West Hampshire
North Hampshire
North Hampshire & Farnham
South Eastern Hampshire
Fareham & Gosport
Isle of Wight
Clinical Commissioning Groups

# MENTAL CAPACITY ACT (2005) POLICY

**(Version 1.1)**

## Mental Capacity Act Policy for the Five Hampshire Clinical Commissioning Groups (CCGs)

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| **Subject and version number of document** | Mental Capacity Act (2005) Policy<br>Version 1.1 |
| **Serial number:** | CLIN/013/V1.01 |
| **Operative date:** | 16 June 2020 |
| **Author:** | Deputy Designated Nurse, Safeguarding Adults (West Hampshire, North Hampshire and North East Hampshire & Farnham CCGs) |
| **CCG owner:** | CCG Director of Quality and Nursing (Board Nurse) |
| **Links to other policies, guidance and legislation:** | • Safeguarding Adult and Children's Policy<br>• Commissioning Policy for Adult Continuing Healthcare<br>• Mental Capacity Act (2005)<br>• Refer to Section 11 for other legislation / codes of practice etc |
| **Review date:** | May 2021 |
| **For action by:** | All staff working with individuals who may lack mental capacity to make specific decisions for themselves to be familiar with how to apply the Mental Capacity Act. |
| **Policy statement:** | The Mental Capacity Act (2005) (MCA) consolidates Human Rights law for people who may lack the ability to make their own decisions. Fundamentally, the Act promotes the autonomy and empowerment of individuals whilst upholding their Human Rights (Human Rights Act 1998).<br><br>The MCA (2005), provides a legal framework to empower people to make decisions for themselves where ever possible.<br><br>This policy provides guidance for staff when working with individuals who may lack Mental Capacity to make specific decisions for themselves. |
| **Responsibility for dissemination to new staff:** | Line Managers |
| **Mechanisms for dissemination:** | All new and updated policies are published on the CCG website and promoted to staff through the CCG staff newsletter and updates |

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| | on the Policy Page on the CCG intranet. Policies are also disseminated through training events such as induction of new staff. |
| **Training implications:** | The CCG as a statutory organisation has a responsibility to ensure that its workforce attends Mental Capacity Act (2005) training to achieve the key skills and competencies required.<br><br>All front line clinicians are expected to attend mandatory training mapped to the National MCA Competency Framework (Staff Group D).<br><br>In addition, it is the responsibility of managers to inform the safeguarding adults team of their staff requirements for Mental Capacity Act (2005) training. The safeguarding adults team will provide training in line with the requirements of the framework |
| **Resource implications** | There are no direct resource implications in relation to this policy. |
| **Further details and additional copies available from:** | CCG website:<br>https://westhampshireccg.nhs.uk/document-tag/clinical-and-su-policies/ |
| **Equality analysis completed?** | Yes, please see Appendix B |
| **Consultation process** | CCGs Directors of Quality & Safeguarding<br>Safeguarding Adult and Children's Team members<br>5 Hampshire CCGs Safeguarding Governance Committee |
| **Approved by:** | 5 Hampshire CCGs Safeguarding Committee (11 May 2020)<br>WHCCG Clinical Governance Committee (virtual May 2020): Approved via Chair's Action |
| **Date approved:** | 2 June 2020 |

**Website upload:**

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| Location in FOI Publication Scheme | https://westhampshireccg.nhs.uk/document-tag/clinical-and-su-policies/ |

**Amendments summary:**

| Amend No | Issued | Page(s) | Subject | Action Date |
|---|---|---|---|---|
| 1 | 16.6.20 | Cover and App A | Amendment to logo to reflect the CCGs for which this policy relates, additional guidance referenced in Appendix A (Version 1.1 – based on Draft V.8 - FINAL incl IoW) | 16.6.20 |
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**Review log:**

Include details of when the document was last reviewed:

| Version Number | Review Date | Name of Reviewer | Ratification Process | Notes |
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## SUMMARY OF KEY POINTS TO NOTE

The Mental Capacity Act (2005) (MCA) consolidates Human Rights law for people who may lack the ability to make their own decisions. Fundamentally, the Act promotes the autonomy and empowerment of individuals whilst upholding their Human Rights (Human Rights Act (1998)).

The Mental Capacity Act (2005) provides a legal framework to empower people to make decisions for themselves wherever possible.

This policy provides guidance for staff when working with individuals who may lack Mental Capacity to make specific decisions for themselves.

The Legislation is supported by its own Statutory Guidance – The Mental Capacity Act - Code of Practice (2007) and the NICE Guidelines - Decision Making and Mental Capacity (October 2018).

In light of the Mental Capacity Act Amendment Bill, the Code of Practice is currently being updated to ensure it reflects new legislation with a revised edition due in 2020.

The Code of Practice implies that a number of individuals will be under a formal duty to have regard to the Code. This includes professionals, paid carers or people acting as attorneys or Court Appointed Deputies. The Code furthermore acknowledges that less formal carers can also be supported by this framework.

Traditionally, the duties under the Act have been associated and aligned with the Safeguarding Adults Agenda. However, it is now widely recognised that The Mental Capacity Act must therefore form part of everyday practice and business as usual.

This policy is not intended to replace the Legislation or Statutory Guidance already in place for The Mental Capacity Act (2005)

All staff should ensure they have read their organisation's Mental Capacity Act Policy and embed the key principles into practice.

Staff should seek advice and support from their line manager if faced with complex situations in relation to assessment of capacity. Alternatively, the Clinical Commissioning Group's safeguarding adults team can be contacted for guidance and support.

## Contents

# MENTAL CAPACITY ACT (2005) POLICY

## 1. INTRODUCTION

The Mental Capacity Act (2005) provides a legal framework and protection for people who lack capacity to make decisions. Health care staff are legally required to have regard to the MCA Code of Practice (2007). The Code provides guidance to anyone working with adults who may lack the ability to make decisions for themselves.

For the purpose of the Mental Capacity Act (2005), a person lacks capacity if:

> They have an impairment or disturbance that affects the way their mind or brain works and because of this they are unable to make a specific decision at the time it needs to be made.

The Act applies to anyone aged 16 years or over in England and Wales and is relevant for care, treatment and accommodation decisions. There are some exceptions to this however which are outlined in Chapter 12 of The Mental Capacity Act Code of Practice. These include Advanced Decisions, The Deprivation of Liberty Safeguards (DoLS) as well as Lasting Power of Attorneys (LPAs).

