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NHS Sheffield Clinical Commissioning Group

Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) Policy and Procedure

September 2018

Version:	1.0
Policy Number:	CL019/03/2019
Date ratified:	22 November 2018
Name of originator/author:	Nurse Quality Manager MCA/DoL
Name of Sponsor:	Chief Nurse
Name of responsible committee	Quality Assurance Committee
Date issued:	November 2018
Review date:	March 2019
Target audience:	SCCG Governing Body, SCCG Quality Assurance Committee and all CCG Staff

To ensure you have the most current version of this policy please access via the NHS Sheffield CCG Intranet Site by following the link below:

http://www.intranet.sheffieldccg.nhs.uk/policies-procedure-forms-templates.htm

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Policy Audit Tool

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Please give status of Policy:	**New**

1.	**Details of Policy/Procedural Document**	
1.1	Policy Number:	CL019/03/2019
1.2	Title of Policy/document:	Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy and Procedure
1.3	Sponsor	Chief Nurse
1.4	Author:	Nurse Quality Manager MCA / DoL
1.5	Lead Committee	SCCG Quality Assurance Committee
1.5	Reason for policy/document:	Compliance with legislation
1.6	Who does the policy affect?	All CCG staff
1.7	Are the National Guidelines/Codes of Practice etc issued?	Yes
	Has an Equality Impact Assessment been carried out?	Yes
2.	**Information Collation**	
2.1	Where was Policy information obtained from?	Current national policy, legislation, case law and practice guidance
3.	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure for the implementation of the Policy?	No
3.2	If YES attach a copy to this form.	N/A
3.3	If NO explain why.	Policy can be operated within existing structures
4.	**Consultation Process**	
4.1	Was there external/internal consultation?	Internal
4.2	List groups/persons involved	Chief Nurse, Safeguarding Adults Lead, Practice Standards Manager MCA
4.3	Have external/internal comments been included?	Yes
4.4	If external/internal comments have not been included, state why.	N/A
5.	**Implementation**	
5.1	How and to whom will the policy be distributed?	All CCG staff via Weekly Comms bulletin, CCG Policies intranet page and Team Briefs
5.2	If there are implementation requirements such as training please detail.	MCA training is mandatory
5.3	What is the cost of implementation and how will this be funded	Cost neutral
6.	**Monitoring**	
6.1	How will this be monitored	See page 22 - 23
6.2	Frequency of Monitoring	

Version Control

VERSION CONTROL				
Version	**Date**	**Author**	**Status**	**Comment**
1.0	**October 2018**	**Nurse Quality Manager MCA/DoL**	**New**	**Organisational requirement. Further update pending legislation changes**

Contents

SECTION 1 - POLICY

1 Introduction & Purpose

1.1 Important to Note: This is an interim corporate policy pending significant legislatory changes to be enacted in 2019, following a detailed review of the Deprivation of Liberty Safeguards 2008 (DoLS) by the Law Commission. The Mental Capacity Act 2005 (MCA) will be revised and DoLS will be replaced by a new and wider reaching legal framework, which will be known as the Liberty Protection Safeguards. A revised policy will be drafted to take effect when the new legislation is enacted. Until then, SCCG will continue to act in accordance with the current legislation via this interim policy.

1.2 Sheffield Clinical Commissioning Group (SCCG) 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 and representatives, public, staff, stakeholders and in the use of public resources.

1.3 SCCG has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare and rights of vulnerable adults and young people over the age of 16, who receive care, treatment and/or services funded by the CCG by:

- Ensuring that the services commissioned by SCCG provide safe, effective and high quality care for vulnerable children and adults, including adults who lack mental capacity.

- Ensuring the care commissioned by SCCG is compliant with the MCA and that providers fulfil their statutory responsibilities to people who access services.

- Ensuring that all staff employed by SCCG are aware of and fulfil their responsibilities under the MCA and that their staff operate at all times in accordance with the statutory framework and the Code of Practice.

- Ensuring that all staff employed by SCCG are aware of and fulfil their responsibilities under the DoLS and that their staff operate at all times in accordance with the statutory framework and the Code of Practice.

- Ensuring that SCCG undertake yearly Safeguarding Adults and Children's mandatory e -learning training which incorporates Mental Capacity Act Training.

1.4 The purpose of this policy is to support SCCG in the discharge of its duties and responsibilities as an NHS Commissioner and to gain assurance that the principles of the MCA 2005 Code of Practice, and DoLS 2008 Code of Practice are being

applied to decisions about care and accommodation arrangements of people who lack capacity to consent to them.

1.5 This policy sets out how SCCG will effectively fulfil its statutory duties and 'positive obligations' in terms of the MCA and DoLS both internally and across the local health economy, via its commissioning arrangements with partner organisations and providers. All services commissioned and contracted by SCCG will be expected to comply with the principles of this policy and the respective legislation and Codes of Practice.

1.6 This policy outlines the procedures involved (derived from the MCA and DoLS Codes of Practice) and the responsibilities of SCCG staff in their respective roles in carrying them out.

1.7 As a member of the Sheffield Adults Safeguarding Partnership (SASP), Local Adult Safeguarding Sub Groups and Local Executive Groups, SCCG has formally adopted the principles of the Safeguarding Adults Inter-Agency Policy and Procedures with reference to the MCA and DoLS.

1.8 As a member of the Sheffield Children Safeguarding Board (SCSB), Safeguarding Sub Groups and Local Executive Groups, SCCG has formally adopted the principles of the Safeguarding Children Policy and Procedures with reference to the MCA and DoLS.

2 Scope

2.1 This policy applies to:

- All adults (over 18) who receive NHS Continuing Health Care, joint NHS and social care, or NHS funded nursing care funding via SCCG
- All young people aged 16-17 who receive funding via SCCG

2.1.1 Important note: DoLS only applies to people who live in a registered care setting, such as a hospital or care home. For all people receiving State funded care in their own homes and community settings (e.g family placement, supported living) an application must be made to the Court of Protection (COP) to authorise any potential deprivation of liberty.

2.1.2 This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff. The CCG requires its employees and those from whom it contracts services to be fully aware of their duties and responsibilities under the MCA 2005 and DoLS 2008, to have regard to the guidance in the Codes of Practice.

2.2 Responsibilities

2.2.1 The Governing Body

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

2.2.2 The CCG Accountable Officer

The Accountable Officer is responsible for ensuring that the organisational accountability for delivering the Mental Capacity Act and Deprivation of Liberty Safeguards is discharged effectively across the local health economy through the CCG commissioning arrangements. The role is supported by the Head of Quality and Safety who holds delegated responsibility and is executive lead for Safeguarding and the MCA.

2.2.3 The Chief Nurse

The Chief Nurse is the executive lead for Safeguarding and MCA/DoLS.

