NHS
North East and North Cumbria

Corporate	ICBP044 Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DOLS) Policy

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EQUALITY IMPACT ASSESSMENT

Date	Issues
May 2022	No issues identified.

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3-year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net

Version Control

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V1	July 2022	Designated Nurse Safeguarding Adults	First Issue

Approval

Role	Name	Date
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Contents

1. Introduction

For the purposes of this policy NHS Integrated Care Board (the ICB) will be referred to as “the ICB”.

This policy sets out how as a commissioning organisation the ICB will fulfil its duties and responsibilities effectively both within its own organisation and across the local health economy via its commissioning arrangements in relation to the Mental Capacity Act 2005 (MCA). It also includes reference to the Deprivation of Liberty Safeguards 2009 (DoLS) amendment. Commissioners must understand the implications of the MCA and DoLS, and the ICB must be able to demonstrate understanding and compliance with this legislation within the organisation and seek assurance that any services commissioned are also compliant.

The ICB aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational, and best practice requirements and support the principles of equal opportunity for all.

The ICB, as a member of the local Safeguarding Adults Partnership / Safeguarding Board has formally adopted the principles of the Safeguarding Adults Inter-Agency Policy and Procedures which references the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards 2009 (DoLS).

The Law Commission review of the DoLS and resulting Mental Capacity Act Amendment Act 2019, introducing the Liberty Protection Safeguards (LPS), has been passed by parliament and received Royal Assent.

There will need to be a review of this policy on publication of the LPS code of practice.

This policy should be read in conjunction with the

- The Mental Capacity Act: Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice https://webarchive.nationalarchives.gov.uk/ukgwa/20130104224411/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Mental Capacity (Amendment) Act 2019 https://www.legislation.gov.uk/ukpga/2019/18/enacted
- Safeguarding Adults Policy (ICB)

1.1. Status

This policy is a corporate policy.

1.2. Purpose and Scope

The purpose of this policy is to support the ICB in discharging its duties and responsibilities as a commissioner. This requires the ICB to understand and be able to apply the principles of the MCA Code of Practice, and DoLS Code of Practice, so they can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests. Commissioned services are expected to demonstrate compliance with both Codes of Practice and any legal changes as a result of case law.

The MCA applies to all people over the age of 16 across England and Wales, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment (ADRT) and being authorised under the Deprivation of Liberty Safeguards (DoLS); in these situations, the Act applies when a person is aged 18 or over.

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

- The Independent Mental Capacity Advocate
- The Office of the Public Guardian
- The Court of Protection
- Advance Decisions to refuse treatment
- Lasting Powers of Attorneys

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

- Observe the principles of the MCA
- Make assessment of capacity and it is reasonably believed that the person lacks capacity in relation to the matter in question
- A reasonable belief the action taken is in the best interests of the person

This policy applies to all staff employed by the ICB, including any agency, self-employed or temporary staff.

All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

2. Definitions

The following terms and abbreviations are used within this document:

Reference	Abbreviated Term
Mental Capacity Act 2005	MCA
Mental Health Act 2007	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	COP
Lasting Power of Attorney	LPA
Enduring Power of Attorney	EPA
Advance Decision to Refuse Treatment	ADRT
General Practitioner	GP
Deprivation of Liberty Safeguards 2009	DoLS
Deprived of Liberty	DoL
Supervisory Body	SB
Managing Authority	MA
Liberty Protection Safeguards	LPS

2.1 Lack of Mental Capacity

'A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain'. *[MCA section 2(1)]*

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

- A stroke or brain injury
- A mental health problem
- Dementia
- A cognitive or neurological condition
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- Under the influence of or a substance misuse

Lacking capacity is time and decision specific, about a particular decision at a certain time. If someone cannot make complex decisions it does not mean they cannot make simple decisions. Someone must be supported to make decisions whenever possible.

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

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

Lack of capacity must be established following the functional test and any subsequent decision or intervention made within the best interests' framework as set out in the MCA 2005.

