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Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

# NHS Bristol, North Somerset and South Gloucestershire ICB Mental Capacity Act and Deprivation of Liberty Policy

| Complete the blank cells in the table below. The rest will be added by the corporate team once the policy approved and before it is added to the website. | |
|---|---|
| **Policy ref no:** | 16 |
| **Responsible Executive Director:** | Rosi Shepherd, Chief Nursing Officer |
| **Author and Job Title:** | Johnson Koikkara, Senior MCA and DoLS Manager |
| **Date Approved:** | 28/05/2026 |
| **Approved by:** | Shane Devlin, Chief Executive |
| **Date of next review:** | May 2028 |

## Policy Review Checklist

| | Yes/No/NA | Supporting information |
|---|---|---|
| Has an EHIA Screening been completed? | No | No |
| Has the review taken account of latest Guidance/Legislation? | Yes | |
| Has legal advice been sought? | No | |
| Has HR been consulted? | N/A | |
| Have training issues been addressed? | Yes | |
| Are there other HR related issues that need to be considered? | No | |
| Has the policy been reviewed by Staff Partnership Forum? | N/A | |
| Are there financial issues and have they been addressed? | N/A | |
| What engagement has there been with patients/members of the public in preparing this policy? | N/A | |
| Are there linked policies and procedures? | Yes | • Safeguarding Adults and Children's Policy<br>• Human Rights (HRA) 1998<br>• Mental Capacity Act (MCA) 2005<br>• Disability Discrimination Acts (DDA) 1995 and 2005<br>Equality Act (EA) 2010 |
| Has the lead Executive Director approved the policy? | | Executive Lead Safeguarding - CNO |
| Which Committees have assured the policy? | | • Discussed at Safeguarding Governance Group.<br>• Discussed at Funded Care Delivery Group<br>• Approved by the Outcomes, Quality and Performance Committee on 26 February 2026 |

| | Yes/No/NA | Supporting information |
|---|---|---|
| Has an implementation plan been provided? | | Monitored by:<br>• Internal Audit<br>• Through 1:1 supervision<br>• Stat Man training |
| How will the policy be shared with staff? | | Through directorate meeting and via Hub and The Voice |
| Will an audit trail demonstrating receipt of policy by staff be required; how will this be done? | | Line managers to ensure this through 1:1 supervision |
| Has a DPIA been considered in regards to this policy? | N/A | |
| Have Data Protection implications have been considered? | Yes | Via Corporate Policy Review Group |

| Version | Date | Consultation |
|---|---|---|
| | | |

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# BNSSG ICB MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY POLICY

## 1. INTRODUCTION

The Mental Capacity Act 2005 (MCA 2005) safeguards the rights of individuals to make their own decisions and establishes a legal framework for those who lack capacity due to impairment of the mind or brain. Applicable to individuals aged 16 and over in England and Wales, the MCA also enables adults to plan for potential future incapacity through mechanisms such as lasting powers of attorney and advance decisions to refuse treatment.

The MCA establishes a statutory framework and responsibilities applicable to all individuals involved in the care, treatment, or support of people aged 16 and over in England and Wales who may be unable to make some or all decisions for themselves. Everyone working with or caring for individuals who may lack capacity must comply fully with the MCA, regardless of whether the decision concerns a life-changing matter or an everyday issue.

The MCA is supported by a statutory Code of Practice, which health and social care staff must consider when supporting individuals who may lack capacity to consent to care or treatment. Additionally, the MCA introduced Independent Mental Capacity Advocates (IMCAs) to provide independent representation in specific circumstances.

The MCA was amended by the Mental Health Act 2007 to introduce the Deprivation of Liberty Safeguards (DoLS), implemented in 2009, to ensure lawful detention in care homes and hospitals for those lacking capacity to consent to their care or treatment. These safeguards include a right of appeal, independent assessments, and advocacy.

**DoLS are set to be replaced by the Liberty Protection Safeguards (LPS) following the enactment of the Mental Capacity (Amendment) Act 2019. However, implementation has been delayed beyond the originally planned date of April 2022. The introduction of the LPS will prompt a further review of this policy once the LPS have been implemented.**

Deprivation of liberty can occur in any setting. Where an individual lacking capacity requires detention outside a registered care home or hospital, authorisation must be sought from the Court of Protection until LPS is enacted.