2.2.4 Nurse Quality Manager MCA/DoL

The Nurse Quality Manager MCA/DoL will take a strategic and professional lead on all aspects of the NHS contribution to and MCA/DoLS across the CCG's areas of responsibility and accountability. This includes all commissioned providers. The responsibilities are:

- Ensuring assurance arrangements are in place within the CCG and provider services.
- Providing regular and exception reports to the CCG's Governing Body via the Quality Assurance Committee (QAC).
- Provide professional leadership, advice and support to CCG staff, adult safeguarding leads and MCA professionals internally and across provider trusts/services and independent contractors.
- Work closely with the Designated Nurse for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA / DoL.
- Lead and support the development of MCA / DoL policy, and procedures in the CCG in accordance with national, regional and 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.
- Ensure that systems are in place within the CCG to make appropriate applications to the Court of Protection.
- Work in partnership with the Local Authority to achieve the above aims.

- Ensure all matters posing significant risk to SCCG (including financial) are appropriately escalated in a timely way.

2.2.5 CCG MCA / DoL Practitioners (DoLiC Assessors)

The CCG MCA / DoL Practitioners are responsible for the implementation of the operational procedures regarding MCA / DoL. This includes:

- Making COP Re X applications for non-complex CHC cases

- Making COP Welfare applications for complex CHC cases
- Case management of Section 21A challenges to DoLS for all CHC, joint and NHS Funded Nursing Care cases in which SCCG is joined as a party to proceedings
- Developing and delivering internal mandatory and role essential training
- Developing and delivering any external training to be provided as part of SCCG's commissioning arrangements.
- Providing advice and guidance to CCG care managers in relation to specific cases.
- Collating audit information as required by the Nurse Quality Manager MCA/DoL.
- Providing quality, performance and compliance report data.
- Responding appropriately to referrals from as part of the MCA/DoL escalation process.
- Escalating any matters requiring more senior CCG advice, guidance or representation to the Designated Professional MCA/DoL.

2.2.6 The SCCG Governance Committee

The QAC have a responsibility for development, implementation, review and monitoring effectiveness of these policies and procedures on behalf of the CCG Governing Body, receiving assurance via regular and exception reporting, annual reports and the safeguarding report updates

2.2.7 CCG Staff

All staff must:

- Be familiar with the requirements of the MCA, MHA and related documents, and with procedures detailed in the CCG Operational Policies. They must be compliant with the MCA and MHA Codes of Practice, apply the Guiding Principles and Practice Guidance of those Codes when carrying out their duties.
- Ensure they keep up to date with MCA / DoLS mandatory training and MCA /MHA practice and learning appropriate to their role.

- Understand and carry out their duty in relation to Safeguarding of Children and Adults throughout this process.
- Where applicable have a responsibility to ensure that MCA and DoLS is reflected in commissioning processes and contracting arrangements.

2.2.8 CCG Care managers

Any member of CCG staff responsible for arranging and reviewing a person's care, treatment and accommodation arrangements, when they are in receipt of Continuing Health Care (CHC) funding must:

- Follow the principles of the MCA and DoLS guidance, paying particular reference to the Codes of Practice.
- Follow the guidance detailed in the CCG's Operational Policies regarding consent to care, treatment and accommodation arrangements and the escalation of any contentious matters that might bring the CCG into litigation proceedings.
- Complete required mandatory MCA/DoL training and role specific training.

2.4 Line Managers

All line managers are responsible for:

- Ensuring their staff are aware of and comply with this policy and the requirements of it.
- Ensure their staff complete required mandatory and role specific MCA/DoL training.

3. Definitions – See Appendix A

SECTION 2 - PROCEDURE

4. Process/Requirements

4.1. When a Mental Capacity Assessment is required

4.1.1. Decision making capacity refers to a person's ability to make decisions and take actions for themselves, from everyday decisions such as what to eat, to more significant ones such as whether to accept or refuse serious medical treatment.

4.1.2 A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter.

4.1.3 Capacity assessments refer to a person's ability to make a particular decision at a particular moment in time; they are not a blanket judgment on a person's ability to make all or a range of decisions.

4.1.4 When a decision needs to be made, but there is concern that the individual may lack capacity then an assessment of the urgency of the decision needs to be made.

4.1.5 When an urgent decision needs to be made:

- It is possible to treat someone if a practitioner reasonably believes a person lacks capacity and that the proposed treatment is necessary to save their life or to prevent a significant deterioration in their condition. The treating practitioner must do what is immediately necessary to prevent serious harm.

- Any decision made by a treating practitioner to provide care, intervention or treatment that is immediately necessary must be recorded. The record must evidence that the person's capacity to make a decision was considered and must details the circumstances and rationale. The record must also show that steps were taken to keep the person as informed as possible during the care/treatment, if appropriate.

4.1.6 If the decision is not urgent and if the person is likely to regain capacity, the decision should be delayed until such a time that the person has the capacity to make the decision.

4.1.7 The MCA specifies that any assessment of mental capacity should be made only in relation to a specific decision at a specific time. A person cannot be said to 'lack capacity' for a range of decisions.

4.1.8 The following are examples of decisions that may need to be made by either SCCG employees or individuals employed within SCCG commissioned services:

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment, including prescribing and administering medication
- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 1983 (amended 2007), (MHA)
- Placing a person into residential or nursing care
- Emergency procedures

4.1.9 The MCA sets out 5 principles that are to be applied in all cases by decision makers which, if adhered to and followed in every matter, will protect the decision maker from liability and potential litigation / prosecution. Any deviation from, or omission of any of the principles is unlawful.

Principle 1:
Assume Capacity:
Every adult has the right to make their own decisions if they have capacity to do so. A person must therefore always be assumed to have capacity unless it is established otherwise.

Principle 2:
Practical steps to maximise decision making capacity:
A person is not to be treated as unable to make a decision unless all practicable steps to help him/her make the decision have been taken without success

Principle 3:
Unwise decisions:
A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision

Principle 4:
Best Interest:
Any act done, or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his\her best interests.

Principle 5:
Least Restrictive Option:
Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive for the person's rights and freedom of action.

4.1.10 A healthcare professional who claims that an individual lacks capacity must assess the person and provide documentary evidence of their assessment. They must prove that they have applied the principles of the MCA in reaching a decision that P lacks the capacity to make the material decision. See Section 7 – Useful Guidance 'My next patient lacks capacity'.

4.2 Who should assess mental capacity?

4.2.1 The individual who assesses a person's capacity to make a decision should be the person who is directly concerned with the individual at the time the decision needs to be made. This person is the decision maker.

4.2.2 The decision as to who is the best person to assess P's capacity depends on the decision that needs to be made. For most day to day decisions, the carer most directly involved with the person will be best placed to assess the capacity of the person to make the decision at the time it needs to be made.

4.2.3 For more complex decisions and assessments it is good practice to involve other specialist professionals so that all the relevant information and risks/benefits of the decision to be made can be explained following principle 2 of the MCA. Specialist practitioners may assist in taking practicable steps to maximise P's ability to make the decision (e.g. Speech and Language Therapist to aid communication and understanding.

