Newcastle Gateshead
Clinical Commissioning Group

Corporate	CCG: CO10: Deprivation of Liberty within a Domestic Setting

Version Number	Date Issued	Review Date
1	March 2019	March 2021

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Consultation Process:	NHS Newcastle Gateshead Clinical Commissioning Group

Policy Adopted From:	New policy
Approval Given By:	Quality, Safety and Risk Committee

Document History

Version	Date	Significant Changes
1	March 2019	New policy

Equality Impact Assessment

Date	Issues
16/01/2019	Please see Section 9 of this document

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.

Contents

Appendices

1. Introduction

For the purposes of this policy, NHS Newcastle Gateshead Clinical Commissioning Groups will be referred to as “the CCG”.

This policy sets out how the CCGs will fulfil their duties and responsibilities effectively, both within their own organisations and across the local health economy via their commissioning arrangements in relation to the Deprivation of Liberty within a domestic setting and authorised via the Court of Protection (CoP)

The CCGs aspire 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 CCGs 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 (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 there under public or private arrangements. They are not available to those people at risk of a DoL within their own home or supported tenancy.

Any DoL must be only

- 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

- CO03: MCA and DOLS Policy

1.1 Status

This policy is a corporate policy.

1.2. Purpose and scope

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

This policy applies to all staff employed by the CCGs, 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:

- 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 IMCA
- Mental Health Act MHA
- Office of the Public Guardian OPG
- Relevant Persons Representative PR
- Supervisory Body (LA) SB
- North East Commissioning Support NECS

2.1. 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. Deprivation of Liberty (DoL) within a Domestic Setting

3.1. 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.

3.2. Deprivation of Liberty

A Deprivation of Liberty may occur in any care setting, the 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 but do not cover those DoL in a domestic setting.

The European Court of Human Rights has identified three elements that all need to be met before a particular set of circumstances will amount to a deprivation of liberty under Article 5:

- The objective element: that the person is confined to a particular restricted place for a non-negligible period of time
- The subjective element: that the person either does not or cannot consent
- imputable to the state: that deprivation is one for which the state can be said to be responsible.

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.

3.3. 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.

Consideration of a Potential DoL should be given within supported living services, shared lives schemes (formerly known as adult placements), as well as within a patient’s own home.

3.4. 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 CCG Head of Continuing Health Care (Adult) & Complex Care will need to be notified so that they can make a decision, in line with their responsibility as commissioner, on the appropriateness of a referral to the Court of Protection.

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 on review in place to identify potential cases so that the relevant CCG is made aware.

3.5. Supported Living

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.

The following are examples of liberty restricting 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, 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

3.6. 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 following are examples of liberty restricting 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.

3.7. 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.

The following are examples of liberty restricting 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;

3.8. 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.

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

- The prescription and administration of medication to control the individual's
- behaviour, including on an as required 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;
- 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

It is important to recognise that arrangements made at home will be more varied and more flexible than arrangements made in other care settings. Therefore 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. As such, in these cases careful consideration should be given as to whether any supervision or control is imputable to the state.

3.9. When a Deprivation is identified

Where a package of care is identified as meeting the Deprivation of Liberty threshold within a domestic setting, one of the followings should occur:

- the care plan must be significantly altered to remove restrictions and end the deprivation
- authorisation must be obtained via a prescribed legal process. Such authorisation should be obtained via the Court of Protection (CoP).

Any unauthorised deprivations carry with it a potential risk of litigation. If a CCG identifies 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.

3.10. Governance and Accountability

The CCG Governing Body is responsible for making certain the CCG and its provider services have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. Therefore, the CCG will seek assurance via the local quality requirements. The governing body, through its governance structures namely, will assure itself that the CCG and its commissioned services are compliant and will receive regular reports and updates with reference to MCA and DOLs in line with agreed reporting schedules.

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

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

4. Duties and Responsibilities

4.1. Governing Body (GB)

The CCG has delegated responsibility to the Governing Body for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.

4.2. The Chief Officer

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

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

This role is supported by the Executive Director of Nursing Patient Safety and Quality who is board lead for MCA who is supported by the Designated Nurse for expert advice to the Governing Body on MCA and MCA DoLS matters.

4.3. The Executive Director of Nursing Patient Safety and Quality

The CCG Executive Director of Nursing Patient Safety and Quality as Executive Lead for MCA and DoLS will, with support from the Designated Nurse, ensure NGCCG has effective staffing, systems, processes and structures in place, ensuring that there is a programme of training and mentoring to support staff within the CCG. The Executive Director of Nursing Patient Safety and Quality is responsible for ensuring that:

- This policy is drafted, approved and disseminated.
- The necessary training required to implement this document is identified and resourced.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.

