007
- Mental Health Code of Practice 2015
- Office of Public Guidance
- Lasting Power of Attorney
- Court of Protection Application

23. Appendix 1: MCA High Level Process



24. Appendix 2: MCA Assessment Form

Section 1: Information About The Person		
Name:		☐**Male** ☐**Female**
Address:		**Postcode:**
Ethnicity:	**First Language:**	**Telephone:**
GP Details:		
Date of Assessment:	**DoB:**	**Time of Assessment:**
Is the person over 16 years old?	☐Yes ☐No	**If under 16 do not complete**

Section 2: Decision To Be Made	
What decision is to be made?	

Section 3: Communication & Reasonable Adjustment		
Are there any communication difficulties?	☐Yes ☐No	Comments
Does the person at risk require an interpreter?	☐Yes ☐No	Comments
Does the person require a Speech and Language Therapist?	☐Yes ☐No	Comments
Does the person at risk require any other reasonable adjustment or support to communicate?	☐Yes ☐No	Comments

Section 4: Legal Powers Of Others To Act On Behalf Of The Adult		
Does the person have a Lasting Power of Attorney?	☐Property and Financial Affairs	☐Health and Welfare
Is this registered with the Office of Public Guardian?	☐Yes ☐No	Must be register for it to be valid
Does the person have a legal Advance Decision to refuse medical treatment?	☐Yes ☐No	Must be explicit, witnessed, dated and signed:
Does the person have a Court Appointed Deputy?	☐Yes ☐No	

Section 5: Functional Test		
Is the person able to understand the information for the decision to be made?	☐Yes ☐No	Comments
Is the person able to retain the information for the decision to be made?	☐Yes ☐No	Comments
Is the person able to communicate the information for the decision to be made?	☐Yes ☐No	Comments
Is the person able to weigh up the risks for the decision to be made?	☐Yes ☐No	Comments

Section 6: Diagnostic Test	
Does the person have a disturbance in the function of the mind or brain? ☐Yes ☐No (If answer is No do not complete this form.	☐Learning Disability ☐Mental Health ☐Stroke ☐Brain Injury ☐Dementia ☐Confusion ☐Drowsiness ☐Unconsciousness ☐Substance Misuse ☐Alcohol Abuse ☐Other……

Section 7: Method of Assessment Skills
As the assessor, what skills did you use before coming to the conclusion that the adult you are assessing does or does not have mental capacity? E.g. Assessing the person slowly, reassessing the person at an appropriate time, providing pictures, videos or other materials, speaking to others etc.

Section 8: What Are The Values, Beliefs And Wishes Of The Person You Are Assessing?

Section 9: Any Other Comments Or Information As An Assessor You Think It Is Important?

Section 10: Outcome of the Assessment	
Does the person lack mental capacity on the decision to be made in accordance with the Mental Capacity Act 2005?	☐Yes ☐No ☐Not Sure
Do you need a second opinion?	☐Yes ☐No
Do you need to request a best interest meeting (if person lacks capacity on the decision to be made)?	☐Yes ☐No
Do you need an Independent Mental Capacity Advocate (IMCA)	☐Yes ☐No
Assessment completed by (Print Name):	
Signed:	**Date:**
Practitioner's role:	

25. Appendix 3: Best Interest Template

AGENDA		Lead
1.	**Introductions & Apologies** Housekeeping Information Sharing & Confidentiality Statement of the legal framework	
2.	**Purpose of the Best Interest Meeting** Clarification of decision required Capacity Assessment confirmed. If there is no Capacity Assessment specific to the Best Interest decision, **THE MEETING MUST STOP.**	
3.	**Review of the Best Interests Checklist:** Please see the reverse side of the agenda for the checklist.	
4.	**Review Mental Capacity Act 2005 Checklist**	
5.	**Review Documentation Check List**	
6.	**Demographics - who is the Best Interest Meeting about?**	
7.	**Attendance List**	
8.	**View of the relevant person (patient, service user, resident, individual etc.)** What is known about their previous wishes, their values and beliefs?	
9.	**Family view point**	
10.	**Information from relevant agencies**	
11.	**Discussion of viewpoints / evidence (pros and cons checklist)**	
12	**Outcome of discussions; reasonable belief as to best interests**	
13.	**Summary & risk assessment of the situation** Benefit and repercussion Pros/cons of proposed action	
14.	**Decision of the meeting about the person's best interests** The decision maker is not obliged to follow the decision of the meeting but would need to give clear reasons why they did not do so.	
15.	**Benefits and Burdens**	
16	**Action plan** If the meeting cannot agree, decisions will need to be made about how to proceed. Make sure the priority remains the welfare and safety of the person whose best interests are being assessed. Is a Case Conference Best Interest Meeting required	
17	**Conclusion – what decision has been reach and why?**	
18	**Communication Strategy** Service User Involvement & Feedback	
19	**Any Other Business**	

1. Introductions & Apologies

Housekeeping

- Respect each other's views
- Everybody has a chance to speak
- Stick to facts and information (not assumptions or emotions)

Information Sharing & Confidentiality

Statement of the legal framework

- Refer to Best interest Checklist (p3)
- Mental Capacity Act 2005 Checklist (p4)

2. Purpose of meeting

These points must be considered.