4.2.4 Other factors that may indicate other professional involvement might be:

- The seriousness of the decision and/or its consequence
- Where P or their representative disputes a finding of incapacity
- Where there is disagreement between family members, carers and/or professionals as to the person's capacity
- Where there is concern that undue pressure or coercion is being placed on the person
- Where there may be legal consequences to a finding of lack of capacity

4.3 How to complete a Mental Capacity Assessment: The two stage functional test

4.3.1 When there is reasonable belief that a person may lack capacity to make a particular decision a two-stage capacity test must be undertaken. The purpose of the test is:

- Stage 1: To establish that there is a temporary or permanent impairment or disturbance of the mind or brain and if so:
- Stage 2: that as a result of this the person is unable to make the decision at the time that it needs to be made

4.3.2 The MCA states that a person is unable to make their own decision if they cannot do one or more of the following four functions:

- understand information given to them
- retain that information long enough to be able to make the decision

- weigh up the information available to make the decision
- communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

4.3.3 Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. To assist with this it will need to involve family, friends, carers or other professionals.

4.3.4 The assessment must be made on the balance of probabilities – i.e. is it more likely than not that the P lacks capacity for the particular decision.

4.4 Supporting people to make their own decisions

4.4.1 When working with a person who needs to make a decision, those working with them must start from the presumption that the person has capacity. It is therefore the responsibility of the assessor to take all practicable steps to help someone make their own decisions, before they can be regarded as unable to make a decision

4.4.2 All information relevant to the decision must be explained to the person, including risks, benefits and consequences. It must include the information likely to be important to the person. This will require a balance to be struck between giving enough information to make an informed decision and too much information or detail which could be confusing.

4.4.3 Decisions that cannot be made on behalf of others who may lack capacity:

- Consenting to marriage or a civil partnership, or a decree of divorce on the basis of two years separation or to the dissolution of a civil partnership on the basis of two years separation
- Consenting to have sexual relations
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibilities for a child in matters not relating to the child's property
- Giving consent under the Human Fertilisation and Embryology Act 1990
- Voting on behalf of a person who lacks capacity.

4.5 Supporting Advanced Decision Making

4.5.1 A person can make an advanced decision to:

- Appoint someone to make decisions on behalf of the person regarding health and welfare via a Last Power of Attorney authorisation

- Refuse specific treatments in advance.

- Nominate people to be consulted when decisions are being made about them.

4.5.2 The person must make an advanced statement in writing, stating their wishes and preferences for their future care.

4.5.3 It is the responsibility of the person making the advanced decision or their nominated representative to bring it to the attention of any practitioner in the appropriate circumstance.

4.5.4 Practitioners must assure themselves that any advanced decision is valid and applicable to the proposed treatment or action.

4.5.5 It is good practice in long term condition management to support a person with advanced care planning by providing necessary information about their condition and its likely progression and by discussing their wishes and feelings with them and their carer. Good advanced care planning and its documentation can avoid future difficulties and disputes about a person's care and treatment when they no longer have capacity.

4.6 Making a decision in Best Interests

4.6.1 The decision maker must have assessed P's capacity to make the material decision at the material time.

4.6.2 The decision maker must follow the guidance in the MCA Code of Practice (Chapter 5).

4.6.3 For more complex Best Interest decisions it is best practice that a balance sheet approach is used. This should outline the 'benefits and burdens' of the decision, including the consequences of not making it. This is essential in contested cases, particularly if the COP may become involved. See Appendix B.

4.7 Medical Treatment or Examination

4.7.1 When consent for medical treatment or examination is required, the practitioner proposing the treatment should decide whether the patient has capacity

to consent to or refuse the treatment. In settings such as a hospital, the multi-disciplinary team can assist. However, the decision maker will be the person who is carrying out or prescribing the treatment and they must assess capacity.

4.8 Legal matters

4.8.1 In circumstances such as legal matters, e.g. making a Lasting Power of Attorney, the Solicitor involved may need to decide whether or not the person has sufficient capacity to make the decision. An opinion from a Doctor or other professional expert may be required.

4.9 Care Planning

4.9.1 The five statutory principles of the MCA are integral to the development of an individual care plan.

4.9.2 Wherever possible individuals who lack capacity must be involved in decisions about their care and treatment as much as those who have capacity. Where practitioners and patients disagree over elements of the care plan the emphasis should be on discussion, reasonableness and compromise where possible.

4.9.3. When care planning for a person who lacks capacity to consent to their care, accommodation and treatment arrangements, principle 4 (section 6.1) of the MCA must be applied in determining what is in their best interests. This ensures P participates and that their wishes, feelings, beliefs and values have been considered and taken into account. It also requires that consultation with specified others (e.g. carers, attorneys and people nominated by the person) about the person's best interests takes place.

4.10 Recording a mental capacity assessment or best interest decision

4.10.1 Accurate records must be kept of decisions made in respect of mental capacity and they must demonstrate why certain actions and decisions have been made on behalf of individuals. The protection from liability will only be available if the assessor can demonstrate they have assessed capacity, reasonably believe the person be lacking and then acted in a way that is reasonably believed to be in the person's best interests. Appendix C provides a prompt sheet for assessing mental capacity.

4.10.2 It is not necessary to document everyday decisions, e.g whether to dress P or clean their teeth. However, those providing such care must demonstrate all daily tasks requiring minor decisions in P's care plan and an assessment and best interest decision must be recorded for consent to the plan.

4.10.3 Examples of decisions for which detailed record keeping are necessary:

- serious medical treatment
- consent to care and accommodation arrangements (i.e. the care plan)
- disagreement about whether or not P lacks or has capacity
- there is an intention to refer to the Independent Mental Capacity Advocate
- There are concerns about conflicting opinions (e.g. between professionals, carers, the person being assessed).

4.11 Lasting Power of Attorney and Court Appointed Deputies

4.11.1 On being told that a person's representative holds a LPA or is a CAD for Health and Welfare, it is the responsibility of the practitioner to either:

- See a valid, signed LPA document, issued by the OPG
- See a valid COP order appointing the named Deputy

Or:

- Check the details with the OPG, by completing a Form OPG100 at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/286541/OPG100_Apply_to_search_PG_registers.pdf

4.11.2 If there is a significant concern about the conduct of a person acting under an LPA, the OPG should be contacted:

safeguardingunit@publicguardian.gsi.gov.uk

Telephone: 0115 934 2777

Text phone: 0115 934 2778

Monday to Friday, 9am to 5pm

Wednesday, 10am to 5pm

Office of the Public Guardian

PO Box 16185

Birmingham B2 2WH

4.11.3 Up to date LPA and CAD information should be recorded in the person's records.

4.12 Appointing an IMCA

4.12.1 The MCA Code of Practice states that an IMCA must be instructed for a person who lacks capacity who has no one (apart from a professional or paid carer) to be consulted in determining what would be in the patient's best interest in the following circumstances

- Where there is a proposal to provide serious medical treatment, (except treatment provided under part 4 of the Mental Health Act, for a person who lacks capacity
- The CCG/Local Authority proposes to provide accommodation in hospital for a period of more than 28 days or in a care home for more than 8 weeks, for a person who lacks capacity.
- The CCG/ Local Authority propose to change the accommodation to another hospital for a period of more than 28 days or a care home for more than 8 weeks. This does not include people who are being cared for under the MHA, except post-discharge arrangements made under Section 117 of the MHA.
- The CCG/ Local Authority propose to provide or change residential accommodation for more than 8 weeks continuously.