- The CCG has in place assurance processes to ensure compliance with MCA and DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers
- Financial resources are made available to enable applications to proceed to CoP (Legal representation and Court Fees)

4.4. Designated Lead for Safeguarding Adults

The Designated Nurse for Safeguarding Adults will provide leadership to ensure that MCA and DoLS is embedded in the Safeguarding and Quality strategy across the health economy. They will raise the profile of the Mental Capacity Act [MCA] and the Deprivation of Liberty Safeguards [DoLS] to ensure they are understood and effectively implemented in our local health services. In doing so they will:

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

4.5. Head of Continuing Health Care (Adult) & Complex Care

The Head of Continuing Health Care (Adult) & Complex Care will have responsibility for ensuring that:

- CHC Panels consider whether or not the acid test for a Deprivation of Liberty is met for patients receiving care in a Domestic Setting
- Staff undertaking reviews/changes to packages of care consider whether or not the acid test for a Deprivation of Liberty is met for patients receiving care in a Domestic Setting
- Any cases requiring application to CoP are allocated to appropriately trained staff and that the applications progress in a timely manner
- Records are maintained of any authorisation made by the CoP and dates for reapplication are adhered to
- Any actions/conditions ordered by the CoP are addressed appropriately.

4.6. Managers and Executive Leads

Managers and Executive leads have responsibility for:

Ensuring they are aware of and carry their responsibilities in relation to MCA, DoLS.

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

4.7. 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 Deprivation of Liberty within a Domestic Setting Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the Deprivation of Liberty within a Domestic Setting policy.
- Identify training needs in respect of the Deprivation of Liberty within a Domestic Setting Policy and informing their line manager

5. Implementation

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

All Executive leads and Managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties.

6. Training Implications

The sponsoring director will ensure that the necessary training or education needs and methods required to implement the policy or procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

The training required to comply with this policy are:

- E-learning
- Multi-Agency training is available from the Local Authority
- Bespoke training is also available from the Safeguarding Adults Team

7. Related Documents

7.1 Other related policy documents

- NGCCG Safeguarding Adults Policy
- Royal College of GP MCA Toolkit
- GMC MCA Flowchart

7.2 Legislation and statutory requirements

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

8. Monitoring, Review and Archiving

8.1 Monitoring

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

8.2 Review

The CCG will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original **approval process.**

8.3 Archiving

The CCG will ensure that archived copies of superseded policy documents are retained in accordance with relevant Code of Practice and legislation.

9. Equality Analysis

North of England Commissioning Support

Partners in improving local health

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

We need to:

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

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

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

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

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

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

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

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

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	**Howard Stanley, Designated Nurse Safeguarding Adults**
Title of service/policy/process:	**Deprivation of Liberty within a Domestic Setting**
Existing: ☐ **New/proposed:** ☑ **Changed:** ☐	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	
This policy sets out how as a commissioning organisation Newcastle Gateshead Clinical Commissioning Group (NGCCG) will fulfil its duties and responsibilities effectively both within its own organisation and across the local health economy via its commissioning arrangements in relation to the Mental Capacity Act (MCA) 2005 Commissioners must understand the implications of the MCA and DoLS, and NGCCG commissioned services must demonstrate compliance with the MCA and as appropriate compliance with DoLS.	
Who will be affected by this policy/service /process? (please tick)	
☑Staff members **☑ Other** **If other please state:**	
What is your source of feedback/existing evidence? (please tick)	
☑ National Reports ☐ Staff Profiles **☐ Staff Surveys ☐ Complaints/Incidents** **☐ Focus Groups ☐ Previous EIAs** **☑Other**	
If other please state: • **Legislation** • **Court Rulings**	

Evidence	What does it tell me? (about the existing policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	**N/A**
Staff Profiles	**N/A**
Staff Surveys	**N/A**
Complaints and Incidents	**N/A**
Staff focus groups	**N/A**
Previous EIA's	**N/A**
Other evidence (please describe)	**N/A**

 **STEP 2 - IMPACT ASSESSMENT**
What impact will the new policy/system/process have on the following staff characteristics: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
None
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
Set out commissioning and provider responsibilities regarding the MCA and DoLS. Human right based legislation to ensure principles of the MCA are maintained for all and in particular those with an impairment of mind. Positive impact.
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.
None
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
None
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
None
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
None
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
None
Sex/Gender A man or a woman.
None
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
None
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
None

 **STEP 3 - ENGAGEMENT AND INVOLVEMENT**
How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?
N/A - this is legislation based policy
Please state how staff engagement will take place:

STEP 4 - METHODS OF COMMUNICATION

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

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

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

Potential Challenge	What problems/issues may this cause?
None identified.	

