NHS
South Tyneside
Clinical Commissioning Group

Mental Capacity Act 205 (MCA) and Deprivation of Liberty Safeguards (DOLS)

Ratified	Approved
Status	Final
Issued	January 2019
Approved By	Quality and Patient Safety Committee
Consultation	CCG Leads, CCG Executive Committee, CCG Quality, Patient and Safety Committee
Equality Impact Assessment	Completed.
Distribution	All Staff
Date Amended following initial ratification	Non-applicable.
Implementation Date	January 2019
Planned Review Date	January 2021
Version	1.2
Author	Mental Capacity Act (MCA) Practice Development Lead.
Reference No	CO03 (Replaces version 1 of CO03 and CO10)

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

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

Version Control

Version	Release Date	Author	Update comments
1.1	October 2016	MCA Practice Development Lead	Newly combined policy
1.2	December 18	Designated Nurse Safeguarding Adults	Updated following role changes and governance changes

Approval

Role	Name	Date
Approval	Quality and Patient Safety Committee	5th October 2016
Approval	Quality and Patient Safety Committee	January 2019

Review

This document will be reviewed two years from its issue date.

Contents

1. Introduction

This policy sets out how as a commissioning organisation South Tyneside Clinical Commissioning Group (STCCG) 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 Commissioners must understand the implications of the MCA and DoLS, and STCCG commissioned services must demonstrate compliance with the MCA and as appropriate compliance with DoLS.

For the purposes of this policy, STCCG will be referred to as 'the CCG'.

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

The CCG, as a member of the local Safeguarding Adults Board, Local Adult Safeguarding Sub Groups and Local Executive Groups 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 (DoLS).

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 http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

- Deprivation of Liberty Safeguard Policy. Covering domestic deprivations of Liberty. http://www.southtynesideccg.nhs.uk/publications/policies/

- Safeguarding Adults Policy CCG CO16 http://www.southtynesideccg.nhs.uk/wp-content/uploads/2015/11/CO16-Safeguarding-Adults-Policy-2.pdf

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 the principles of the Mental Capacity Act (MCA) 2005 Code of Practice, and Deprivation of Liberty Safeguards (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; 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 CCG, 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	MCA
Mental Health Act	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	COP
Lasting Power of Attorney	LPA
Enduring Power of Attorney	EPA
Advance Decision to refuse treatment	ADRT
General Practitioner	GP
Deprivation of Liberty Safeguard	DoLs
Supervisory Body	SB
Managing Authority	MA

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
- 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. 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 capacity testing 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 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 is a form available to support recording. This is also available direct into the EMIS system within the MCA template

Deciding Right Regional Forms | Northern England Strategic Clinical Networks

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

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. 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.

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 CCG.

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 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.

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)

This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. 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 CCG 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 NECS Governance Team and in consultation with the Equality and Diversity Lead.

2.12 Deprivation of Liberty Safeguards

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.

On 1st April 2013, Primary Care Trusts ceased to exist and their Supervisory Body (SB) role was transferred to Local Authorities (LA). As such the CCG's are not Supervisory Bodies (SBs) but they are required to work closely with providers and the LA's to ensure the protections offered by the safeguards 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).

STCCG 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. This can be found in the Domestic Deprivation of Liberty policy CCGO03

The CCG is able to seek assurance from its commissioned services that they are compliant with the DoLS framework and COP requirements. This includes the Joint Commissioning service that provides Continuing Health Care Services (CHC), and other providers of NHS funded care.

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 Risk management arrangements.

3 Governance and Accountability

The CCG 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 Alliance Business Group, the Quality and Patient Safety Committee and the Designated and Name Safeguarding Assurance group, will assure itself that its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DOLs

- Quarterly
- Annual report

The CCG 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 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) and that STCCG commissioning, contracting, contract monitoring and quality assurance processes fully reflects this.
- MCA and DoLS is an agenda item within Safeguarding, on the provider services' Clinical Quality Review Groups (CQRGs) in accordance with the CQRG 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 Risk Registers and CQRGs.

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

4. Duties and Responsibilities

4.1 Governing Body (GB)

The CCG has delegated responsibility to the Governing Body 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.

4.2 The Chief Officer

The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.

The Chief Officer is accountable for ensuring that the health contribution to MCA and DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements.

This role is supported by the Clinical Director for Mental Health and Learning Disability who is board lead for MCA who is supported by the Quality and Safeguarding Leads for expert advice to the Governing Body on MCA and MCA DoLS matters.

4.3 The Clinical Director for Mental Health and Learning Disability (MH&LD)

The CCG Clinical Director for MH&LD as Executive Lead for MCA and DoLS is the Sponsoring Director for this policy and is responsible for ensuring that:

- This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
- The necessary training required to implement this document is identified and resourced.

- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.
- The CCG has in place assurance processes to ensure compliance with MCA and DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers

They are supported in this by the Designated Nurse for Safeguarding Adults.

4.4 Designated Nurse for Safeguarding Adults.

The Designated Nurse for Safeguarding Adults will support the Executive Lead on aspects of the NHS contribution to MCA and DoLS across the CCG's area, which includes all commissioned providers. The post will:

- Work with the Clinical Director of MH & LD to ensure robust assurance arrangements are in place within the CCGs and provider services.
- Provide advice and expertise to the CCG's governing bodies and associated groups and to professionals across both the NHS and partner agencies.
- Provide professional leadership, advice and support to lead professionals across provider trusts/services and independent contractors.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, DoLS.
- Lead and support the development of MCA, DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.
- Provide advice and guidance in relation to MCA, DoLS training including standards.
- Ensure quality standards for MCA, DoLS are developed and included in all provider contracts and compliance is evidenced.
- Work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's safeguarding services.