The MCA also introduced safeguards against abuse, including the offence of wilful neglect or ill-treatment of a person lacking capacity under section 44. In accordance with the Act, there is a presumption of capacity unless an assessment determines otherwise. Individuals with capacity retain the right to make their own decisions, even where those decisions may be considered unwise by professionals.

The MCA plays a critical role in quality improvement, patient involvement, and empowerment. BNSSG ICB has a duty to commission services that uphold the rights of individuals, particularly those who are vulnerable due to their inability to make decisions independently.

This policy supports BNSSG ICB colleagues in understanding and applying the MCA and DoL in practice, ensuring compliance with statutory responsibilities under the Human Rights Act 1998. Given that the Deprivation of Liberty Safeguards Code of Practice (2008) has largely been surpassed by case law, colleagues should, in the first instance, seek additional guidance from their line manager or supervisor, and escalate to senior managers if required.

This policy outlines the key provisions of the MCA and sets out the steps that relevant staff in the health and social care sector should take when assessing an individual's capacity to make decisions. It will be subject to regular review by the MCA and DOLS Lead as and when required to incorporate amendments arising from:

- The Mental Health Act 1983 and related case law
- Case law affecting the interpretation and application of the Mental Capacity Act and Deprivation of Liberty
- Data Protection Act 2018 (UK General Data Protection Regulation – GDPR)
- The Human Rights Act 1998
- The Children Acts 1989 and 2004
- The Human Tissue Act 1998

- The Deprivation of Liberty Safeguards 2008
- The Care Act 2014

This policy outlines how BNSSG ICB will effectively fulfil its duties and responsibilities:

a) Within its own organisation, including Continuing and Complex Healthcare
b) Across the local health economy, ensuring compliance with its Mental Capacity Act obligations through its commissioning arrangements.

## 2. BNSSG ICB VALUES

The Mental Capacity Act and Deprivation of Liberty Policy sets out the ICB's commitment to compliance with the Mental Capacity Act 2005, the Deprivation of Liberty framework, and relevant legislation and case law. It reflects the ICB's dedication to upholding statutory duties within the legal framework governing mental capacity and deprivation of liberty, ensuring best practice and excellence in implementation. It supports the ICB doing the right thing and acting with integrity.

## 3. PURPOSE AND SCOPE

### 3.1. Purpose

The primary objectives of this policy are to:

- Provide clear guidance to the ICB workforce on assessing mental capacity and determining when formal assessments are required.
- Outline procedures to safeguard individuals who lack capacity to consent to their care and accommodation arrangements, ensuring compliance with statutory duties related to deprivation of liberty.
- Ensure that all healthcare providers commissioned by BNSSG ICB comply with the MCA.

The ICB has a duty to commission high-quality care while ensuring providers understand and adhere to the legal requirements of the MCA, Deprivation of Liberty Safeguards (DoLS), and other statutory frameworks.

### 3.2. Scope

This policy applies to all individuals in a paid, professional, or voluntary capacity who are involved in the care, treatment, or support of people aged 16 and over within BNSSG ICB. This includes staff directly employed by the ICB, those seconded to the organisation, individuals working in partnership with the ICB, and volunteers operating within its remit.

This policy provides directions to staff on assessing mental capacity and ensuring compliance with statutory obligations, particularly in relation to patient care, interactions with families and carers, and the commissioning of NHS Funded Care. Where services are commissioned jointly, the individual responsible for the case within the ICB shall inform other commissioners of any non-compliance with the MCA.

The ICB remains committed to ensuring that individuals and their families receive care that respects dignity, autonomy, and legal safeguards. This policy is intended as a supplementary guide; staff should also refer to the MCA Code of Practice (2007) and the DoLS Code of Practice (2008) to ensure best practice.

### 3.3. People Covered by the MCA 2005

Under the MCA 2005, which applies to individuals aged 16 and over, mental capacity refers to a person's ability to make decisions independently. Capacity can fluctuate over time and vary depending on the complexity of the decision. A lack of capacity may result from a **permanent, temporary, or fluctuating condition**.

