Bournemouth University

The National Centre for Post-Qualifying Social Work and Professional Practice

National Mental Capacity Forum

# National Mental Capacity Act Competency Framework


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Supporting workforce development across the Social Care Sector

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# Forewords

Welcome to the National Competency Framework for MCA produced in association with The National Mental Capacity Forum and a number of key national organisations working in this area.

We are passionately committed to working within the Health and Social Care sector to promote the best possible professional practice and to help explore and find new ways of working within the field.

We strive to be as open as possible with our ideas and findings and we welcome any feedback on our publications or reports – we too want to strive to offer an excellent service.

This framework was developed and designed with a number of key organisations and I would like to express my sincere thanks to all who have commented on the various drafts to help refine this framework together. It is our sincere desire that it will become a key resource for all who work in this sector.

You will find details of our other publications and research reports on our websites (www.ncpqsw.com and www.buclimb.com) plus details of our CPD courses, which are endorsed by the College of Social Work. Please do take a moment to look at these sites; together, with partners like yourself, we want to make a real and profound difference to the lives of vulnerable citizens in our society.

If you would like to discuss any aspect of this publication with myself or a member of the team, or you would like to discuss an aspect of Health or Social Care provision with us, please do not hesitate to contact us.

Professor Keith Brown,

Director for The National Centre for Post-Qualifying Social Work and Professional Practice,
Bournemouth University

The core principles of the Mental Capacity Act should underpin all interactions in health and social care, from the simplest form of consent (such as agreeing to have a blood pressure taken) right through to complex decision-making such as consent to various interventions, and decisions over the place of care and long-term residence.

The skill of listening underpins all the competencies required in this framework. Failures in care can usually be traced back to a failure to listen to the person and the failure to hold the person's needs at the heart of all care provided.

This framework is designed to help staff at every level to be able to demonstrate that they are indeed keeping the needs of the person at the forefront and doing all they can to empower the person to make their own decisions, only resorting to best interests decision-making when the person lacks capacity.

Baroness Ilora Finlay

Chair of the National Mental Capacity Forum

The Centre would like to acknowledge the work and contributions to this framework by NHS England, Dorset Healthcare University NHS Foundation Trust, National Mental Capacity Forum, Adults PSW Network, Alzheimer's Society, DOH Adult Safeguarding Leadership Group, Learn to Care and the Office of Public Guardian.

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## Introduction

The presumption of capacity should be the underpinning ethos of the interactions between health, social care and public sector workers whenever they are required to interact and/or build relationships with any member of the public.

In some circumstances there may be concerns which lead staff across the full range of public service settings to work with individuals who may, for a whole host of reasons, be unable to decide for themselves. In these cases, staff need to understand, and apply, the framework of the Mental Capacity Act to their areas of responsibility, ensuring the individual's rights in situations where someone needs additional support or safeguards to be put in place.

## The Mental Capacity Act 2005

Prior to this legislation, the way people understood and worked with mental capacity was variable, often making a global judgement based on diagnosis or behaviour, rather than clearly understanding what capacity might mean in each specific circumstance.

The Mental Capacity Act (MCA) received Royal Assent in 2005 and was fully implemented in October 2007, with the Deprivation of Liberty Safeguards (DoLS) being added to the Act in 2007 with implementation in April 2009. Codes of practice were published in 2007 and 2008 and, for the first time, health, social care and other public sector professionals had a clear framework they could use to think about mental capacity and best interests decision-making in a way that promoted the individual's rights.

The purpose of the 2005 Act was to provide a clear framework for assessment and making decisions. Although the application of the MCA has been variable (for example, see House of Lords Post-Legislative Scrutiny Report, 2014), when applied appropriately it is an empowering piece of legislation that focuses on individual strengths and civil rights and places the emphasis on the individual making their own decisions.

## The Statutory Principles of the Mental Capacity Act 2005

The importance of the core principles of this Act is clear, with the principles included in the primary legislation, as section 1 (s.1) of the MCA, with chapter 2 of the accompanying 2007 Code of Practice devoted to their application in practice.

As the principles have statutory status they are part of the legal framework rather than best practice guidance and, as such, all those working with individuals experiencing problems with their mental capacity or decision-making must ensure that their actions, or inactions, are guided by them.

The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity (s.1 (2)).
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (s.1 (3)).
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision (s.1 (4)).
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests (s.1 (5)).
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action (s.1 (6)).

This framework is built around these 5 statutory principles, as they encompass all the key knowledge, interventions, and skills that are required by those working with individuals, in a variety of settings, for who mental capacity is a consideration.

| 1. Presumption of capacity | |
|---|---|
| Description | Outcome for individual |
| Individuals are able to make their own decisions unless they lack the capacity to do so, which must be proved by the person who is seeking to make the decision on the person's behalf.<br><br>Capacity should only be assessed if there is a reason to doubt that the person is able to take a particular decision at a specific time; it does not relate to a particular diagnostic label. | • Individual autonomy is respected.<br>• Capacity is properly assessed and the persons needs in terms of understanding, retaining and weighing up the information and communicating their decisions is understood and supported. |

| 2. Helping the person to make their own decision | |
|---|---|
| Description | Outcome for individual |
| A person must be given all possible help before anyone treats them as not being able to make their own decisions. This means you must make every effort to encourage and support people to make the decision for themselves, for example, treating conditions that may undermine capacity, considering deferring the decision until capacity is improved, ensuring all information is given in a way the person can understand.<br><br>Communication and engagement skills are essential for anyone working with those affected by difficulties with their ability to make a/some decisions themselves.<br><br>If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions. | • Individuals wishes, feelings and preferences are taken into account.<br>• Individuals are able to take part in decisions.<br>• Individuals retain control over their own lives wherever possible and this is supported by decision makers. |

| 3. The right to make unwise decisions | |
|---|---|
| Description | Outcome for individual |
| A person should never be considered to be lacking capacity solely on the basis of a decision or decisions that appear unwise or otherwise not in the person's best interests.<br><br>People prioritise risk differently, they value different things and are entitled to make decisions that are not only unwise but may also be damaging to their health or welfare if they are able to understand, retain, and weigh up the relevant information in order to make that decision and are able to communicate their decision. | • Individual autonomy is respected.<br>• Individuals retain control over their own lives.<br>• Individuals are supported to identify and understand consequences of their actions.<br>• Individuals are supported to make informed decisions. |

| 4. Best interests | |
|---|---|
| Description | Outcome for individual |
| Any decision taken on behalf of someone should consider all the factors relevant to them, including their wishes and feelings, the views of others, beliefs and medical, social and emotional welfare, using the section 4 checklist as a guide to 'working-out' what might be in a person's best interest.<br><br>Actions taken in relation to the person's care, treatment or other supports are based on a decision that reflects the person's best interests in the most holistic way possible. | • Decisions are only taken that take account of what that person would have wanted.<br>• Those who know the person best are involved in decisions.<br>• Decisions made on the individual's behalf are based on what is important to them. |

| 5. Less Restriction | |
|---|---|
| Description | Outcome for individual |
| Any interventions take account of whether there is a less restrictive way of achieving the same purpose with an emphasis on reducing restrictions wherever possible.<br><br>Any restrictions placed upon a person are considered in terms of whether they are a proportionate response to any restrictions on the person's rights and freedoms, whether direct or indirect (e.g. the result of harm to others).<br><br>An individual's rights must always be balanced against any risk of harm and any restrictions must be only applied if it is determined to be in a person's best interests. | • Individuals are not subject to any more restriction to their liberty than is absolutely necessary.<br>• Individual's residual liberty is promoted when restrictions (or deprivations) of liberty are necessary.<br>• Restrictions are only used to protect the individual from harm. |

## Essential Awareness

The MCA is a law that affects all of us. Anyone in any position where interaction with the public is a part of their role will need to have a basic awareness of the principles of the Act and what it means to them in their roles.

