Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

MENTAL CAPACITY ACT POLICY

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Consultation Group:	Pan-Lancashire CCG's Contracting and Safeguarding Leads
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Version Control

Version	Date	Author	Status	Comment / Details of Amendments
2.0	April 2020	Kristy Atkinson Deputy, Designated Professional for Safeguarding Adults and MCA	Final	Reference to Mental Capacity (Amendment) Act (2019) and forthcoming Liberty Protection Safeguards

Circulation List

Prior to approval, this Policy was circulated to the following for consultation:

- Contracting and Safeguarding Leads across pan-Lancashire CCGs
- Members of the CCG Joint Quality and Performance Committee

Following approval this Policy document will be circulated to:

- All CCG staff
- To be incorporated within contract arrangements with all commissioned services

Equality Impact Assessment

This policy has been reviewed by the Equality and Diversity Lead on behalf of pan-Lancashire CCG's on 3 January 2018.

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1. INTRODUCTION

The CCG is required to take account of the principles within the Mental Capacity Act (2005) (MCA) and to ensure all services from whom it commissions services (both public, independent and voluntary and faith sectors) have a comprehensive policy relating to the MCA (2005) and if appropriate The Deprivation of Liberty Safeguards [1](DoLS) (2009). The function of this policy is to detail the roles and responsibilities of the CCG as a commissioning organisation and that of its employees and GP member practices.

1.1 Scope

This policy aims to ensure that no act or omission by the CCG as a commissioning organisation, or via the services it commissions, is in breach of the MCA (2005) or DoLs (2009) and to support staff in fulfilling their obligations. The MCA 2005 sets out who can and how to make decisions relating to care and treatment for those who lack capacity to make such decisions. The Act covers decisions relating to finance, social care, medical care and treatments, research and everyday living decisions, as well as planning for the future. The policy applies to the CCG as a commissioning organisation and its GP member practices.

1.2 Principles

In developing this policy the CCG recognises that implementation of the MCA is a shared responsibility with the need for effective joint working between agencies and professionals. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- The commitment of chief officers, senior managers and board members to Implement the MCA across their organisation.
- Clear lines of accountability within the organisation for work relating to MCA.
- Service developments that take account of the need to incorporate the MCA Into practice and is informed where appropriate, by the views of service users.
- Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in relation to implementing the MCA.
- Effective interagency working, including effective information sharing.

1.3 Definitions

1.3.1 Mental Capacity

Within the MCA (2005) the term capacity relates to the person's ability make decisions for themselves including consent to or refuse care or treatment. The Act provides a two stage test for assessing a person's capacity and this must be used

[1] The Liberty Protection Safeguards became law on 16th May 2019 when the Mental Capacity (Amendment) Act 2019 received Royal ascent. It is expected to replace The Deprivation of Liberty of Safeguards (2009) in 2020

for each individual decision to be made and guided by the key principles of the MCA (2005)

Five key principles when assessing capacity

- Every adult must be assumed to have capacity unless it is proven otherwise
- All reasonable steps must be taken to assist the person to make a decision
- Individuals have the right to make unwise decisions, even those others may consider eccentric
- All actions on behalf of those who lack capacity must be in their 'best interests'
- Any treatment should be done in the least restrictive manner of the persons basic rights and freedoms

Two stage test

- Is there an impairment or disturbance in the functioning of the mind or brain?
- Does this impairment or disturbance affect the decision making ability at the time a decision needs to be made?

1.3.2 Best Interests

Everything that is done to, or on behalf of a person who lacks mental capacity must be done in that persons best interests. The MCA (2005) defines how best interests' decisions should be made.

1.3.3 Lasting Power of Attorney (LPA)

The MCA (2005) allows a person aged 18 and over, who has capacity to make this decision, to appoint attorneys to act on their behalf should they lose mental capacity in the future. The provision replaces the previous Enduring Power of Attorney (EPA)

Lasting power of attorney (LPA) is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

This gives them more control over what happens to them if they have an accident or an illness and can't make their own decisions (they 'lack mental capacity').

A person must be 18 or over and have mental capacity (the ability to make their own decisions) when they make their LPA.

A person doesn't need to live in the UK or be a British citizen.

There are 2 types of LPA:

- Health and welfare
- Property and financial affairs

A person can choose to make one type or both types.

1.3.4 Court Appointed Deputies

The MCA (2005) provides for a system of court appointed deputies to replace the previous system of receivership in the court of protection. Deputies are able to make decisions on welfare, healthcare, and financial matters as authorised by the court of protection. They are not able to refuse consent to life sustaining treatment.

1.3.5 Court of Protection

The court of protection has jurisdiction relating to the whole MCA (2005) and is the final arbiter for capacity matters. It has its own procedures and nominated judges.

1.3.6 Advance Decision to Refuse Treatment (ADRT)

The MCA (2005) creates ways for people 18 and over, and able to make a decision in advance to refuse treatment if they should lack capacity in the future. An advance decision to refuse treatment that is not life sustaining does not need to be in writing but the person must ensure the 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.

