

CO03: Mental Capacity Act and Deprivation of Liberty Policy

Including Judicial Deprivations of Liberty



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Accessible Information Standards

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1. Introduction

For the purposes of this policy, NHS Sunderland Commissioning Group will be referred to as 'the CCG'.

This policy sets out how, as a commissioning organisation, the CCG will fulfil their statutory duties and responsibilities effectively both within their own organisation and across their local health economies via their commissioning arrangements in relation to the [Mental Capacity Act \(MCA\) 2005](#) including [Deprivation of Liberty Safeguards 2007](#) (DoLS) authorised via the Safeguards and DoL authorised via the [Court of Protection](#) (COP).

The CCG will ensure that they have in place robust structures, systems, standards and an assurance framework which enable compliance with legal and local governance arrangements.

The CCG, as members of the local Safeguarding Adult Board has formally adopted the principles of the Sunderland Multi Agency Safeguarding Adults Procedural Framework which references the MCA and DoLS and authorisation from the COP.

This policy should be read in conjunction with the:

- [The Mental Capacity Act: Code of Practice](#)
- [Mental Capacity Act and Deprivation of Liberty Safeguards. Sunderland Safeguarding Adults board.](#)
- [A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance](#)

1.1 Status

This policy is a corporate policy.

1.2. Purpose and Scope

The purpose of this policy is to support the CCG in discharging its duties and responsibilities as a commissioner. This requires the CCG to understand and be able to apply MCA and DoLS and their associated codes of practice, including current case law when commissioning services. Commissioned services are expected to demonstrate compliance with both codes of practice and any legal changes as a result of case law.

It is also to support the CCG in fulfilling its responsibilities regarding [Court of Protection](#) (COP) applications, for those individuals whose care needs amount to a Deprivation of Liberty (DoL) within a domestic setting which cannot be authorised by the Local Authority and need to be approved by the [Court of Protection](#) .

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 DoLS; in these situations the Act applies when a person is aged 18 or over or a DoL is authorised by the court for individuals aged 16-18 years.

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

- The [Office of the Public Guardian \(OPG\)](#)
- The [Court of Protection \(COP\)](#)
- The [Independent Mental Capacity Act Advocate \(IMCA\)](#)
- [Advance Decisions to Refuse Treatment \(ADRT\)](#)
- [Lasting Power of Attorney \(LPA\)](#)

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 as set out within the Act, and it is reasonably believed that the person lacks capacity in relation to the matter in question.
- That any action taken or decision made on behalf of the person who lacks capacity is decided upon following the best interests framework and in the best interests of the person.

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

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.

All staff have a duty to understand the legislation and have a duty to pay regard to the principles in their practice. Clinical staff must be aware of the expectations set out in the Act regarding assessing lack of mental capacity and actions taken in a person's best interests.

Staff must also be aware of the criteria for the statutory IMCA.

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 their 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.

3. 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 (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- A substance misuse

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

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

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

Lack of capacity must be established following the functional test and any subsequent decision or intervention made within the Best Interests framework as set out in the [Mental Capacity Act \(MCA\) 2005 section 4](#) .

4. Assessment of Lack of Capacity

The evidence the Act requires to establish a lack of capacity is known as the 2 stage test that is both diagnostic and functional. Practitioners must set out their assessment and subsequent record, following this test.

Stage 1: Establishing if the disorder or impairment may affect the ability to make specific decision in question.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent).

- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Stage 2: Assessing the ability to make specific decision.

- 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?

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).

There are [MCA Assessment Forms \(MCA1 and MCA2\)](#) available to support recording. These are also available direct into the EMIS system within the MCA template.

Deciding Right Regional Forms | Northern England Strategic Clinical Networks [deciding right regional forms.](#)

Detailed information on capacity assessment is set out in chapter 5 of the MCA code.

5. 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. That is the same whether the person making the decision or acting is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional, and whether the decision is a minor issue – like what to wear – or a major issue, like whether to provide particular healthcare.

As long as these acts or decisions are in the best interests of the person who lacks capacity to make the decision for themselves or to consent to acts concerned with their care or treatment, then the decision-maker or carer will be protected from liability.

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. But otherwise the underpinning principle of the Act is that all acts and decisions should be made in the best interests of the person without capacity.

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. As long as the person who acts or makes the decision has followed the steps to establish whether a person has capacity, and done everything they reasonably can to work out what someone's best interests are, the law should protect them.

5.1 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- 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.

5.2 Clinical Interventions

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](#) or the use of different legislation to make the particular decision. Sections [27-29](#) and 62 of the [Mental Capacity Act \(MCA\) 2005](#) 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 1983](#) matters e.g. treatment under [Part 4 of Mental Health Act 1983](#) amended 2007
- Voting rights ([section 29](#))
- Unlawful killing or assisted suicide ([section 62](#))

6. 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 section 35](#) sets a requirement of statutory 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 when:

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

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 CCG.

