James Paget University Hospitals NHS Foundation Trust

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Policy

Document Control:

Document Author:	**Head of Safeguarding (Interim)**		
Document Owner:	**Document Review Group**		
Electronic File Name:	**Mental Capacity Act & DoLS Policy February 2022**		
Document Type:	**Corporate Policy**		
Stakeholder Consultation:	**Reader Panel (as described within this document) and Document Review Group**		
Approval Level:	**Document Review Group**		
Approval Body:	**Chair of the Document Review Group**		
Version Number:	**5.1**	**Reference Number:**	**POL/TWD/KB0222/5.1**
Version Issue Date:	**February 2022**	**Effective Date:**	**June 2009**
Review Frequency:	**3 Yearly**		
Method of Dissemination:	**Intranet**		
Search Keywords	**Deprivation of Liberty Safeguards, DoLS, MCA, Mental Capacity Act, Best Interests, IMCA**		
For Use By:	**All Staff**		

Version History:

Version	Date	Author	Reason
V1.0	June 2009	Marlene Snodgrass	To originate document
V2.0	December 2013	Cherry Townsend	New template
V2.1	February 2014	Cherry Townsend	Update to IMCA details
V3.0	August 2015	Kelly Boyce	Update legislation and guidance
V4.0	September 2016	Kelly Boyce	Update
V4.1	June 2018	Kelly Boyce	Remove an appendix
V5.0	September 2019	Kelly Boyce	Update
V5.1	February 2022	Kelly Boyce	Review

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

EXECUTIVE SUMMARY

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can make decisions, in which situations, and how they should go about this.

The Deprivation of Liberty Safeguards (DoLS) were introduced into the Mental Capacity Act (MCA) 2005 by the Mental Health Act (MHA) 2007. The Deprivation of Liberty Safeguards came into force on 01 April 2009.

The DoLS provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. The safeguards legislation contains detailed requirements about when and how deprivation of liberty may be authorised. It provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

The MCA Code of Practice has statutory force, which means that those working within Health and Social Care have a legal duty to have “regard to” it when working with or caring for adults who may lack capacity to make decisions for themselves.

JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
MENTAL CAPACITY ACT (MCA) & DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) POLICY

CONTENTS

1.0 INTRODUCTION

1.1 Background

Mental Capacity Act (MCA) 2005

MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

The MCA says:

- Everyone has the right to make their own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.

- People must be given help to make a decision themselves. This might include, for example, providing the person with information in a format that is easier for them to understand.

- Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision. Everyone has the right to make their own life choices, where they have the capacity to do so.

Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.
Treatment and care provided to someone who lacks capacity should be the less restrictive of their basic rights and freedoms as possible, while still providing the required treatment and care.

Mental Health Act (MHA) 1983

The MHA is mainly focused on the assessment and treatment of mental disorder in hospital settings, which may be provided under compulsory powers if the person is unable or unwilling to consent, and it is necessary to detain them in hospital to protect them and/or others from harm.

Applies if a patient has a mental disorder, such as depression or bipolar disorder.

A patient cannot be detained under this Act unless they meet the conditions for sectioning under the Mental Health Act 1983 – Norfolk and Suffolk Foundation Trust Mental Health Liaison Team can support and advise on this. They are available on site 24 hours a day.

If a patient is detained under this Act, the health professionals must follow this Act when making decisions for them. They do not need to follow the best interests checklist in the Mental Capacity Act.

- Applies to treatment given for **mental health disorders**, such as antipsychotic medication. This means patients can be given the treatment regardless of whether they have the mental capacity to agree to it.

The MCA was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). It is important to note that DoLS is part of the MCA and not a standalone piece of legislation.

Deprivation of Liberty Safeguards (DoLS) 2009

Deprivation of liberty is a legal concept whose origins lie in the European Convention on Human Rights (ECHR). Article 5.1 of the ECHR states that everyone has a right to liberty and security of person and that no one shall be deprived of their liberty except in accordance with a procedure prescribed by law. In all legal cases, there is a process by which the detention of people may be authorised, reviewed and under which they may appeal to a Court with authority to release them, as required by article 5.4. They are lawfully deprived of their liberty.

The Deprivation of Liberty Safeguards (DoLS) were introduced to care provider settings and hospitals because, following a test case (*HL V UK*, known as the Bournewood case); a group of people were identified who may have been unlawfully deprived of their liberty. These are people in hospital or residential care who lack capacity to consent to their care regime.