Specific
Proportionality
Least restrictive options

3. Best Interest Checklist – Please read the following statements prior to commencing the best interest meeting to ensure the following points are considered.

1	Can the decision be delayed in case they regain the ability to make the decision in the future, for example, as a result of recovering from an episode or illness, learning new skills, or getting support with communicating their wishes?
2	The law says that when someone is working out what is in the best interests of another person, they cannot make a decision based merely on their appearance, age, medical condition, or behaviour.
2	When deciding what would be in their best interests all the relevant information needs to be considered, and it is important to involve the person as much as possible in decisions affecting them.
3	Consider the Person's wishes, feelings, values and beliefs. This includes any views they have expressed in the past that would help to understand what their wishes and feelings might be. This may be things they have said to other people, how they have behaved in similar circumstances in the past and especially things they have written down. This places them at the centre of any decision being made on their behalf.
4	The views of their family members, parents, carers and other relevant people who support them or are interested in their welfare, if this is practical and appropriate. If they have named someone particular or given someone powers to decide for them then they should be consulted.
5	If decisions are being made about treatment that is needed to keep them alive, people are not allowed to be motivated by a desire to bring about their death, and they must not make assumptions about the quality of their life.

4. Mental Capacity Act 2005 Checklist

☐Yes	☐No	Is the person 16 years and over? (If under 16 do not proceed).
☐Yes	☐No	Does the person meet section(s) 1 of the Mental Capacity Act 2005 - Persons who lack capacity (if no, do not proceed).
☐Yes	☐No	Does the person meet section 4 of the Act a person who lacks capacity must be done, or made, in his best interests? (If no, do not proceed).
☐Yes	☐No	If Best Interest decision is challenged then under section 16 of the MCA one could apply to the Court of Protection who have the powers to make decisions and appoint deputies to make the decision.
Any other comments?		

5. Documentation Check List

Tick relevant box		Documentation	Comments
☐Yes	☐No	Is there an advance decision in place?	
☐Yes	☐No	Has a statement of intent been issued by the GP?	
☐Yes	☐No	Is there a Lasting Power of Attorney (LPA) in place for Health and Welfare or Financial and Property Affairs in place?	
☐Yes	☐No	Is there an Enduring Power of Attorney (EPA) for Health and Welfare or Financial and Property Affairs in place?	(EPA) is no longer valid after 2007.
☐Yes	☐No	Is the EPA or LPA registered with the Office of Public Guardian (OPG)?	
☐Yes	☐No	Do you have a copy of the certificate from the OPG? The EPA or LPA must be registered with the OPG.	
☐Yes	☐No	Is there a Deputy who is a person appointed by the Court of Protection for Health and Welfare or Financial and Property Affairs?	
☐Yes	☐No	If there is a Deputy identified what is his/ her name, address and contact number?	
☐Yes	☐No	Is there a DNAR Order in place?	
☐Yes	☐No	Is the person subject to a DoLS?	
☐Yes	☐No	If the person is subject to a DoLS, what is the condition and when is the review date?	

Date:		Venue:
Patient's Name:		NHS No:
Address:		
Chair:		Decision Maker:
Minute Taker:		Time:

6. Demographics - who is the Best Interest Meeting about?

Please include the relevant people that have been invited. Also include those who have sent their apologies, are not able to attend or sent information to help towards the best interest discussion.

7. Attendance List

Name	Role	Signature	Comments

8. View of the relevant person (patient, service user, resident, individual etc.)

9. Family view point

10. Information from relevant agencies

- Views from anyone named to be consulted, any LPA/ EPA or Deputy.
- Social services
- Professionals opinions
- IMCA (if involved)
- Decision-makers opinion
- Others

11. Discussion of viewpoints / evidence (pros and cons checklist)
12 Outcome of discussions; reasonable belief as to best interests
13. Summary & Risk Assessment of the Situation Benefit and repercussion Pros/cons of proposed action

14. Decision of the meeting about the person's best interests
The decision maker is not obliged to follow the decision of the meeting but would need to give clear reasons why they did not do so.

