NHS
North Tyneside
Clinical Commissioning Group

Corporate	CCG CO10 Mental Capacity Act Policy

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Consultation Process:	CCG Executive Director of Nursing & Transformation and Safeguarding Professionals for North Tyneside CCG. North Tyneside CCG Quality and Safety committee
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Policy Adopted From:	North Tyneside CCG Mental Capacity Act Policy (v1, 2013) and Newcastle Gateshead CCG MCA Policy (2015)
Approval Given By:	North Tyneside CCG Governing Body

Document History

Version	Date	Significant Changes
Version 1	12.11.15	First Issue
Version 2	01.11.16	Scheduled review

Equality Impact Assessment

Date	Issues
1 October 2015	None identified

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

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1. Introduction

The North Tyneside 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 impact of the Mental Capacity Act 2005 (MCA) for CCGs is in relation to Commissioner's duties to ensure provider services are delivered in accordance with the MCA and that the rights of those who use services are promoted and protected. The CCG has responsibility for commissioning high quality care and treatment. The CCG must ensure providers understand the MCA, apply it to practice and monitor compliance.

Fundamentally the CCG will need to ensure that;

- The MCA is given a high profile and priority within the CCG
- Compliance and how this will be achieved is a key part of the tendering process
- On-going compliance is monitored in detail through performance review and quality monitoring processes.

The main policy covers the areas outlined in the Department of Health Code of Practice.

The Governing Body and Accountable Officer of the CCG are committed to the development of a just and fair "no blame" culture, and this document supports that ethos.

The preparation of this document has included an assessment of risk covering clinical, financial, business and operational risks arising specifically from the implementation of the procedures described herein.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

1.1 Status

This policy is a corporate policy

1.2 Purpose and scope

To outline the responsibilities of the CCG in applying the Mental Capacity Act Code of Practice, with regard to ensuring that as Commissioners of services, these responsibilities are also adopted by those that we commission services from.

2. Definitions

2.1 The following terms and abbreviations are used within this document:

Reference	Abbreviated Term
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
Enduring Power of Attorney	EPA
Advance Decision to refuse treatment	ADRT
General Practitioner	GP

2.2 Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain.

An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- The effects of drugs and/or alcohol
- Delirium

Lacking capacity is about a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.

Capacity cannot be established merely by reference to a person's age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person's cultural values.

Lack of Capacity must be established following the processes outlined in Appendix A.

3. Mental Capacity Act Principles

3.1 The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- You have observed the principles of the MCA
- You have carried out, or been party to, an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in questions **and**;
- You reasonably believe the action you have taken is in the best interests of the person

3.2 Provided you have complied with the MCA in assessing capacity and acting in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA))
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay under the common law doctrine of necessity/emergency.
- Placements in residential care

3.3 There are five key principles underpinning the MCA as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not unable to make a decision unless all steps have been taken unsuccessfully.
3. A person is not unable to make a decision merely because he makes an unwise decision.
4. An act/decision made behalf of a person who lacks capacity must be in his best interests.
5. Before the act or decision, ensure it is achieved in the least restrictive way.

3.4 The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, **a person must be aged 18 or over.**

The Act also introduces new bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate (section a)
- The Office of the Public Guardian (section b)
- The Court of Protection (section c)
- Advance Decisions to refuse treatment (section d)
- Lasting Powers of Attorneys (section e)

3.5 The Independent Mental Capacity Advocate (IMCA)

3.5.1 Advocacy is taking action to help people:

- Express their views
- Secure their rights
- have their interests represented
- access information and services
- explore choices and options

3.5.2 Advocacy promotes equality, social justice and social inclusion. Therefore an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

3.5.3 Referrals to an IMCA **MUST** be considered when:

- There needs to be a decision relating to serious medical treatment.
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home)
- A long-term move to different accommodation is being considered for a period of over 8 weeks

Referrals to an IMCA **MAY** be considered when

- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

3.5.4 If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. If it is urgent then the decision can be taken without an IMCA but they must be instructed afterwards.

3.5.5 If, after consultation with your line manager, you consider appointment of an IMCA would be of particular benefit to an individual then a referral must be made as outlined within Appendix A.