## 2. PURPOSE OF THIS POLICY

This policy highlights the duty of the Clinical Commissioning Groups (CCGs) and their statutory responsibilities. The policy is intended to support staff in practice.

Commissioners have a responsibility to ensure that providers of NHS funded services deliver services in accordance with the Mental Capacity Act (2005) and that the rights of those who use services are protected and upheld. Furthermore, CCGs have a responsibility for commissioning safe and high quality care. Therefore, assurance will be sought that providers are embedding the key principles of the Mental Capacity Act (2005) into everyday practice.

**Essentially in developing this policy, the Clinical Commissioning Groups recognise that the implementation of the Mental Capacity Act (2005) is a shared responsibility, with the need for effective joint working between agencies and professionals.**

## 3. SCOPE

This policy aims to provide direction and guidance to all staff employed directly by the CCGs who are involved in the assessment, care, treatment or support of people over 16 years of age who may lack the capacity to make some, or all, decisions for themselves.

## 4. DEFINITIONS

| Term | Definition |
|---|---|
| **Consent** | Consent is a person's agreement to undertake examinations and or receive treatment or care. |
| **Valid Consent** | For valid consent the patient must:<br>• Have mental capacity to make the particular decision<br>• Have received sufficient information<br>• Not acting under duress. |
| **Mental Capacity** | The ability of an individual to make a specific decision about a particular matter, at the time the decision needs to be made.<br>(MCA Code of Practice, Chapter 1) |
| **Best Interest Decisions** | Any act done or decision made on behalf of a person who lacks capacity must be made in their best interests.<br>(MCA Code of Practice, Chapter 5) |
| **Decision Maker** | This is the person making a decision or acting on behalf of someone who lacks the capacity to make the decision for themselves.<br>The decision maker is responsible for deciding what is in the best interests of a person who lacks capacity.<br>(MCA Code of Practice, Chapter 5) |
| **Informed** | Legally the individual needs to be advised of:<br>1. Proposed risks and downsides of the decision<br>2. Benefits of the decision<br>3. Alternatives to the decision (and the risks, downsides and benefits of each alternative)<br>4. Material information (information that the patient would likely attach significance to because of their unique personality and circumstances).<br>(MCA Code of Practice, Chapter 4) |
| **Lasting Power of Attorney (LPA)** | A Power of Attorney, created under the MCA, allows for the appointment of an attorney(s) to make decisions about a specific person's (the donor) personal welfare and / or their property and affairs.<br>(MCA Code of Practice, Chapter 7) |
| **Court Appointed Deputy** | A person appointed by the Court of Protection with legal authority as prescribed by the court, to make decisions on behalf of a person who lacks capacity to make decisions.<br>(MCA Code of Practice, Chapter 8) |

| Term | Definition |
|---|---|
| **Independent Mental Capacity Advocate (IMCA)** | An IMCA supports and provides representation for a person who lacks capacity to make specific decisions where the person has no one else to support them.<br><br>(MCA Code of Practice, Chapter 10) |
| **Advanced Decision** | A decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision.<br><br>(MCA Code of Practice, Chapter 9) |
| **Court of Protection** | Specialist Court for all issues relating to people who lack capacity to make specific decisions.<br><br>(MCA Code of Practice, Chapter 8) |
| **Best Interest Assessor (BIA)** | Best Interests Assessors are authorised practitioners who complete Best Interest's Assessments in accordance with the MCA who have undertaken further and continuous training to maintain their competence. |
| **Restraint** | Restraint is the use of, or threat of, force to help do an act which the person resists OR the restriction of the person's liberty or movement whether or not they resist. Restraint may only be used where it is deemed necessary to protect the person from harm and is proportionate to the risk of harm.<br><br>(MCA Code of Practice, Chapter 6) |
| **The Deprivation of Liberty Safeguards** | The Deprivation of Liberty Safeguards (DoLS) form part of The Mental Capacity Act (2005). They are the legal procedures used to deprive someone of their liberty in registered care homes or hospitals in circumstances amounting to a deprivation of their liberty (Article 5, Human Rights Act 1998) and who lack Mental Capacity to consent to their arrangements. Guidance regarding DoLS is provided with the Deprivation of Liberty Safeguards Code of Practice (2009). |
| **The Liberty Protection Safeguards** | A new statutory framework as set out in the Mental Capacity Amendment Bill 2019 will replace the Deprivation of Liberty Safeguards. The new legislation, in the form of the Liberty Protection Safeguards is anticipated October 2020. It will set out the new process for authorising a deprivation of liberty. Furthermore, it will provide an increased scope in terms of multiple settings for a potential Deprivation of Liberty as well as an increased role for the NHS. The new Framework will apply to those aged 16 years and upwards. Transition arrangements however, will apply when the new Liberty Protection Safeguards are introduced. |

## 5. DUTIES AND RESPONSIBILITIES

### 5.1 All Staff

All staff have a legal duty to apply the principles of the Mental Capacity Act (MCA) as everyday business and to have due regard to the MCA Code of Practice (2007). Staff should seek advice when faced with complex and difficult situations regarding assessment of capacity.

### 5.2 Managers

Line managers should ensure they have the necessary skills and knowledge to support clinical staff in practice in relation to the Mental Capacity Act (2005) or be aware how to seek specialist advice and support.

### 5.3 On Call Duty Managers

On call duty managers should also ensure they have the necessary skills and knowledge to support and supervise staff in carrying out their duties in relation to the Mental Capacity Act (2005) or be aware how to seek specialist advice and support.

### 5.4 Organisational Leadership

The chief operating officer within the Clinical Commissioning Group is the Executive lead for the Mental Capacity Act (2005). Support can be accessed from the safeguarding adults team within the CCGs.

## 6 APPLYING THE ACT IN PRACTICE

### 6.1 Assessing Capacity

Mental Capacity is the ability to make a decision.

An assessment of capacity must be based on making a particular decision at the time it needs to be made and not decisions in general. A person may lack capacity to make a decision in regards to one area, however this does not mean that they necessarily lack the ability to make decisions in relation to other areas.

A person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.
* MCA Code of Practice Chapter 2.

A person's ability to make decisions may change or fluctuate over time. These may include acute infections or ingestion of drugs and/or alcohol. Therefore, due consideration must be given as to whether the particular decision can be postponed until the person can make the decision for themselves.