4.12.2 It is good practice, in accordance with the MCA Code of Practice to appoint an IMCA for a person who lacks capacity and who has no one (apart from a professional or paid carer) to be consulted in determining what would be in the patient's best interest for:

- Reviews of care and/or treatment, where no-one else is available to be consulted
- Adult protection procedures, whether or not family, friends or others are involved

4.12.2 The duty to instruct an IMCA does not preclude intervention where it is immediately or urgently necessary. In cases where emergency or lifesaving treatment is necessary, the treating practitioner must make the decision and act without delay.

4.12.3 When referring a person to another agency/department for further assessment / treatment, a referral to the IMCA Service should be made at the same time if the person is likely to require their services for future decision making.

Sheffield Advocacy Hub
Telephone: 0800 035 0396
E-mail: referrals@sheffieldadvocacyhub.org.uk
Website: https://sheffieldadvocacyhub.org.uk/

4.13 Do Not Resuscitate (DNAR) / Cardiopulmonary Resuscitation (CPR) decisions

4.13.1 DNACPR decisions should only be made for a person who does not have capacity, if the decision is believed to be in their best interests (as defined by the MCA).

4.13.2 DNACPR decisions must never be motivated by a desire to bring about the person's death. Professionals should seek to establish the person's previously and currently held views and wishes either from them or the person with LPA, or an Independent Mental Capacity Advocate (IMCA) before making a DNACPR decision.

4.13.3 Decisions should reflect what the person would have wanted in such circumstances.

4.13.4 Every effect should be made to involve and enable the person in the decision making.

4.13.5 Any views or wishes of the person's representative can only be taken into account if they are based on what the person would have wanted.

4.13.6 Practitioners should tell the people closest to the person if they reach a DNACPR decision and explain the reasons to them.

4.13.7 If there is a dispute as to a person's best interests when CPR is to be withheld or withdrawn, a second opinion should be offered.

4.13.8 If any dispute about a DNACPR cannot be resolved, legal advice must be sought by the decision maker.

4.14 Safeguarding Adults

5.14.1 This policy should be read in conjunction with the Sheffield Safeguarding Adults multi - agency policy and procedures.

4.14.2 People who lack capacity are amongst the most vulnerable group at risk of abuse and/or neglect. The decisions made on behalf of vulnerable people are among the most important and have most impact.

4.14.3 Mental capacity will need to be considered in cases where adult abuse is suspected or proven and any decisions about their future protection needs must be made in their best interests and in compliance with statutory guidance . Such decisions will often involve complex sets of circumstances and decision makers will need to consider P's previously expressed wishes and feelings, the likely effects of them person remaining within the abusive environment and the effects of removing them from the environment. The wider social aspects of a P's circumstances must be considered when determining what is in his or her best interests.

4.14.4 A person who wilfully neglects or ill-treats a person who lacks capacity can be prosecuted under section 44 of the MCA and risks a custodial sentence.

4.15 Applying the Deprivation of Liberty Safeguards

4.15.1 It is important to understand that DoLS is not a mechanism to deprive P of their liberty – this is already potentially being done by virtue of their care, treatment and accommodation arrangements. DoLS is a mechanism which scrutinises the arrangements and places them with a legal framework to:

- Ensure P is given the care they need in the least restrictive way
- Prevent arbitrary decisions being made in the interests of the home or hospital rather than the needs of the adult at risk
- Entitle P to take Court proceedings to challenge the lawfulness of a deprivation of liberty

4.16 Deprivation of Liberty in hospital and care homes

4.16.1 DoLS applies to patients in hospitals (including hospices) and people in care homes who are either placed under public or private arrangements.

4.16.2 The Managing Authority (care home, hospital or hospice) must apply to the Supervisory Body as soon as it becomes apparent that P may need restrictions in place and could be deprived of their liberty. This can be up to 28 days in advance of when they plan to deprive the person of their liberty.

4.16.3 The Managing Authority must complete a form requesting a Standard Authorisation (SA) and submit this to the Supervisory Body.

The authorisation process involves independent assessments carried out by the Best Interest Assessor appointed by the Supervisory Body. The assessments inform the Supervisory Body's decision to either grant or not grant the authorisation. There are 6 criteria that must be assessed and fulfilled for the authorisation to be granted. The Supervisory Body must complete the authorisation process within 21 days

4.16.4 The Managing Authority can deprive a person of their liberty for up to seven days using an Urgent Authorisation in circumstances where the care arrangements mean the person is already being deprived of their liberty. It can only be extended (for up to a further seven days) if the Supervisory Body agrees to a request made by the Managing Authority to do this.

4.16.5 When using an urgent authorisation the Managing Authority must also make a request for a Standard Authorisation and have a reasonable belief that one would be granted. The Supervisory Body must complete the Standard Authorisation process within 7 days.

4.17 Deprivation of Liberty in the Community (DoLiC)

4.17.1 A deprivation of liberty can occur in domestic settings where the state is aware of or responsible for imposing such arrangements. This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements it must be authorised by the Court of Protection (COP).

4.17.2 Where CCG staff are aware of a potential Deprivation of Liberty in a domestic setting, they must firstly seek advice from the CCG's DoLiC team and follow the appropriate procedure. The DoLiC Team will consider if the case meets the threshold for a COP application and if so, will then make the application.

4.17.3 There are two processes to apply to the COP for an authorisation of a DoLiC:

1)The streamlined Re X procedure which is designed to enable the court to decide applications on the papers only, without holding a hearing, providing certain criteria are met:

- P and all relevant people in their life are consulted about the application and have an opportunity to express their wishes and views to the court.
- P has not expressed a wish to take part in the court proceedings
- P and all relevant people in their life do not object to the application

- There are no other significant factors that ought to be brought to the attention of the court that would make the application unsuitable for the streamlined procedure.

4.17.4 Where the Re X criteria are not met an application to the Court of Protection for a full oral hearing must be made.

4.17.5 All applications to COP must be made using the correct COP forms and processes.

4.17.6 In all cases where an application to the COP is required, the CCG must be represented by their commissioned legal service.

4.18 Deprivation of Liberty: Children and Young People

4.18.1 A DoLS authorisation cannot be used to authorise a deprivation of liberty taking place in a children's home. The Court of Protection can authorise the deprivation of a person's liberty from the age of 16. Under the age of 16 years, a deprivation of liberty must be authorised under inherent jurisdiction of the High Court.