Target Audience: including but not limited to: Local communities and community leaders; Voluntary organisations and volunteers; Service users; Informal carers and relatives, DWP, Job Centre advisors, Trading Standards, Educational providers, Customer service staff across all organisations, with the aim of raising awareness of the provisions and protections of the Mental Capacity Act 2005 and to promote the individual's rights to make their own decisions wherever possible.

| Essential Awareness – 'The MCA Affects us All" |
|---|
| Understanding that mental capacity is to be assumed unless there is a reason to question and assess it. |
| Understanding that the onus is on the worker to determine incapacity to make a specific decision at the time it needs to be made on the balance of probabilities, not on the person to prove they have capacity. |
| Ability to use communication and engagement skills to support a person who has difficulties with mental capacity to make (or take part in) decisions for/about themselves. |
| Knowledge of how capacity is defined and that mental capacity is time and decision specific. |
| Knowledge and understanding of the statutory principles and how they underpin any decisions or actions. |
| Knowledge that the decision maker may be a person with relevant legal powers, such as an Attorney appointed under an LPA, the person most appropriate in each decision being made if there is no Attorney or Deputy, or in some cases referral to the court is required. |
| Understanding of supported decision making and the steps that should be taken to involve individuals in their own lives. |
| Knowledge of, and confidence to report concerns and request input from others and consult with both the person and their family and supporters. |

## Purpose of the Framework

This framework incorporates and links to a number of other competence standards, for example the National Safeguarding Competence Framework and the BIA capabilities. It is divided by staff group and is focused on what different groups need to demonstrate under each of the 5 principle areas.

## What is Competency?

Each professional competency standard within this framework refers to a combination of skills, knowledge and experience expected of individual staff. This framework aims to ensure that these qualities inform MCA practice in a way that is commensurate with an individual's occupational role and responsibility.

Competency involves being able to demonstrate the ability to be critically reflective and self-aware as you analyse, review and evaluate your skills, knowledge and professional practice, exploring alternative approaches and being open to change.

## Carrying out the assessment of competency

The assessment of competencies should combine a mix of direct observation of practice, as well as a process of exploration, discussion and questioning in supervision and appraisal meetings to develop analytical and evaluative thinking, developing professional judgment. Assessment should also reflect a knowledge and understanding of Local Authority Multi-Agency Policy and Procedures for Safeguarding Adults, Operational Instructions and Safeguarding Practice Standards.

The assessment of competencies should be undertaken by an appropriate competent staff member such as a supervisor. This can combine a mix of direct observation of practice, discussion and questioning in supervision and appraisal meetings.

All staff and volunteers should be helped to develop MCA competencies. This can be done by participating in formal training and development opportunities. However, there are also many opportunities for staff to learn and develop within the workplace, for example, discussions in team meetings, shadowing with more experienced staff, and mentoring opportunities.

## Staff Groups

The MCA is relevant to any staff of any public service, whether directly delivered by statutory agencies (e.g. Local Authority, NHS, Police, Fire service, etc.) or via third sector care providers (e.g. private or charitable organisations providing health, social care or other public service support services). For the purposes of clarity, these staff groups have been identified as per the following table.

| | Including, but not limited to: | |
|---|---|---|
| Staff Group A: Health & Care workers and other Public Sector Staff | • Care assistants<br>• Unqualified social care staff<br>• Care home workers<br>• Home care workers<br>• Health care assistants<br>• Support workers/Nursing Assistants/ care workers<br>• Community support workers<br>• Support Time & Recovery workers / Re-ablement Workers<br>• Transitions workers<br>• Personal assistants | • Volunteers<br>• Befrienders, mentors and advisers<br>• Medical receptionists<br>• Service receptionists, ward clerks and other admin with service user contact<br>• Social Care Customer Service<br>• Housing Staff<br>• Adult Foster Carers<br>• Fire service Vulnerable Persons Officers (VPO) (or equivalent)<br>• Community policing staff |
| Staff Group B: Provider Managers | • Care home managers<br>• Home care coordinators and managers<br>• CQC Registered managers in all provider settings<br>• Ward Managers | • Other residential or nursing provider service managers<br>• Supported housing and extra care managers<br>• Other housing managers |
| Staff Group C: Professional Health & Social Care Staff (Qualified non specialist) | • Children & Family Social Workers<br>• Adult Newly Qualified Social Workers<br>• Transitions social workers<br>• Occupational Therapists<br>• General & Physical Health Nurses<br>• General & Physical Health Medical Staff<br>• GPs<br>• Surgical Staff<br>• Health Visitor | • Dieticians<br>• Physiotherapists<br>• Pharmacists<br>• Radiologists<br>• Dentists and dental nurses<br>• Phlebotomists<br>• Other Allied Health Professionals<br>• Team managers and Senior Practitioners<br>• CCG and LA commissioners and contract managers |
| Staff Group D: Professional Health & Social Care Staff (Qualified Specialist) | • Dementia Nurses<br>• Learning Disability Nurses<br>• Mental Health Nurses<br>• Approved Mental Health Professionals (AMHPs)<br>• Adult Social Workers (inc Mental | Health and Learning Disability Social Workers)<br>• Forensic SW<br>• Psychologists / Other therapists<br>• Psychiatrists (including section 12 doctors) |
| Staff Group E: LA Authorisers & Leads | • LA DoLS Authorisers<br>• MCA / DoLS leads in LA and NHS organisations<br>• Board and Senior Management MCA / DoLS portfolio holders | |

| | |
|---|---|
| Best Interest Assessors | • Social Workers, Nurses, OTs, Psychologists who have completed an accredited Best Interests Assessor (BIA) qualification programme |

## What is Mental Capacity?

Mental Capacity means the ability to make a decision at a time it needs to be made. It is not about insight into your own needs, sensible decision making or doing what is best for yourself, but rather it is defined by whether a person has an impairment of disturbance of the mind or brain (s.2 MCA), and whether that impairment means they are unable to understand, retain and weigh the relevant information and communicate the decision (s.3, MCA). Capacity can vary over time and on the decision being made. Physical conditions, including environmental issues, can also affect a person's capacity. The emphasis within the MCA is about taking all this into account and taking steps to make sure a person is supported.