## 6.2 Assumption of Capacity

The starting assumption is that the person has capacity to make the decision. Professionals should not make assumptions based on age, looks or appearance. The person has to 'prove' nothing. This ethos underpins the adult's right to empowerment and autonomy for the individual as set out within the Act.

Statutory Principle 1 MCA Code of Practice Chapter 2.

## 6.3 Who should assess Capacity?

Different people may be involved in the assessment of capacity, depending on the decision being made.

Any decision maker must have the skills and ability to follow the principles in statue set out in the MCA Code of Practice (2007).

Advice should be sought when dealing with a complex assessment of capacity.

When there is cause to doubt that a person has capacity to make a particular decision a two-stage capacity test should be undertaken. The two-stage test comprises of:

### Stage 1

1) **Does the person have an impairment of or a disturbance of their mind or brain?**

   If a person does not have such an impairment of the mind or brain, they will not lack capacity under the Act.

   Examples of an impairment or disturbance in the functioning of the mind or brain may include:

   - Dementia
   - Delirium
   - Concussion / head injury
   - Symptoms of alcohol or drug use.

### Stage 2

2) **Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?**

   A person is considered unable to make a decision if they are unable to do any one of the following things:

   - Understand the relevant information
   - Retain the information
   - Use and weigh up the information as part of the decision making process
   - Communicate their decision by any means.

   *MCA Code of Practice (2007) Chapter 4

## 6.4 Supporting people to make their own decisions

A person is not to be treated as unable to make a decision until all practicable steps have been taken to support and enable the person to make the decision for themselves.

It is the responsibility of the decision maker to ensure they have taken all practicable steps to help the person make the decision for themselves before they can be regarded as unable to make the decision. This may include different forms of communication, use of visual aids, presenting the information in a different format and giving the person time to consider the information available to them.

All relevant information in relation to the decision should be explained, including the risks, benefits as well as the consequences.

A person is not to be treated as unable to make a decision merely because they make an unwise decision. This applies even if family members or health care staff are unhappy with the decision made.

Any act done or decision made under the Act for or on behalf of the person who lacks capacity must be done or made in their best interests.

Before the Act is done or decision made, the less restrictive option should be sought. This is to try to avoid interference with the person's human rights and civil liberties where at all possible.

Best Interest is personal to the individual. The decision maker should try to avoid thinking what the practitioner would do but instead consider what would the person want to do in light of the decision being made.

## 6.5 Best Interests

The Mental Capacity Act Code of Practice (2007) sets out a checklist of factors that must be considered when deciding on what is in the best interests of the person. Due emphasis must be given to the views and wishes of the person.
*MCA Code of Practice (2007) Chapter 2

These include:

- Encouraging participation
- Identifying all relevant circumstances
- Finding out the person's views and wishes
- Avoiding discrimination
- Assessing whether the person may regain capacity and may be able to make the decision for themselves
- Assumptions should not be made regarding the person's quality of life

- Consulting with others widely to take account of their views – these may include close relatives and friends as well as those involved in caring for the individual and advocates.

The process of working out what is actually in the person's best interests should be formally documented and include:

- How decisions were reached, including the advantages and disadvantages
- Who was consulted as part of the best interest process
- What factors were taken into account

Emergency Situations

The MCA Code of Practice states that:

> In an emergency situation, it is acknowledged that urgent decisions will need to be made and immediate action taken in the person's best interests. In these particular situations, it may not be practical or appropriate to delay treatment whilst trying to help and support the person to make their own decisions.

### 6.6 Decisions not covered by the Mental Capacity Act (2005)

There are decisions that cannot be made on behalf of others, regardless of their capacity: these may be because the decisions are too personal to the individual or covered under a different Act.

- Consenting to marriage or a civil partnership, or a decree of divorce on the basis of two year's separation or to the dissolution of a civil partnership on the basis of two year's 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
- A person cannot vote on behalf of a person who lacks capacity.

### 6.7 Recording assessments of Capacity

Accurate records must be kept of decisions made in respect of the individual's mental capacity and they must demonstrate why certain actions and decisions have been made on behalf of the person. 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.

All assessments of capacity must be recorded using the Hampshire Mental Capacity Toolkit, as endorsed by the 4 local Safeguarding Adult Boards.

However, there may be serious decisions that may need to be made on a person's behalf. These situations could create some legal challenge and it is particularly important that clear documented evidence of the assessment of capacity, is completed and recorded in the person's records.

### 6.8 Inverting the two-part test

Case Law has found that professionals may on rare occasions find it helpful to invert the two part test when managing particularly complex cases such as hoarding or self-neglect. The Act however clearly sets out the legal framework which must be followed in terms of assessment of capacity. Therefore, the inversion of the two-part test should not be considered usual practice when carrying out an assessment of capacity, without having sought expert advice.

### 6.9 Wilful neglect, ill-treatment of a person who lacks capacity

A person who wilfully neglects or ill-treats a person who lacks capacity can be prosecuted under section 44 of the MCA which carries a custodial sentence. Since the introduction of the Act there have been a number of successful prosecutions.

### 6.10 Interface with the Mental Health Act 1983

The Mental Health Act (1983) is a different piece of legislation that allows professionals to intervene in a person's life regardless of whether they are deemed to have capacity to make the decision for themselves, such as compulsory admission to hospital for treatment of a mental disorder.
Being held under The Mental Health Act (1983) **does not** mean that you lack mental capacity.

The Mental Capacity Act does however apply to any treatment **not** covered by the Mental Health Act 1983. An example may include treatment for a physical health condition that does not amount to treatment of the mental disorder.

### 6.11 Restraint

Section 6.4 of the Mental Capacity Act (2005) states that someone is using restraint if they:

> use or threaten force to make someone do something that they are resisting or restrict a person's freedom of movement, whether they resist or not.

Staff need to be able to demonstrate that:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
- The amount or type of restraint used, including the length of time restraint is used, must be proportionate to the likelihood of serious harm.

Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy. Examples of these include using covert medication, the use of physical force to prevent someone doing something and the use of mechanical restrictions.

Any incidences of restraint should be reported using the organisation's internal reporting mechanisms and recorded in the person's care plan. All care plans and risk assessments should be subsequently reviewed and updated.