STEP 6- ACTION PLAN

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
	None identified.					

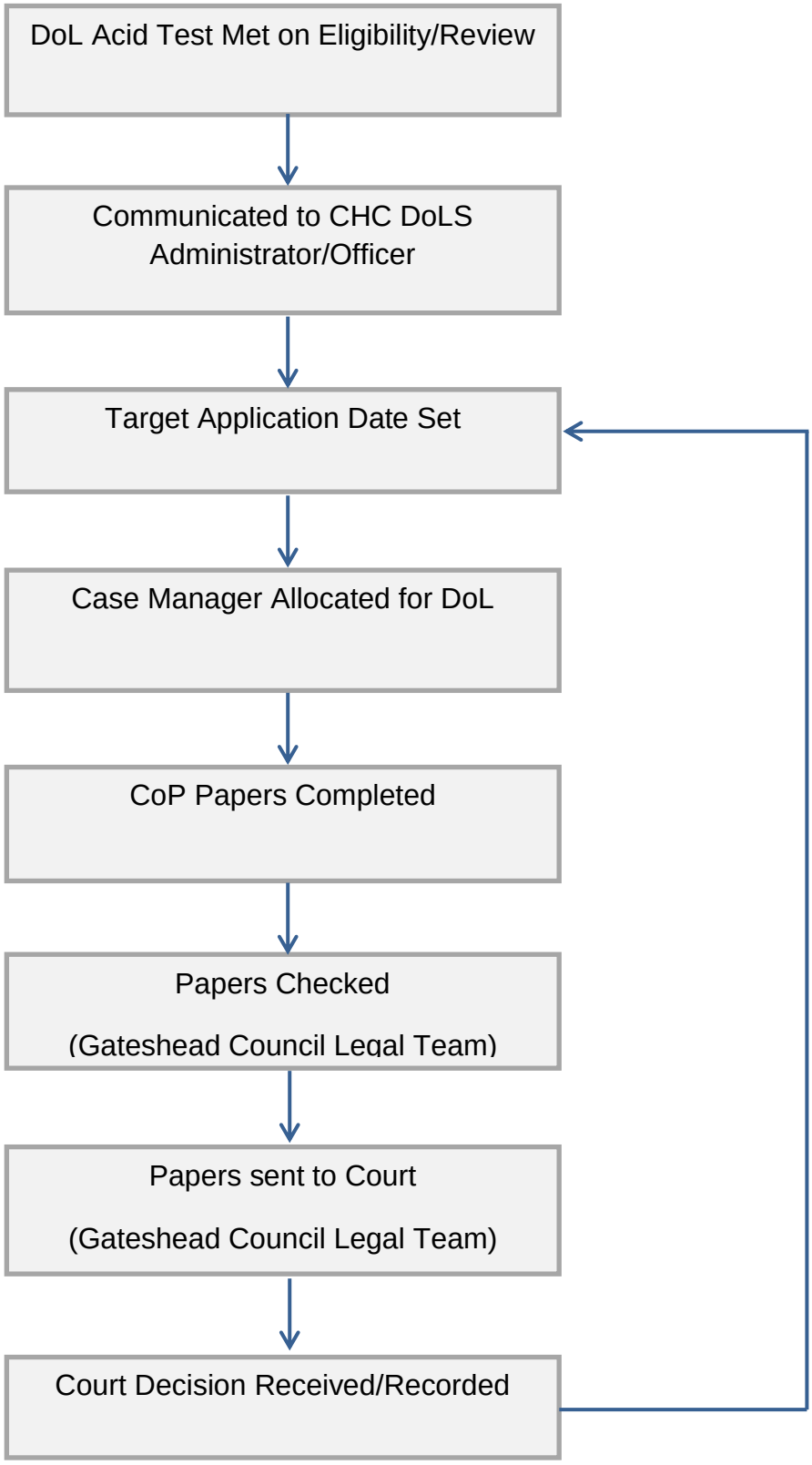
Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
	None identified.		

SIGN OFF

Completed by:	**Howard Stanley**
Date:	**March 2019**
Presented to: (appropriate committee)	**QSR Committee**
Publication date:	**March 2019**

Appendix 1

Making a DoL Application in a Domestic Setting



NOTE: Where there are complex issues related to the assessment of Capacity and/or Best Interests Decision making, the CCG Safeguarding Adult Team should be contacted for advice/support