If a specific decision is not needing to be made then the assessment of capacity should not be applied. The first step in any MCA process is the identification of the decision that needs to be made and the relevant or 'salient[1]' information a person would be expected to understand, weigh and retain to make the decision.

## What Mental Capacity is not

How we think about and work with mental capacity has changed over time and much needs to be done to raise awareness and challenge assumptions that are often made about a person's capacity based on their condition or diagnosis.

Capacity for each decision should be considered and assessed where there is a concern. It is not based solely on -

- The ability to do a task
- Insight into your own condition
- Having a dementia or mental illness
- The outcome of a mental examination or another clinical tool, or
- A measure of cognitive performance

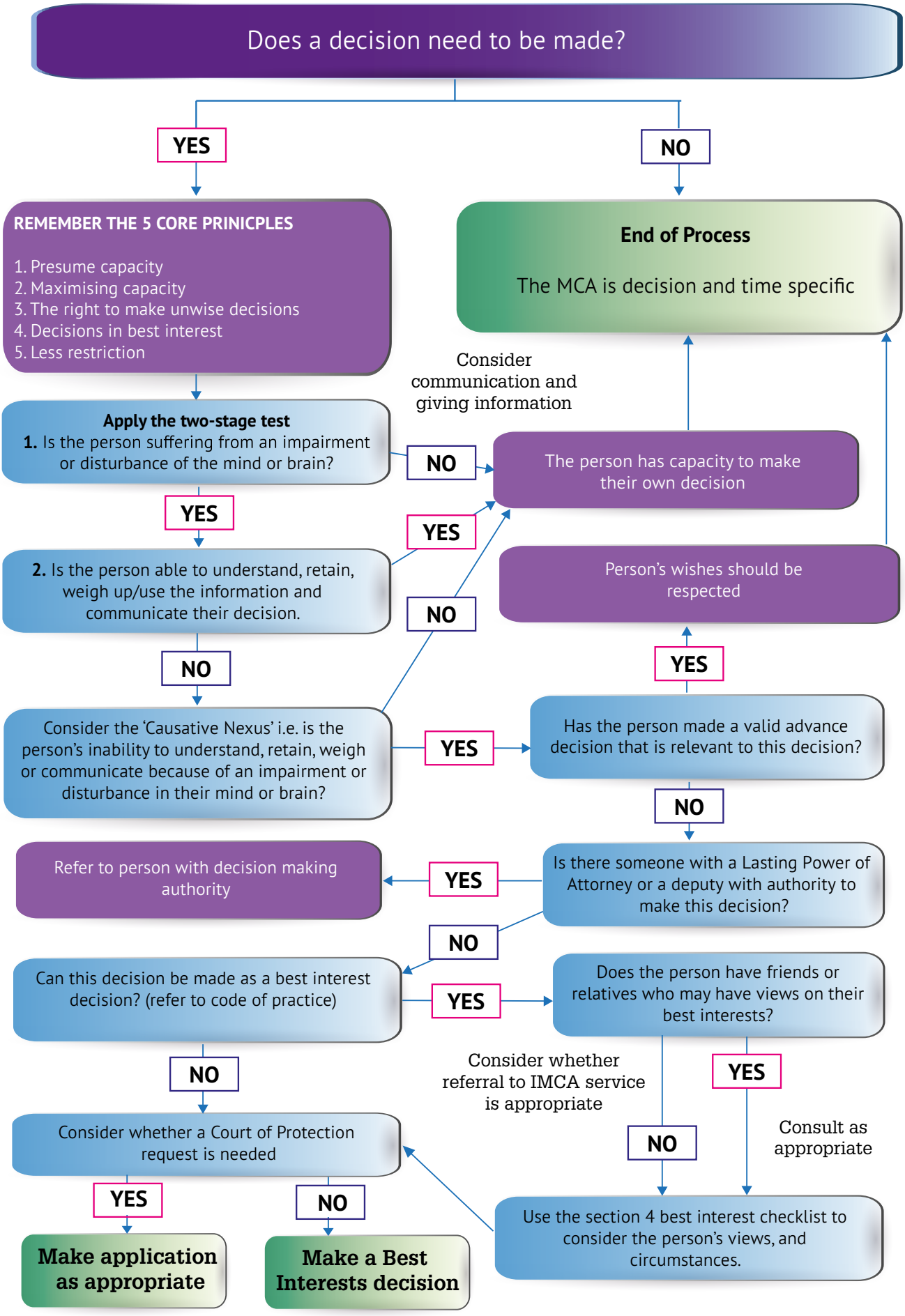
## The MCA Process

The MCA provides a clear process and emphasises that capacity is a time-specific, decision-specific issue. The following flow chart illustrates the processes involved in thinking about whether an individual has the mental capacity to make a decision for themselves.

The Act includes several ways that the person can plan for the future.  It also contains a framework for working out what might be in the person's best interests.

[1] From Wandsworth CCG v IA [2014] EWHC 990 (COP)

# Assessment of Capacity to Make a Decision




Adapted from: DBC (2016) GP Toolkit: MCA Process Flowchart.
Freely available for not-for-profit use at: http://mentalcapacityresources.co.uk/index.html

## Decision-Making Authorities

Under the MCA it is clear where the authority for decisions should be taken from when the person themselves is unable to make a given decision. The Act includes several ways that the person can plan for the future via advance decisions and Lasting Powers of Attorney (LPA) for either/both property and affairs and health and welfare decisions. It also contains a framework for working out what might be in the person's best interests.

Where there is no applicable Lasting Power of Attorney in place, and a decision needs to be made there are two possible options in terms of decision-making authorities. Firstly, for day-to-day decisions where the individual is not appearing to object (for example personal care, social activities, accommodation decisions and support plans) the person intending to carry out the intervention will be the most appropriate person to make the decision. For more complex decisions, for example, in relation to end-of-life care or serious medical treatment that may have significant complications or risks, or where the person is deprived of their liberty and objecting, it may be that a referral to the Court of Protection is appropriate. The court can make decisions directly, or where ongoing decisions may be needed the appointment of a deputy may be required. Staff in all groups should seek advice and support from their own managers and legal departments where more complex or serious decisions need to be made.

## Next of Kin

The term Next of Kin (NoK) is commonly used and there is a presumption that such a person has certain rights and duties; this is not actually the case. Staff and professionals may seek to consult the next of kin but that person cannot consent to anything on the person's behalf unless they have a Lasting Power of Attorney or other authority to make the decision (e.g. deputyship, EPA). Seeking NoK consent is a mistake often made in public sector settings, as it is not a legally valid consent.