Staff should always consider de-escalation where possible and the use of less restrictive options before resorting to restraint.
*MCA Code of Practice (2007) Chapter 6

### 6.12 Lasting Power of Attorney (LPA)

In establishing best interest, it is critical to determine who the decision-maker is.

The Mental Capacity Act (2005) makes provision for the creation of Lasting Powers of Attorney (LPA). Under this arrangement a person can nominate someone to have power of attorney over their affairs in the event that they no longer have capacity, in relation to:

- Health and welfare (including care and treatment), and
- Finances and property.

The Mental Capacity Act (2005) replaces the Enduring Power of Attorney (EPA) with the Lasting Power of Attorney. No more Enduring Powers of Attorney can be made, however the Act has made provisions for transitions for existing EPAs.

An LPA allows a person over the age of 18 to formally appoint one or more persons to look after their health and welfare and / or financial decisions if the person at some stage in the future lacks the capacity to make decisions for themselves.

The person making the LPA is called the donor and the person or persons appointed are known as the attorney. The person making the LPA gives the attorney the authority to make decisions on behalf of the donor. The attorney has a legal responsibility to make decisions which are considered in the best interests of the person who has made the LPA.

An attorney for health and welfare is the decision maker on all matters relating to the donors care and treatment. This includes consenting to or refusing treatment on the donor's behalf. These decisions must be made in the best interests of the person lacking capacity.

In cases where the decision involves life sustaining treatment, staff should refer to the LPA document to ascertain whether the donor has specifically stated that they wish their attorney to have this authority. Any decision must be made in the best interest of the

person when making such decisions. This will involve consulting widely with others and following of the Best Interest Checklist. The attorney must not be motivated in any way to end the person's life.

A personal welfare attorney has no power to consent to or refuse treatment at any time when the donor has the capacity to make decisions for themselves.

The Office of the Public Guardian protects people in England and Wales who may lack capacity to make decisions for themselves. LPAs are only valid when they are registered with the Office of the Public Guardian (OPG). The registered LPA will bear an authorised stamp indicating whether it is a Health and Welfare or Finances and Property LPA or both. Staff should always seek confirmation that an LPA is valid and applicable and registered by requesting to see a copy of the certificate. Alternatively the Office of Public Guardian can verify the person, if paper copies of authorisation are not available at: www.guardianship.gov.uk

Any disputes that cannot be resolved for example between the doctor and the attorney should be referred for legal remedy to the Court of Protection. In such cases, specialist advice should be sought. Life sustaining treatment can be continued whist writing for the Court to reach a decision.
*MCA Code of Practice (2007) Chapter 7

### 6.13 Court of Protection (COP)

The Court of Protection is a specialist Court existing under the provisions of the MCA to deal with all issues relating to people who lack capacity to make specific decisions. The Court has powers to:

- Make declarations about whether or not a person has the capacity to make a particular decision
- Make decisions on serious issues in relation to health care and treatment
- Make decisions about property and financial affairs
- Make decisions in relation to Lasting Powers of Attorneys and Enduring Powers of Attorneys
- Appoint deputies with the authority to make decisions
- Remove deputies who have failed to carry out their duties.

Court deputies are appointed to make decisions for a person who lacks the capacity to do this for themselves. Very often Court appointed deputies are family members or someone well known by the person. In some cases however, they may be independent.

Deputies are able to take decisions as authorised by the Court on welfare, health care and or financial matters. They are not however able to refuse or consent to life sustaining treatment.

Deputies will only be appointed where there will be a need for on-going decisions to be made and the Court is not able to make a one off decision.

Deputies need to adhere to the Mental Capacity Act Code of Practice (2007), evidencing they are acting in the best interest of the person who lacks capacity, ensuring that they are only making decisions that fall within their authorisation to do so.

Where there are very complex and difficult decisions to be made, the COP can make these. Moreover, there are certain decisions that can only be made by the COP. If it is decided that a case may require legal remedy in the Courts early advice should be sought.
*MCA Code of Practice (2007) Chapter 8

### 6.14 Advanced Statements

Advanced Statements are written statements the person may have made about their wishes and feelings before losing capacity. The statements should be used in terms of working out what is in the person's best interests.

Advanced Statements however are different to Advanced Decisions as they are not considered legally binding, they should however be given due consideration and taken into account by the professionals involved.

### 6.15 Advanced Decisions to refuse treatment

In law, people have the principled right to consent or refuse treatment. Adults have the right to say in advance that they want to refuse treatment should they lose capacity in the future, even if this results in their death. The mechanism through which this is achieved is through an Advanced Decision.

An Advanced Decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

An Advanced Decision that is deemed to be valid and applicable has the same force as a contemporaneous decision.

To the best of their ability, health care professionals must determine whether the advanced decision is considered to be valid and applicable:

1) Has the person withdrawn their decision?
2) Has the person acted in a way that is inconsistent with the advanced decision?
3) Has conferred the power to another person – via an LPA. An LPA made after an Advanced Decision will make the Advanced Decision invalid
4) Would have changed their mind had they known about current circumstances.

The MCA sets out additional requirements if the Advanced Decision refuses life sustaining treatment:

- It must be in writing

- It must be signed by the person in the presence of a witness who also needs to sign the document
- It must be explicit that the advanced decision stands **even** if their life is put at risk as a consequence of this.
- Any separate statements must also be signed and witnessed.

### 6.16 Advanced Decisions regarding treatment for mental disorders

Advanced Decisions can refuse any kind of treatment, whether for a physical or a mental disorder.

In general, an Advanced Decision to refuse treatment for a mental disorder can be over-ruled if the person is detained in hospital under the Mental Health Act (1983).

Advanced Decisions to refuse treatment for other illness or conditions are not affected by the fact that a person is detained in hospital under the Mental Health Act (1983).

It is recommended that expert advice is sought from within your organisation.
*MCA Code of Practice (2007) Chapter 9

### 6.17 Independent Mental Capacity Advocates (IMCA)

The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted. The IMCA's role is to understand and advocate for the person's current and previously expressed wishes and feelings.

The role of the IMCA is to support and represent the person who lacks capacity. Therefore, IMCAS have the right to be provided with access to relevant health and social care records

Any information and or reports provided by the IMCA must be taken into account as part of the best interest's checklist.

An IMCA must be appointed where an 'unbefriended' individual faces the following decisions:

- An NHS body is proposing to provide, withhold or stop serious medical treatment
- An NHS body or Local Authority is proposing to arrange accommodation in a long stay hospital or care home where the person will stay in hospital for 28 days or in the care home for more than 8 weeks
- An NHS body or Local Authority is proposing to move the person to a different hospital or care home.