4.18.2 The criteria for a deprivation of liberty (see below) is the same for children and young people as it is for adults. Children under the age of 16 who live with their parents would not ordinarily fall into the remit of deprivation of liberty legislation as a parent is able to consent to arrangements on their behalf.

4.18.3 Parents cannot consent to a deprivation of liberty for children aged 16-18 years.

4.18.4 Parents may consent to a deprivation of liberty for their child who is under the age of 16 years, except in circumstances where the parent does not have parental responsibility.

4.18.5 Where a child is looked after by the Local Authority (LA) and they have parental responsibility for them, that LA cannot consent to a deprivation of liberty on behalf of the child. In such circumstances an application needs to be made (for either inherent jurisdiction of the High Court order for those under 16 years old or to the Court of Protection for 16-17 years old children).

4.18.6 The law regarding a deprivation of liberty for children and young people is contentious and developing via case law. It is important that for all such matters, formal legal advice is sought.

4.19 Reporting unauthorised deprivation of liberty

4.19.1 Any member of SCCG staff visiting a hospital or care home who is concerned that a person may be unlawfully deprived of their liberty

must:

- Advise the Hospital or Care Home to allow the organisation to review their arrangements
- Inform the Nurse Quality Manager for MCA/DoLS and seek further advice

4.19.2 Any unauthorised deprivation of a person could amount to abuse and in such cases a safeguarding concern may need to be raised via the agreed Multiagency procedure.

4.19.3 In deciding whether safeguarding concern/alert a decision needs to be made as to whether the response is proportionate to the nature of the concern, and in the best interests of the adult at risk. Examples of where a concern/alert may need to be raised include:-

- Where a person is deprived of their liberty without appropriate authorisation and this is overly restrictive or not being addressed in a timely manner
- Where a person is deprived of their liberty without authorisation and experiences harm, including physical, emotional psychological distress or the loss of fundamental human rights.
- Where the Managing authority (e.g. Care Home or Hospital) repeatedly or seriously fails in its responsibilities to seek authorisation for deprivation of liberty of patients, or fails to end a deprivation of liberty after it is no longer required.

4.20 Death of a Person Under a DoLS/COP Authorisation

4.20.1 A death occurring on or after 3rd April 2017 of any person subject to a DoL or COP order is not seen as a death ‘in state detention’. There is no automatic requirement to inform the Coroner unless there are circumstances around the cause of death that are unclear.

5 Monitoring effectiveness of the policy/procedural document

5.1 Internal to SCCG

5.1.1 MCA / DoLS compliance and performance will be a standing agenda item on SCCG Quality Assurance Committee meetings, Quality Team meetings and Safeguarding meetings. Please refer to the overarching commissioning safeguarding adults and children’s policy for relevant appendices relating to auditing requirements

5.1.2 All SCCG staff will be required to continue to have yearly mandatory e learning training which encompasses safeguarding adults and children and MCA/DoLS.

5.1.3 SCCG staff who are involved in decision making and arranging care, treatment and accommodation for people receiving funding via the CCG will be required to attend essential training and refresher training. The levels of training will be stated on SCCG' Mandatory and Statutory training matrix.

5.1.4 A method of clinical audit will be agreed for monitoring compliance with MCA/DoLS legislation and this policy.

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

5.2 External to SCCG

5.2.1 SCCG's MCA Lead and Contract Manager will monitor NHS and private hospital compliance with MCA and DoL existing contract monitoring arrangements.

5.2.2 Information will be provided to SCCG on a quarterly and/or annual basis (via the completion of the provider's 'Safeguarding Annual Assurance Self-assessment Tool'. Providers will be advised in advance of when this information is required if it is out of their existing internal reporting schedules.

5.2.3 SCCG's Care Homes Quality Team will monitor compliance, training needs and risk as part of routine quality monitoring and escalation process.

5.2.4 In addition to the standards required by this policy, legislation, national guidance or other stakeholders, SCCG may also use local quality and incentive schemes to identify additional standards or related targets for providers.

5.2.5 SCCG may receive and use information from other agencies and organisations where this is relevant to the performance management of the provider in relation to MCA/DoLS. This may include information from:

- SASP, SSCB and Sheffield Domestic Abuse Strategic Board and their sub groups
- Police
- Service user / Advocacy groups
- Local Authority Departments
- NHS Providers and contractors
- Care Quality Commission
- NHS England

6 Review

6.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after twelve months and thereafter on a bi-annual basis or when a change in legislation dictates.

6.2 The CCG governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval.

6.3 This policy will be reviewed and monitored by SCCG Safeguarding leads on an annual basis or sooner dependent on any changes to legislation.

6.4 No policy or procedure will remain operational for a period exceeding three years without a review taking place.

6.5 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.

6.6 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.

6.7 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.

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

6.9 The CCG's Governance Committee will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

7. References and links to other documents

7.1 Legislation

7.1.1 Cabinet Office. (1983), *The Mental Health Act 1983 (amended 2007).* Retrieved from:
https://www.legislation.gov.uk/ukpga/1983/20/contents
https://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_2 0070012_en.pdf

7.1.2 Cabinet Office, (1989).*The Children Act.* Retrieved from:
https://www.legislation.gov.uk/ukpga/1989/41/contents

7.1.3 Cabinet Office, (1998). *The Human Rights Act.* Retrieved from: https://www.legislation.gov.uk/ukpga/1998/42/contents

7.1.4 Cabinet Office, (2004). *The Children Act (amended).* Retrieved from: https://www.legislation.gov.uk/ukpga/2004/31/contents

7.1.5 Cabinet Office. *The Mental Capacity Act* (2005). Retrieved from: https://www.legislation.gov.uk/ukpga/2005/9

7.1.6 Cabinet Office, (2018). *The Data Protection Act.* Retrieved from: http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

7.1.7 Cabinet Office, (2018). *Mental Capacity (Amendment) Bill.* Retrieved from: https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html

7.1.8 Department of Health (2014). *Care Act 2014/ Care and Support Statutory Guidance.* Retrieved from: https://www.legislation.gov.uk/ukpga/2014/23/contents

7.1.9 Department of Health, (2017). *Care Standards.* Retrieved from: https://www.health-ni.gov.uk/publications/care-standards-documents

7.1.10 Department of Health, (2015). *The Mental Health Act 1983 (amended 2007) Code of Practice.* Retrieved from: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

7.1.11 Doncaster CCG, (2016). *Mental Capacity Act and Deprivation of Liberty Safeguards Policy.* Retrieved from: http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/12/MCA-DOLS-Policy-Nov-2016.pdf

7.1.12 European Court of Human Rights: Council of Europe, (2013). *The European Convention on Human Rights.* Retrieved from: https://www.echr.coe.int/Documents/Convention_ENG.pdf