For more information, please see our booklet 'Next of Kin: Understanding Decision Making Authorities' (Bogg & Brown, 2016) available here - http://www.scie.org.uk/mca-directory/files/next-of-kin-booklet.pdf

## Advance Decisions to Refuse Treatment

Under the Mental Capacity Act 2005, these types of decisions have legal status. An advance decision can only be made by a person if they are over the age of 18 and have capacity to make that decision. They relate to medical decisions, and the statement must state which treatment they are refusing. The decision can be amended at any time by the person themselves.

Staff and professionals seeking to provide treatment, once the person has lost capacity to decide for themselves, will need to check whether an advance decision exists, if it does is it valid (i.e. the person has not altered the decision) and is it applicable to the treatment being proposed. A valid and applicable advance decision to refuse treatment has the same effect as the person making the decision themselves at the time it needs to be made. The advance decision may be communicated verbally, or where it concerns life-sustaining or lifesaving treatment, in writing.

## Advance Statement of Wishes

A person can stipulate what they would like to happen if certain situations arise. Such a statement may form part of their care plan or may be recorded separately. It is not legally binding, but it should be considered if a best interest's decision has to be taken on the person's behalf. See for instance RGB v Cwm Taf Health Board & Ors [2013] EWHC B23 (COP)

## Lasting Powers' of Attorney

Before the Mental Capacity Act was introduced, there was an arrangement called an Enduring Power of Attorney (EPA). These are now less common but there are still a small number in existence. These

relate to financial and property matters only.

The MCA creates a system in which the person can select who they want to make decisions on their behalf and the decisions which they will have authority to make; these are called Lasting Power of Attorney (LPA).

There are two types of LPA, one for property and affairs, including finances, and one for health and welfare, including medical treatment and accommodation issues. For an LPA to be valid it must be registered with the Office of the Public Guardian (OPG) before it can be used.

## Enduring Powers of Attorney

Enduring Powers of Attorney (EPA) were valid under previous legislation, prior to the implementation of the Mental Capacity Act. Whilst these are now fewer in number, there are still some EPA's in existence. An EPA applied to property and finance decisions, and is not a valid decision-making authority for health and welfare decisions.

## Court of Protection and Court Appointed Deputies

Where a person has not made an advance decision or LPA and a complex, or series of decisions need to be made it may be necessary to apply to the Court of Protection. In these cases, the Court may make a specific judgement or, where a number of decisions may need to be made, appoint a Deputy to continue to act in the person's best interests if they are unable to decide for themselves.

## Communication for consent

The MCA principles require a person to be fully informed of the decision to be made, the options available and the potential outcome of any decision.

For a person to be fully informed, time should be spent discussing their options and clearly informing them of any foreseeable outcomes and impact of the different options available to them.

An informed decision can only be achieved once the person is clear about all the options available to them and the potentially or likely outcomes of each of those options.

Where there are language difficulties it is imperative that support should be gained. This is most appropriately achieved through translation services and is not always effective to use family members in MCA discussions.

## Office of the Public Guardian

The Office of the Public Guardian (OPG) has an important role in both registering LPAs – health and welfare and property and affairs – and supervising deputies. They can also investigate concerns about deputies or attorneys acting under a registered EPA or LPA.

More information about the OPG, including the services they provide, is available on their website at - https://www.gov.uk/government/organisations/office-of-the-public-guardian

## Making Best Interest Decisions

When the person lacks capacity to make their own decisions, and there is no other decision-making authority in place, it may be necessary for someone else, often a staff member or other professional, to make the decision for the person. These are called best interest decisions, and should be made by the person best placed and proposing to make the decision (e.g. if it is a medical decision, the doctor is likely to be best placed; a social care decision, the social worker; a fire safety risk, the fire officer, etc.).

## The Section 4 (MCA) Checklist

While there is no formal definition of best interests, the aspects of a person's life and experience that should be taken into account when making a decision are set out in section 4 of the MCA, with further guidance provided in the 2007 MCA code of practice.

### The Best Interest Checklist

- Decisions should not be made solely based on age, appearance, condition, or behaviour that could lead to assumptions being made.
- All relevant circumstances are considered by the person making the determination.
- Consider whether the person is likely to regain capacity and, if so, when.
- Where practicable, encourage the person to participate in the decision.
- If life sustaining treatment, must not be motivated to bring about death.
- Consider the person's past and present wishes and feelings (including any relevant written statement).
- The beliefs and values that would be likely to influence his/her decision if s/he had capacity (e.g. cultural background, religious affiliation).
- The other factors that s/he would be likely to consider if he/she were able to do so (e.g. emotional bonds, family obligations).
- Must consult with anyone named by the person to be consulted, anyone engaged in caring for the person or interested in their welfare, a donee of a LPA, a deputy appointed by the Court of Protection.
- Have identified and preferred the least restrictive alternative for the person's rights and freedom of action.

(Adapted from MCA 2005, s4)

## Acts in Connection with Care and Treatment

Once an assessment of capacity has been made and a best interest decision considered, as per the section 4 checklist, only then can care, treatment, or other social support be given to a person that lacks capacity to make his or her own decision about the matter.

While the general legal principle is that no-one can interfere with an adult's body or property without their consent, section 5 of the MCA provides protection for acts done if the person is established as being mentally incapacitated, and the act (which would normally require consent) is in the person's best interests. The MCA Code of Practice (2007) provides examples of the types of acts that this section covers. These lists are not exhaustive and other care and support activities may also apply.

| Mental Capacity Act Code of Practice: Acts in Connection with care and treatment | |
|---|---|
| In connection with personal care | In connection with treatment |
| • Assistance with physical care, e.g. washing, dressing, toileting, changing a catheter, colostomy care<br>• Help with eating and drinking<br>• Help with mobility or travelling<br>• Helping someone with shopping, paying bills or other domestic and household maintenance<br>• Helping someone to move home<br>• Providing services around the home or in the community<br>• Helping someone to take part in education, social or leisure activities. (see MCA CoP, para 6.5) | • Administering medication<br>• Diabetes injections<br>• Diagnostic examinations and tests<br>• Medical and dental treatment<br>• Nursing care at home or in hospital<br>• Taking someone to hospital for assessment or treatment<br>• Emergency procedures and care<br>• Invasive medical procedures including surgery (see MCA CoP, para 6.5) |

There are limitations to what section 5 can be used for; these include -

- when the treatment in question is specified in a valid and applicable advance decision to refuse that treatment, and
- where restraint is needed to provide the care and treatment and this is not proportionate to the risk of harm and is not in the person's best interests.

Restraint is defined in the Act in section 6 as -

- the use or threat of force to secure the doing of an act that the individual resists; or
- the restriction of the individual's liberty, whether that individual resists or not.

## Less and Least Restriction

Any restrictions that are imposed on a person need to consider the principle of Less Restriction, i.e. can restrictions that are in place be reduced or minimised in any way while still ensuring the person's wellbeing is safeguarded and risks are managed? Also consideration should be given to the principle of least restriction (as set out in the s4 best interest checklist) i.e. what is the least restrictive option available that protects the person's rights and freedoms. This only applies to restrictions that are necessary to protect the person without capacity from the risk of harm.

