NHS
Lincolnshire
Integrated Care Board

Lincolnshire Integrated Care Board

Mental Capacity Act (2005) and

Deprivation of Liberty (2007) Policy

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CONTENTS

1. INTRODUCTION

1.1. This policy outlines how Lincolnshire Integrated Care Boards (ICB) will discharge its statutory obligation within its commissioning duties, of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) 2007.

1.2. The Mental Capacity Act (2005) (MCA) is intended to assist and support people who may lack capacity; it aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves.

1.3. A Deprivation of Liberty occurs where a person cannot consent to the arrangements for their care and restriction and restraint is to a level that infringes their Article 5 European Convention Human Rights - right to liberty.

1.4. In these circumstances, legal authorisation is required to deprive the person of their liberty. The Deprivation of Liberty Safeguards, provide safeguards for an individual's liberty and apply in care home and hospital settings. In other settings, authorisation must be sought through the Court of Protection.

1.5. The MCA and DoLS is accompanied by statutory codes of practice, which provides statutory guidance for how these procedures must be applied on a day to day basis and can be accessed via the following link: www.justice.gov.uk/downloads/protecting-the- vulnerable/mca/mca-code-practice-0509.pdf http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

2. POLICY STATEMENT

2.1. The ICB is statutorily responsible for ensuring that the organisations from which it commissions services provide a safe system which safeguards vulnerable children and adults at risk.

2.2. It will, therefore, ensure that it commissions MCA and DoLS compliant care and will ensure that providers meet their statutory responsibilities to the people who are without capacity to consent to care and treatment.

2.3. The ICB will ensure through existing monitoring arrangements that all staff employed by them are aware of their responsibilities under the MCA and DoLS within their given commissioning roles.

2.4. The MCA including Deprivation of Liberty Safeguards (DoLS) Policy should be read in conjunction with the ICBs' Safeguarding Adult Policy.

3. SCOPE OF THE POLICY

3.1. This policy applies to all staff working or volunteering within the ICB. The key principles are applicable to all services commissioned by the ICB. It is applicable to all ICB staff temporary or permanent including agency staff and volunteers.

3.2. All employees of the ICB have an individual responsibility for the protection and safeguarding of children, young people and adults at risk including people who lack capacity.

3.3. All managers must ensure that their staff are aware of this policy and know how to access it.

3.4. Managers should also ensure the implementation of the policy in accordance with their line of responsibility and accountability.

4. DEFINITION

4.1. The Mental Capacity Act (2005) (MCA) applies to all patients/service users aged 16, or over, who want to plan for the future, and covers decisions about finance, social care, medical treatment and research, as well as every-day living decisions.

4.2. The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity providing it can be demonstrated that:

- The principles of the MCA have been observed.
- An assessment of capacity has been carried out and documented.
- It is reasonably believed that the person lacks capacity in relation to the matter.
- It is in the best interests of the person for the action to be taken.

4.3. The MCA encapsulates the Deprivation of Liberty Safeguards, and is designed to promote the empowerment of individuals and the protection of their rights. The MCA is built on five statutory principles that guide and inform all decision making in relation to people who may lack capacity in some aspect of their lives. The MCA underpins health and social care commissioning and practice.

4.4. A deprivation of liberty can only be authorised under the MCA when there is evidence that a person lacks capacity as defined by the MCA, and where the proposed arrangements that deprive the person of their liberty are made in their best interests. A person can be deprived of their liberty only if authorised.

4.5. **The Deprivation of Liberty Safeguards (DoLS) applies to patients/service users aged 18 or over.** The safeguards apply to:

i. People in hospitals;
ii. People in care homes.

4.6. Both self-funded and publicly funded residents are covered by the safeguards as described in paragraph 4.4 above. For people being cared for somewhere other than a care home or hospital, deprivation of liberty will only be lawful with an order from the Court of Protection. For people under 18 years, in the absence of valid consent, this authorisation must be through the Court.[1]

4.7. All providers and commissioners of health and social care must therefore have a good understanding of the MCA. This will ensure that appropriate assessments of capacity are carried out and that decisions made for those who lack the required mental capacity are made in their best interests. Any situation calling for a request for authorisation under the Deprivation of Liberty Safeguards must first meet the general requirements of the MCA.

