North Tyneside
Clinical Commissioning Group

Corporate	CO03 Deprivation of Liberty Safeguards (DoLS) Policy

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V3.4	November 2021	November 2023

Prepared By:	Joint Commissioning Manager
Consultation Process:	CCG Executive Director of Nursing & Transformation and Safeguarding Professionals for North Tyneside CCG. North Tyneside CCG Quality and Safety committee
Formally Approved:	Quality and Safety Committee; TBC

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Document History

Version	Date	Significant Changes
1	28/02/2013	First Issue
2	12/11/2015	Substantially revised to reflect current legislation, guidance and case law
3	01/11/2016	Revised to reflect transfer of CHC to Local Authority
3.1	November 2019	Review date extended in line with awaited national guidance.
3.2	April 2020	No legislation update. Extension request due to COVID19.
3.3	October 2020	Delay in release of national guidance. Extension request. Accessible Information Standard Statement included.
3.4	November 2021	Extension request

Equality Impact Assessment

Date	Issues
1 October 2015	None identified

POLICY VALIDITY STATEMENT
This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

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

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

Contents

"The deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned.**"**
Deprivation of Liberty Safeguards: Code of Practice

1. Introduction

For the purposes of this policy, North Tyneside Clinical Commissioning Group will be referred to as "the CCG".

This policy sets out how the CCG will fulfil its duties and responsibilities effectively, both within its own organisations and across the local health economy via their commissioning arrangements in relation to the Deprivation of Liberty Safeguards (DoLS).

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

The Deprivation of Liberty Safeguards provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed there under public or private arrangements. Those affected by DoLS include people with a "mental disorder", as defined within the Mental Health Act 2007, who lack the capacity to make informed decisions about arrangements for their care or treatment. A risk that the person may be deprived of their liberty must be identified. The safeguards do not apply to people detained under the Mental Health Act (MHA) 1983. The DoLS clarify that a person may be deprived of their liberty:

- *in their own best interests to protect them from harm*
- *if it is a proportionate response to the likelihood and seriousness of the harm,*

and

- *if there is no less restrictive alternative*.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

This policy should be read in conjunction with the:

- The Mental Capacity Act: Code of Practice
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- Deprivation of Liberty Safeguards (DoLS): Code of Practice

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

On 1 April 2013, Primary Care Trusts ceased to exist and their Supervisory Body (SB) role was transferred to Local Authorities (LA). Consequently, the CCG is not a Supervisory Body (SBs) but is required to work closely with providers and the LAs to ensure the protections offered by DoLS are implemented appropriately.

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

This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff. All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

2. Definitions

The following terms are used in this document:

Reference	Abbreviated Term
Advance Decision to refuse treatment	ADRT
Best Interests Assessor	BIA
Court of Protection	CoP
Deprivation of Liberty	DOL
Enduring Power of Attorney	EPA
General Practitioner	GP
Independent Mental Capacity Advocate	IMCA
Lasting Power of Attorney	LPA
Managing Authority (Hospital)	MA
Mental Capacity Act	MCA
Mental Health Act	MHA
Office of the Public Guardian	OPG
Relevant Persons Representative	RPR
Supervisory Body (LA)	SB

2.1. Equality and Diversity Leads:

The CCG Head of Governance is the equality and diversity lead for the CCG

2.2. Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain. An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

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

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

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

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

3. Mental Capacity Act Principles

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

- the principles of the MCA have been observed
- an assessment of capacity has been carried out and it is reasonable to believe that the person lacks capacity in relation to the matter in questions
- it is reasonable to believe the action to be taken is in the best interests of the person

There are five key principles underpinning the MCA as follows:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not unable to make a decision unless all steps have been taken unsuccessfully.
- A person is not unable to make a decision merely because he makes an unwise decision.
- An act/decision made on behalf of a person who lacks capacity must be in his best interests.
- Before the act or decision, ensure it is achieved in the least restrictive way.

The Mental Capacity Act applies to all people over the age of 16, except when making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, a person must be aged 18 or over.

4. Deprivation of Liberty Safeguards (DoLS)

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

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- it is in their own best interests to protect them from harm, and;
- if it is a proportionate response to the likelihood and seriousness of the harm, and;
- it is the least restrictive way of meeting their needs safely.