Restrictions should not be imposed under the MCA that are for the protection of other people; where this is the case, an alternative framework will be required, e.g. Mental Health Act 1983, criminal justice interventions, etc.

## Coercion and Control

Coercion, with or without accompanying abuse or violence, has been recognised as a significant factor in domestic abuse and adult safeguarding situations. A new offence was created in 2015 by the Serious Crime Act, - 'controlling or coercive behaviour in intimate or familial relationships' (section 76), which closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between family members or partners.

For more information about the complexities of coercion where capacity is an issue please see the Research in Practice resource focusing on this subject at - http://coercivecontrol.ripfa.org.uk

## Safeguarding and Mental Capacity

In situations where a person who may need care and support is actually, or potentially, at risk of harm the Local Authority has a statutory duty to safeguard the person whether they have capacity in relation to the process or not. The MCA also created two criminal offences – ill-treatment and wilful neglect – that can be committed by anyone responsible for the person's care and support (paid and informal supporters). It also makes it clear that while professionals must approach any situation with the presumption of capacity, where there are concerns they may need to consider, for example, whether the person has the capacity to decide about their own situation, or whether they can refuse consent for information to be shared in any safeguarding enquiry.

## Where does Deprivation of Liberty and Article 5 fit in?

The European Convention of Human Rights (1950) and the Human Rights Act (1998), which is the Government's interpretation of the convention within UK Law, governs the relationship between the state and its citizens.

Human rights are universal and apply to us all. Some of our rights are 'absolute', for example in England and Wales, the right to protection from torture and inhumane and degrading treatment (Article 3). Others are 'qualified', meaning that the state can interfere with them if there is a 'procedure prescribed by law' to authorise it. Deprivation of a person's liberty is one of these qualified rights and is set out in Article 5 of both the Human Rights Act 1998 and the European Convention, which state –

- Article 5 (1). Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save … in accordance with a procedure prescribed by law.

- Article 5 (4). Everyone who is deprived of his liberty … shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

The Deprivation of Liberty Safeguards (DoLS) were added to the MCA by the Mental Health Act 2007. This means that DoLS is part of the MCA and, as such, is underpinned by the same processes and considerations as those for mental capacity more generally; crucially this includes the core principles of the MCA.

## Financial Abuse and Scamming

The Care Act (2014) has recognised the risk posed by financial abuse/crime on individuals, families and society.

Financial abuse is the second most common form of abuse experienced by adults at risk of harm, and there is growing awareness that individuals are being increasingly targeted by mass marketing scams and other types of financial fraud (Social Care Institute for Excellence, 2011). Scams are criminal schemes, often disguised as business practices that rely on the premise of false promise. Many are run by networks of organised crime. They offer, for example, a product, investment or relationship, but the perceived value of the offer does not exist. Scamming is increasingly a global problem and those who may have difficulties understanding or using complex information and who may lack capacity in this area, are likely to be at risk.

For more information on financial scamming, please see the BU booklet "Financial Scamming: A Brief Guide" (Brown, 2016), available at - http://www.ncpqsw.com/financial-scamming/

## Section 42, Care Act 2014

A Section 42 enquiry must take place if there is reason to believe that abuse or neglect is taking place, or is at risk of taking place, and the local authority believes that an enquiry is needed to help it to decide what action to take to support and protect the person in question.

Within the context of 'Making Safeguarding Personal', the particular circumstances of each individual will determine the scope of each enquiry, as well as who leads it and the form it takes.

### Care Act 2014

The Care Act 2014 creates a legal framework for how local authorities and other parts of the system should work together to protect adults at risk of abuse or neglect. The Act requires the local authority to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse.

The statutory guidance to the Care Act 2014 also outlines a number of fundamental principles that must now underpin the practices of a range of public service organisations in relation to adult safeguarding and mental capacity; these include the importance of:

1. Promoting wellbeing when providing support or making a decision in relation to a person.
2. Beginning with the assumption that the individual is best placed to make judgments about their own wellbeing.
3. Taking into account any particular views, feelings or beliefs (including religious beliefs) which impact on the choices that a person may wish to make about their support. This is especially important where a person has expressed views in the past but no longer has capacity to make decisions themselves.
4. A preventive approach because wellbeing cannot be achieved through crisis management. By providing effective intervention at the right time, risk factors may be prevented from escalating.
5. Ensuring the person is able to participate as fully as possible in decisions about them and being given the information and support necessary to consider options and make decisions rather than decisions being made from which the person is excluded.
6. Considering the person in the context of their family and wider support networks, taking into account the impact of an individual's need on those who support them, and take steps to help others access information or support.
7. Protecting the person from abuse and neglect and, in carrying out any care and support functions, professionals consider how to ensure that the person is and remains protected from abuse or neglect. This is not confined only to safeguarding issues, but should be a general principle applied in every case.
8. Ensuring that any restriction on the person's rights or freedom of action is kept to the minimum necessary. Where action has to be taken which restrict these, the course followed balances both the person's best interests and the principle of less restriction.

## Understanding the competence grids

These competencies build upon the 'essential awareness' requirements set out earlier in this framework which apply to all groups and provide a framework for the level of understanding and application needed for staff and professionals working across a range of public sector settings.

Each staff group has a different role and function, and the competencies expected reflect this. The grids can be used as an assessment tool by identifying evidence under each requirement, or as a guide for continuing professional development and identifying training needs for individuals or teams working in different contexts. Where they are used for assessment purposes, the evidence to support competence in each area should be recorded in the last column of each grid.

The grids for each staff group are based on the five key principles of the MCA and outline what staff in each group should understand and be aware of. The framework is designed to build through the staff groups, rather than as a standalone set of competencies for each group.

### Example:

- Group A would be expected to demonstrate the competencies set out for group A.
- Group B would be expected to demonstrate the competencies set out for staff group A, plus the specific ones for group B.

and so on for each group until -

- Group E would be expected to demonstrate the competencies set out for staff group A, B, C and D plus the specific ones for them.

Best Interest Assessors would be expected to demonstrate the competencies set for staff group A, B, C and D plus the BIA capabilities 1-6.

## Relationship to Other Relevant/Related Frameworks

These competencies are designed to build on existing professional standards and requirements across the full range of delivery and professional settings. Where directly relevant these have been cross-referenced and/or incorporated in the relevant staff group, these include:

- Knowledge and Skills Statement for Adult Social Workers (DH, 2014)
- National Safeguarding Adults Competence Framework (BU, 2016)
- Best Interests Assessor Capabilities (TCSW, 2014)
- Professional Capabilities Framework (PCF) (TCSW, 2012, updated BASW, 2015).
- Forensic Social Work Capability Framework (DH, 2016)
- PACE Code of Practice C (MoJ, 2012)

## Staff Group A – Health, Care and Public Sector Staff

Function: Public service workers in all settings, who may have day-to-day contact with individuals for whom mental capacity in all, or certain, areas of their lives may be an issue or concern.