4.8. Supreme Court Ruling: Cheshire West

- The Courts[2] have determined that a deprivation of liberty has occurred where the person is unable to consent to the arrangements for their care and are subject to

i) Continuous Supervision and Control *and*
ii) Would not be free to leave

- There are implications for commissioners regarding the acid test which needs to be considered in relation to Deprivation of Liberty (DoL) resulting from the Supreme Court decision on the 19 March 2014 in P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".

1) The broad definition of deprivation of liberty will increase the numbers of authorisations that commissioned services will need to apply for through the Deprivation of Liberty Safeguards provisions

2) The circumstances where the ICB will need to apply for authorisation directly to the Courts e.g. individual packages of care outside of care home settings commissioned through CHC or section 117 Mental Health Act.

5. ASSURANCE

5.1. Professionals must remember that the Mental Capacity Act and Deprivation of liberty provisions are rooted in the principles of that Act and exist to provide protection to individuals, including to safeguard individuals when a deprivation of liberty is an unavoidable part of a best interests care plan. Individuals who are identified as potentially deprived of their liberty must be considered on a case-by-case basis.

[1] Note: Recent case law has identified that for young people between the age of 16- 18yrs, consent may not be provided by those with parental responsibility. For young people under 16 years, where the young person cannot consent, those with parental responsibility *may* be able to consent but there may also be circumstances e.g. Care Order, where the consent is deemed to be outside of the zone of parental responsibility and authorization must be sought through the Family Division Court

[2]http://www.mentalhealthlaw.co.uk/Cheshire_West_and_Chester_Council_v_P_(2014)_UKSC_19,_(2014)_MHLO_16

5.2. The ICB will assure that commissioned services take all appropriate steps to provide care in concordance with the MCA including that the least restrictive care is provided in meeting the person's needs. The emphasis should be on empowerment and enablement. These responsibilities apply to all ICB staff in carrying out their commissioning functions.

6. LEGISLATON / GUIDANCE

Various legislation and guidance is published that is relevant to this policy:

- The Mental Capacity Act (2005) and Amendment (2019)
- The Mental Capacity Act: Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- The Mental Health Act (2007)
- The Human Rights Act (1998)
- The European Convention on Human Rights
- The Care Act (2014)
- NHS Accountability Framework
- Supreme Court Ruling handed: 19 March (2014) P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".
- The Children Acts (1989 & 2004).

Case Law – the courts are likely to give judgments in cases after this policy is issued and is subject to change after each court judgment. Therefore staff will need to keep up to date and take account of further relevant legal developments

7. ACCOUNTABILITIES, RESPONSIBILITIES AND GOVERNANCE

7.1 The Chief Officer is accountable and responsible for ensuring that the ICB is able to discharge its duties in relation to the Mental Capacity Act (2005) both within the ICB and across the local health economy through the ICB's commissioning arrangements. This role is supported by the Director of Nursing and Quality who holds delegated responsibility.

7.2. Responsibilities of the Director of Nursing and Quality:

7.2.1 The Director of Nursing and Quality is responsible for safeguarding children and adults at risk, and Chief Officers have individual responsibility for their own ICB. This role includes the responsibility of overseeing the discharge of the ICB's responsibility in relation to the Mental Capacity Act (2005).

7.2.2 The Associated Director's of Nursing and Quality will:

Ensure arrangements are in place to support the implementation and monitoring of this policy

Represent the ICB as a member of the Lincolnshire Safeguarding Children Board and Safeguarding Adults Board.

Ensure appropriate training and support is made available to the Designated Mental Capacity Act Lead (Designate Safeguarding Nurse) to enable them to effectively conduct their roles.

7.3 Responsibilities of the Safeguarding Strategic Group:

7.3.1 The Safeguarding Strategic Group reports into the Quality Patient Experience Committee (QPEC) and identified risks are shared with the Governing Body meetings.