The duty to instruct an IMCA does not preclude intervention where it is immediately or urgently necessary.

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.
*MCA Code of Practice (2007) Chapter 10

### 6.18 Consent

When consent for medical treatment or examination is required, the doctor proposing the treatment should decide whether the patient has the capacity to consent or refuse the treatment. In settings such as a hospital, this can involve the multi-disciplinary team. Ultimately, it is up to the professional responsible for the person's treatment to make sure that valid consent has been obtained.

For consent to be deemed valid, the patient must:

- Have Mental Capacity to make the particular decision
- Have received sufficient information
- Not be acting under duress.

### 6.19 Children and Young People Aged 16-17 Years

The Mental Capacity Act (2005) applies to all individuals who are 16 years and over. Most of the Act applies to individuals aged between 16 and 17 years old, however there are exceptions:

- Only persons aged 18 years and over can make a Lasting Power of Attorney
- Only persons aged 18 years and over can make an Advanced Decision
- The Court of Protection may only make a statutory will for people aged 18 years and over
- The Deprivation of Liberty Safeguards only apply to those aged 18 and over.

Once children have reached the age of 16 years old, they are deemed in law to be competent.

For the MCA to apply to a young person, they must lack capacity to make a particular decision through impairment to mental functioning rather than immaturity (in line with the Act definition of capacity described previously). In such situations, the Mental Capacity Act (2005) or other relevant legislation such as the Children Act 1989 may apply, depending on the particular circumstances.

When there are disagreements concerning care, treatment or welfare of a young person aged between 16 and 17 years who lacks capacity to make specific decisions, the case may be heard either in the Court of Protection or the Family Court depending on the circumstances involved. Cases can also be transferred between the Courts.

There may also be situations when neither of these Acts provides an appropriate solution. In such cases it may be necessary to look to the powers available under the

Mental Health Act (1983), or the High Court‘s inherent powers to deal with cases involving young people.

### 6.20 Young persons and consent

Young people aged 16–17 years are presumed to have sufficient capacity to decide on their treatment.

Whenever a decision needs to be made in relation to a young person, a fundamental consideration must be whether the young person can give valid consent.

Consent to treatment for a child or young person must be obtained from either:

- The child or young person if deemed competent to make the decision for themselves
- Or someone with parental responsibility in accordance with The Children Act (1989)
- Or the Courts.

Where a child is looked after by the Local Authority it is important to establish whether they are subject to a care order or are being voluntarily accommodated.

Unlike adults, the refusal by a competent child or young person with capacity under the age of 18 years may in rare circumstances, be considered by a court.

### 6.21 Gillick Competence and Fraser Guidelines

Children under the age of 16 years of age can consent to their treatment, if they are believed to have the intelligence, competence and understanding to fully appreciate what is involved with their treatment. This is known as being ‘Gillick Competent’. The Gillick Competence is concerned with determining the child’s capacity to consent to medical treatment or intervention.

Fraser guidelines however, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Advice should be sought from the Clinical Commissioning Groups Safeguarding Children’s team as needed.
*MCA Code of Practice (2007) Chapter 12

### 6.22 Research

The MCA provides a legal framework for involving people who lack capacity to consent to taking part in research, setting out key requirements to participate in research projects.

Research covered by the MCA cannot include people who lack capacity unless it has been formally agreed through an Ethics Committee and the requirements of the MCA have been followed.

The views of carers or relevant others should be considered. This involves identifying a consultee to discuss whether the person who lacks capacity should be involved in the research including the previous feelings and wishes of the person who lacks capacity.

Treat the person's interest with more importance than the interest of society and science.

Respect any objections that a person who lacks capacity makes during the course of the research and withdraw them from the research project.
*MCA Code of Practice (2007) Chapter 11

### 6.23 Key Principles of the Deprivation of Liberty Safeguards (DoLS 2009)

Article 5 of the Human Rights Act (1998) states that: "*Everyone has the right to liberty and security of person". No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law".*

The Deprivation of Liberty Safeguards (DoLS) came into force in April 2009. The amendment tackles human rights incompatibilities by introducing specific safeguards for people.

DoLS protect people who are 18 years and over who **lack** capacity to make decisions about treatment or care, and who after all other avenues have been explored need to be cared for in a particularly restrictive way, in a particular place in order to provide care and/or treatment.

The aim of the safeguards is to:

- Provide safeguards for people who lack capacity to decide where to be accommodated for care/treatment
- Ensure people are given the care they need in the least restrictive way
- Prevent decisions being made to suit the home or hospital rather than the needs of the adult at risk
- Entitle people to take proceedings by which the lawfulness of a deprivation will be decided speedily by a court and release ordered if the deprivation is seen as unlawful.

The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

### 6.24 The Acid Test to determine a Deprivation of Liberty: The Judgment of the Supreme Court 2014

The Supreme Court in 2014 response to a specific case (*P v Cheshire West and Chester Council* and *P&Q v Surrey County Council)* identified two key criteria to assess if a person may be being deprived of their liberty if they met the criteria set out within the 'acid test.

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus, the Law Society advises, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave
- The person lacks capacity to consent to their care arrangements.

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. However even with the 'acid test' it can be difficult to be clear when the use of restrictions and restraint in someone's support crosses the line to depriving a person of their liberty. Each case must be considered on its own merits.

Due consideration should be given as to whether the deprivation of liberty can be avoided by removing some of the restrictions. Every effort should be made to prevent a deprivation of liberty when providing care or treatment.

The following factors are no longer relevant to the decision that a person is being deprived of their liberty:

- The person is compliant or does not object
- The placement is relatively normal, and
- The reason or purpose behind or quality of a particular placement.

DoLS cover patients in hospitals (including hospices) and people in care homes whether placed under public or private arrangements.

A deprivation of liberty in another care setting such as supported living requires a different legal procedure to authorise a Deprivation of Liberty. This is through the Court of Protection.
*MCA Code of Practice (2007) Chapters 6 & 7

### 6.25 Deprivation of Liberty: Children and Young People

Children under the age of 16 who live with their parents would usually not fall into the remit of Deprivation of Liberty legislation as a parent is able to consent to arrangements on their behalf.