In determining whether a deprivation of liberty has occurred or is likely to occur, staff must consider all of the facts. No universal definition can be applied to every case, and no single factor will determine the overall steps being taken which will amount to a deprivation of liberty. The case of HL v United Kingdom (The Bournewood case) assists practitioners by stating that “the distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance” (para.89), staff should therefore consider:

- All the circumstances in each and every case and the measures taken.
- When they are required & what period do they endure?
- The effects of any restraints/restrictions on the individual - Are they necessary?
- What aim do the restrictions seek to meet?

- What are the views of the relevant person, family or carers? Do any of them object?
- How are any restraints or restrictions implemented?
- Do the constraints go beyond 'restraint'/'restriction' to the extent they constitute a deprivation of liberty?
- Are there less restrictive options that would avoid deprivation of liberty altogether?
- Does the effect of all of the restrictions amount to deprivation of liberty, even if individually they don't?
- That practical steps can be taken to reduce the risk of deprivation of liberty occurring?

The CCG will aim to reduce the risk of deprivation of liberty to include minimising the restrictions imposed and ensuring decisions are taken with the involvement of all relevant people. The processes for staff to follow are:

- Ensure that decisions are taken, reviewed & recorded in a structured way.
- Assess whether the person lacks capacity to see whether or not to accept the care
- Consider the least restrictive form of care.
- Help the person retain contact with family/friends/carers/advocacy service support.
- Review the care plan including an independent view e.g. advocacy service.

Section 6(4) of the MCA states that someone is using restraint if they use force, or threaten, to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. However, where the restriction or restraint is frequent, cumulative and on-going, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint.

On 19th March 2014, the Supreme Court published its judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases. This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an 'Acid Test'. For a person to be deprived of their liberty, they must:

- lack capacity to consent to the relevant care and support arrangements
- be subject both to continuous supervision and control

and

- not be free to leave.

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

- The person's compliance or lack of objection to the care arrangements.
- The reason or purpose behind a particular placement; and

- The relative normality of the placement (whatever the comparison made). This means that the person should not be compared with anyone else in determining whether there is a Deprivation of Liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities).

The introduction of the 'Acid Test' has reduced the threshold and widened the scope of who may be affected to include Independent Living Schemes, Adult Placements, Children's Foster Placements and people at home receiving funded packages of care.

This test is far broader than those set by previous judgements - disabled people should not face a tougher standard for being deprived of their liberty than non-disabled people.

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This can include a placement in a supported living arrangement in the community or in the person's own home. These must be authorised by the Court of Protection.

5. Consideration of a Potential Deprivation of Liberty within supported living services, shared lives schemes (formerly known as adult placements) and extra care housing.

Application of guidelines

These guidelines are relevant to people who receive commissioned support within a setting other than a hospital or care home, and whose care arrangements may amount to a deprivation of their liberty. The guidelines specifically apply to those individuals who have a mental disorder (as defined by the Mental Health Act 1983) and lack capacity to consent to the arrangements made for their care and treatment and where the circumstances of that care and treatment may amount to a deprivation of liberty.

Overview of Process

When the case manager assisting in identification of the health outcomes develops the support plan in conjunction with the individual (and their family if appropriate), they must also consider whether the plan results in the individual being deprived of their liberty. If following discussion it is felt that this maybe the case, then there is a responsibility to take all reasonable steps to consider whether the support plan can be amended to reduce the level of restrictions so that a deprivation is not occurring.

If this is not possible then the responsible CCG will need to be notified so that they can make a decision, in line with their responsibility as the decision maker, on the appropriateness of a referral to the Court of Protection. Dependent on the contractual agreement between the Local Authority and the CCG, in some cases it maybe that the submission of the application is the responsibility of the Local Authority. However, this will need to be discussed on an individual case-by-case basis and clarity should be sought locally.

Due to the high probability that there will be commissioned cases where individuals are already having their liberty deprived in the their own home/supported tenancy, then CHC teams need to ensure that there is a clear process in place to identify potential cases so that the relevant CCG is aware of the potential level of non-compliance.

To assist in the identification of potential cases, it is suggested that there should be a locality based action plan developed. Appendix 1 outlines the potential areas the action plan needs to address, including clear plans developed in relation to how historical cases are going to assessed. Dependent on the CCG's preference, a potential solution would be to use the tool developed by ADASS to prioritise work load (Appendix 2). However, the CCG needs to be aware that if there is a legal challenge in relation to unauthorised deprivation of liberty then an individual may successfully claim damages for breach of their human rights. This would also involve legal costs.