3.5.6 It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker, nor are they mediators between parties in dispute.

3.5.7 The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker.

3.6 The Office of the Public Guardian (OPG)

3.6.1 This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the Court of Protection, as requested.

3.6.2 The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. Application to search the registers costs **£25.00**

3.6.3 Further information regarding the Office of the Public Guardian can be found by the following link:

http://www.publicguardian.gov.uk/

3.7 The Court of Protection (CoP)

3.7.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

3.7.2 The Act provides for a new CoP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (set examples to follow in future cases).

3.7.3 The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- appoint deputies to make decisions for people lacking capacity to make those decisions;
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties,
- and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

3.7.4 Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.

3.7.5 Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:

http://www.hmcourts-service.gov.uk/HMCSCourtFinder/

3.7.6 It must be stressed that any reference to the Court of Protection must be discussed with the Equality & Human Rights service in the first instance. The CCG must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. This is outlined in Appendix A.

3.8 Advance Decisions to Refuse Treatment (ADRT)

3.8.1 A person may have given advance decisions regarding health treatments, which will relate mainly to medical decisions. These should be recorded in the persons file where there is knowledge of them. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.

3.8.2 I f over the age of 18 years , a person making an advance decision to refuse treatment allows their decision about particular types of treatment, to be honoured in the event of losing capacity. This is legally binding and doctors and other healthcare professionals must follow directions.

3.8.3 You must take all reasonable efforts to be aware of the advance decision and that it exists, is valid and applicable to the particular treatment in question.

3.8.4 The Act introduces a number of rules to follow. Therefore a person should check that their current advance decision meets the rules if it is to take effect.

3.8.5 An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive and without which they may die) this must be in writing.

3.8.6 Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. You cannot ask for an advance decision to end your life or request treatment in future.

3.8.7 The validity of an advance decision may be challenge on the following grounds;

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act is the criteria for admission are met.
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision

3.9 Lasting Powers of Attorney (LPA)

3.9.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters
- Personal Welfare LPA re decisions about health and welfare, where you live day to day care or medical treatment.

This must be recorded in the person's file where there is knowledge of it. It only comes into effect after the person loses capacity and must be registered with the Office of the Public Guardian. An LPA can only act within the remit of their authority.

3.9.2 Important facts about LPAs

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes an LPA they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

3.10 Clinical Intervention

3.10.1 Decisions that are not covered by the MCA:

- Making a will
- Making a gift (unless they have a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering in to marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office

3.10.2 There must always be an assumption of capacity. Procedural guidance at Appendix A tells a practitioner what to do if it is suspected that a vulnerable person has a disturbance in the function of the mind or brain and may lack capacity to make a decision at this particular time. The second test, often referred to as the Functional Test, supports assessors to determine whether or not the patient can make the decision or lacks the mental capacity to do so.

3.10.3 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf, as long as they decisions they make are within their job remit.

3.10.4 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation.

3.10.5 Practitioners have to show that they

- have followed the five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity,
- have enabled a person, so far as is possible, to make their own decisions
- have taken reasonable steps to establish lack of capacity,
- have reasonable belief that the person lacks capacity,
- have demonstrated their action will be in the person's best interest.

3.10.6 Section 5 of the Act offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity, provided they have followed due process. Appendix A covers the procedure required.

4. Duties and Responsibilities

Council of Practices	The council of practices has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
The Chief Officer	The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements. The Chief Officer is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements. This role is supported by the Executive Nurse who holds delegated responsibility and is the executive lead for Safeguarding Adults. The Head of Quality and Safety provides expert advice to the Governing Body on MCA and MCA DoLS matters.
The Executive Lead for Safeguarding Adults	**The Executive Lead for safeguarding adults** The Executive Nurse, as executive lead for safeguarding adults, MCA and MCA DoLS, will ensure that the CCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a programme of training. The Executive Director is the Sponsoring Director for this policy and is responsible for ensuring that: • This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies • The necessary training required to implement this document is identified and resourced. • Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document. • The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service. • The CCG has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers

Lead Professional MCA and DoIs	Accountable to Executive Director of Nursing and Transformation. Reports to Executive Director of Nursing and Transformation. CCGs are required to have a designated MCA Lead and MCA DoLs lead to take a strategic and professional lead on all aspects of the NHS contribution to MCA and MCA DoLs across the CCG area; which include all commissioned providers. The lead will • Provide advice and expertise to the CCG governing body and Safeguarding Adults Board and associated groups and to professionals across both the NHS and partner agencies. • Provide professional leadership, advice and support to lead adult safeguarding professionals across provider trusts/services and independent contractors. • Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS. • Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements. • Provide advice and guidance in relation to MCA, MCA DoLS training including standards. • Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and compliance is evidenced. • The Head of Quality and Safety will work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's safeguarding teams.
CCG Staff	All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular: • Comply with the MCA and DoLS Policy. • Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy. • Identify training needs in respect of the MCA and DoLS Policy and informing their line manager • Complete mandatory MCA and MCA DoLS training in accordance with the CCG Safeguarding Adult and MCA, MCA DoLS Training Plan.
Commissioning Support Unit (CSU)	The CCG contracts with a Commissioning Support Unit. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSU will be expected to comply with the Service contract standards relating to MCA and DoLS.

Primary Medical Services (GP practices)	GP practices will be informed of the Service contract standards and encouraged to take account of these. The CCG in partnership with NHS England and supported by the CSU will develop a programme to support and monitor their adoption, and implementation in GP practices.

5. Implementation

5.1 This policy will be available to all Staff for use in the circumstances described on the title page.

5.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described

6. Training Implications

The training required to comply with this policy are:

- Policy awareness sessions
- Mandatory training programme
- E-learning
- Multi-Agency training is available from the Local Authority

7. Documentation

7.1 Other related policy documents.

Guidance on Advance Decision to Refuse Treatment (ADRT)

Safeguarding Vulnerable Adults Policy.

7.2 Legislation and statutory requirements

Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.

Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.

Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO. Cabinet

Office (2006) *Equality Act 2006.* London. HMSO.

Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.

Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.

Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.

House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office

7.3 Best practice recommendations

Document and Records Management Policy v3.0 NHSE Feb 2014

NHSLA Risk Management Standards 2013-2014

NHS England (London) (April 2014) Mental Capacity Act 2005: A guide for Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance. London: NHS England

HM Government (June 2014) Valuing Every Voice, respecting every right: Making the Case for the Mental Capacity Act. The Government's response to the House of Lords Select Committee report on the Mental Capacity Act 2005. Lord Chancellor and Secretary of State for Justice and Secretary of State for Health

Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

Ruck Keene, Alex and Dobson, Catherine (April 2014) Mental Capacity Law: Guidance Note. Deprivation of Liberty in the Hospital Setting. London: 39 Essex Street

Social Care, Local Government and Care partnership (2014). Positive and Proactive Care: Reducing the need for restrictive interventions. London: Department of Health

Social Care Institute for Excellence (august 2014) Adult Services: Report, Deprivation of Liberty Safeguards: putting them into practice. London: www.scie.org.uk

8. Monitoring, Review and Archiving

North Tyneside CCG will monitor compliance with this policy - see table below.

No.	Monitoring/audit arrangements of compliance with policy and methodology	Reporting		
		Source	Committee	Frequency
1.	**Safeguarding Adults training (CCG staff).**			
	Review of training data.	CCG data.	CCG Quality and safety Committee.	Quarterly
2.	**CCG Risk register:**			
	Review and updating risk register.	Complaints. Performance Dashboard. Serious Incidents.	CCG Quality and safety Committee.	Quarterly
3.	**Standards from Provider Performance Dashboard (developed by CCG for Providers from whom they commission services).**			
	Review of data provided.	Provider performance dashboard	Quality and safety Committee.	Quarterly
4.	**Providers compliance MCA and Dols:**			
	Review provider compliance with training.	Local Authority and other partner agencies. General public and patients.	Quality and safety Committee.	

9 Equality Analysis

A full Equality Impact Assessment has been completed

EIA - MCA Policy (2).doc

Appendix A Policy Flowchart