Parents cannot however consent to a Deprivation of Liberty for those children aged between 16 and 18 years.

The judgement in relation to Child D – 2019 has highlighted the issues of consent to deprive young people, aged between 16 and 17 year olds of their liberty. As such, parents or those who are holders of parental responsibility are confirmed as **unable to provide consent** to deprive the 16-17-year-old of their liberty. The Mental Health Act 1983 where relevant can provide authority for deprivation but otherwise professionals would need to apply to the courts to deprive a young person of their liberty. Once the anticipated Liberty Protection Safeguards come into force the new safeguards will for the first time apply to Deprivation of Liberty of 16-17 year olds.

Where a child is subject to care arrangements and the Local Authority has parental responsibility for the child, the Local Authority **cannot** consent to a Deprivation of Liberty on behalf of the child. In these circumstances an application needs to be made (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).

### 6.26 Applications for DoLS

There are many situations where it is necessary to deprive someone of their liberty in order to protect them from harm in their best interests. Having the deprivation authorised is a legal requirement and provides the person with safeguards to ensure that their human rights are upheld.

There are two types of Authorisation:

- Standard Authorisation

  A Standard Authorisation may last up to a maximum of twelve months. It is granted by the relevant Local Authority on completion of six DoLS Assessments which are completed by a Mental Health Assessor and a Best Interest Assessor. (BIA)

- Urgent Authorisation

  If the situation is urgent and a Deprivation of Liberty is occurring before a standard authorisation can be granted, then the Managing Authority (the hospital or care home) may grant itself an Urgent Authorisation lasting a maximum of seven days. This then allows the Local Authority to complete the necessary DoLS Assessments for a Standard Authorisation. In certain cases, an urgent authorisation may be extended for a further seven days

For care homes and hospitals, the Supervisory Body is the Local Authority where the person is ordinarily resident. Usually this will be the Local Authority where the care home is located unless the person is funded by a different Local Authority.

When using an Urgent Authorisation, the managing authority must also make a request for a Standard Authorisation. The managing authority must have a reasonable belief that a Standard Authorisation would be granted if using an Urgent Authorisation.

Before granting an Urgent Authorisation, the managing authority should try to speak to the family, friends and carers of the person. The managing authority should make a record of their efforts to consult others.
*MCA Code of Practice (2007) Chapters 6&7

### 6.27 CCG responsibilities

Those staff employed by the CCG's who visit, assess, treat, monitor and review patients residing in registered care establishments and or residing in hospitals should be aware of the Deprivation of Liberty Safeguards.

### 6.28 When might a DoLS application not be necessary

If the patient is expected to regain capacity to consent to their care arrangements within a few days of their admission DoLS would not be required with no need to request a standard authorisation and the Deprivation of Liberty should be recorded as a best interest decision in the clinical records

For palliative care patients, if when they are admitted into hospital or a hospice with capacity to consent to their care arrangements and agree during their stay to a potential Deprivation of Liberty in the future, their consent is regarded as covering the period until their death. If however the individual's care arrangements then differ significantly and are much more restrictive than those originally considered, then consideration should be given to applying for a DoLS authorisation.

### 6.29 Deprivation of Liberty in community settings – Guidance (Community DoL)

If a potential Deprivation of Liberty is taking place within a Community setting a different process applies. This would apply to domestic settings as well as supported living.

An application must instead be made to the Court of Protection requesting for the Court to review the arrangements and to subsequently authorise the Deprivation of Liberty.

A Court of Protection (COP) DoL 11 Form should be used for this process – An application to authorise a Deprivation of Liberty.

Further evidence as set out within the form is also required to be submitted to the Court including a Court of Protection (COP) 3 Form – Evidence of Mental Capacity, the Best Interest Statement as well as the application fee.

It would be usual for family members to be consulted with by the Court as part of this process.
**MCA Code of Practice (2007) Chapters 6&7

## 7. TRAINING REQUIREMENTS / MANDATORY TRAINING

The Clinical Commissioning Group as a statutory organisation has a responsibility to ensure that its workforce attends Mental Capacity Act (2005) training to achieve the key skills and competencies required.

All front line clinicians are expected to attend mandatory training mapped to the National MCA Competency Framework (Staff Group D).

In addition, it is the responsibility of managers in the CCG to inform the safeguarding adults team of their staff requirements for Mental Capacity Act (2005) training. The safeguarding adults team will provide training in line with the requirements of the framework.

Each CCG will maintain records of compliance for their own organisation.

All managers will ensure that;

- All new frontline members of staff are to be made aware of the organisation's MCA Policy
- They have robust arrangements in place for monitoring staff compliance in relation to Mental Capacity Act (2005) training requirements
- Departments foster and maintain a culture where the Mental Capacity Act (2005) Framework is embedded as everyday business
- Clinical staff on the professional register are given the opportunity to raise any concerns in relation to the Mental Capacity Act Framework (2005).

## 8. EQUALITY ANALYSIS

In line with the CCG commitment to equality, diversity and inclusion, an equality impact assessment has been completed to inform the development of this policy (see Appendix B).

## 9. SUCCESS CRITERIA, MONITORING THE EFFECTIVENESS OF THE POLICY

The effectiveness of this policy will be monitored by safeguarding adults team to ensure the correct procedures have been followed and timescales met. Any learning points and trends will be identified by the safeguarding adults team who will make recommendations to the appropriate CCG committee in relation to any changes which need to be made.

## 10. REVIEW

This document may be reviewed at any time at the request of either the staff or management, or in response to changes in legislation, but will automatically be reviewed after twelve months and thereafter on a biennial basis

## 11. REFERENCES AND LINKS TO OTHER DOCUMENTS

- CCG Safeguarding Adults & Children's Policy
- Commissioning Policy for Adult Continuing Healthcare
- Mental Capacity Act (2005)
- The Mental Capacity Act – Code of Practice (2007)
- Mental Capacity Act Amendment Bill (2019)
- NICE Guidelines – Decision making and mental capacity (October 2018)
- Human Rights Act (1998)
- Deprivation of Liberty Safeguards
- Deprivation of Liberty Safeguards - Code of Practice
- Children Act (1989)
- Equality Act (2010)

## APPENDIX A 4LSAB One Minute Guide of the Mental Capacity Act (2005)

### One Minute Guide to the Mental Capacity Act (2005) (MCA)

The Mental Capacity Act (2005) (MCA) exists to support people who can make decisions for themselves to do so and to provide a legal framework for families or professionals to make decisions for people who are assessed as lacking mental capacity to make certain decisions for themselves.