7.3.2 The Safeguarding Strategic Group meets quarterly and receives a report from the Designated Professionals on performance monitoring of the ICB, commissioned services, local arrangements and be advised of emerging safeguarding risks and actions required to mitigate those risk.

7.4 Responsibilities of the ICB

7.4.1 The Safeguarding Team is hosted by South West Lincolnshire locality on behalf of Lincolnshire ICB.

7.4.2 The ICB is responsible for ensuring the organisation has a named Designated Mental Capacity Act Lead who will be proficient in this area and is able to provide the necessary direction and expertise required. 5.4.3 The Designate Safeguarding Nurse within the safeguarding team is the named Designated Mental Capacity Act Lead. Ultimate responsibility will remain with the Director of Nursing and Quality.

7.4.3 The Designated Mental Capacity Act Lead will take on a strategic, professional advisory lead on all aspects of the health service contribution to the implementation of the MCA (including DoL'S) across the area within which the ICB commissions services and includes all health providers. The Designated Mental Capacity Act Lead will provide expert advice or source the expertise if required for the ICB on requirements that will inform the commissioning and strategic development of the MCA to ensure high quality service provision for patients lacking capacity.

7.4.4 The Designated Mental Capacity Act Lead will be responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and /or complex.

7.4.5 The Designated Mental Capacity Act Lead will support operational responsibilities for the ICB duties where direct application to the Court is required to seek authorisation for care commissioned by the ICB that deprives a person of their liberty other than within a care home or hospital environment.

7.4.6 With reference to paragraph 4.7 of this report, which outlines the recent Supreme Court ruling, handed down on the 19 March 2014 in relation to the Cheshire West case, the ICB will need to:

- Establish governance and assurance reporting arrangements through existing channels for CHC Quality and Performance management, and provider services.
- Act within legal boundaries in an effort to understand the legal

implications of the ruling for the ICB in the context of CHC patients with particular focus on those living at home/supported living.

- To identify cases that meets the acid test, and ensures an appropriate DoLS authorisation is sought through the Court of Protection if required.
- Scope the training and resource implications.
- Ensure contract monitoring agreements with providers' evidence the adoption of the new acid test.
- Ensure the ICB has appropriate insurance arrangements in place to cover any liability and/or litigation costs should they arise
- Ensure Training with regard to the Mental Capacity Act and its effective implementation is provided to ICB staff (Appendix 3).
- Work with local agencies to provide joint strategic leadership on MCA and DoLS in partnership with Local Authorities, provider organisations, CQC and the Police
- Ensure Provider contracts specify compliance with MCA and DoLS legislation and that commissioned services are supported and contract monitored for compliance with MCA.
- Ensure MCA leads work within the health and social care economies to influence local thinking and practice around MCA.
- Ensure best practice around MCA is promoted, implemented and monitored both within the ICB and within commissioned provider services.
- Engage with the local Safeguarding Adults Board and the board sub groups
- Have clear lines of accountability which are visible through robust governance arrangements.
- Ensure learning from cases is used to inform future commissioning and practice

7.5 Responsibilities of all ICB staff:

7.5.1 All managers must ensure that their staff (employed, contracted or volunteers) are aware of this policy and know how to access it. Managers should also ensure the implementation of the policy in accordance with their line of responsibility and accountability.

7.5.2 All staff employed by the ICB must be aware of their responsibilities with respect to the MCA and DoLS (Appendix 3).

7.6 Responsibilities of Providers

7.6.1 Provider organisations are responsible for ensuring compliance with MCA legislation (including DoLS) within and across their organisation

7.6.2 The ICB will oversee these responsibilities

8. Information Governance

8.1 The ICB will comply with the following rules of information sharing:

- The Data Protection Act (1998) and the EU General Data Protection Regulation (GDPR) 2018 is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately
- Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so
- Seek advice if you are in any doubt, without disclosing the identity of the person where possible
- Sharing with consent is the preferred route and, where possible, respects the wishes of those who do not consent to sharing confidential information. You may still share information without consent if you believe the patient lacks capacity under the MCA or if you feel that it is in the public interest. You will need to base your judgment on the facts of the case and to document the reasons as to why
- Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions
- Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely
- Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

9. POLICY GOVERNANCE AND MONITORING

This policy will be reviewed every three years. It will be the responsibility of the ICB Safeguarding Strategic Group to:

i. Identify a suitable reviewer
ii. Ensure that the review is conducted
iii. Ensure that required changes are made.