DoLS aim to ensure that people are looked after in a way that does not inappropriately restrict their freedom. A person should only be deprived of their liberty in a safe and correct way that is only done when it is in the best interests of the person and there is no other way to look after them. **Patients who lack mental capacity to make decisions for themselves do not automatically require a DoLS.**

1.2 Scope

Regarding DoLS the policy covers all adult inpatient admissions age 18 years and over at the James Paget University Hospital (the Trust).

Court authorisation will have to be sought for care/accommodation arrangements for young people of 16 or 17 who lack capacity to consent to those arrangements themselves. Consent from parents to those arrangements will no longer be sufficient to prevent there being an unlawful deprivation of liberty otherwise. Seek advice from the Trust's Safeguarding or legal team for these cases.

1.3 Responsibilities

Director of Nursing

As Executive Lead for Safeguarding, the Director of Nursing is responsible for ensuring the Trust's Safeguarding arrangements are in adherence to legislation and national policy.

Head of Safeguarding/Named Nurses for Safeguarding

As Safeguarding Leads for the Trust, it is their responsibility to ensure that training and leadership within the Trust meets national and legislative requirements. It is also their responsibility to lead the Trust's arrangements to support an agenda where people who may lack the capacity to consent to their care and treatment are cared for with dignity, compassion and with a clear focus on least restrictive practices. The Safeguarding Leads must support best practice

All staff with clinical responsibility

All staff with clinical responsibility for patients have a duty to familiarise themselves with the policy content and their individual professional responsibility. The MCA Code of Practice has statutory force, which means that those working within Health and Social Care have a legal duty to have "regard to" it when working with or caring for adults who may lack capacity to make decisions for themselves. Where appropriate, all staff have a responsibility to document assessments of capacity and best interest decisions made.
The Safeguarding Team will offer support and guidance to Trust staff.

1.4 Monitoring and Review

The Head of Safeguarding and Named Nurses will be responsible for monitoring the effectiveness of this policy. This will be achieved by an ongoing evaluation of the processes and a yearly review of the policy.

The compliance of this policy will be monitored by the Head of Safeguarding and Named Nurses through feedback from the Trust's Safeguarding G, Trust colleagues, Norfolk and Suffolk DoLS Best Interest Assessors and the Independent Mental Capacity Advocacy Service.

1.5 Related Documents

- Mental Capacity Act Code of Practice (2005)
- Deprivation of Liberty Safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.
- The Department of Health's Mental Capacity Act Deprivation of Liberty Safeguards – Guidance to the Forms 2015.
- Human Rights Act 1998 - sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. The Act sets out human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the ECHR and are commonly known as 'the Convention Rights'
- The Law Society – Identifying a deprivation of liberty: a practical guide 2015
- Trust Mental Health Act Policy
- Trust Enhanced Supervision and Engagement Policy

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title
Director of Nursing (Chair)
Deputy Director of Nursing (Vice Chair)
Head of Safeguarding (Interim)
Workforce Department Representative
Head of Midwifery/Deputy Head of Midwifery
Named Safeguarding Midwife
Division of Medicine Representative
Division of Surgery Representative
Named Doctor for Safeguarding Children
Named Nurses for Safeguarding Children and Adults

Named Doctor for Safeguarding Adults
Head of Neonatal, Children and Young Person's Services
Operational Manager/ Patient Flow Lead
Senior Nurse Emergency Department

1.7 Trust Values

This Policy conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.8 Glossary

The following terms and abbreviations have been used within this Policy:

Term	Definition
DoL/S	Deprivation of Liberty/ Safeguards
MCA	Mental Capacity Act
IMCA	Independent Mental Capacity Advocate
ECHR	European Convention on Human Rights
BIA	Best Interest Assessor
SB	Supervisory Body
MA	Managing Authority
DoH	Department of Health
MHA	Mental Health Act
CQC	Care Quality Commission

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

2.0 STATEMENT OF POLICY

The Mental Capacity Act is used to support patients who lack mental capacity to make decisions about their lives whenever they possibly can. Trust staff must adhere to the act when supporting patients to make decisions about their care and treatment. Trust staff must evidence decisions that are made either by the patient themselves or that they take on behalf of the patient in their best interests.