The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- By allowing people to plan ahead for a time in the future when they might lack the capacity, for any number of reasons.

The Mental Capacity Act (2005) applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.

The Act says that people must be assumed to have capacity to make their own decisions and be given all practicable help before they are considered not to be able to make their own decisions. Where a person is found to lack capacity to make a decision then any action taken, or any decision made for, or on their behalf, must be made in their best interests.

All professionals have a duty to comply with the Mental Capacity Act (2005) Code of Practice. It also provides support and guidance for less formal carers.

As well as assessment of Mental Capacity, the Act also governs the Deputyship, Lasting Powers of Attorney, Advanced Decisions, Independent Mental Capacity Advocates and Deprivation of Liberty Safeguards (DoLS).

The Act is underpinned by five key principles (Section 1, MCA). The following are the Act's five statutory principles which are the benchmark and must underpin all acts carried out and decisions taken in relation to the Act:

*Principle 1: A presumption of capacity*
Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

*Principle 2: Individuals being supported to make their own decisions*
A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

*Principle 3: Unwise decisions*
People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

*Principle 4: Best interests*
Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

*Principle 5: Less restrictive option*
Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

**Assessment of capacity and best interests' decision-making (Sections 2–4, MCA)**

Having mental capacity means that a person is able to make their own decisions. Always start from the assumption that the person has the capacity to make the decision in question (principle 1). The assessor should also be able to show that they have made every effort to encourage and support the person to make the decision themselves (principle 2). If a person makes a decision which is considered eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, there is a requirement to make an assessment of capacity **before** carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be.

**When should capacity be assessed?**

A person's capacity may need to be assessed when they are unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition. Assessments of

capacity must be **time and decision specific**. Decisions cannot be based upon age, appearance, condition or behavior alone.

Two-stage functional test of capacity

In order to decide whether an individual has the capacity to make a particular decision, the following two questions must be answered:

**Stage 1 -** is there an impairment of or disturbance in the functioning of a person's mind or brain? If so,

**Stage 2 -** is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?
The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- 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.

The Act requires that every effort is 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. Family, friends, carers or other professionals should also be involved.

The assessment must be made on the balance of probabilities e.g. is it more likely than not that the person lacks capacity? The capacity assessment should be recorded and this should show why the conclusion has been reached that capacity is lacking for the particular decision.

**Best interests decision-making**

If a person has been assessed as lacking capacity then any action taken, or any decision made for or on their behalf, must be made in his or her best interests (principle 4). The person determining capacity is known as the 'decision-maker' and normally this will be the carer responsible for the day-to-day care, or a professional such as a social worker, doctor or nurse where decisions about care arrangements, accommodation or treatment need to be made.

The MCA Code of Practice provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests. The person can put his/her wishes and feelings into a written statement if they so wish, which the person determining capacity must consider. People involved in caring for the person lacking capacity have to be consulted concerning a person's best interests.

**Hampshire MCA Toolkit:**

| | |
|---|---|
| Part A – Assessment of Capacity |  Hampshire-Mental-Capacity-Toolkit-Part-A |
| Part B – Best Interests Decision Making |  HCC_MCA_toolkit_Part_B_Best_Int_Decisi |
| Part C – Balance Sheet |  HCC_MCA_toolkit_Part_C_Balance_Sheet_ |
| Part D – Risk Assessment |  HCC_MCA_toolkit_Part_D_Risk_Assessmer |
| Part E – Best Interests Meeting Agenda |  HCC_MCA_toolkit_Part_E_Best_Int_meetir |
| **Bournemouth MCA Competency Framework** |  Bournemouth MCA Competency Framew |
| **The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) during the coronavirus (COVID-19) pandemic** | https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity?utm_source=a4ad3220-fbe7-424e-bc47-ed85741782a8&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate |
| **The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguard (DoLS) during the coronavirus (COVID-19) pandemic updated version 10 June 2020** | https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic |
| **The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguard (DoLS) during the coronavirus (COVID-19) pandemic; additional guidance 10 June 2020** | https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity/the-mental-capacity-act-2005-mca-and-deprivation-of-liberty-safeguards-dols-during-the-coronavirus-covid-19-pandemic-additional-guidancea |

**APPENDIX B Equality Impact Assessment**

West Hampshire Clinical Commissioning Group

## Equality analysis

| **Title of policy, project or proposal:** |
|---|
| Mental Capacity Act (2005) Policy |

| | |
|---|---|
| **Lead manager:** | Deputy Designated Nurse for Safeguarding Adults |
| **Directorate:** | Quality & Nursing |

**Q1 What are the intended outcomes of this policy, project or proposal?**

This policy highlights the duty of CCGs and their statutory responsibilities in relation to the Mental Capacity Act (2005). The policy is intended to support the broader Human Rights Agenda. The policy is designed to support staff in practice and to have a positive impact by promoting the autonomy and empowerment of individuals whilst upholding their human rights (Human Rights Act 1998).

Much work is being undertaken across the health economy to embed the Mental Capacity Act (2005) as everyday business.

The outcome of this work will be to have a robust policy that is embedded across the five Hampshire CCGs for all staff to ensure an equitable and consistent approach.

**Q2 Who will be affected by this policy, project or proposal?**

This policy applies to all persons in a professional paid role including volunteers across the five Hampshire CCG's.

Commissioners have a responsibility to ensure that providers of NHS funded services deliver services in accordance with the Mental Capacity Act (2005) and that the rights of those who use services are protected and upheld. The Code of Practice implies that a number of people have a formal duty to have due regard to the code. This includes professionals and paid carers.

## Evidence

**Q3 What evidence have you considered?**

The Mental Capacity Act (2005) provides a legal framework to empower individuals and consolidate Human Rights Law.

A new statutory framework as set out in the Mental Capacity Amendment Bill (2019) will result in a new legislation in the form of the Liberty Protection Safeguards and a revised Code of Practice.

Much work is being undertaken nationally to embed the newly anticipated Liberty Protection Safeguards.

Learning from safeguarding adults reviews highlights that the Mental Capacity Act (2005) is not particularly well embedded in every day practice. Much work is being undertaken across the health economy to embed The Mental Capacity Act (2005) as everyday business.