Changes may be required due to legislation, national or local guidance, findings of Safeguarding Adult Reviews, recommendations of audits or from other sources.

10. EQUAILTY AND HUMAN RIGHTS LEGISLATION

10.1 In applying this policy and procedure, managers, employees, workers and their representatives will have regard to the Equality Act 2010 – public sector duty for the principles and requirements of the Lincolnshire ICB Equality and Diversity Strategy. The organisation is committed to equality, diversity and

human rights; accordingly the implementation of this policy and its impact will be monitored across all equality protected characteristic strands and reported regularly to the appropriate Lincolnshire ICB Board.

10.2 Managers will not discriminate in the application of this policy and procedure in respect of age, disability, race, ethnic or national origin, gender, religion, beliefs, sexual orientation, marital/partnership status, social and employment status, gender identification, language, trade union membership or mental health status

APPENDIX 1

References

Mental Capacity Act 2005
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm

Code of Practice (2007) for Mental Capacity Act 2005 (2007)
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf

Data protection Act (1998)
http://www.legislation.gov.uk/ukpga/1998/29/contents

The DOLS Code of Practice:
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Deprivation of Liberty Safeguards: A guide for hospitals and care homes:
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094348

Deprivation of Liberty Safeguards: A guide for relevant person's representatives:-
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094346

Making Decisions: The Independent Mental Capacity Advocate (IMCA) service

Supreme Court Ruling handed down 19th March 2014. P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".

http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

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

Safeguarding Vulnerable People in the Reformed NHS (2013): Accountability and Assurance Framework. NHS Commissioning board.