4.5 Managers and Executive Leads

Managers and Executive leads have responsibility for:

- Ensuring they are aware of and carry their responsibilities in relation to MCA, DoLS.
- Ensure that the MCA and DoLS policy is implemented in their area of practice.
- Ensuring staff are aware of the contact details of the Quality and Safeguarding leads for any issues of concern regarding care or commissioning practice relating to the MCA & DoLS.
- Ensuring that all CCG staff undertakes mandatory MCA, and DoLS training commensurate to their role as set out within the Safeguarding policy training section.

4.6 CCG Staff

All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:

- Comply with the MCA and DoLS Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.
- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager
- Complete mandatory MCA and DoLS training in accordance with the CCG MCA, DoLS Training Plan.

4.7 Commissioning Support Service (NECS)

The CCG commission, Medicines Optimisation Services from the Commissioning Support Service. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSS will be expected to comply with the Service contract standards relating to MCA and DoLS.

4.8 Primary Medical Services (GP practices)

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

5. 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.

6. Training Implications

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

- Mandatory, MCA, including DoLS as set out within the training matrix of the Safeguarding Adults policy. http://www.southtynesideccg.nhs.uk/wp-content/uploads/2015/11/CO16-Safeguarding-Adults-Policy-3.pdf

7. Documentation

7.1 Other related policy and resource

- Safeguarding Adults Policy: http://www.southtynesideccg.nhs.uk/wp-content/uploads/2015/11/CO16-Safeguarding-Adults-Policy-2.pdf
- GMC MCA tool kit http://www.gmc-uk.org/Mental_Capacity_flowchart
- GP MCA tool kit http://mentalcapacityresources.co.uk/gp-mca-toolkit.html

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.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- Cabinet Office (1983) *Mental Health Act 1983*. London. HMSO
- 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

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 CCG governing body 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 CCG governing body 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 governing body 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.

9. Equality Analysis

A full Equality Impact Assessment has been completed;

necs

Partners in improving local health

NHS

North of England Commissioning Support

Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	Sharon Thompson
Title of service/policy/process:	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	
This policy sets out how as a commissioning organisation South Tyneside Clinical Commissioning Group (STCCG) 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 Commissioners must understand the implications of the MCA and DoLS, and STCCG commissioned services must demonstrate compliance with the MCA and as appropriate compliance with DoLS.	

Who will be affected by this policy/service /process? (please tick)
√ **Consultants** √ **Nurses** √ **Doctors** √ **Staff members** √ **Patients** □ **Public** √ **Other**
If other please state: Legal delegate consents such as LPA or appointees
What is your source of feedback/existing evidence? (please tick)
√ **National Reports** □ **Internal Audits** □ **Patient Surveys** □ **Staff Surveys** □ **Complaints/Incidents** □ **Focus Groups** □ **Stakeholder groups** □**Previous EIAs** √ **Other**
If other please state: Legislation/ Acts of Law

National Reports	**What does it tell me? (about the existing service/policy/process? Is there anything suggest there may be challenges when designing something new?)**
Patient Surveys	Mental Capacity Act 2006 and Deprivation of Liberty Safeguards 2009 House of Lords select committee report on above Acts March 2014 DoH response to recommendations on above. 'The Act has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.' [HoL March 2014]
Staff Surveys	
Complaints and Incidents	
Results of consultations with different stakeholder groups – staff/local community groups	
Focus Groups	

STEP 2 - IMPACT ASSESSMENT
What impact will the new policy/system/process have on the following: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
Non – Policy to comply with Adult legislation 16 +
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
Set out commissioning and provider responsibilities regarding the MCA and DoLS. Human right based legislation to ensure principles of the MCA are maintained for all and in particular those with a mental impairment. Positive impact.
Gender reassignment (including transgender) 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.
Non – appropriate for all 16+
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
Non – appropriate for all 16+
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.
Non – appropriate for all 16+
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
Non – appropriate for all 16+
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.
Non – appropriate for all 16+
Sex/Gender A man or a woman.
Non – appropriate for all 16+
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Non – appropriate for all 16+
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
Non – appropriate for all 16+ Positive impact on rights set out within Acts
Other identified groups such as deprived socio-economic groups, substance/alcohol abuse and sex workers
Non – appropriate for all 16+

STEP 3 - ENGAGEMENT AND INVOLVEMENT
How have you engaged stakeholders in testing the policy or process proposals including the impact on protected characteristics?
No this is legislation based policy
Please list the stakeholders engaged:

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users of the policy?
□ **Verbal – stakeholder groups/meetings** □ **Verbal - Telephone** □ **Written – Letter** √ **Written – Leaflets/guidance booklets** □ **Email** √ **Internet** √ **Other**
If other please state: Disseminated to CCG staff via line management and referenced in training

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Tick to confirm you have you considered an agreed process for:
√**Sending out correspondence in alternative formats.** Easy read leaflets on DoLS- consulted with service users. □ **Sending out correspondence in alternative languages.** □ **Producing / obtaining information in alternative formats.** □ **Arranging / booking professional communication support.** □ **Booking / arranging longer appointments for patients / service users with communication needs.**
If any of the above have not been considered, please state the reason: This policy is primarily for staff to support their legal requirement to act within the legislation. Its target audience is not service users. Information on advocacy provided in alternative language by commissioned advocacy service to customers / service user

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1	There are no aspects of the policy that impact negatively on service users.

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?

SIGN OFF

Completed by:	**Sharon Thompson**
Date:	**03/12/2018**
Presented to: (appropriate committee)	**QPSC**
Publication date:	**January 2019**

Policy Flowchart

Appendix A