7. 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 well 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 and 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. A person can cancel their decision – or part of it – at any time and current case law indicates that where a patient now lacking mental capacity expresses a wish to accept treatment they have currently refused within a ADRT it would be inconceivable to decline to provide that treatment.

An advance decision that is not refusal of life sustaining treatment 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 an independent witness i.e. Someone who will not gain financially or otherwise from the outcome of an ADRT.
- Signed by the witness in front of the person

To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- Has done anything that clearly goes against their advance decision
- Has withdrawn their decision
- Has subsequently conferred the power to make that decision on an attorney, or would have changed their decision if they had known more about the current circumstances.

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 ADRT 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 ADRT
- They have appointed an LPA for Health and Welfare after the date of the ADRT

7.1 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 and end of life care planning.

Regional forms for anticipatory and emergency health care planning can be found at the Deciding Right web site [deciding right regional forms](#)

7.2 Lasting Powers of Attorney

[Lasting Power of Attorney](#) (LPAs) enable 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. 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](#) (OPC) 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.

Healthcare workers must understand the authorities of LPA's in particular those relating to health and wellbeing as they provide the legal framework for decision making and clarify who the decision maker is regarding decisions in best interests.

7.3 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 purpose of the document and be free from coercion or persuasion in their choice of attorney.
- Before an LPA can be used by the attorney 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 with the persons consent, unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse, treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA for welfare, 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 employed by and directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

7.4 The Office of the Public Guardian

This exists to help protect people who lack capacity by setting up a register of [Lasting Power of Attorney](#), court appointed deputies, receiving reports from attorneys acting under LPAs and from deputies and providing reports to the COP, as requested.

The [Office of the Public Guardian](#) (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 and can be accessed via the OPG website.

Further information regarding the OPG including all the forms to make powers of attorney, can be found by the following link: [public guardian](#)

7.5 The Court of Protection

The [Court of Protection](#) (COP) 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) that 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 COP 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,
- ✓ 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](#)

8. Deprivation of Liberty Safeguards

As from 1 April 2013, primary care trusts ceased to exist and their supervisory body (SB) role was transferred to local authorities (LA). As such CCGs are not SBs but they are required to work closely with providers and the LAs to ensure the protections offered by the safeguards are implemented appropriately and that care they commission is compliant with the MCA and DoLS.

Whilst a Deprivation of Liberty (DoL) may occur in any care setting, the 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 setting registered with the CQC such as a **hospital or care home environment**. This is whether placed under public or private arrangements where the local authority has oversight of the care regarding standards, safeguarding and monitoring.

Those affected by the DoLS will include people with a 'mental disorder', as defined within the [Mental Health Act 1983](#) amended [MHA \(2007\)](#), who lack the mental capacity to make informed decisions about arrangements for their care or treatment.

On 19th March 2014, the Supreme Court published its' judgement in the [P v Cheshire West and Chester Council and P and Q v Surry County Council](#)

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

A person is deprived of their liberty, when they are both:

- ✓ Subject both to continuous supervision and control and
- ✓ Not be free to leave.

The DoLS provide assessment of and authorisation for the DoL and provides the individual concerned with rights of advocacy review and appeal to the COP. This includes the requirement to notify the coroner for inquest, upon their death.

The Supreme Court judgment clarified that in all cases the following are not relevant to the application of the test:

- The person's compliance or lack of objection to the care arrangements.
- The reason or purpose behind a particular placement; 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 DoL. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities).

8.1 Deprivations of Liberty within a Domestic Setting

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

The Supreme Court judgment widened the scope of whom may be considered DoL and includes those not covered by the safeguards, living in independent living schemes, adult placements, children's foster placements (16 and above) and potentially even people at home receiving continuing health care (CHC) funded packages of care. These will require authorisation via the [Court of Protection](#).

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

Any unauthorised deprivations will carry with it a potential risk of litigation. If the CCG 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 CCG's risk management arrangements.

9. Governance and Accountability

The Governing Body is responsible for making certain 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. Provider management will seek assurance via the local quality requirements.

The Governing Body, through its governance structures (namely the Designated and Named Safeguarding Assurance Group (NADSAG), will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DoLS. These reports will be received on a quarterly and annual basis. The NADSAG will report by exception to Provider Quality review Groups (QRGs).

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

- Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the MCA and DoLS and that CCG commissioning, contracting, contract monitoring and quality assurance processes fully reflects this.
- MCA and DoLS is an agenda item within safeguarding, on the provider services' quality review groups (QRGs) in accordance with the QRG forward plan.
- 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 the CCG's risk register process and QRGs.