www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

APPENDIX 2

Equality Impact Assessment

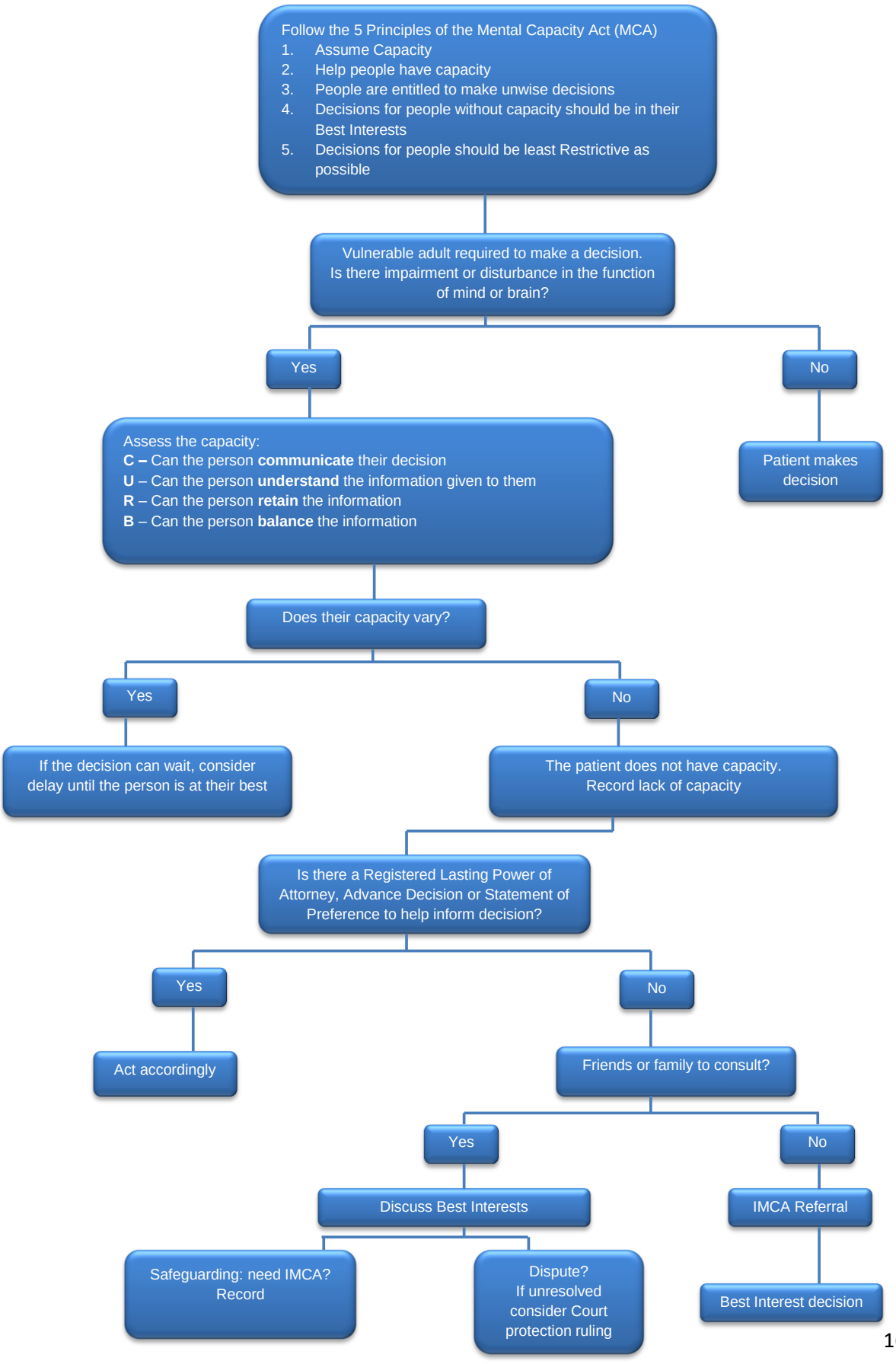
EIA MCA.docx

Appendix 3 – Recommended Training for ICB staff

Guidance on Mental Capacity Act and Deprivation of Liberty Safeguarding Training for ICB Staff			
Level	**Who**	**What**	**Learning Resource**
Mental Capacity Act Foundation **Level 1**	Targeting all individuals who work with or may come in to contact with people 16 years upwards.	Explain the 5 Principles of the MCA and how they use them when working with residents/ patients • Describe what is meant by 'lack of capacity' and that capacity is decision and time specific • Identify what steps need to be taken to ensure that any decision is taken is in a person's Best Interests • Define the reasons an IMCA may be appointed • Explain what provisions the MCA 2005 has put in place to enable people to make decisions now that have an impact later in their life	e-learning work book videos
Mental Capacity Act Intermediate **Level 2**	Targeting all staff who have direct and regular contact with people aged 16 upwards including GP's and practice staff	As Level 1 • Understand their role as decision maker and what to do if they are not a decision maker. • Describe how to undertake an assessment of an individual's capacity using the stage 2 assessment process • Explain how to ensure any decision that is made on behalf of a person who lacks capacity is in their Best Interests and how they consider the least restrictive option • Demonstrate how to record a capacity assessment and best interest decision • Describe the roles of other individuals in decision making e.g. LPA's, Deputies, IMCA's • Explain what an Advance Decision is and what impact this has on an individual's care • Understanding their role in End of Life care planning and what support an individual may need to make these decisions • Consent and DNACPR when applicable **Where applicable** Understand the concept of serious medical treatment.	Face to face training e-learning Videos Radio Broadcasts Webinars 'How to' guides Mobile Apps
Mental Capacity Act Expert **Level 3**	Targeting senior staff that have a lead responsibility in the organisation. Continuing Healthcare	• As Levels 1 & 2 • Describe 'What good looks like' in MCA assessment completion • Demonstrate the ability to coach/ inform others to enhance their MCA practice and development • Understand the latest policy on MCA • Identify when a decision should be	Face to face learning Webinars Briefings