Including, but not limited to: Care assistants, Unqualified social care staff, Care home workers, Home care workers, Health care assistants, Support workers, Community support workers, STR workers, Transitions workers, Personal assistants, Volunteers, Befrienders, mentors and advisers, Medical receptionists, Service receptionists, ward clerks and other admin with service user contact, Social Care Customer Service staff, Housing Staff, Adult Foster Carers, Fire service, Vulnerable Persons Officers (VPO) (or equivalent), Community policing staff.

| Staff Group A: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 1. Presuming Capacity | |
| This includes –<br>• Understand their roles and responsibilities in relation to the Mental Capacity Act 2005 and be able to explain this to others.<br>• Knowledge of the first principle of the MCA and apply it to all interactions with people within their specific job role.<br>• Understand the meaning of mental capacity in relation to how care is provided (CCS, standard 9.6).<br>• Application of the time-specific and decision-specific nature of mental capacity as it applies to interactions and job contexts.<br>• Identify concerns that would lead to an assessment of capacity being made and articulate these.<br>• Identify the specific decision in each case and who might be the most appropriate person to assess capacity where there is a concern evident.<br>• Understand and apply organisational policies and procedures in relation to mental capacity and assessment of mental capacity.<br>• Maintaining appropriate records where an assessment is necessary. | |
| 2. Helping the person to make their own decision | |
| This includes -<br>• Knowledge of the second principle of the MCA and staff responsibility to support people to make their own decisions wherever possible.<br>• Recognise and respond to a person's communication needs and recognise when additional communication aids are needed (e.g. signers, interpreters, braille etc.).<br>• Providing information in a range of formats relevant to the person's needs and understanding (e.g. easy read, pictorial, audio descriptions, etc.).<br>• Considering environmental or other factors that might impact on a person's capacity (e.g. time of day, noise levels, who else is present).<br>• Listening to individuals and allowing individuals time to communicate any preferences and wishes.<br>• Utilising effective communication and engagement skills to maximise the person's capacity to make a decision.<br>• be able to recognise coercive behaviour and the impact that it may be having on someone's ability to make their own decisions. | |

| Staff Group A: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 3. Unwise Decisions | |
| This includes -<br>• Knowledge of the third principle of the MCA and the individual's right to exercise freedom of choice and individuality.<br>• Understand that people with capacity can make decisions others think are unwise.<br>• Understand that a safeguarding referral may be needed even if a person has capacity and their consent for this should be sought wherever possible with decisions only being made in the person's best interests, where they are shown to lack capacity in relation to the decision.<br>• Undertake risk assessments with the person as appropriate to role.<br>• Recognise the importance of record keeping.<br>• Work within the Data Protection Act 1998 in relation to information sharing where risks are identified. | |
| 4. Best Interests | |
| This includes -<br>• Knowledge of the fourth principle of the MCA and how it should underpin any actions or decisions taken where a person has been shown to lack capacity for a specific decision.<br>• Understand that best interests can only be considered if the person has been shown to lack capacity in relation to a specific decision and there is no alternative decision maker such as an Attorney.<br>• Contribute to best interest decision-making processes relevant to role and relationship with the person in question.<br>• Awareness of how personal values and attitudes can influence the understanding of situations.<br>• Understand and apply organisational policies and procedures in relation to best interest decision-making processes.<br>• See also 'National Safeguarding Adults Competence Framework (BU, 2016) – staff group A – for additional competency requirements where mental capacity in relation to safeguarding adults is relevant.<br>• See also PACE code of practice C para 1.4 and Note 1G. | |
| 5. Less Restriction | |
| This includes -<br>• Recognise restrictions and consider whether these can be reduced.<br>• Recognise where restrictions are being placed on a person which may be out of proportion to the evident risk of harm and know how to raise a concern in relation to this.<br>• Awareness, and application of, organisational policies and procedures in relation to any necessary restrictions relevant to role, and how and when these should be applied, reviewed and recorded. | |

## Staff Group B – Provider Managers

Function: Responsible for the operational delivery of health, care or other services providing treatment, personal care or other social support packages.

Including, but not limited to: Care home managers, Home care coordinators and managers, CQC Registered managers in all provider settings, Ward Managers, Other residential or nursing provider service managers, Supported housing and extra care managers, Other housing, health and social care provider services managers.

| Staff Group B: | |
|---|---|
| Provided evidence must be relevant and proportionate to role.<br>All of the elements set out in Staff Group A, plus - | Completed |
| 1. Presuming Capacity | |
| This includes –<br>• Application of the principle in practice.<br>• Understand policies and procedures and recognise that capacity should only be assessed where a concern about capacity is identified.<br>• A working knowledge of how and when capacity should be assessed. | |
| 2. Helping the person to make their own decision | |
| This includes -<br>• Recognise the importance of communication skills and identify the tools and training needed to support different styles and forms of communication. | |
| 3. Unwise Decisions | |
| This includes -<br>• Understand the meaning of 'adult at risk' as defined in relevant policy guidance, e.g. Care Act 2014 definition and undertake / supervise / oversee the assessment of risk in situations where a person's capacity is a concern, taking appropriate steps to support and/or safeguard as appropriate.<br>• Consideration of the most appropriate and proportionate response to restrictions on a person's rights and freedom of action. | |
| 4. Best Interests | |
| This includes -<br>• Knowledge of the section 4 best interests checklist and how it is located with current legislation and policy including, but not limited to: Human Rights Act 1998, Safeguarding Adults, Dignity in Care, Deprivation of Liberty Safeguards 2009, Care Act 2014, Making Safeguarding Personal as they apply to the MCA as appropriate to role and context. | |
| 5. Less Restriction | |
| This includes –<br>• Know how to identify a deprivation of liberty.<br>• Understand how to make a request for authorisation to the Local Authority.<br>• Understand when an urgent authorisation may be required and work within the organisational policies and procedures and the DoLS code of practice, making a request or providing advice for others to make a request as appropriate to role and context.<br>• Recognise restrictive care and scrutinise whether it is necessary and proportionate to the risk of harm, challenging restrictive practices where appropriate. | |

## Staff Group C – Professional Health & Social Care Staff

Function: Providing professional health or social care treatment or support to people who may have difficulties with mental capacity and ability to consent to assessment or intervention.