There is no simple definition of deprivation of liberty. Sections 5 and 6 of the MCA Code of Practice offer protection from civil and criminal liability for acts done in connection with care or treatment of a person (P) who lacks capacity to consent to that act, as long as the person doing the act reasonably believes that P lacks capacity to consent and that it is in P's best interests for the act to be done. Section 6 adds the requirement that when an act is intended to restrain P, the person doing it must believe that it is necessary to do it to prevent harm to P and it must be a proportionate response to the likelihood and seriousness of that harm. The MCA therefore authorises many interventions, including the use of proportionate restraint and restriction of liberty.

It does not however authorise deprivation of liberty (DoL). The following factors taken from The Law Society are likely to point towards a DoL in a hospital setting:

- Continuous monitoring
- The use of restraint/medication being used forcibly during admission
- Staff taking decisions on a person's behalf regarding treatments and contact with visitors
- Duration of the restrictions
- The patient not being free to leave
- The package of care taken as a whole

After a substantial period of uncertainty, guidance was issued by the Supreme Court that there are two key questions to ask – the 'acid test':

(1) Is the person subject to continuous supervision and control?
AND

(2) Is the person free to leave?

It is no longer relevant whether the person is compliant or whether there is a lack of objection. The focus is not on the person's ability to express a desire to leave, but on what those with control over their care would do if they sought to leave. **So, not is the patient trying to leave, but if they did try, would you stop them?**

In general, restraint which is immediately necessary to prevent harm, which is thought to be in the patient's best interests and which is proportionate to the likelihood and severity of harm, is unlikely to constitute a DoL. DoLS does not apply to the provision of immediately necessary life-sustaining treatment. DoLS generally apply for patients who:

- Lack mental capacity to consent to their care and treatment
- No longer require life sustaining treatment
- Are subject to continuous supervision and control (highest level of Enhanced (Purple) Supervision
- Are not free to leave

When restraint becomes frequent or regular or any of the factors above or a combination of them apply, and the situation persists with no obvious end point in sight, then a DoLS referral must be considered.

When might restraint become a Deprivation of Liberty? Guidance can be seen Appendix C.

2.1 Policy Objectives

The objective of the policy is to provide Trust staff with accurate and simple information about using the MCA to support patients and to consider when DoLS applications may be needed for patients. It also provides guidance as to who may be subject to a DoLS and how to make an application.

3.0 DETAILS SECTION

3.1 Mental Capacity and Best Interest Decisions (Mental Capacity Act- 2005)

Assessing Capacity

Trust staff should use the Green MCA Assessment 'Sticker' to evidence they have assessed a patient's mental capacity to make a particular decision and the best interest decision they took if the patient lacks capacity (Appendix A).

In order to protect those who lack capacity and to enable them to take part as much as possible in decisions that affect them, the following statutory principles apply:

1. You must always assume a person has capacity unless it is proved otherwise
2. You must take all practicable steps to enable people to make their own decisions
3. You must not assume incapacity simply because someone makes an unwise decision
4. Always act, or decide for a person without capacity in their best interests
5. Carefully consider actions to ensure the option taken is less restrictive

A mental capacity assessment can be triggered in one of many ways following the establishment of a need for the patient to make a specific decision e.g. the patient's behaviour, circumstances or previous issues suggests they may lack capacity or someone else has raised concerns.

Assessment of capacity to make a decision can be made by any registered professional e.g. Nurse, Doctor, Occupational Therapist, Physiotherapist or Social Worker.

A capacity assessment to make a decision should be undertaken using the Mental Capacity Act (MCA) 2005 Two Stage Test. In the Trust the 'Green Sticker' is used to support MCA assessment and to evidence that Trust staff have assessed capacity in a decision and time specific way.

Best Interests

If a patient lacks mental capacity to make a decision then a best interest decision must be recorded. It is essential that you record the decision you had to make in a patient's best interests, if they lack the mental capacity to make it themselves. In making a best interest decision you must:

- Involve the person who lacks capacity as much as practically possible
- **Consider the person's past and present beliefs, values, wishes and feelings**
- Take into account the views of carers, relatives, friends and advocates
- Consult others who are involved in the person's care and well-being (with either a formal meeting or via telephone if relatives/carers cannot attend in person or time is of the essence)
- Consider whether the patient will regain capacity sometime in the future in relation to the decision required
- Do not base the decision solely on age, appearance, behaviour or condition

Decision Makers (Assessors)

- The decision-maker is determined by the nature and complexity of the decision to be made. Day-to-day care decisions may be made by the professional most

directly involved with the person at the time. Where nursing care is provided, the member of the healthcare team responsible for delivering the care will be the decision-maker. Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.