		referred to the Court of Protection • Demonstrate how to complete Court of Protection documentation	
Deprivation of Liberty Safeguards Foundation **Level 1**	Targeting all individuals who work with people 16 years upwards	• Explain what is meant by the term restraint and identify different levels of restraint • Explain how a deprivation can be legally authorised • Describe their role in identifying and reporting when they believe an individual is being deprived of their liberty or restricted	Face to face training Webinars Briefings
Deprivation of Liberty Safeguards Intermediate **Level 2**	Targeting all staff who have direct and regular contact with people aged 16 upwards (including GP's and practice staff)	• Describe the connection of a DoLs with the ECHR (articles 5 & 8) • Demonstrate the process you should follow if you believe a deprivation is occurring; o Within a Care Home/ Hospital o Within a domestic setting • Explain the role of the BIA, MHA, IMCA, RPR within the DoLs process • Describe the process if someone leaves/ moves/ dies whilst subject to a DoLs Authorisation/ Court of Protection order • Understand the process that should be followed when considering the restrictions in place before a person is placed into a care home/ admitted into hospital, or, when reviewing their care needs within a domestic setting	Face to face training e-learning Videos Radio Broadcasts Webinars 'How to' guides Mobile Apps
Deprivation Liberty Safeguards Expert **Level 3**	Targeting senior staff that have lead responsibility in the organisation. Continuing Healthcare	• Understand the implications of current court judgments in relation to deprivation of liberty and how that impacts on their decision making	Face to face training Webinars Briefings

Appendix 4 – Mental Capacity Act/Best Interest Assessment Flowchart



Appendix 4 a.

Mental Capacity Assessment Template

MCA template.doc

Appendix 4 b.

Best Interest Decision Flow Chart

Decision making process for patients t

Appendix 4 c.