5.1. What is a supported living service?

The generic term, 'supported living', describes a form of domiciliary care whereby a CCG or local authority arranges a package of care and accommodation to be provided to a disabled, elderly or ill person. The individual lives in their own (often rented) home and typically receives social care and/or support to enable them to be as autonomous and independent as possible. The provision of accommodation is thereby separated from the delivery of care at an organisational level. There is usually some form of tenancy or licence arrangement with a landlord attracting housing benefit, with means-tested tailored support being provided by a distinct care provider with activities of daily living, education, training, employment and social interaction. The care setting is therefore not likely to constitute a "care home" for registration purposes.

Supported living services need only be registered with the Care Quality Commission ("CQC") if they carry on a regulated activity that is nursing or personal care. If, for example, the individual is supported with cleaning, cooking and shopping, or is supervised to take prescribed medicine, the service does not require registration. If personal care is being provided but not in the place where they are living, for example at day services, then registration of the service is not required. However, where nursing or personal care is provided to those, for example, with more complex needs, then such care will need to be a regulated activity requiring CQC registration. The Care Act 2014 adopts the definition of nursing and personal care presently provided for in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

"nursing care" means any services provided by a nurse and involving:
(a) the provision of care; or
(b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a nurse;

"personal care" means:
(a) physical assistance given to a person in connection with:
(i) eating or drinking (including the administration of parenteral nutrition),
(ii) toileting (including in relation to the process of menstruation),
(iii) washing or bathing,
(iv) dressing,
(v) oral care, or
(vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision."

Such regulated activities do not apply to the provision of accommodation to someone by a carer under a shared lives scheme (see below), school, or a further education institution.

5.2. Supported living: liberty-restricting measures

The following are measures which may be found in the specific features of this care setting:

- Decision on where to live being taken by others;
- Decision on contact with others not being taken by the individual;
- Doors of the property locked, and/or chained, and/or bolted for security reasons or to prevent residents leaving;
- Access to the community being limited by staff availability;
- A member or members of staff accompanying a resident to access the community to support and meet their care needs;
- Mechanical restraint, such as wheelchairs with a lapstrap or harness (e.g. Crelling), reinforced glass in mobility vehicles, protective helmets;
- Varying levels of staffing and frequency of observation by staff;
- Restricted access to finances, with money being controlled by staff or welfare benefits appointee;
- Restricted access to personal items to prevent harm;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks;
- Chemical restraint, such as medication with a sedative or tranquilising effect;
- Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds;
- Restricted access to modes of social communication, such as internet, landline or mobile telephone, correspondence;
- Positive behavioural reward systems, to reward "good" behaviour;

- Restricted access to family, depending on level of risk and availability of staff and resources;
- Lack of flexibility, in terms of having activities timetabled, set meal times, expected sleep times

5.3. What are Shared Lives schemes?

These schemes, formerly known as adult placements, differ from supported living arrangements as they involve the individual being placed in a family setting. They are likened to adult fostering arrangements and are available to those aged 16 and over. Usually a local authority arranges for the person to receive day support, short breaks or respite, or long term care in the family home of a Shared Lives carer so as to enable them to share the family life, social life and community activities. The schemes are designed for those wanting to live independently but not on their own. The majority of those receiving such care have learning disabilities, although the scheme extends to those with physical disabilities, mental health issues or drug or alcohol problems. Shared Lives carers are self-employed, with rates of payment set by the local authority or the scheme itself according to the location and the person's level of need. Carers receive payments to cover some of their time, rent and a contribution towards the household running costs.

Although accommodation is often provided together with personal care, it is not required to be registered as a "care home". But Shared Lives schemes are regulated under the Health and Social Care Act 2008. The schemes approve and train the carer, receive referrals (typically from the local authority), match the needs of the person with the carer, and monitor the arrangements. A maximum of three people (two in Wales) can be supported by the carer at any one time and carers do not employ staff.

5.4. Shared Lives schemes: liberty-restricting measures

The following are measures which may be found in the specific features of this care setting:

- Varying levels of supervision and guidance with activities of daily living;
- Encouraging participation in family and community activities;
- Preventing the person from leaving unaccompanied for their immediate safety;
- Ensuring behavioural boundaries;
- Conveying the person to health and other appointments;
- Addressing challenging behaviour;
- Assist with medication, including sedative effect.