The MCA is designed to apply in situations where a person is unable to make a decision due to an impairment affecting their **mind or brain**, whether caused by illness, disability, or the effects of drugs or alcohol. A lack of mental capacity may arise from:

- Stroke or brain injury
- Mental health conditions
- Dementia

- Learning disability
- Physical or mental conditions leading to confusion, drowsiness, or loss of consciousness, including delirium, concussion, and the long-term effects of brain damage
- Alcohol or drug use

## 4. DUTIES - LEGAL AND POLICY FRAMEWORK FOR THIS POLICY

This policy is informed by key **legal and national guidelines** (not an exhaustive list), including:

a) **Mental Capacity Act (MCA) 2005 and its Code of Practice**
   - Ensuring compliance with MCA provisions for individuals aged 16 and over.

b) **Deprivation of Liberty Safeguards (DoLS) Framework and Code of Practice**
   - DOLS was introduced in April 2009 to prevent arbitrary decisions regarding care and treatment for individuals lacking capacity in hospitals and care homes.
   - Care must always be delivered in the least restrictive manner. Where deprivation of liberty is deemed necessary and, in a person's, best interests, applications must be made to the Supervisory Body (see definitions/explanations of terms used).
   - In supported living environments and individuals living in their own homes, a deprivation of liberty requires an application to the Court of Protection. If the ICB funds a person's care arrangements through Funded Care, it must initiate this process.

c) **The Children Act (1989 & 2004) and Mental Capacity Considerations**
   - The Children Act 1989 governs the care and welfare of children but does not explicitly address deprivation of liberty.
   - The Mental Capacity Act (MCA) applies to children under 16 in two ways:
     - The Court of Protection can decide on property and financial affairs if the child is likely to lack capacity at 16.
     - The criminal offence of ill-treatment or neglect applies to children who lack capacity.

- The Court of Protection may appoint a deputy for property or finances where a child's capacity is likely to remain impaired upon turning 18.

- Case law around consent and capacity of children under the age of 16 continues to evolve, especially around deprivation of liberty, parental responsibility, and information sharing. It is good practice for practitioners to seek advice from line managers when dealing with complex or borderline cases.

**d) Human Rights Act 1998**

**e) Supreme Court Ruling on Deprivation of Liberty – *Cheshire West* (2014)**

- Established the acid test for deprivation of liberty:
  - Is the person free to leave (regardless of consent)?
  - Are they subject to continuous supervision and control?

**f) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022)**

**g) National Framework for Children and Young People's Continuing Care (2016)**

- Where a 16- or 17-year-old lacks capacity and meets the acid test for deprivation of liberty, court authorisation is required. In *Re D [2019] UKSC 42,* the Supreme Court clarified that parental responsibility does not extend to authorising a deprivation of liberty for a 16- or 17-year-old child who lacks capacity.

**h) NHS England: Commissioning for Compliance with the MCA (2014)**

- NHS England published guidance stating that:
  - ICBs (formerly CCGs) are responsible for commissioning high-quality care and treatment.
  - Providers must understand, apply, and monitor compliance with the MCA across all commissioned services.
  - The ICB must ensure compliance for individuals aged 16 and over in services it commissions.

**i) Mental Capacity (Amendment) Act 2019**

- Introduces the Liberty Protection Safeguards (LPS), intended to replace DoLS, though implementation has been delayed.

# 5. RESPONSIBILITIES AND ACCOUNTABILITIES

## 5.1. Chief Executive Officer

The Chief Executive Officer (CEO) holds ultimate accountability for the strategic direction and operational management of BNSSG ICB, ensuring compliance with all legal, statutory, and policy requirements. The CEO is responsible for ensuring that all services commissioned by the ICB comply with the MCA 2005. The CEO is responsible for meeting all statutory obligations and implementing guidance issued by the Department of Health and Social Care (DHSC) concerning the MCA 2005, ensuring its effective application across commissioned services.

The CEO is accountable for ensuring that the health system's contribution to safeguarding, including MCA and DoL matters, is effectively discharged across the local health economy through ICB commissioning arrangements. This responsibility is supported by the Chief Nursing Officer (CNO), who holds delegated authority and serves as the Executive Lead for Safeguarding.

## 5.2. Policy Sponsor

The CNO is responsible for:

- Ensuring that the policy is appropriate for consideration and approval.
- Endorsing the policy prior to its submission for approval.
- Working alongside the Policy Lead to maintain and update procedures, protocols, and other supporting documents related to this policy.
- Ensuring that the necessary resources are deployed to meet the needs of this policy and the ICB's obligations.