2.2 Mental Capacity Act Principles

There are five key principles underpinning the MCA as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
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.
5. Before the act is done or 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.

2.3 Assessment of Lack of Capacity

The Act requires evidence to establish a lack of capacity. Practitioners must set out their assessment and subsequent record, following the Act and Supreme Court findings in case A Local Authority v JB [2021] UKSC 52. This case gives clarity to the stages of the capacity test set out in the current Code of Practice.

Is the person unable to make the decision?

Inability to make decision shown if the person is unable

1. Understand information about the decision to be made (the Act calls this relevant information).
2. Retain that information in their mind (long enough to make an effective decision)
3. Use or weigh that information as part of the decision-making process, or
4. Communicate their decision (by talking, using sign language or any other means)

- Does the person have a general understanding of what decision they need to make and why they need to make it? Including the likely consequences of making, or not making, this decision?
- Is the person able to retain the information relevant to this decision?
- Is the person able to use and weigh up the information? Inability to do this must relate to the disorder or impairment and not a person's preferences or opinions such as cultural or religious views.

- Can the person communicate their decision by talking, using sign language or any other means? Would the services of a professional such as a speech and language therapist be helpful?

If So:

Is there impairment or disturbance in the functioning of the persons mind or brain?

And If so:

Is the persons inability to make the decision because of the identified impairment or disturbance?

Where a decision is complex or more serious, a practitioner may consider there is a need for a more thorough assessment (perhaps by involving a doctor or other professional expert).

2.4 Making a best interest decision

One of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests.

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

- You have observed the principles of the MCA
- You have carried out and recorded an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question.
- You reasonably believe the action you have taken is in the best interests of the person.

There are exceptions to this, including circumstances where a person has made an advance decision to refuse treatment and, in specific circumstances, the involvement of a person who lacks capacity in research.

Working out what is in someone else's best interests may be difficult, and the Act requires people to follow certain steps to help them work out whether a particular act or decision is in a person's best interests. In some cases, there may be disagreement about what someone's best interests really are.

2.5 Best interests decision making framework

A person trying to work out the best interests of a person who lacks capacity to make a particular decision should:

- ✓ Encourage participation - do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision.
- ✓ Identify all relevant circumstances - Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

- ✓ Find out the person's views - try to find out the views of the person who lacks capacity, including:

    - the person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
    - any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
    - any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

- ✓ Avoid discrimination- do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- ✓ Assess whether the person might regain capacity - consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- ✓ If the decision concerns life-sustaining treatment - not be motivated in any way by a desire to bring about the person's death.
- ✓ They should not make assumptions about the person's quality of life.

2.6 Clinical Interventions in best interests

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

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

However, certain decisions are outside of the framework of best interests in the MCA and they may require the Court of Protection to make the particular decision. Sections 27-29 and 62 of the MCA set out such decisions. These include:

- Decisions concerning family relationships (section 27) e.g. consenting to sexual relations, consent to marriage, divorce, a child being placed for adoption or the making of an adoption order.
- Mental Health Act matters e.g. treatment under Part 4 the Mental Health Act 1983 amended 2007
- Voting rights (section 29)
- Unlawful killing or assisted suicide (section 62)

2.7 The Independent Mental Capacity Advocate (IMCA)

Advocacy is taking action to help people:

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

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

The MCA sets a requirement of statutory Independent Mental Capacity Advocacy (IMCA) and aims to provide independent safeguards for people who lack capacity to make certain important decisions and have no-one else other than paid staff to support or represent them or be consulted.

An IMCA **must** be instructed when:

- An NHS body is proposing to provide serious medical treatment.
- An NHS body or local authority is proposing to arrange accommodation or a change of accommodation, in a hospital or a care home and the person will stay in hospital for more than 28 days or 8 weeks in a care home.

An IMCA *may* be instructed

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

If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. The only exception to this is when an urgent decision is needed, for example to save a person's life. This decision must be recorded with the reason for non-referral. The IMCA will still need to be instructed for any serious medical treatment that follows the emergency treatment and a decision maker must continue to act in a person's best interests whilst waiting the IMCA report, for example, providing treatment that stops a condition getting worse.