7.1.13 Hartlepool and Stockton on Tees CCG, (2016). *Mental Capacity Act and Deprivation of Liberty Policy. Retrieved from:* http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2016/12/CO10-MCA-and-DoLs-Policy-3.pdf

7.1.14 House of Lords, Select Committee, (2014).*Mental Capacity Act 2005: post-legislative scrutiny*. Retrieved from: https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

7.1.15 Law Commission, (2017). *Mental Capacity and Deprivation of Liberty Summary*. Retrieved from: https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

7.1.16 Office of the Public Guardian, (2007). *The Mental Capacity Act Code of Practice.* Retrieved from: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

7.1.17 Office of the Public Guardian, (2009).*Deprivation of Liberty Safeguards (DoLS): Code of Practice.* Retrieved from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

7.2 Useful information and guidance:

7.2.1 Advance Care Planning. Retrieved from: http://www.goldstandardsframework.org.uk/advance-care-planning

7.2.2 Audit Tool for Mental Capacity Assessments (AMCAT) https://www.bps.org.uk/sites/default/files/documents/audit-tool-mental-capacity-assessments_0.pdf

7.2.3 Best Interest Determination General Research and Evaluation Decisions (BRIDGET) tool https://www.mentalhealth.org.uk/a-to-z/m/mental-capacity

7.2.4 Deprivation of Liberty after Cheshire West: key questions for social workers and medical practitioners http://www.39essex.com/docs/newsletters/deprivation_of_liberty_after_cheshire_west-_a_guide_for_front-line_staff.pdf

7.2.5 My next patient may lack capacity http://www.asist.co.uk/assets/uploads/PDF/My_next_patient_lacks_capacity_pack_17-12-14_NAT.pdf

7.2.6 NHS England, (2014). *Mental Capacity Act 2005 A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance.* Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf

7.2.7 NHS England, (2015). *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework*. Retrieved from: https://www.networks.nhs.uk/news/safeguarding-vulnerable-people-in-the-reformed-nhs-accountability-and-assurance-framework

7.2.8 NICE. (2018). Decision Making and Mental Capacity [NG108]. Retrieved from: https://www.nice.org.uk/guidance/ng108

7.2.9 Social Care Institute for Excellence (SCIE). *Mental Capacity Directory.* Retrieved from: https://www.scie.org.uk/mca-directory/assessingcapacity/

8. Interaction with other procedural documents

8.1 This policy should be read in conjunction with:

- The Mental Capacity Act 2005
- The Mental Capacity Act Code of Practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- The Mental Health Act 1983 (amended 2007
- The Mental Health Act 1983 (amended 2007) Code of Practice 2015
- Care Act 2014/ Care and Support Statutory Guidance (DH, 2014)
- The Human Rights Act 1998
- The European Convention on Human Rights
- The Care Standards Act 2003
- The Children Act 1989 and 2004
- The Data Protection Act 2018
- SCCG Procedure for COP Welfare Applications
- The policies and procedures of Sheffield Adults Safeguarding Partnership(SASP) https://www.sheffield.gov.uk/home/social-care/adult-safeguarding.html
- The policies and procedures of Sheffield Children Safeguarding Board https://www.safeguardingsheffieldchildren.org/sscb/
- SCCG Information Governance Framework http://www.intranet.sheffieldccg.nhs.uk/Downloads/Policies/Information%20Governance%20Framework%20February%202018.pdf
- SCCG Equality and Diversity Policy http://www.intranet.sheffieldccg.nhs.uk/Downloads/Policies/Equality%20and%20Diversity%20Policy%20February%202017.pdf
- Sheffield Restraint Framework for Good Practice http://www.intranet.sheffieldccg.nhs.uk/policies.html
- SCCG Clinical Audit Policy http://www.intranet.sheffieldccg.nhs.uk/policies.htm?siteid=3193
- Nice Guideline [NG108) Decision making and mental capacity. https://www.nice.org.uk/guidance/ng108

9 Mental Capacity Act

9.1 Having considered and completed the MCA compliance statement at Appendix C, the MCA is applicable to this policy.

10 Equality & Diversity Statement

10.1 NHS Sheffield CCG aims to design and implement services, policies and measures that meet the diverse needs of our service population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability (See Appendix D). Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

10.2 NHS Sheffield CCG embraces the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

11 Disability Confident

11.1 NHS Sheffield CCG has been accredited with the Disability Confident Award – level 1. This is in recognition of meeting the commitments regarding employment of disabled people and permits the organisation to use the Disability Confident logo on all of its stationery. The Disability Confident symbol should be added as a footer to all policies / procedural documents.

Appendix A - Definitions

Mental Capacity Act 2005 (MCA). A statutory framework to empower and protect vulnerable people aged 16 years and over, who are temporarily or permanently unable to make some, or all of their own decisions, due to a disturbance or impairment of the mind or brain.

Mental Capacity

Mental capacity is the ability of an individual to make a specific or 'material' decision at a specific time.

A person (P) is said to lack capacity 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. This can be either long term / permanent or short term / temporary and could be as a result of (not an exhaustive list):

- A brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an medical condition and/ or any required treatment
- Alcohol or substance misuse

Best Interests in decision making

This is a key principle of the MCA (principle 4 in section 6.1) which states that *any act done for, or decision made on behalf of a person that lacks capacity must be done in their best interests.*

Best interests is deciding on the best course of action for P, based on their previously and currently held beliefs, values and expressed wishes. This principle requires a decision maker to consider the decision P is likely to have made if they had capacity. It must never be based on what the decision maker wants to happen.

The MCA sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in a particular situation at a particular time. See Useful Guidance in Section 7 ('My next patient lacks capacity').

Deprivation of Liberty (DoL)
It is important to note that there is no statutory definition of a Deprivation of Liberty and it is defined only in landmark case law. In 2014, two landmark Supreme Court cases *[P v Cheshire West and Chester Council and P & Q v Surrey County Council]* (commonly referred to as 'Cheshire West') established an 'Acid Test' which outlines that for a person to be deprived of their liberty they must:

- lack the mental capacity to consent to the relevant care and accommodation arrangements
- be subject to continuous supervision and control and are not free to leave

The following considerations are NOT relevant when considering if a person is subject to a deprivation of liberty:

- P's compliance or lack of objection to the care arrangements.
- The reason or purpose behind a particular placement / care arrangements
- The 'relative normality' of the placement (e.g. supported living placement in an ordinary house)

Deprivation of Liberty Safeguards (DoLS)
The Mental Capacity Act allows restraint and restrictions to be used in P's care plan– but only if they are in P's best interests.

The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. They refer specifically to restrictions and restraints included in P's care, treatment and accommodation arrangements (the care plan) that may cause them to be deprived of their liberty under Article 5 of the European Convention of Human Rights (ECHR) 2013 (amended) and the Human Rights Act 1998. The care arrangements must be 'imputable' to the State, i.e. where a State body such as the Local Authority or NHS knows about and/or is involved in arranging and / or funding them.