Including, but not limited to: Children & Family Social Workers, Adult Newly-Qualified Social Workers, Transitions social workers, Occupational Therapists, General & Physical Health Nurses, General & Physical Health Medical Staff, GPs, Surgical Staff, Dieticians, Physiotherapists, Pharmacists, Radiologists, Dentists and dental nurses, Phlebotomists, Other Allied Health Professionals, Team managers and Senior Practitioners across Health and Social Care.

| Staff Group C: | |
|---|---|
| Provided evidence must be relevant and proportionate to role.<br>• For Adult Social Workers only: KSS (5) - Mental Capacity<br>All of the elements set out in Staff Group A & B, plus – | Completed |
| 1. Presuming Capacity | |
| This includes –<br>• A thorough knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice. They should always begin from the presumption that individuals have capacity to make the decision in question (KSS 5).<br>• Understand how to make a capacity assessment, the decision and time-specific nature of capacity and hence the need to reassess capacity appropriately. They should know when and how to refer on (KSS 5). | |
| 2. Helping the person to make their own decision | |
| This includes -<br>• Recognise where general or independent mental capacity advocates (IMCA) may be appropriate and beneficial to support a person to make a decision.<br>• Use a range of communication methods to help people make their own decisions wherever possible.<br>• Seek specialist communication support where necessary.<br>• Understand how principle 2 links to the personalisation and Care Act 2014 responsibilities for supported decision making and co-productive approaches.<br>• Understand their responsibilities for people who are assessed as lacking capacity at a particular time and must ensure that they are supported to be involved in decisions about themselves and their care as far as is possible. Where they are unable to be involved in the decision-making process, decisions should be taken in their best interests following consultation with all appropriate parties, including families and carers. Social workers must seek to ensure that an individual's care plan is the least restrictive possible to achieve the intended outcomes (KSS 5).<br>• Understand the likely impact of coercion on someone's mental capacity (regardless of whether they have an impairment of their mind or brain). | |

| Staff Group C: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 3. Unwise Decisions | |
| This includes -<br>• Knowledge of the Human Rights Act 1998.<br>• Where there is no concern over capacity, social workers should take all practicable steps to empower people to make their own decisions, recognising that people are experts in their own lives and working alongside them to identify person-centred solutions to risk and harm, recognising the individual's right to make "unwise" decisions (KSS 5). | |
| 4. Best Interests | |
| This includes -<br>• Knowledge of the Care Act 2014 and the Well-being principle and their application in situations where mental capacity and best interests are in question. | |
| 5. Less Restriction | |
| This includes -<br>• Recognise restrictions being placed on an individual and assess whether these are proportionate to the person's needs and risks of harm.<br>• Attend and contribute to investigations/meetings/information sharing.<br>• Understand that the MCA exists to empower those who lack capacity as much as it exists to protect them. Social workers must model and lead a change of approach, away from that where the default setting is "safety first", towards a person-centred culture where individual choice is encouraged and where the right of all individuals to express their own lifestyle choices is recognised and valued (KSS 5). | |

## Staff Group D – Professional Health & Social Care Staff (Qualified Specialist)

Function: Providing care, treatment, assessment or other intervention – medical, psychological and social, or responsible for commissioning such services.

Including, but not limited to: Dementia Nurses, Learning Disability Nurses, Mental Health Nurses, AMHPs, Adult Social Workers (inc MHSW, LDSW), Forensic SW, Psychologists / Other therapists, Psychiatrists (inc s12 Drs).

| Staff Group D: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 1. Presuming Capacity | |
| This includes -<br>• A detailed knowledge and understanding, including practice experience, of the first principle.<br>• A working knowledge of the capacity assessment process.<br>• Undertake complex capacity assessments and report findings to multi-disciplinary teams, commissioners or managers. | |
| 2. Helping the person to make their own decision | |
| This includes -<br>• Identify salient information, appropriate assessor, and advice colleagues in staff groups A-C, as appropriate to role and function, on MCA practice and supported decision making.<br>• Support people to plan for when they may lack capacity in the future, including knowledge of advance decisions, lasting powers of attorney and excluded decisions.<br>• Use highly developed communication and rapport-building skills to help individuals make (or participate in) decisions for themselves.<br>• Recognise, assess and, where appropriate, intervene in situations where coercion is impacting on a person's ability to decide. | |
| 3. Unwise Decisions | |
| This includes -<br>• A thorough understanding of positive risk and strengths-based approaches as a means of risk management in cases where individuals with capacity choose to make unwise decisions.<br>• Identify harm and risk of harm, and make appropriate referrals / seek support in order to safeguard adults or children, being aware of issues such as mental capacity and vulnerability (Forensic PCF, Domain 4). | |
| 4. Best Interests | |
| This includes -<br>• Chair best interests meetings where appropriate to role and context where it is deemed an independent chair or lead practitioner would be appropriate. | |
| 5. Less Restriction | |
| This includes –<br>• Recognise where care is restrictive and apply the principles of less and least restriction to assessments and treatment and care decisions.<br>• Review and challenge restrictive practices in care provision and assess restrictions in terms of proportionality to the risk of harm. | |

## Staff Group E – Organisational MCA/DoLS Leads

Function: to provide leadership, management and/or appropriate governance within organisations and ensure organisational policies and procedures are legally compliant and promote best MCA practice.

Including, but not limited to: LA DoLS Authorisers, MCA / DoLS leads in LA and NHS organisations, Board and Senior Management MCA / DoLS portfolio holders.

| Staff Group E: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 1. Presuming Capacity | |
| This includes -<br>• Promote the principle of presumption of capacity within the team and/or organisation as appropriate to role.<br>• Scrutinise capacity assessments to ensure robustness of process and evidence as impacted by relevant case law and policy updates.<br>• Ensure organisational policy and practice applies principle 1 within and across the organisation and where relevant multi-agency partners and partnerships. | |
| 2. Helping the person to make their own decision | |
| This includes -<br>• Provide leadership in relation to the promotion of supported decision-making, co-production and participation in care, treatment, and where appropriate to role and context, organisational and strategic development.<br>• Support and develop information and communication skills within the workforce, providing leadership in relation to engagement and relationship building with individuals and families as a means of maximising and supporting a person's ability to make / take part in decisions about them. | |
| 3. Unwise Decisions | |
| This includes -<br>• Promote a culture of positive risk and risk management within the organisation and/or team, ensuring policy, procedures and practices support staff to take a rights-based approach to decisions and interventions. | |
| 4. Best Interests | |
| This includes -<br>• Chair and lead appropriate meetings and support the multi-disciplinary team in relation to issues of…mental capacity (Forensic PCF, Domain 4).<br>• Scrutinise best interests' assessments within DoLS and/or Care Act assessments and apply best practice to decision making as set out in the MCA code and Care Act Statutory Guidance.<br>• Promote awareness of best interests and the factors that need to be considered, including consultation and recording, and ensure organisational policies and procedures are aligned to the requirements of the MCA to guide staff to work within the appropriate legislative framework.<br>• Identify and act in situations where a court of protection referral is needed to provide additional safeguards or to scrutinise and mediate complex decisions.<br>• Recognise the role of the OPG and support frontline staff to access the service as appropriate. | |

| Staff Group E: | |
|---|---|
| Provided evidence must be pertinent and proportionate to role | Completed |
| 5. Less Restriction | |
| This includes -<br>• Remain aware and up to date with processes, procedures and case law impacting on the MCA and DoLS practice and cascade these to staff groups as appropriate to role and context.<br>• Review and challenge restrictions placed on individuals and scrutinise proportionality of restrictions and potential deprivations of liberty.<br>• Liaise with and instruct solicitors, as appropriate to role, where an individual's rights are being infringed and court of protection intervention is required. | |

## Best Interest Assessors

Function: Best Interests Assessors undertaking assessments within the Local Authority Deprivation of Liberty Safeguards (DoLS) procedures.