It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker. The decision maker has a duty to consider the IMCA report but remains the decision maker.

Information on local IMCA providers is available from the Local Authority or the Designated Nurses for Safeguarding Adults at place within the ICB.

2.8 Advance Decisions to Refuse Treatment (ADRT)

People with capacity over the age of 18 years, are able to make advance decisions regarding refusal of health treatments, which will relate mainly to medical decisions, these should be recorded in the persons file where there is knowledge of them. These may be lodged with the person's GP and are legally binding if made in accordance with the Act.

Making an advance decision to refuse treatment allows particular types of treatment you would never want, to be honored in the event of losing capacity – this is legally binding and health care professionals must follow ADRT when found to be valid and applicable.

Practitioners must take all reasonable efforts to check if an advance decision exists, and that it is valid and applicable to the particular treatment in question. Reasonable steps would include, checking the records, asking the patient, their friends or family, and checking with the GP if one is known or recorded. Reasonable steps are dependent on the urgency and nature of the treatment in question.

The Act introduces a number of rules you must follow. Therefore, a person making an ADRT should check that their current advance decision meets the rules if it is to take effect.

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

Life sustaining advance decisions must:

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

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

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

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

2.9 Advance statements of preference

Advance statements of preference are evidence of a person's wishes and preferences regarding care and treatment. Unlike ADRT's they are not legally binding however should be considered by the practitioner in decisions of best interest. They are evidence of the person's wishes and feelings and may provide a clear indication of what the person would have wished for when capacitated to make the relevant decision for themselves. Statements of preference often form part of anticipatory care planning, treatment escalation plans, emergency health care plans and end of life care planning.

2.10 Lasting Powers of Attorney (LPA)

A Lasting Power of Attorney enables a person with capacity to appoint another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. LPAs can be friends, relatives or a professional for:

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

This must be recorded in the person's file where there is knowledge of it. It must be registered with the Office of the Public Guardian to take effect and an LPA can only act within the remit of the authority set out in the LPA. For example, a LPA for property and affairs does not give authority for health and welfare decisions and a Health and Welfare LPA only covers life sustaining decisions if explicitly set out to do so.

Important facts about LPAs

- Enduring Powers of Attorney (EPAs) can no longer be made after 2007 and they only apply to financial matters.
- When a person makes an LPA they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.

- If a person is in your care and has a Health and Welfare LPA, the attorney will be the decision maker on matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved professionally in care or treatment of a patient you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

The Office of the Public Guardian (OPG)

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

The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. This is a free service.

Further information regarding the Office of the Public Guardian including all the forms to make powers of Attorney, can be found by the following link: http://www.publicguardian.gov.uk/

2.11 The Court of Protection (COP)

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

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

The Court of Protection has the powers to:

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

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

Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link: Court of Protection - GOV.UK

The ICB must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. However, where an application is required, this must not be delayed. Advice and support for legal services should be sought from the CSS Governance Team and in consultation with the Equality and Diversity Lead.

2.12 Deprivation of Liberty Safeguards (DoLS)

Whilst a Deprivation of Liberty (DoL) may occur in any care setting, the DoL safeguards (DoLS) form part of the MCA and provide legal protection for people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements. Those affected by the DoLS will include people with a "mental disorder", as defined within the Mental Health Act (1983) amended (2007), who lack the capacity to make informed decisions about arrangements for their care or treatment. The DoLS clarify that a person may be deprived of their liberty:

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- it is in their own best interests to protect them from harm.

A DoL is authorised under the safeguards by possess of assessment, and Local Authorities (LA) are Supervisory Bodies (SB) and responsible for arranging these authorisations.
These arrangements will change with the enactment of the MCA amendment Act 2018, that introduces the Liberty Protection Safeguards (LPS). The LPS will replace the DoLS arrangements and the ICB will become responsible for authorisations of DoL for people whose care is commissioned via Continuing Health Care (CHC).
At the current time, the ICB is not currently either a Supervisory Body (SB) within the DoLs process or a Responsible Body (RB) as set out within the LPS (as not yet in force). They are however, required to work closely with providers and the LA to ensure the protections offered by the DoLS are implemented appropriately and that care they commission is compliant with the MCA and DoLS.
On 19th March 2014, the Supreme Court published its' judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases.