5.5. Extra care housing

Extra care housing represents a hybrid between living at home and living in residential care. Usually purpose built, self-contained properties on a single site, schemes provide access to 24-hour domiciliary care and support and community resources. Their models differ from assistive technology in someone's own home to retirement and care villages to, for example, specialist dedicated schemes for those with dementia. Unlike residential care, those in extra care housing usually rent, purchase, or share ownership of typically a one or two-bedroomed apartment or bungalow in the housing scheme or care village and do not receive one-to-one care. Unlike living in one's own home, those in extra care housing will have 24-hour access to personal care with progressive degrees of privacy, dependent upon their level of need.

Some individuals will have a domiciliary carer. A warden is also usually on site to check on the welfare of residents. For the larger schemes, there are also on-site facilities and social care services usually available for those requiring daily support. These can include on-site care teams, rehabilitation services, day centre activities, restaurants, laundrettes, hairdressing and beauty suites, and possibly shops, cinemas, gyms, even the garden shed. Moving into extra care housing may be a lifestyle choice. Or it may be necessary due to an individual's level of social and/or health care need. The decision to move in may or may not be made at a time when the individual had mental capacity, or their mental functioning may deteriorate subsequently, with it no longer being safe for them to go out unaccompanied. It is therefore a common occurrence for those in extra care housing to not be free to access the community but the intensity of care measures varies enormously.

5.6. Extra care housing: liberty-restricting measures

- The following are measures which may be found in the specific features of this care setting:
- Location devices;
- Door sensors to raise to alert staff to the person's exit from their property;
- Movement sensors to raise alert staff to the person's movements within their property;
- Verbal or physical distraction techniques used, for example, to dissuade the person from going out unaccompanied;

5.7. Within their own home

This could be a home that they own or rent themselves, or a home owned or rented by a family member or members with whom they live.

5.8. The home environment: liberty restricting measures

Almost by definition, arrangements made at home will be more varied and more flexible than arrangements made in any institutional or quasi-institutional setting. It is also more likely that, because the arrangements are likely to be more tailored to the individual, they will less obviously be directed to the control of that individual in the interests of others within a placement (whether other service users or the staff).

It is important to remember that, in the case MIG and MEG (2010) EWHC 785 (Fam), MIG (Mental health law online, case: MIG and MEG (2010) EWHC 785 (Fam)) was found to be deprived of her liberty in an adult foster placement – i.e. a home-like environment – in circumstances where the supervision and control to which she was subject was *"intensive support in most aspects of daily living,"* even though she attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

The following features may constitute liberty-restricting measures in the home environment:

- The prescription and administration of medication to control the individual's behaviour, including on a PRN basis;
- The provision of physical support with the majority of aspects of daily living, especially where that support is provided according to a timetable set not by the individual but by others;
- The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);
- The regular use of restraint by family members or professional carers which should always be recorded.in the individual's care plan;
- The door being locked, and where the individual does not have the key (or the number to a key pad) and is unable to come and go as they please, strongly suggests that they are not free to leave;
- The individual regularly being locked in their room (or in an area of the house) or otherwise prevented from moving freely about the house.
- Use of medication to sedate or manage behaviour, including PRN

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorisation must be obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), the Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (CoP). The CCGs should be able to seek assurance from commissioned services that they are compliant with the DoLS framework and CoP requirements. This includes providers of Continuing Health Care Services (CHC) and NHS Funded Care.

As Supervisory Bodies, local authorities have established MCA DoLs policies and procedures which clearly outline expectations of NHS hospital providers and care homes, as Managing Authorities (MA) to apply for a DoLS.

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

6. Governance and Accountability

The CCG is responsible for having assurance that providers have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. CCGs are to assure themselves that commissioned services are compliant with MCA DoLS, and should receive regular reports and updates to this effect. The CCG will also need assurance about effective leadership, commissioning and governance through :

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

7. Duties and Responsibilities

Council of Practices	The council of practices has delegated responsibility to the governing body (GB) 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.
The Chief Officer	The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements. The Chief Officer is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements. This role is supported by the Executive Nurse who holds delegated responsibility and is the executive lead for Safeguarding Adults. The Head of Quality and Safety provides expert advice to the Governing Body on MCA and MCA DoLS matters.