10. Duties and Responsibilities

Governing Body	The Governing Body has delegated authority from the CCG membership to set 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.
Quality, Safety and Risk Committee (QSRC)	The Quality and Safety Committee has delegated authority from the Governing Body to approve, review and monitor compliance with any clinical, quality or patient safety related policies for the CCG.
Chief Officer	<p>The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.</p> <p>The Chief Officer is accountable for ensuring that the health contribution to MCA and DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements.</p>
The Executive Director of Nursing, Quality and Safety	<p>The Executive Director of Nursing, Quality and safety is the Executive Director Lead for the Mental Capacity Act and Deprivation of Liberty Safeguards MCA/DoLS and ensures that expert advice is provided to the Governing Body on MCA /DoLS.</p> <p>They ensure that the CCG has effective professional appointments, systems, processes, structures and training to ensure that the CCG complies with its statutory responsibilities.</p> <p>They are the sponsoring Director for this policy and are responsible for ensuring that:</p> <ul style="list-style-type: none"> • This policy is drafted, approved and disseminated and reviewed in accordance with CCG Procedures. • The training required to implement this document is identified and resourced. • The Chief Officer and Governing Body members are made aware of any concerns relating to a commissioned service. • The CCG has in place assurance processes to ensure compliance with MCA, DoLS legislation, guidance, policy and procedures, and contract monitoring of providers.

Designated Nurse Safeguarding Adults	<p>The Designated Nurse Safeguarding Adults will support the Executive Director of Nursing, quality and safety to:</p> <ul style="list-style-type: none"> • Ensure the CCG's compliance in relation to MCA. • Work with the CCG's commissioning team and the Local Authority to develop and provide assurance for MCA /DoLS compliant commissioning.
All CCG employees	<p>All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:</p> <ul style="list-style-type: none"> • Comply with the MCA and DoLS policy. • Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy. • Identify training needs in respect of the MCA and DoLS policy and informing their line manager • Complete mandatory MCA and DoLS training in accordance with the CCG safeguarding adult and MCA, DoLS training plan.
North of England Commissioning Support Service (NECS)	<p>The CCG commissions some services from NECS to provide additional resource to enable it to fulfil its statutory duties and responsibilities. NECS will be expected to comply with the service contract standards relating to MCA and DoLS.</p>

11. Implementation

This policy will be available to all staff within the CCG 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.

12. Training Implications

The training required for staff to comply with this policy is:

- Mandatory safeguarding adults
- MCA, including DoLS as set out within the CCG Training Strategy training matrix

12.1 MCA DOLS Mandatory Training

Title	CCG Staff	Status	Method of Training	Period
MCA / DoLS Basic Awareness	All CCG Staff	Mandatory	E-learning or face to face	Every 3 years
Level 2 MCA/DoLS	Specialist Safeguarding/MCA roles Quality and Patient Safety Team Continuing Health Care	Mandatory	E learning Face to face via local authority or CCG safeguarding training modules	Every 3 years

13. Related Documents

Related documents are hyperlinked throughout this policy.

13.1 Legislation and statutory requirements

Legislation and statutory requirements are hyperlinked throughout this policy.

13.2 Best practice Guidance Documents

Best practice guidance documents are hyperlinked throughout this policy.

14. Monitoring, Review and Archiving

14.1 Monitoring

The Quality and Safety Committee (QSC) will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

14.2 Review

The QSC 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 'version control' table on the second 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.

14.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

15. Equality Analysis

An Equality Impact Assessment has been completed;

Equality Impact Assessment 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: Wendy Proctor

Job Title: Designated Nurse Adult Safeguarding

Organisation: Sunderland CCG

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

To advise the Quality and Safety Committee of key changes /updates to the policy

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** [Click here to enter text.](#)

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has there been or likely to be any staff/patient/public concerns?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Could this piece of work affect the workforce or employment practices?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the piece of work involve or have a negative impact on: <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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:

This policy has been reviewed and refreshed there are no significant changes or detrimental impact on any equality group caused by this refreshed policy

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Please provide the following caveat at the start of any written documentation:		

<p>“If you require this document in an alternative format such as easy read, large text, braille or an alternative language please contact (ENTER CONTACT DETAILS HERE)”</p>
<p>If any of the above have not been implemented, please state the reason:</p> <p style="text-align: center;">Click here to enter text.</p>

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	Job title	Date
Wendy Proctor	Designated Nurse Adult Safeguarding	09/09/2021
Presented to (Appropriate Committee)		Publication Date
Quality and Safety Committee		October 2021

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.

**Please send a copy of this screening documentation to:
NECSU.Equality@nhs.net for audit purposes.**