This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an 'Acid Test'.

For a person to be deprived of their liberty, they must be:

- subject both to continuous supervision and control
- and not be free to leave.

They must also lack the mental capacity to consent to the relevant care and support arrangements, and the state hold a responsibility for that care. This includes where placements are made privately in to care home settings that the local authority have oversight of regarding standards, safeguarding and monitoring.

In all cases the following are not relevant to the application of the test:

1. The person's compliance or lack of objection to the care arrangements.
2. The reason or purpose behind a particular placement.
3. And the relative normality of the placement (whatever the comparison made).

This means that the person should not be compared with anyone else in determining whether there is a Deprivation of Liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities.
The DoLS afford people, who are vulnerable, due to lack of mental capacity, an independent review of their care and the provision of additional rights and advocacy.

In introducing the 'Acid Test', it has widened the scope of whom may be affected, to cover Independent Living Schemes, Adult Placements, Children's Foster Placements and potentially even people at home receiving Continuing Health Care (CHC) funded packages of care.

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorised, obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), The Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (COP).

The ICB has outlined the process in cases where deprivation of liberty falls outside the remit of the DoLS and application to the Court of Protection is required.

The ICB is able to seek assurance from its commissioned services that they are compliant with the DoLS framework and COP requirements.

Any unauthorised Deprivation of Liberty will carry with it a potential risk of litigation. If the ICB identifies, via its commissioned services such a risk exists, this is to be included on the risk register and an action plan to address the risk developed and reviewed in accordance with the ICB Risk management arrangements.

The LA's as Supervisory Bodies have established MCA DoLS Policies and procedures which clearly outline expectations of NHS hospital providers and care homes, as Managing Authorities (MA) to apply for a DoLS.

3 Governance and Accountability

The ICB is responsible for ensuring all its provider services have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. The ICB through its governance structures and Quality Performance arrangements will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DoLS.

The ICB will ensure effective leadership, commissioning and governance through the following:

- Annual report
- Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and that ICB commissioning, contracting, contract monitoring, and quality assurance processes fully reflects this.
- Ensuring service specifications, invitations to tender and service contracts fully reflect MCA and MCA DoLS requirements as outlined in this policy with specific reference to the clear standards for service delivery.
- Ensuring a system is in place for escalating risks via Risk Registers and Quality arrangements.

3.1 Service Contract Standards

Clear service standards for ensuring compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) will be included in NHS commissioned services contracts, as appropriate to the service.

The ICB will seek assurance from providers in relation to these standards via its contract management and quality assurance processes.

4. Duties and Responsibilities

Lead	Duties and Responsibilities
ICB Chief Executive	The Chief Executive for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Executive Chief Nurse	The Executive Chief Nurse has overall accountability and responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice requirements. The Executive Chief Nurse is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through ICB commissioning arrangements. The Executive Chief Nurse is the Sponsoring Director for this policy and is responsible for ensuring that: • this policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies • the necessary training required to implement this document