Relevant Person (P)

The person for whom an act needs to be done or a decision needs to be made.

Consent.
The voluntary and continuing permission of the person to the intervention or decision in question. It is based on adequate knowledge and understanding of the purpose, nature, likely effects and risk of an intervention or decision, including the

likelihood of success of that intervention and any alternative to it. Permission given under any unfair or undue pressure or coercion is not consent.

Decision-maker
The person responsible for deciding what is in the Best Interests of a person who lacks capacity – i.e. the person who is carrying out an act or decision with or on behalf of a person.

Independent Mental Capacity Advocate (IMCA)
An Advocate from an independent advice agency. The IMCA service provides safeguards for a person:

• When they lack capacity to make a decision at the time it needs to be made and are unbefriended (i.e. do not have anyone other than a paid carer or professional).
• When it is planned they will move to a different care setting.
• During adult safeguarding procedures, whether or not family or carers are involved.

Mental Health Act 1983 (amended 2007).
The statutory framework to detain and treat people with a mental illness, impairment or disorder. This Act supercedes the MCA and should always be considered first. Part 4 of the Act concerns detained patients.

Managing Authority (MA)

The hospital or care home in which the person is, or may become deprived of their liberty. They must make the application to the Supervisory Body to authorise a DoLS.

Supervisory Body (SB)
The Local Authority that is responsible for considering a DoLS authorisation request. It instructs a BIA to complete the necessary assessment for a potential deprivation of liberty. This applies only to a registered care setting. The Supervisory Body is the Local Authority where the person is ordinarily resident. Usually this will be the local authority where the home or hospital is located unless the person is funded by a different Local Authority.

Best Interests Assessors (BIAs)
Authorised practitioners appointed by the Supervisory Body to complete Best Interests assessments in accordance with the MCA whom have undertaken further and continuous training to maintain their competence.

Deprivation of Liberty in the Community (DoLiC)
Care and treatment arrangements that deprive a person of their liberty when they are living in their own home or another community setting.

Court of Protection (COP)
A specialist family Court created by The MCA 2005. The COP has jurisdiction relating to the whole of the Act.

Re X
Reference to a landmark COP case: *Re X v Ors [2014].* A streamlined procedure that allows straight forward non-contested cases of deprivation of liberty in the community to be authorised without a full COP hearing. The Judge will make a ruling 'on the papers'. This is a much less expensive and less time intensive process. Strict criteria must be met for these cases. All cases that do not meet the criteria must have a full hearing.

Office of the Public Guardian (OPG)
An executive agency of the Ministry of Justice. The OPG exercises powers to protect people in England and Wales who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.

Lasting Power of Attorney (LPA)
A person or persons appointed to act on behalf of a P in relation to decisions about their financial and/or health and welfare (including healthcare) at a time when they no longer have capacity. An LPA must be applied for and granted when a person has capacity and only takes effect when they lose capacity. Applications are made to the OPG, who retains a copy.

Court Appointed Deputy (CAD)
A person with similar powers to an LPA. The difference is that this can only be granted for P who lacks capacity and must be granted by the COP.

Advance Decision (AD)
A decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will take effect at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision.

Advanced care planning (ACP)
A process by which a person can plan ahead to make decisions about what they wish to happen with their care and treatment if they lose capacity to make such decisions for themselves.

Standard DoLS Authorisation (SA)

An authorisation granted by the Supervisory Body that a person can be lawfully deprived of their liberty in a registered care setting providing the statutory assessments have been carried out by a BIA.

Urgent DoLS Authorisation (UA)

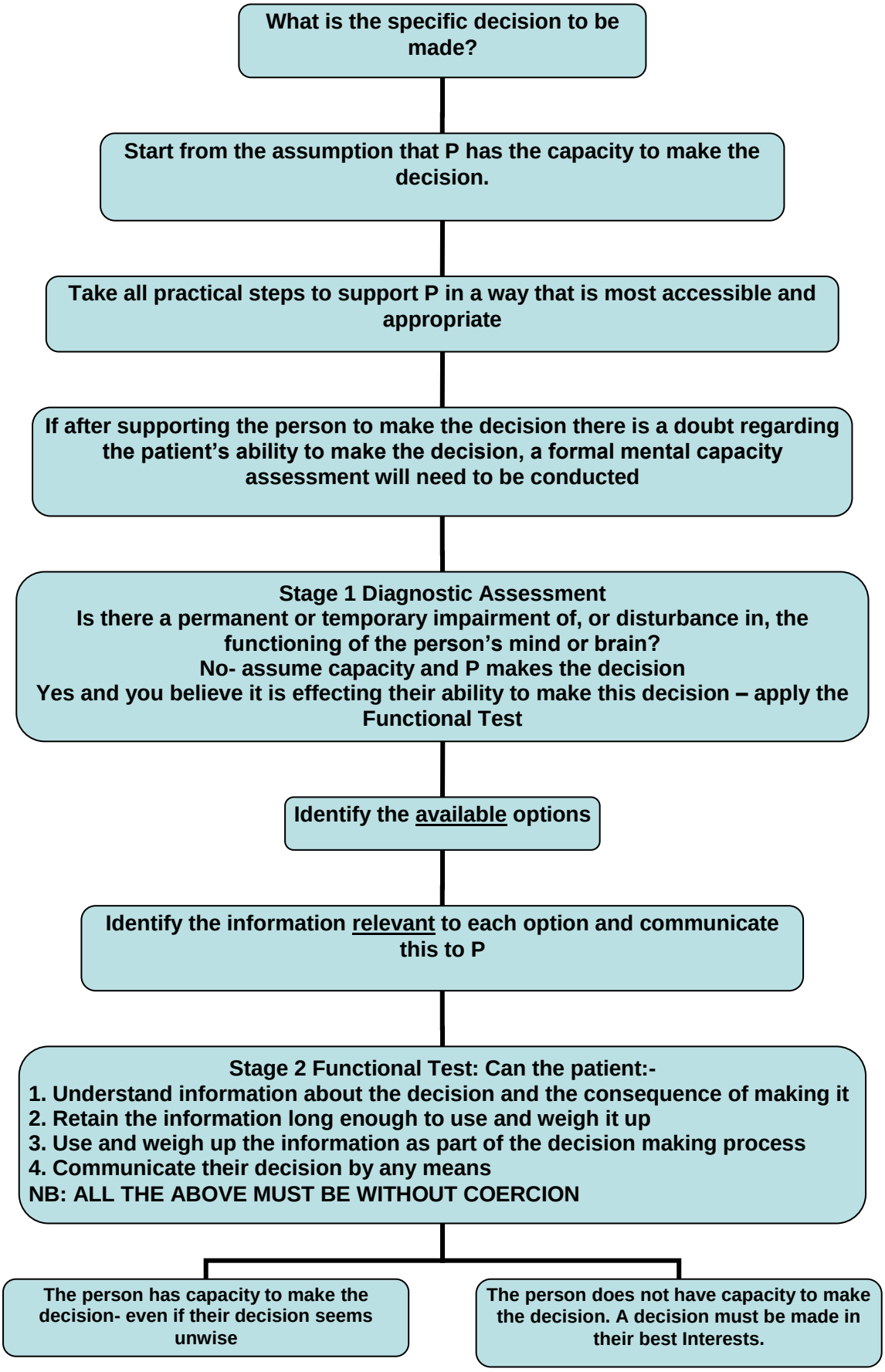
An authorisation made by the Managing Authority for a period of up to seven days that a person can be lawfully deprived of their liberty in that registered care setting until a Standard Authorisation can be completed (must be applied for and completed within 7 days).