1.3.7 Independent Mental Capacity Advocate (IMCA)

An IMCA is an advocate appointed by the local authority or NHS body, in certain circumstances, to support a person who lacks capacity in the decision making process. The decision maker must consider the views of the IMCA but is not bound by them.

1.3.8 Mental Capacity and Young People

The Mental Capacity Act applies 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. Depending upon the decision staff may then use the Children Act 1989 or the Mental Capacity Act to proceed with making a decision for the young person lacking capacity.

Where staff can demonstrate that they have acted in accordance with the Mental Capacity Act their actions will be protected from liability whether or not a person with parental responsibility consents. A young person's views on whether their parents should be consulted during the best interests' process should be considered.

Where staff choose to proceed with consent from someone with parental responsibility, they must inform the parent that they are required to act in the young person's best interests as outlined within the Act.

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.

2 ROLES AND RESPONSIBILITIES FOR IMPLEMENTATION OF THE MCA

2.1 General Roles and Responsibilities of the CCG

1. Establish clear lines of accountability for implementation of the MCA, which is reflected in governance arrangements
2. Secure the expertise of a lead for the MCA to support policy and training development
3. Ensure that the MCA is embedded into practice and this is discharged effectively across the health economy through the CCGs commissioning arrangements
4. Ensure that the CCG exercises a responsibility in ensuring service users receive treatment within the guidelines of the MCA Code of Practice
5. Ensure that MCA is identified as a key priority area in all strategic planning processes
6. Ensure that MCA implementation is integral to clinical governance and audit arrangements
7. The CCGs oversee through governance arrangements that hospitals as managing authorities comply with DoLS legislation
8. Ensure that all health providers commissioned by the CCG have comprehensive policies and procedures for MCA implementation and MCA Deprivation of Liberty Safeguards, and are easily accessible to staff at all levels
9. Ensure that all employees of the CCG have MCA training and competency appropriate to their role and responsibilities
10. Work in partnership with all health providers and GP member practices in achieving MCA training and competency appropriate to their role and responsibilities
11. Ensure that all contracts for the delivery of health care include clear standards for implementing the MCA; these standards are monitored thereby providing assurance that the MCA is being correctly implemented

12. Ensure that all health organisations with whom the CCG has commissioning arrangements have links with the local Mental Capacity networks and the work of the Local Safeguarding Adults Board MCA sub group
13. 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
14. Ensure the CCG is prepared for the Liberty Protection Safeguards implementation.
15. Ensure all health organisations with whom the CCG has commissioning arrangements have strategies in place to prepare for the Liberty Protection Safeguards.

2.1.1 CCG Executive Director with Responsibility for MCA

1. Ensure that all service plans/specifications/contracts/invitations to tender etc. include reference to the MCA and MCA Deprivation of Liberty safeguards. Further guidance on standards expected is detailed in the CCG Safeguarding Assurance Framework (SAF).

2.1.2 CCG Individual Staff Members including GP Member Practices

1. To be aware of patient groups who may require assessment under the MCA due to an impairment or disturbance of the mind or brain. Any treatment decisions that follow an assessment of capacity must be fully documented to ensure the best interest process has been followed
2. According to role, undertake training (as appropriate), including attending regular updates so that they maintain their skills when assessing capacity and are familiar with the legal requirements of the MCA
3. Understand the principles of confidentiality and information sharing in line with the MCA
4. All staff contribute, when requested to do so, to the multi-agency best interest meetings when related to funding of placements/care and treatment decisions

3. IMPLEMENTATION

3.1 Method of Monitoring Compliance

Healthcare providers will be required to complete the Safeguarding Assurance Framework which includes standards for MCA. As part of the monitoring of safeguarding arrangements for commissioned services, Safeguarding standards are incorporated into the annual contract process. Assurance is provided through the CCG self- assessment based on the safeguarding vulnerable people in the NHS Accountability and Assurance Framework.

3.2 Breaches of Policy

This policy is mandatory. Where it is not possible to comply with the policy or a decision is taken to depart from it, this must be notified to the CCG so that the level of risk can be assessed and an action plan can be formulated (see section 3.3 for contact details).

3.3 Contact Details

Designated Lead Nurse for Safeguarding Adults and Mental Capacity Act	01772 214317
Deputy Designated Professional for Safeguarding Adults and Mental Capacity Act	01772 214066
Safeguarding Administration Team Email: csrccg.safeguarding@nhs.net	01772 214376

4. REFERENCE DOCUMENTS

In developing this Policy, account has been taken of the following statutory guidance:

Statutory Guidance

- Department for Constitutional Affairs (2007) MCA 2005: Code of Practice. TSO: London
- Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to Supplement MCA 2005. London TSO
- The stationery Office, Children's commissioner (2004) Children Act 2004, London TSO

Care Quality Commission

- Care Quality Commission (2009) Guidance about compliance: Essential Standards of Quality and Safety

5. APPENDICES

5.1 MCA Learning and Development Framework which can be located on the Lancashire Safeguarding Adult Board MCA section on their website