	is identified and resourced. • mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document. • the ICB has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers
Nurse Director of Place	• Nurse Directors of Place hold devolved responsibility and as the place-based Director of Nursing is the lead for Safeguarding Adults and Children/Looked After Children and will provide advice to the ICB Board on MCA/DOLS matters. • Nurse Directors of place will support the Executive Chief Nurse in the ICB to comply with statutory duties and responsibilities.
Policy Author	The Designated Safeguarding Adult professionals at place are responsible for: • generating and formulating this policy document • identifying the need for any change to the document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional standards and local/national directives • establishing mechanisms for the regular monitoring of compliance • notifying the Nurse Directors of place should any revision to this document be required. Nurse Directors at place will notify the Executive Chief Nurse in the ICB.
Designated Professionals at Place.	The Designated professionals at place will take a professional lead on all aspects of the NHS contribution to MCA and MCA DoLS across the ICB area, which includes all commissioned providers. They will support the Nurse Directors at place to: • to ensure robust assurance arrangements are in place within the ICB and ICP • to provide advice and expertise to the ICB and to the Local Safeguarding Partnerships and to professionals across both the NHS and partner agencies • to provide professional leadership, advice, support and professional supervision to the lead adult safeguarding professionals in each provider organisations • to represent the ICB on relevant committees, networks and multi-agency groups charged with responsibility for leadership, oversight and implementation of MCA, MCA DoLS • to lead and support the development of MCA, MCA DoLS policy and procedures in the ICB in accordance with national, regional and local requirements. • to provide advice and guidance in relation to MCA, MCA DoLS training including standards • to Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and that compliance is evidenced.

Named GP and Named Primary Care Clinical Professionals at place	The Named GP and/or Named Primary Care Clinical Professionals at place will lead and support the development of practice within Primary Care (GPs) which includes training standards and compliance with statutory guidance.
Managers and Executive Leads	Executive leads and Managers have responsibility for: • ensuring they are aware of and are able to carry out their responsibilities in relation to MCA, MCA DoLS • ensure that the MCA, MCA DoLS policy is implemented in their Place Based Delivery area. • ensuring staff are aware of the contact details of the Designated Professionals for Safeguarding Adults at place and the local authority contact number for MCA, MCA DoLS • ensuring that all staff undertake mandatory MCA, MCA DoLS training at the appropriate level for their role

5. Implementation

This policy will be available to all Staff within the ICB via the shared intranet and the internet sites.

All Executive leads and Managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties.

6. Training Implications

The training required for CCG staff to comply with this policy are:

- Mandatory, Safeguarding Adults
- MCA, including DoLS.

In line with their role and responsibilities as outlined in the Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018)

7. Documentation

7.1 Other related policy and resource

- Safeguarding Adults Policy:
- GMC MCA tool kit

7.2 Legislation and statutory requirements

- Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.
- Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.
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- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO
- Department of Health (2007) *Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.* London. DH.
- Department of Health (2009) *The Mental Capacity Act Deprivation of Liberty Safeguards.* London. DH.
- Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office
- P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190
- A Local Authority v JB [2021] UKSC 52

7.3 Best practice recommendations

- Department of Health. (2006) *Records Management: NHS Code of Practice.* London: DH.
- Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

8. Monitoring, Review and Archiving

8.1 Monitoring

The ICB will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

The ICB will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be

issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The ICB will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

Appendix 1: Equality Analysis

Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Sharon Thompson
Job Title: Designated Nurse Safeguarding Adults.
Organisation: NENC ICB

Title of the service/project or policy: Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other Click here to enter text.

What are the aim(s) and objectives of the service, project or policy:
This policy sets out how the ICB will fulfil its duties and responsibilities effectively both within its own organisation and across the local health economy via its commissioning arrangements in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards 2009. The ICB as commissioners must understand the implications of the MCA and DoLS, and ICB commissioned services must demonstrate compliance with the MCA and as appropriate compliance with DoLS.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☒
- **Other Public Sector Organisations**☒
- **Voluntary / Community groups / Trade Unions** ☒
- **Others, please specify** Legal delegate consents such as LPA or appointees

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☒	☐
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐
Please provide the following caveat at the start of any written documentation: **"If you require this document in an alternative format such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net**		
If any of the above have not been implemented, please state the reason: Not applicable.		

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
David Purdue	Executive Chief Nurse NENC ICB	July 2022

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

If you are not completing 'STEP 2 - Equality Impact Assessment' this screening document will need to be approved and published alongside your documentation.

Equality Impact Assessment: Policy – Strategy – Guidance (STEP 2)

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment.