15. Benefits & Burdens – To be completed by the decision maker	
Benefit of Options 1	**Burden of Options 1**
Benefit of Option 2	**Burden of Options 2**

16. Action Plan

Action	Responsible person	Action to be completed by:

17. Conclusion – what decision has been reach and why?

18. Communication strategy
Where the court is not involved, carers, relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances. The undersigned believe this to be a fair representation of the discussions that took place. We have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

19. Sign off

Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Name: Designation: Signature	Name: Designation: Signature
Minutes distributed on:	
Minutes completed by:	
Relatives / Correspondents	

20 Best Interest Case Conference Guidance for the Chair

20.1 Preparation

20.2 The Chair should request to see all previous Best Interest meeting minutes.

20.3 Understand any arising disputes or known challenge, which will help them in making decisions about how to best organise and facilitate the case conference.

20.4 Consider whether to request a legal adviser to be present.

20.5 Understand who the essential attendees are and why any other people are considered relevant to consult in the decision.

20.5 Consider how to manage any issues relating to confidentiality and Data protection within the meeting.

20.6 Understand what information and guidance has already been provided to the attendees.

21. The Day of the Case Conference

21.1 The chair should meet in a quiet area with the person and any family members, Lasting Power of Attorney (LPA) Enduring Power of Attorney (EPA) or a Deputy who is a person appointed by the Court of Protection. **Note: Enduring Power of Attorney is no longer valid after 2007.**

21.2 Prior to the meeting commencing to explain the purpose of the meeting, the legislation to be used, who will be attending the meeting and why, and finally to offer the opportunity for any questions / concerns to be explored.

21.3 As with Best Interest Meetings, the Chair should consider whether this should take place immediately before the meeting, or to consider whether it would be more appropriate to offer the opportunity to meet with the person/family at an earlier stage. Where there are known tensions, open and timely communication between the Chair and the person/family etc. can help to reduce any building tensions and help both parties to plan how to achieve a more relaxed meeting process. This process is especially important in situations where there is dispute.

21.4 The Chair must remain mindful that at this stage they should not engage in any level of discussion about the decision to be made, but to remain solely focused on supporting attendees to understand the process and be as comfortable as possible throughout.

22. Opening the case conference

22.1 Open the meeting by reminding the attendees that the case conference is being held under the principles and provisions as set out in the Mental Capacity Act 2005. The meeting will be paying particular regard to the Statutory Best Interest Checklist, and lastly remind all of the need to pay regard to confidentiality.

22.2 (The minute taker may find it useful to use the questions set out below as mini headings to capture and clearly record the content of the meeting).

22.3 Ask each person to say who they are and why they are attending the case conference.

22.4 Inform everyone that the meeting will focus on the decision that is required to be made and no other.

23. Ask the following questions to the meeting

23.1 What is the specific decision to be made? (The meeting must agree as this will be the focus of the meeting from this point onwards).

24.2 Why is it being proposed?

24.3 What steps have been taken to help the person attend the conference today and be involved in the decision making process?

24.4 What steps have been taken to support the person in making the decision themselves? (Why have these attempts failed).

24.5 Is there an up to date Mental Capacity Assessment to evidence the person lacks the capacity to make the decision required? **(If not the meeting must stop).**

24.6 Is it possible to delay the decision until the person regains capacity and will be able to make the decision themselves. Are there any risks to the person in delaying the decision?

24.7 Who is the Decision Maker? Is an appropriate LPA/EPA/Court Appointed Deputy in place who has the relevant authority to make the required decision?

24.8 Is there a valid and applicable Advance Decision, or Advance Statement that is relevant to the decision?

24.9 What do we already know about the person's values, wants and wishes?

24.10 What are the available/possible options to be considered? What are the positive and negative aspects of each, keeping the person's views and opinions central and taking into consideration all assessed and known risk?

24.11 How will the options impact on the following?

- Any medical aspects
- Any welfare aspects (how they live their lives)
- Any social aspects (relationships)
- Any emotional aspects (how they may feel or react)

24.12 What Health and Social staff/professionals have been consulted? What are their views and opinions?

24.14 Is there a report from an Independent Mental Capacity Advocate (IMCA)? If the person reaches the qualifying criteria for an IMCA instruction, it becomes a statutory requirement.

24.15 If the person has reached the qualifying criteria and an IMCA has not been instructed why is this case?

24.16 Is there any feedback from an Independent Advocate?

24.17 Are there any other reports to be tabled?

24.18 Now that the family, LPA/EPA have heard all the relevant information, what are their views?

24.19 Outcome of decision. The identified decision maker to make the final decision once all reports etc. Have been tabled.

24.20 Has the decision maker chosen the least restrictive option? If not what is the rationale for the decision made.

24.21 Identify any actions, who has responsibility for each action and the timescale within which each must be completed.

24.22 If there is continued dispute or challenge at this stage, Chair to provide information on how to make a complaint, consider whether it would be appropriate to offer independent mediation and advise that consultation will be sought immediately with the legal service for advice.