Best Interest Agenda and guidance

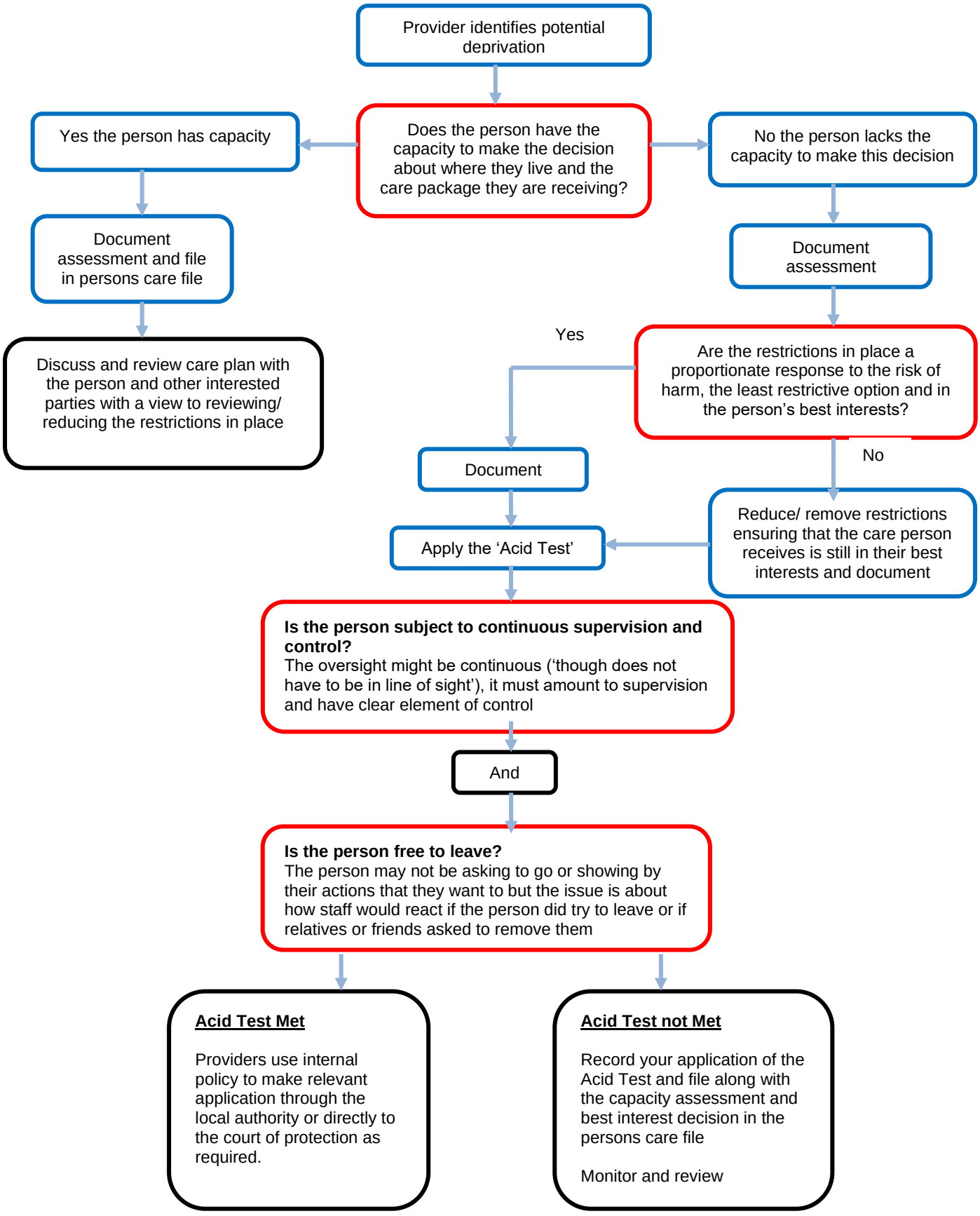
Best Interest Meeting Agenda.doc›

best-interests-meetings-guidance.pdf

Guidance adopted with thanks to Lincolnshire County Council to ensure consistency across social and health care funding streams.

Appendix 5 – Deprivation of Liberty Flowchart for reference

Provider flowchart for DOLS



Appendix 6

ADVANCE DECISIONS TO REFUSE TREATMENT (ADRT)

A person with capacity can make a decision in advance regarding future medical treatment that they **do not** want to receive. This decision will apply at a future time if the person lacks capacity to consent to, or refuse, the specified treatment. If life sustaining treatment is involved the ADRT must be signed and witnessed.

If an individual expresses opinions and preferences about future medical treatment, staff working with them should advise them to contact their General Practitioner (GP), consultant etc. to discuss making an ADRT, or provide further information.

There is no specified format for an ADRT. They may be in written form, as in a 'living will' or other record; they may be verbal, or recorded in case notes or files. It is the responsibility of the individual to ensure that the existence of the ADRT is known to the appropriate people, e.g., family, GP or other health professionals.

If an ADRT is valid and applicable it overrides the Best Interest principle, as it directly provides the views and wishes of the individual concerned. However, the ADRT may be disregarded if the decision maker is unsure if the ADRT is valid or reasonably believes that the individual has subsequently changed their mind.

It is the responsibility of medical staff to make reasonable efforts to discover if an ADRT exists. However, in emergency situations medical staff are advised to provide immediate treatment rather than waiting to confirm that there is a valid ADRT.

Anticipatory and Advance care planning (ACP)

Anticipatory and Advance care planning (ACP), are both about adopting a "thinking ahead" philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done at the right time by the right person(s) with the right outcome. Advance care planning is the term most commonly referred to in end of life care, although it does incorporate the writing of wills or "Living Wills" now known as advance directives or advance decisions which can be done by the well person early on in life to plan for what **may** happen at the end of life. Anticipatory care planning is more commonly applied to support those living with a long term condition to plan for an **expected** change in health or social status. It also incorporates health improvement and staying well. Completion of a common document called an anticipatory care plan is suggested for both long term conditions and in palliative care. An Anticipatory Care Plan is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of Thinking Ahead discussions between the person, those close to them and the practitioner. The ACP is a record of the preferred actions, interventions and responses that care providers should make following a clinical deterioration or a crisis in the person's care or support. It should be reviewed and updated as the condition or the personal circumstances change and different things take priority.