This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

STEP 2 EVIDENCE GATHERING

Name(s) and role(s) of person completing this assessment:

Name: Sharon Thompson
Job Title: Designated Nurse Safeguarding Adults
Organisation: ICB NENC

Title of the service/project or policy: Mental Capacity Act and Deprivation of Liberty Safeguards Policy

Existing ☐ **New / Proposed** ☐ **Changed** ☒

What are the intended outcomes of this policy/ service / process? (Include outline of objectives and aims;
To set out the policy for health to meet its statutory responsibilities of safeguarding children and looked after children as detailed in the Children Act (1989, 2004) and Government's Working Together to safeguard children (2018)

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Consultants** ☒
- **Nurses** ☒
- **Doctors** ☒
- **Staff** ☒
- **Service User / Patients** ☒
- **Others, please specify** Click here to enter text.

Current Evidence / Information held	Outline what current data / information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	The existing policy has been reviewed and amended in preparation for transition to the Integrated Care Board.

STEP 3: FULL EQUALITY IMPACT ASSESSMENT

PLEASE NOTE THE INFORMATION OUTLINED IN THE TEXT BOXES LISTS PROMPTS FOR GUIDANCE PURPOSES. PLEASE INPUT INFORMATION OR DELETE AS APPROPRIATE.

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:
Age *A person belonging to a particular age*
No impact
Disability *A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities*
No impact
Gender reassignment (including transgender) and Gender Identity *Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into*

alignment with his or her internal self perception.
No impact
Marriage and civil partnership *Marriage is defined as a union of a man and a woman or two people of the same sex as partners in a relationship. Civil partners must be treated the same as married couples on a wide range of legal matters*
No impact
Pregnancy and maternity *Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.*
No impact

Race *It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.*
No impact
Religion or Belief *Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.*
No impact
Sex/Gender *A man or a woman.*
No impact
Sexual orientation *Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes*
No impact
Carers *A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person*
No impact
Other identified groups relating to Health Inequalities *such as deprived socio-economic groups, rural areas, armed forces, people with substance/alcohol abuse and sex workers.* *(Health inequalities have been defined as "Differences in health status or in the distribution of health determinants between different population groups."* *Health inequalities can therefore occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical locations.)*
No impact

STEP 4: ENGAGEMENT AND INVOLVEMENT

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics? **Guidance Notes** • List the stakeholders engaged • What was their feedback? • List changes/improvements made as a result of their feedback • List the mitigations provided following engagement for potential or actual impacts identified in the impact assessment.
CCG representatives, NHSE and NECS have all been involved and in agreement with the amendment of this policy
If no engagement has taken place, please state why:
Click here to enter text.

STEP 5: METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☒ Verbal – meetings ☐ Verbal - Telephone ☐ Written – Letter ☐ Written – Leaflets/guidance booklets ☐ Written - Email ☒ Internet/website ☒ Intranet page ☒ Other If other please state: Available in other formats on request

Step 6 – Accessible Information Standard Check

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

Tick to confirm you have you considered an agreed process for:
☒ Asking people if they have any information or communication needs, and find out how to meet their needs. ☒ Have processes in place that ensure people receive information which they can access and understand, and receive communication support they need it.
Please provide the following caveat at the start of any written documentation' **"If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact NECSU.comms@nhs.net**
If any of the above have not been implemented, please state the reason: Click here to enter text.