**Age**

The Mental Capacity Act (2005) applies to individuals aged 16 years and above and aims to have a positive impact by empowering the rights of those who use services.

There are just over 1.07 million adults aged 18 and over in Hampshire, accounting for 79% of the total population. Hampshire has an older population compared to England with a higher proportion of the population aged 45 years and fewer young working aged people (aged 20-39).

The CCGs are committed to ensuring that their workforce, irrespective of age or disability can access, advice, support and training updates using a blended approach consisting of face to face training and e-learning modules.

**Disability (physical and mental)**

The proportion of residents with a limiting long term illness or disability is comparable to England. However, the size of the Hampshire population means that the absolute numbers of people experiencing ill health or disability are large. There are approximately 87,900 people in Hampshire (6.7%) with a long term health problem or disability which greatly limits their day to day activities; a further 119,400 people (9.1%) are limited a little on a daily basis. Four percent of the population (n= 54,000) report their health to be bad or very bad.

**Dementia**

The increase of the frequency of people living with dementia, both early onset and that associated with older age and co-morbidities means that vulnerabilities can increase for individuals who have needs for care and support.

Social isolation and loneliness can also increase vulnerability.

**Gender reassignment (including transgender)**

This policy aims to have a positive impact on all individuals irrespective of their gender by promoting and upholding the individuals human rights (1998)

The BBC data shows that 20-29 year-olds are the age group most likely to report being victims of homophobic or transgender hate crime.

The Government Equalities Office tentatively estimates that there are approximately 200,000-500,000 trans people in the UK.

The CCG's have Equality and Diversity leads in place.

**Marriage and civil partnership**

The safeguarding agenda upholds the human rights of all individuals and their right to private and family life.

The safeguarding agenda includes working to protect those individuals at risk of forced marriage as well as those who may be subject to coercion and control.

Coercion and control may impact on a person's ability to make an informed decision under the Mental Capacity Act (2005) Framework.

**Pregnancy and maternity**

The safeguarding agenda upholds the rights of the unborn child and women in a situation of domestic abuse or exploitation.

As such within the safeguarding agenda there are a suite of polices, documents and tool kits that safeguard children or adults who may be deemed at risk, including the unborn child.

| |
|---|
| **Race**<br>The CCGs recognise the importance of equality and diversity.<br>The policy upholds the human rights of all and a life free from abuse and discrimination.<br>Where English is not the first language for the CCGs' workforce or there are difficulties in understanding this policy, employees should contact their line / other appropriate manager or senior officer within their organisation, an HR or employee representative for advice and guidance. |
| **Religion or belief**<br>The policy upholds the human rights of all, irrespective of religious beliefs.<br>The CCG's recognise that our service users and workforce may have different ethnicities, faiths, attitudes and believes that need to be respected and taken into account. |
| **Sex (gender)**<br>This policy applies to all genders. Males and females may experience different vulnerabilities.<br>As females tend to live into older age more frequently than men, vulnerabilities related to old age may become more noticeable. |
| **Sexual orientation**<br>The Mental Capacity Act (2005) promotes and upholds the fundamental Human Rights of all individuals.<br>This policy takes into account individuals, their preferences, including sexual orientation. |
| **Carers**<br>The Mental Capacity Act (2005) and the Code of Practice refer to the role of paid and more informal carers. Carers have a fundamental role in supporting individuals where relevant to make decisions for themselves by supporting the decision making process. |
| **Serving Armed Forces personnel, their families and veterans**<br>There is an Armed Forces covenant in place.<br>In terms of the demographics across the system there is a large military cohort. This is particularly evident in the Fareham, Gosport and South Eastern CCG demographics as well as the North East Hampshire & Farnham CCG locality.<br>The CCG's recognise therefore that many of the individuals and their families who come into contact with our services are serving in the armed forces. |
| **Meeting psychological needs**<br>The CCG's promote the importance of mental health and wellbeing across the populations that they serve.<br>There are dedicated services in place to ensure that the psychological needs of its service users and workforce are met. |
| **Other identified groups**<br>The Mental Capacity Act (2005) promotes and upholds the fundamental Human Rights of all individuals. |

## Involvement and consultation

*For each engagement activity, briefly outline who was involved, how and when they were engaged, and the key outputs.*

**Q4 How have you involved stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**

This policy has been written to outline the responsibility and increase awareness across all stake holders.

In terms of ongoing monitoring and scrutiny of the policy, feedback from all stake holders is welcomed.

**Q5 How have you involved stakeholders in testing the policy or programme proposals?**

The policy will go forward through CCG governance processes for consultation.

**Q6 For each involvement activity, please state who was involved, how and when they were engaged, and the key outputs:**

This policy has been shared with both the children and adults safeguarding teams for their views and feedback. Further amendments have been made after comments were received from the wider team.

## Equality statement

In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations for all employees, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

**Positive impacts**

The Mental Capacity Act (2005) applies to individuals aged 16 years and above and aims to have a positive impact by empowering the rights of those who use services.

The Act allows people to plan ahead for a time in the future when they may lack the capacity for any number of reasons.

The effectiveness of this policy will be monitored by safeguarding adults team to ensure the correct procedures have been followed and timescales met. Any learning points and trends will be identified by the safeguarding adults team who will make recommendations to the appropriate CCG committee in relation to any changes which need to be made.

**Negative impacts**

It is envisaged that there will be no negative impact from the Policy which aims to uphold the human rights of all individuals.

**Health inequalities**

A person should not be deemed unable to make a decision for themselves in relation to age, appearance or known health disorders.

The Mental Capacity Act (2005) policy protects individuals who lack capacity by providing a legal framework that places individuals at the heart of the decision making process

## Action planning for improvement, and to address health equalities and discrimination

*Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

| Action | Person responsible | By date | Progress/ review<br>(Add new actions if required) |
|---|---|---|---|
| Ensure that all training venues are suitable for less abled employees | Ali Bailey | Ongoing | To review with Line Manager as required |
| Ensure that all training flyers and presentations can be made available in different formats (depending on needs) to ensure that training is accessible for all staff. | Ali Bailey | Ongoing | To review with Line Manager as required |

## For your records

| | |
|---|---|
| **Person who carried out this assessment:** | |
| **Date assessment completed:** | |
| **Date to review actions:** | |
| **Responsible Director:** | Director of Nursing (Board Nurse) |
| **Date assessment was approved:** | |