Anticipatory care encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis. An anticipatory care approach supports important outcomes:

- Person centred care, dignity, choice and control
- Effective co-ordination and communication between the individual, their family and the health and social care professionals involved
- Care at home where appropriate, or care which is more local and closer to home

LASTING POWER OF ATTORNEY (LPA)
The MCA allows anyone to appoint an attorney to act on their behalf. The person who gives the power to the attorney (the donor) must have capacity when they appoint the LPA. The donor sets out the conditions and restrictions to the LPA's role. The LPA can make decisions on behalf of the person who has lost capacity, and is required to act in their best interests.

An LPA must be registered with the Office of the Public Guardian (OPG) before they can operate. LPA's are required to follow the Code of Practice. They are accountable to the Court of Protection and if there are concerns that they are not acting in the best interests of the donor, the Court may take away their authority to act. LPA's are issued with a certificate to confirm appointment.

LPA's can be appointed to make finance and property decisions and can act whether the donor has capacity or whether they have lost capacity.
LPA's can also be appointed to make health and welfare decisions. However, in this case they can only act when the donor has lost capacity.

Staff should request sight of the certificate of registration if healthcare decisions are being made by an LPA. If there are concerns about whether an LPA is authorised or the extent of their powers, a request can be made to the Office of the Public Guardian for this information.

COURT OF PROTECTION
Section 45 of the Act sets up a specialist court, the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves.

The Court of Protection has 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.

Before accepting an appointment as a deputy, a person the court nominates should consider whether:
- they have the skills and ability to carry out a deputy's duties (especially in relation to property and affairs)
- they actually want to take on the duties and responsibilities.

If there is a need for ongoing decision-making powers and there is no relevant EPA or LPA, the court may appoint a deputy to make future decisions. It will also state what decisions the deputy has the authority to make on the person's behalf.

THE OFFICE OF THE PUBLIC GUARDIAN
The MCA creates a new public office known as the public guardian. The public guardian protects people who lack capacity by:

- Establishing and maintaining a register of LPA's
- Establishing and maintaining a register of orders appointing deputies
- Supervising deputies appointed by the Court
- Directing Court of Protection visitors to visit people who lack capacity

- Receiving reports from attorneys acting under LPA's and from deputies
- Providing reports to the court when requested
- Dealing with representations about the way in which deputies and attorneys exercise their powers

APPENDIX 7 Do Not Attempt CPR (DNACPR)

This is a decision not to attempt CPR, made and recorded in advance, to guide those present if a person subsequently suffers sudden cardiac arrest or dies.

A DNACPR decision may be made and recorded:

- at the request of the person themselves
- as a shared decision (made by the person themselves and their doctor and/or other healthcare team members) that the likelihood of CPR being beneficial in their current situation would not outweigh the potential burdens and risks of receiving attempted CPR
- by the healthcare team, because CPR should not be offered to a person who is dying from an advanced and irreversible condition and therefore CPR will not prevent their death
- by the healthcare team because the person themselves is not able to contribute to a shared decision and a decision has to be made in their best interests.

If a person is unable to contribute to making the decision (for example because they are unconscious, severely demented, or too severely ill to participate in the discussion) the decision will be made by the senior clinician responsible for their care, whenever possible after taking advice from those close to the person, such as family members. However family members are not expected to or entitled to make the decision unless they have been given legal power (e.g. Power of Attorney) to make such decisions on the person's behalf.

The decision is usually recorded on a specific 'CPR decision form', so that it can be recognised quickly and its content assessed very quickly by those who may need it to guide their decisions and actions in an emergency situation. Increasingly such forms are designed and used to allow recording of a decision that attempted CPR is still appropriate as well as a DNACPR decision, and to allow recording of decisions about other life-sustaining treatments that may or may not be wanted by or effective for the person.

For further advice please access the following the links:

http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_DNACPR_decision.asp

https://www.resus.org.uk/#