## 5.3. ICB Senior MCA and DoLS manager

The Senior MCA and DoLS manager is the named MCA Lead within the ICB. It is the responsibility of the Senior MCA and DoLS manager to work with others in the ICB to ensure BNSSG ICB upholds its statutory duties in relation to the Mental Capacity Act and associated code of practice. The ICB Senior MCA and DoLS manager is the author and policy lead. It is the responsibility of the Policy Lead/author to:

- Ensure, as far as possible, that the policy aligns with Department of Health and Social Care guidance, legal requirements, and clinical body recommendations.
- Complete an Equality and Health Inequalities Impact Assessment (EHIA) and Implementation Plan, where required.
- Undertake a fair and proportionate consultation period with relevant stakeholders as part of the document's development.
- Ensure the policy aligns with BNSSG ICB's strategy and values.
- Ensure the policy is developed, approved, disseminated, and monitored as set out in the document.
- Work alongside Policy Sponsors to maintain and update procedures, protocols, and other supporting documents related to this policy.
- Arrange necessary training and review standard forms, guidance documents, and professional development opportunities as required.

### 5.4. Head of Safeguarding

The Senior MCA and DoLS manager is accountable to the ICB Head of Safeguarding, who is responsible for the overall provision of advice and training and the arrangements for line managers to take the necessary steps to comply with their responsibilities.

The Head of Safeguarding (All Age) provides leadership and support across the broad MCA/DoL agenda across the ICB. Therefore, with the support of the ICB Safeguarding team, this postholder will also lead the implementation of this policy. This post holder will also have oversight of the ICB MCA/DoL training compliance for the organisation and be responsible for training provision. The Head of Safeguarding with their team will ensure liaison with wider ICB and ICS groups responsible for commissioning and assuring the safe delivery of services for adults and children to support effective strategic decision making, using a safeguarding lens.

### 5.5. Line Managers

Line managers are responsible for ensuring that their staff comply with BNSSG ICB's policies and standards within their areas of responsibility. For specific staff, including those who work in patient facing services, this may include case discussions, supporting access to the Care

Discussion Forum, formerly known as Care Assurance Panel, Care Commissioning Panel and one to one supervision.

Line managers are also responsible for ensuring practitioners remain up to date with training and adhere to professional standards.

### 5.6. Commissioning and contract managers

Commissioners and contract managers, when commissioning and contracting services, must ensure that service specifications and contracts are aligned with the principles of the MCA 2005 and the deprivation of liberty framework relevant to the service. As the strategic commissioner of health services, the ICB must ensure that all health organisations with which it has commissioning arrangements or contracts have robust policies and effective measures in place to comply with statutory responsibilities under the MCA and DoL frameworks, in line with the evolving legal landscape.

All contracts for the delivery of healthcare must include clear standards for implementing the MCA 2005 and relevant deprivation of liberty framework, and these standards must be monitored to provide assurance that the legal framework is being correctly applied. Where uncertainty arises, commissioning staff should consult the safeguarding team and/or the MCA Lead to uphold the rights of individuals who may lack capacity to make specific decisions.

**All Staff**

All BNSSG ICB staff have a duty to comply with this policy, as outlined in their contracts of employment and any professional codes of conduct. All ICB employees are responsible for upholding the principles of the MCA 2005 and fulfilling their obligations regarding any deprivation of liberty. Professionally qualified staff have additional responsibilities to ensure their learning and development concerning the MCA and DoL remains up to date.

Individuals participating in panels responsible for approving care funding must be able to identify potential deprivation of liberty and seek or provide assurance that appropriate legal and procedural safeguards have been followed in each case.

## 6. DEFINITIONS/EXPLANATIONS OF TERMS USED

**Mental Capacity**: A person's ability to make a particular decision at a particular time.

**Lack of capacity: ‘**a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain’. Capacity is both time and decision specific, there is no such thing as global lack of capacity.

**Advance Decision**: When an individual has capacity to make a decision, they may choose to refuse specific treatments should they lack capacity at a later point. If an Advance Decision relates to life-sustaining treatment, such as resuscitation, it must be in writing and should ideally be witnessed by a carer or relative. Where this is not appropriate, an advocate or an independent third party may act as a witness.

**Advance Statement**: An advance statement outlines an individual’s wishes and feelings should they lack capacity in the future; however, it is not legally binding.

**Best Interests**: Any act done, or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the Mental Capacity Act sets out a non-exhaustive checklist.

**Care Home**: A care facility registered under the Care Standards Act 2000.

**Consent**: Agreeing to a course of action for example to a care plan or treatment. For consent to be legally binding the person giving must have capacity to make the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

**Decision Maker**: This is the person responsible for deciding what is in the best interests of a person who lacks capacity. This could be a professional, family member, carer, or close friend, depending on the decision that needs to be made.