- The decision-maker must involve an Independent Mental Capacity Advocate (IMCA) for decisions about Serious Medical Treatment or certain changes of accommodation where the person lacks capacity and there is no family member, friends or un-paid carers for the decision-maker to consult (see 3.4)

- If a Lasting Power of Attorney (LPA) has been made and registered, or a deputy appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority.

3.2 The Application Process for a DoLS

Under Schedule 1A of the Mental Capacity Act 2005 the following requirements must be met before a Deprivation of Liberty will be satisfied:

1. The person must be at least 18 years of age
2. Must be suffering from a mental disorder as defined by the Mental Health Act (2007).
3. The person must lack mental capacity to consent to care and treatment.
4. It is in the best interest of the person, it is necessary to prevent harm to the person and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm
5. They must not be detained under the Mental Health Act or subject to other restrictions on their freedom
6. There must not be a valid and applicable advance refusal of treatment for which the Deprivation of Liberty is being sought.

For a DoLS application, the Trust is known as the 'Managing Authority' (MA). The applications are authorised or denied by the 'Supervisory Body' (SB) For the Trust, the SB's are most often:

- Norfolk County Council for Norfolk Patients
- Suffolk County Council for Suffolk Patients
- Although sometimes a patient may be ordinarily resident Out of Area

There are two types of authorisation which are now combined within Form 1 (Appendix B). This form allows the MA to apply for:

- Standard Authorisation
- Urgent Authorisation – MA can grant for themselves immediately
- Request for an extension of the Urgent Authorisation

When Trust staff think they can identify a potential DoL for any patient, they can consult with the Safeguarding Team and complete Form 1 for an Urgent and Standard Authorisation (Appendix B). This form is then emailed to DOLS@jpaget.nhs.uk and a note should be made in the medical records, Enhanced Supervision and Engagement paperwork and on handover that the patient is subject to a DoL.

Once the Trust has applied for a DoLS for a patient, the Safeguarding Team will complete a daily review with the ward to ensure that the DoLS continues to be required.

Urgent and Standard Authorisation
A MA can apply to grant itself the Urgent Authorisation on Form 1 (Appendix B) for a DoL for a maximum of 7 days (today plus 6).

An Urgent Authorisation should only be given where the need for the DoL is so urgent it is already happening and is unavoidable. As an acute hospital, the Trust almost always has need for an Urgent Authorisation.

When completing Form 1 for Urgent Authorisation, a request for an extension to the urgent authorisation should also be requested. This grants a further maximum of 7 days.

The completion of Form 1 also requests a Standard Authorisation.

The Supervisory Body (SB) will make contact with the Safeguarding Team in the first instance around any DoLS application. The Safeguarding Team takes responsibility for ensuring the CQC are notified of the outcome of the application.

3.3 Duration of Authority

The legislation states that a maximum time for which a Supervisory Body may authorise a Deprivation of Liberty is one year. This should not be necessary in the context of the Trust, as it is extremely rare for an inpatients admission to last for that length of time.

The legislation also states that a deprivation of liberty should last for the shortest time possible.

This is in line with delivery of patient centred care and Discharge to Assess models.