The Executive Lead for Safeguarding Adults	**The Executive Lead for safeguarding adults** The Executive Nurse, as executive lead for safeguarding adults, MCA and MCA DoLS, will ensure that the CCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a programme of training. The Executive Director is the Sponsoring Director for this policy and is responsible for ensuring that: • This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies • The necessary training required to implement this document is identified and resourced. • Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document. • The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service. • The CCG has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers
Lead Professional MCA and Dols	Accountable to Executive Director of Nursing and Transformation. Reports to Executive Director of Nursing and Transformation. CCGs are required to have a designated MCA Lead and MCA Dols to take a strategic and professional lead on all aspects of the NHS contribution to MCA and MCA Dols across the CCG's area; which include all commissioned providers. They will • Provide advice and expertise to the CCG governing bodys and Safeguarding Adults Board and associated groups and to professionals across both the NHS and partner agencies. • Provide professional leadership, advice and support to lead adult safeguarding professionals across provider trusts/services and independent contractors. • Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS. • Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements. • Provide advice and guidance in relation to MCA, MCA DoLS training including standards. • Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and compliance is evidenced. • The Head of Quality and Safety will work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children's safeguarding teams.

CCG Staff	All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular: • Comply with the MCA and DoLS Policy. • Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy. • Identify training needs in respect of the MCA and DoLS Policy and informing their line manager • Complete mandatory MCA and MCA DoLS training in accordance with the CCG Safeguarding Adult and MCA, MCA DoLS Training Plan.
Commissioning Support Unit (CSU)	The CCG obtains services from the Commissioning Support Unit. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSU will be expected to comply with the Service contract standards relating to MCA and DoLS.
Primary Medical Services (GP practices)	GP practices will be informed of the Service contract standards and encouraged to take account of these. The CCG in partnership with NHS England and supported by the CSU will develop a programme to support and monitor their adoption, and implementation in GP practices.

8. Implementation

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

8.1. Training Implications

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

- Mandatory Safeguarding Adults , MCA, including MCA DoLS training programme

8.2. Documentation

Other related policy documents:

- Guidance on Advance Decision to Refuse Treatment (ADRT)
- Safeguarding Adults Policy

8.3. Legislation and statutory requirements

- Cabinet Office (1998) *Human Rights Act 1998.* London. HMSO.
- Cabinet Office (2000) *Freedom of Information Act 2000.* London. HMSO.
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- Cabinet Office (1983) *Mental Health Act 1983*. London. HMSO
- Cabinet Office (2005) *Mental Capacity Act 2005*. London. HMSO.
- Cabinet Office (2007) *Mental Health Act 2007*. London. HMSO
- Department of Health (2007) Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. London. DH.
- Department of Health (2009) The Mental Capacity Act Deprivation of Liberty Safeguards. London. DH.
- Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence.
- Health and Safety Executive (1974) *Health and Safety at Work etc. Act 1974.* London. HMSO.
- House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office
- P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190

8.4. Best practice recommendations

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

9. Document Consultation, Approval & Ratification Process

9.1 Document Consultation

This document has been produced by the Designated Adult Safeguarding Manager on behalf of North Tyneside CCG. In preparing the document for official ratification by the Governing Body, the following stakeholders were consulted upon and their comments added to the document as appropriate:

- CCG Director and Executive Lead for Safeguarding Adults
- Designated Adult Safeguarding Manager.

9.2 Document Approval and Ratification

North Tyneside CCG Governing Body is the committee with authority for the approval and ratification of this document. The Committee has ensured that there has been appropriate consultation and has considered the content of the document in terms of current best practice, guidelines, legislation and mandatory and statutory requirements before approval. In considering the document for approval the committee also took into account the results and recommendations of the Equality Analysis.

9.3 Document Development

The Quality and Safety Committee and nominated author are responsible for the development, review, implementation, performance management and distribution of this Policy.

9.4 Version Control and Review Section

Version control of this document is the responsibility of the Executive Director of Nursing & Transformation who must ensure that timely reviews are completed.

This Policy document will be reviewed at least every three years by the CCG Safeguarding Adults or as and when significant changes make earlier review necessary.

10. Monitoring Compliance with this policy

North Tyneside CCG will monitor compliance with this policy - see table below.