Includes: Social Workers, Nurses, OTs, Psychologists who have completed an accredited BIA qualification programme and maintain their professional registration and CPD.

See BIA Capabilities for full capability statements and detailed capability requirements which BIA's are required to evidence both at qualification and on an ongoing basis - http://socialworkresources.org.uk/download/bia-capabilities/

| Best Interest Assessors: | |
|---|---|
| Provided evidence must be relevant and proportionate to role.<br>All of the elements set out in Staff Group A, B, C & D plus - | Completed |
| 1. Presuming Capacity | |
| This includes -<br>• Key Capability 1: The ability to apply in practice, and maintain knowledge of, relevant legal and policy frameworks.<br>• Key Capability 2: The ability to work in a manner congruent with the presumption of capacity. | |
| 2. Helping the person to make their own decision | |
| This includes -<br>▪ Key Capability 3: The ability to take all practical steps to help someone to make a decision. | |
| 3. Unwise Decisions | |
| This includes -<br>▪ Key Capability 6: The ability to effectively assess risk, in complex situations, and use analysis to make proportionate decisions. | |
| 4. Best Interests | |
| This includes -<br>▪ Key Capability 5: The ability to make informed, independent best interests decisions within the context of a Deprivation of Liberty Safeguards (DoLS) assessment. | |
| 5. Less Restriction | |
| This includes -<br>▪ Key Capability 4: The ability to balance a person's right to autonomy and self-determination with their right to safety, and respond proportionately. | |

Evidence for this staff group should include appropriate qualification documents, ongoing CPD and continuing professional registration as per regulations governing the BIA role -

- The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (in England)
- The Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations & Disputes about Residence) (Wales) Regulations 2009 (in Wales)
- The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008.

# References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Ministry of Justice (2008) Mental Capacity Act 2005: Deprivation of liberty safeguards – code of practice to supplement the main MCA 2005 Code of practice. Available from -http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

TCSW (2012) Best Interest Assessor Capabilities. Available from - http://socialworkresources.org.uk/download/bia-capabilities/


# Resources

There are many resources available both online and in books that may be useful resources to support competence and capability in practice.

Some of those we have found helpful include –

National Mental Capacity Forum - http://www.scie.org.uk/mca-directory/forum/

Mental Capacity Directory - http://www.scie.org.uk/mca-directory/

Research in Practice for Adults (RiPfA) - http://coercivecontrol.ripfa.org.uk/

SCIE Mental Capacity Act: e-Learning course - http://www.scie.org.uk/mca/e-learning/

Mental Capacity Resources website – http://www.mentalcapacityresources.co.uk

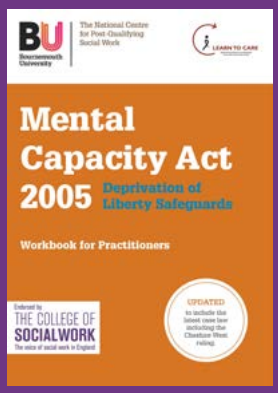
Office of the Public Guardian - https://www.gov.uk/government/organisations/office-of-the-public-guardian

LGA Mental Capacity Act resource page - http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/7395321/ARTICLE

LGA ADASS Promoting less restrictive practice: Reducing restrictions tool - http://www.local.gov.uk/documents/10180/11779/adult+social+care+-+mental+capacity+act+-+Promoting+less+restrictive+practice/ccd52731-29d9-48f9-aa9a-512593ed8c95


Written by Professor Keith Brown, Daisy Bogg and Michael Lyne, February 2017
The National Centre for Post-Qualifying Social Work and Professional Practice

# Other Relevant Publications



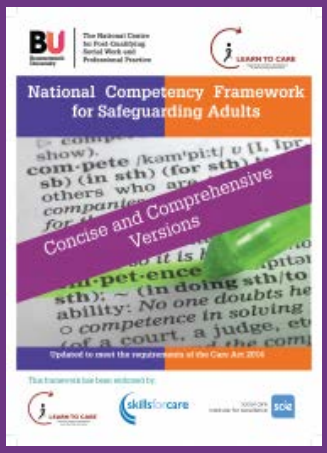

## Mental Capacity Act 2005 Workbook for Practitioners

This flip reverse workbook on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards has been designed and developed by the National Centre for Post-Qualifying Social Work at Bournemouth University in partnership with Learn to Care, the professional association of workforce development managers in local authorities.

This is an accessible and informative workbook, packed full of case studies, activities and advice about the Mental Capacity Act 2005. We hope it will support practitioners to improve their professional practice and develop their knowledge and skills within key legislative and ethical frameworks.

## Safeguarding Adults at Risk Resources

These workbooks provide the information and training needed to establish the minimum standard of competence required of those who work with adults.







The National Competency Framework for Safeguarding Adults and these workbooks, used together, enables employers and employees to establish consistency in approach to Safeguarding Adults.

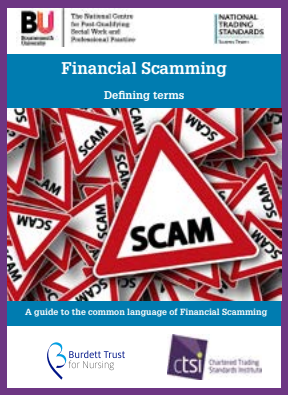
These workbooks will enable employees to demonstrate competence in their practice in a way that is in line with their occupational role and responsibilities.

## Next of Kin: Understanding decision making authorities

The term 'Next of Kin' is often used in Health and Social Care as a euphemistic shorthand for 'Who is the person we communicate with about you and who do we contact when you are dead?'


This helpful leaflet clarifies how people can plan ways, with those they love, to ensure their wishes are taken into account if, through illness, they cannot take decisions for themselves. I cannot stress enough how important it is to plan ahead and let our wishes be known, in the event we cannot express them.

## Financial Scamming: Defining Terms




Financial Scamming is a growing problem that is now being recognised as a crime. The negative impact it has on individuals and society as a whole is gradually becoming clear as further research probes into the consequences and damage caused by financial scamming.

We have been working with key national organisations in the UK to develop a better understanding of this issue, seeking ways and solutions to reduce the risk of financial scamming.

Bournemouth University

The National Centre for Post-Qualifying Social Work and Professional Practice

## Contact details

We are able to offer a single point of contact for all questions and enquiries regarding all the research and educational programmes we administer. Our contact details are below:

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