3.4 Independent Mental Capacity Advocacy (IMCA)

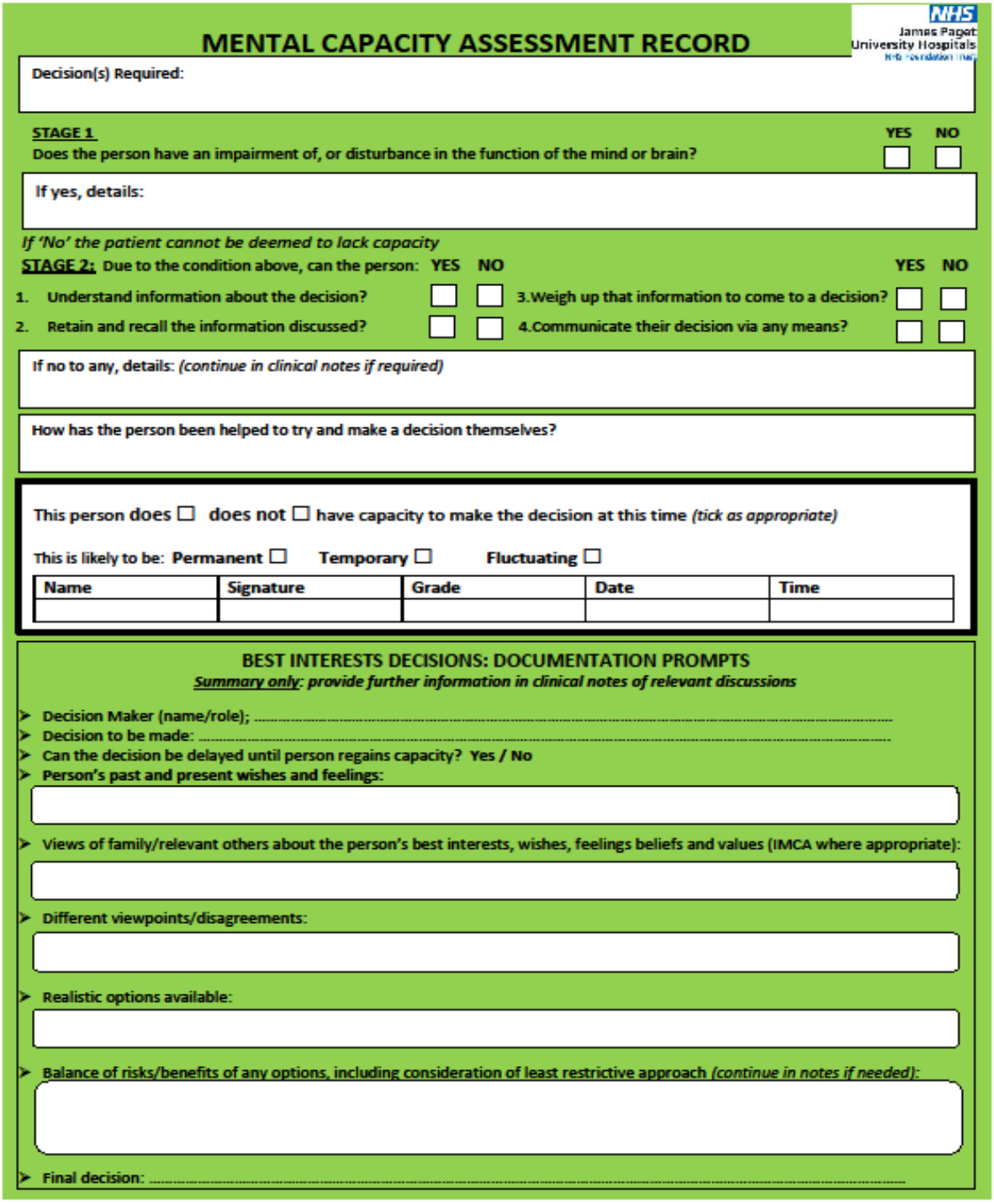
When someone is assessed as lacking mental capacity to make key decisions in their lives they may have the help of a specialist independent mental capacity advocate (IMCA). This is a legal right for people over 16 who lack mental capacity and who **do not have an appropriate family member or friend to represent their views**, in particular about Serious Medical Treatment and certain changes to accommodation. Trust staff should advise Safeguarding Team of any need for an IMCA.

For Norfolk Patients	For Suffolk Patients
Tel: 0300 456 2370	Tel: 01473 857 631
http://www.pohwer.net/in-your-area/where-you-live/norfolk	http://www.voiceability.org/in_your_area/suffolk/independent_mental_capacity_advocacy_imca

3.5 Training for MCA/DoLS

The Trust has a robust training plan around MCA and DoLS. This training can be accessed through attending Trust corporate training. The Safeguarding Team also provide ward based education and can deliver bespoke training to your ward/area on request.