Appendix B - Options Appraisal Balance Sheet

Specific Decision: Decision Maker:
Date and time of decision:

Option 1:	
Benefits	Burdens
Emotional	Emotional
Welfare	Welfare
Social	Social
Ethical	Ethical
Option 2:	
Benefits	Burdens
Medical	Medical
Emotional	Emotional
Welfare	Welfare
Social	Social
Ethical	Ethical
Option 3:	
Benefits	Burdens
Medical	Medical
Emotional	Emotional
Welfare	Welfare
Social	Social
Ethical	Ethical

Appendix C – Mental Capacity Assessment Flowchart



Appendix D - Mental Capacity Act Compliance Statement

Any policy, guideline or procedure which deals with circumstances where a service user has a decision to make, or has to be consulted, or their agreement is required, must include a Mental Capacity Act policy compliance statement setting out:

Mental Capacity Act Compliance Statement	Number of paragraph in policy, guideline or procedure where referenced or N/A
What service user decisions / consent / agreement may need to be sought during the operation of the policy / guideline or procedure	2.2.7, 2.2.8
For each level of decision-making, who will be required to assess the client's mental capacity at each level	4.2
What decisions staff may not make under the policy / guideline / procedure	4.4.3
How the existence of advance decisions, an Enduring Power of Attorney, Lasting Power of Attorney or deputy will be identified and recorded	4.11
Any other specific guidance that the policy / guideline / procedure requires staff to follow in relation to mental capacity	4.12, 4.13, 4.14, 4.15, 4.16, 4.17, 4.18, 4.19, 4.20

To provide practical support for staff, a link to the Mental Capacity Act 2005 Implementation Guidance can be found at: http://nww.sheffield.nhs.uk/policies/clinical.php#m and can be included in the electronic version of the document being developed.

This Mental Capacity Act compliance statement is a consideration for all policies, guidelines and procedures. Where the MCA does not apply, authors need to make this clear in a statement to this effect inserted at the Mental Capacity Act section of the policy, guideline or procedure.

Appendix E

NHS Sheffield CCG Equality Impact Assessment 2016
Equality Impact Assessment

Title of policy or service:	Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy and Procedure	
Name and role of officer/s completing the assessment:	Jo Harrison – Nurse Quality Manager for MCA/DoL	
Date of assessment:	04.09.2018.	
Type of EIA completed:	**Initial EIA 'Screening'** ✓ ***or*** **'Full' EIA process**	

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	This policy is an interim policy which aims to support SCCG in the discharge of its duties and responsibilities as an NHS Commissioner and to gain assurance that the principles of the MCA 2005 Code of Practice, and DoLS 2008 Code of Practice are being applied to decisions about care and accommodation arrangements of people who lack capacity to consent to them.

Identifying impact:
- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;

- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information
This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

	What key impact have you identified?			For impact identified (either positive an or negative) give details below:	
(Please complete each area)	**Positive Impact**	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐✓	☐	☐	Protects the Human Rights of vulnerable people over the age of 16 in Sheffield.	
Age	☐✓	☐	☐	Ensures everyone over the age of 16 falls within scope as per legislation.	
Carers	☐✓	☐	☐	Takes into account a person's representative in terms of expressing wishes and feelings on behalf of a person who may lack capacity.	
Disability	☐✓	☐	☐	Promotes disability equality.	
Sex	☐	☐✓	☐		
Race	☐	☐✓	☐		
Religion or belief	☐	☐✓	☐		
Sexual orientation	☐	☐✓	☐		
Gender reassignment	☐	☐✓	☐		
Pregnancy and maternity	☐	☐✓	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☐✓	☐		

Other relevant groups	☐	☐✓	☐		
HR Policies only: Part or Fixed term staff	☐✓	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	Jo Harrison	**Date of next Review:**	March 2019

Appendix F – Policy Appraisal Instrument

	Yes	No	N/A	Comments
Rationale				
1. Is the rationale for the clinical policy/guideline clearly defined?	Yes			
Policy/Guideline Development Group				
2. Is the group responsible for policy development clearly identified?	Yes			
3. Is there a clear description of the individuals involved in policy development?	Yes			
4. Does the group represent all key disciplines?	Yes			
Context and Content				
5. Are the reasons for developing the policy clearly stated?	Yes			
6. Are the objectives clearly identified?	Yes			
7. Is there a clear description or the patients/staff/groups to which this policy applies?	Yes			
8. Are there any circumstances in which exceptions might be made in using this policy? If so are the circumstances of this exception clearly documented?		No		Statutory duty applies.
Clarity				
9. Does the policy describe the condition/process to be treated/detected/prevented?			N/A	
10. Are the possible management options clearly stated?			N/A	
11. Are the recommendations clearly stated?	Yes			
12. Are the health benefits/potential harms and risks/costs of utilising the policy clearly identified?	Yes			
13. Are there implications for services if implemented?	Yes			Information will be readily available and collected systematically

	Yes	No	N/A	Comments
Identification and interpretation of Evidence				
14. Are the sources of information used to devise the policy or procedure clearly described? E.G. National Guidelines/Codes of Practice	Yes			
15. If so are they adequate?	Yes			
16. Is there a satisfactory description of the method used to interpret and assess the strength of evidence and formulate appropriate recommendations?	Yes			
17. Is there an indication of how the views of interested parties were taken into account?	Yes			
Rigour of Development				
18. Was the policy independently reviewed prior to publication/issue?	Yes			
19. Was the policy piloted and if so has this been effectively evaluated?			N/A	This is a review so the policy is already in place
Application				
20. Are the staff that should receive this policy clearly identified?	Yes			
21. Are there any staff awareness raising/training sessions required as a result of the new/revised guidelines? If yes, have training and development leads been informed of this?	Yes			Awareness raising ongoing by author
22. Are methods of dissemination and implementation of the procedure/policy clearly identified?	Yes			
Updating				
23. Has a date for reviewing or updating the policy been agreed?	Yes			
24. Has an individual/group responsible for this process been clearly identified?	Yes			
Monitoring				
25. Does the policy define measurable outcomes that can be monitored?	Yes			
26. Has a process for monitoring and evaluating the effectiveness of the policy been agreed including, testing awareness and obtaining evidence of policy being put in place?	Yes			