STEP 7: POTENTIAL IMPACTS IDENTIFIED; ACTION PLAN

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

GOVERNANCE, OWNERSHIP AND APPROVAL

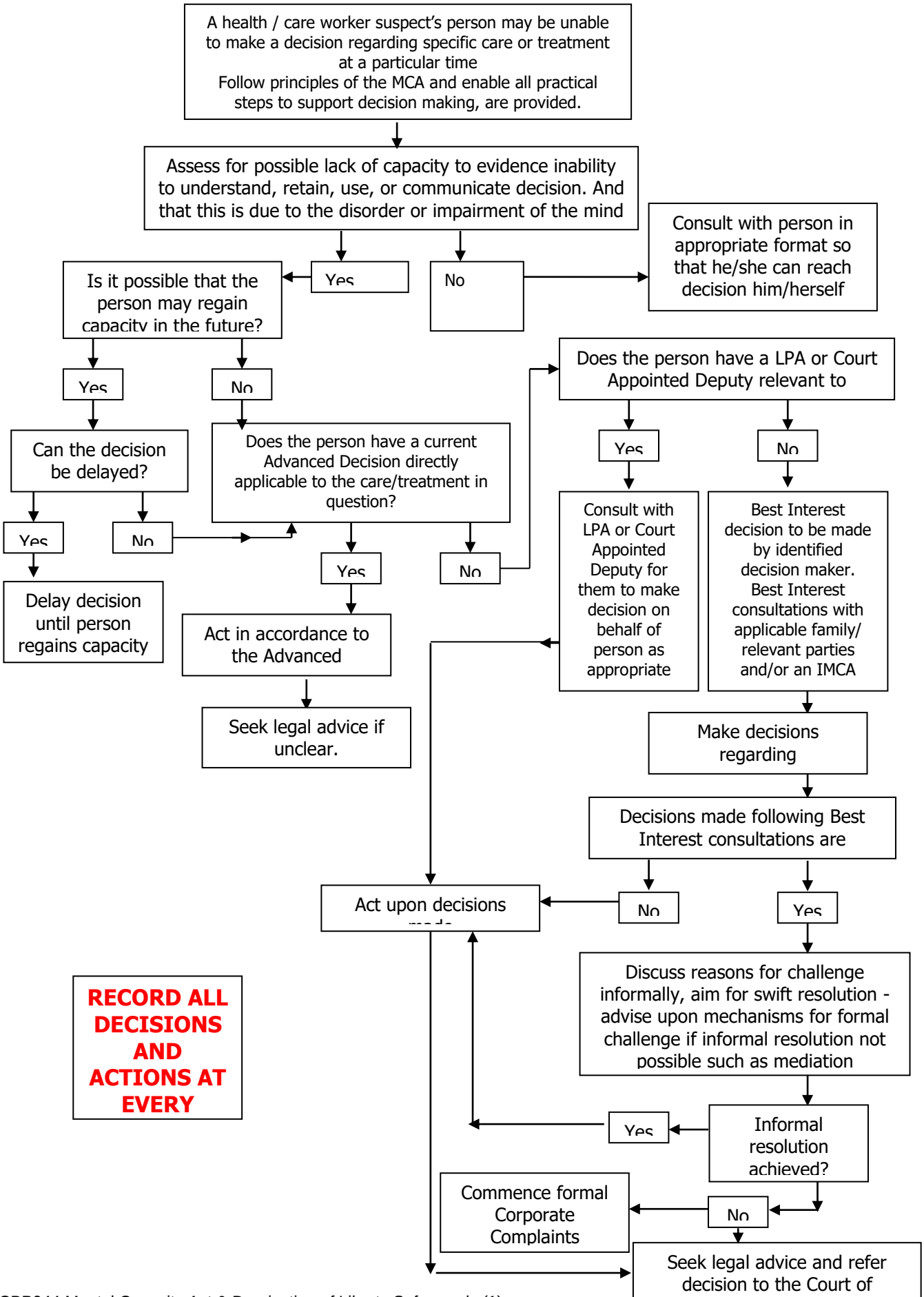
Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
David Purdue.	Executive Chief Nurse NENC ICB	July 2022

Presented to (Appropriate Committee)	**Publication Date**
NENC ICB Board	July 2022

1. Please send the completed Equality Impact Assessment with your document to: necsu.equality@nhs.net
2. Make arrangements to have the Equality Impact Assessment added to all relevant documentation for approval at the appropriate Committee.
3. Publish this Equality Impact Assessment alongside your document.
4. File for audit purposes as appropriate

For further advice or guidance on this form, please contact the NECS Equality Team: necsu.equality@nhs.net

Appendix A: Policy Flow



Glossary of Terms

Accountable:

- subject to the obligation to report, explain, or justify something; responsible; answerable.
- capable of being explained; explicable; explainable.

Devolve:

- to transfer or delegate (a duty, responsibility, etc.) to or upon another; pass on.