No.	Monitoring/audit arrangements of compliance with policy and methodology	Reporting		
		Source	Committee	Frequency
1.	**Safeguarding Adults training (CCG staff).**			
	Review of training data.	CCG data.	CCG Quality and safety Committee.	Quarterly
2.	**CCG Risk register:**			
	Review and updating risk register.	Complaints. Performance Dashboard. Serious Incidents.	CCG Quality and safety Committee.	Quarterly
3.	**Standards from Provider Performance Dashboard (developed by CCG for Providers from whom they commission services).**			
	Review of data provided.	Provider performance dashboard	Quality and safety Committee.	Quarterly
4.	**Providers compliance MCA and Dols:**			
	Review provider compliance with training.	Local Authority and other partner agencies. General public and patients.	Quality and safety Committee.	

11. Equality Impact Assessment

A full Equality Impact Assessment has been completed (adopted for North Tyneside CCG)

EIA - MCA DOLS (South Tyneside) July

Appendix 1

Deprivation of Liberty Action Plan

Issue	Objective	Action	Lead	Timescale
Raising Staff awareness of the Supreme Court Ruling 'Cheshire West' implications.	Ensure CHC assessors are aware of the implications in relation to CCG funded packages.	Take legal advice from legal services Training could be provided by CCG Safeguarding Adults Team		
Review which cases need to be referred to relevant Supervisory Body for DoLS	Identify cases which can be authorised via Deprivation of Liberty Safeguards process	CHC funded cases in Care homes can be authorised via the DoLS safeguards – this function was transferred to Local Authorities in April 2013		
Identify Which CHC funded care packages in their own homes, etc have capacity to consent	Ensure consent is recorded for CHC funded care packages where recipients have mental capacity	CHC assessors to identify which service users have the capacity to consent to their care packages and record their consent		
Review care packages of CHC funded care at home, ISL or foster/adult placements	Care packages need to be reviewed to see is restrictions could be removed	CHC assessors should explore less restrictive ways of delivering care to negate the risk of a deprivation of liberty occurring		
Identify potential deprivations of liberty that need authorisation form the Court of Protection	Create a substantive list of cases likely to meet the 'acid test' that stand in need of an application to the Court of Protection	Notify CCG reference overview of cases and consider next steps. Take Legal advice on how to proceed. Draw up a priority risk which targets those most likely deprived first Identify costs of court proceedings and potential funding		
Plan for the increase in Section 117 budget demand	Ensure there is sufficient resource to cover an increase in S117 funded care	Discuss with Local Authority arrangements for Joint Funded packages The Supreme Court Ruling has led to an increase in MHA detentions which has a knock on effect of more people entitled to Section 117 aftercare and this will create budget growth		

Appendix 2

ADASS TASK FORCE

A Screening tool to prioritise the allocation of requests to authorise a deprivation of liberty

Due to the vast increase in demand for assessments under the Deprivation of liberty safeguards the ADASS task force members have shared practice in relation to prioritisation and produced this screening tool. The aim of the tool is to assist Councils to respond in a timely manner to those requests which have the highest priority. The tool sets out the criteria most commonly applied which indicates that an urgent response may be needed so as to safeguard the individuals concerned. The use of this tool must be balanced against the legal criteria for the Deprivation of Liberty Safeguards which remains unchanged. **The criteria should be used as an indicative guide only as it will generally be based on information provided by the Managing Authority in the application and each case must be judged on its own facts.**

HIGHER	MEDIUM	LOWER
• Psychiatric or Acute Hospital and not free to leave • Continuous 1:1 care during the day and / or night • Sedation/medication used frequently to control behaviour • Physical restraint used regularly – equipment or persons • Restrictions on family/friend contact (or other Article 8 issue) • Objections from relevant person (verbal or physical) • Objections from family /friends • Attempts to leave • Confinement to a particular part of the establishment for considerable period of time • New or unstable placement • Possible challenge to Court of Protection, or Complaint • Already subject to DoL about to expire	• Asking to leave but not consistently • **Not making any active attempts to leave** • **Appears to be unsettled some of the time** • **Restraint or medication used infrequently.** • Appears to meet some but not all aspects of the acid test	• Minimal evidence of control and supervision • No specific restraints or restrictions being used. E.g. in a care home not objecting, no additional restrictions in place. • Have been living in the care home for some time (at least a year) • Settled placement in care home/hospital placement, no evidence of objection etc. but may meet the requirements of the acid test. • End of life situations, intensive care situations which may meet the acid test but there will be no benefit to the person from the Safeguards

CASE NO:		DATE:		PRIORITISED BY :
SUMMARY OF CRITERIA				
ALLOCATED PRIORITY:				