Appendix A – MCA 'Green Sticker' Label



MENTAL CAPACITY ASSESSMENT RECORD

NHS James Paget University Hospitals

Decision(s) Required:

STAGE 1 — **Does the person have an impairment of, or disturbance in the function of the mind or brain?** YES ☐ NO ☐

If yes, details:

If 'No' the patient cannot be deemed to lack capacity

STAGE 2: Due to the condition above, can the person: YES NO

1. Understand information about the decision? ☐ ☐
2. Retain and recall the information discussed? ☐ ☐
3. Weigh up that information to come to a decision? ☐ ☐
4. Communicate their decision via any means? ☐ ☐

If no to any, details: *(continue in clinical notes if required)*

How has the person been helped to try and make a decision themselves?

This person **does** ☐ **does not** ☐ have capacity to make the decision at this time *(tick as appropriate)*

This is likely to be: **Permanent** ☐ **Temporary** ☐ **Fluctuating** ☐

Name	Signature	Grade	Date	Time

BEST INTERESTS DECISIONS: DOCUMENTATION PROMPTS

***Summary only*: provide further information in clinical notes of relevant discussions**

- Decision Maker (name/role); .....
- Decision to be made: .....
- Can the decision be delayed until person regains capacity? Yes / No
- Person's past and present wishes and feelings:
- Views of family/relevant others about the person's best interests, wishes, feelings beliefs and values (IMCA where appropriate):
- Different viewpoints/disagreements:
- Realistic options available:
- Balance of risks/benefits of any options, including consideration of least restrictive approach *(continue in notes if needed)*:
- Final decision: .....

Appendix B – Deprivation of Liberty Safeguards (DoLS) Form 1*This document has 7 pages – it can be accessed by double-clicking the form below or found on the Safeguarding Team Intranet page*

adass adult social services

Department of Health

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**			
Request a **Standard Authorisation** only (*you DO NOT need to complete pages 6 or 7*)			
Grant an **Urgent Authorisation** (*please ALSO complete pages 6 and 7 if appropriate/required*)			
Full name of person being deprived of liberty		Sex	
Date of Birth *(or estimated age if unknown)*		Est. Age	
Relevant Medical History (*including diagnosis of mental disorder if known*)			
Sensory Loss		Communication Requirements	
Name and address of the care home or hospital requesting this authorisation			
Telephone Number			
Person to contact at the care home or hospital, (including ward details if appropriate)	Name		
	Telephone		
	Email		
	Ward (if appropriate)		
Usual address of the person, (if different to above)			
Telephone Number			
Name of the Supervisory Body where this form is being sent			
How the care is funded	Local Authority *please specify*		
	NHS	Local Authority and NHS (jointly funded)	
	Self-funded by person	Funded through insurance or other	

March 2015 – V4 - Final | Deprivation of Liberty Safeguards Form 1 Standard and Urgent Authorisation Request | Page 1 of 7

Appendix C – Equality Impact Assessment

Policy or function being assessed: Deprivation of Liberty Safeguards Policy
Department/Service: Safeguarding
Assessment completed by: Kelly Boyce, Head of Safeguarding (Interim)
Date of assessment: February 2022

1.	Describe the aim, objective and purpose of this policy or function.		To inform staff about the deprivation of liberty safeguards and instruct them on the procedure to follow in order to obtain authorisation for a DOL	
2i.	Who is intended to benefit from the policy or function?		**Staff X** **Patients X** **Public ☐** **Organisation X**	
2ii	How are they likely to benefit?		The Policy ensures that the application of MCA 2005 and Deprivation of Liberty conforms with legislation..	
2iii	What outcomes are wanted from this policy or function?		A clear understanding of MCA 2005 and what a DOL may be, and the procedure to follow should a DOL be considered for a Trust Patient.	
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).	**Y**		The policy has the potential to detrimentally affect the liberty of any patient who meets the eligibility criteria but particularly those with learning disabilities or cognitive impairment.
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
14.	**Specific Issues Identified**			

	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment	Page/paragraph/section of policy/function that the issue relates to
	1. INSERT HERE	**1.**
	2. INSERT HERE	**2**
	3. INSERT HERE	**3**

15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	**N/A**	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?		**N**
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?		**N**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Paul Morris **Title:** Director of Nursing **Date:** February 2022 **Name of Policy/function Author:** Kelly Boyce **Title:** Head of Safeguarding (Interim) **Date:** February 2022 (A paper copy of the EIA which has been signed is available on request).		
18.	**Proposed Date for Policy/Function Review**		
	Please detail the date for policy/function review (3 yearly): February 2025		
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the*		

	Trust's website).
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