**Deputy**: Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.

**European Convention on Human Rights (ECHR)**: A convention drawn up within the Council of Europe setting out a number of civil and political rights and freedoms, and setting up mechanism for the enforcement of the obligations entered into by contracting states.

**Independent Mental Capacity Advocate (IMCA)**: This is a person who supports and represents a person who lacks capacity and where that person only has paid staff to speak on their behalf them.

**Lasting Power of Attorney (LPA)**: This is a power of attorney created under the Mental Capacity Act 2005. It enables a person (the donor) with capacity to appoint another person to act on their behalf (the donee) in relation to decisions about the donor's financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used.

**Liberty Protection Safeguards (LPS)**: LPS is the proposed replacement for the Deprivation of Liberty Safeguards (DoLS), enacted through the Mental Capacity (Amendment) Act 2019. It is designed to streamline and simplify the process of authorising deprivations of liberty for individuals who lack capacity to consent to their care arrangements.

**Life sustaining treatment**: Treatment, in the view of the person providing healthcare, is necessary to keep a person alive.

**Managing Authority**: The person or body with management responsibility for the hospital or care facility in which a person is or may become deprived of their liberty.

**Office of the Public Guardian**: The Office of the Public Guardian is a government body that polices the activities of deputies, attorneys and guardians who act on behalf of people who lack the mental capacity for making decisions about finances, health and welfare.

**Restriction/Restraint**: The MCA 2005 defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement, whether or not the person resists.

**Supervisory Body**: A local authority, that is responsible for considering applications under the DoLS process, commissioning the assessments, and where all the assessments agree, authorising deprivation of liberty.

# 7. APPLYING THE MENTAL CAPACITY ACT

## 7.1. Consent to care and treatment:

Obtaining informed consent for care and treatment is a fundamental legal and professional obligation for health and social care practitioners and a crucial safeguard of individuals' human rights. Ensuring informed consent is often complex, and individuals may require tailored support to facilitate decision-making. This may include accessible communication methods, additional time to process information, or involvement from advocates, family members, or professionals.

## 7.2. The Principles of the Act

The MCA is underpinned by five statutory principles:

- **Presumption of capacity** – Under the MCA, anyone aged 16 or over is presumed to have the capacity to make their own decisions unless proven otherwise. If there is reason to doubt a person's ability to make a decision, or if their capacity has been called into question, an assessment is expected. The burden of proving a lack of capacity rests with the individual seeking to make a decision on their behalf, and the standard of proof is on the balance of probabilities.
- **Supported decision-making** – Individuals have the right to receive all practicable support in making decisions before being deemed unable to do so. Practicable steps may include providing information in accessible formats, repetition of key details, allowing time for processing, using simple language or visual aids, seeking input from a speech and language therapist, or involving family, friends, or an advocate.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- **Best interests** – Any action or decision made on behalf of someone who lacks capacity must be in their best interests.
- **Least restrictive intervention** – Any intervention must be the least restrictive of the individual's rights and freedoms.

## 7.3. When is a Mental Capacity Act assessment needed?

A Mental Capacity Act assessment is required when there is reason to believe an individual may lack the capacity to make a specific decision at a particular time. It should be conducted when:

- There is doubt about capacity – if an individual's ability to make a decision is called into question due to illness, disability, or fluctuating conditions.
- A significant decision needs to be made – particularly in relation to healthcare, welfare, financial matters, or legal arrangements.
- Capacity appears inconsistent – if the person can make some decisions but struggles with others, or if their ability to decide fluctuates over time.
- Concerns are raised by professionals or family – if carers, healthcare providers, or social workers have concerns about the individual's ability to understand, retain, weigh up, or communicate their decision.
- The individual is making a decision that seems uncharacteristically risky or irrational – while individuals are entitled to make unwise decisions, an assessment may be needed if there are concerns about whether they fully understand the implications.
- The person has a condition affecting cognitive function – such as dementia, a brain injury, learning disability, or the effects of medication, drugs, or alcohol.
- There are legal or safeguarding implications – if the decision relates to areas such as deprivation of liberty, consent to serious medical treatment, or financial affairs requiring Court of Protection intervention.

Capacity assessments determine a person's ability to make a specific decision at a particular moment in time; they are not a blanket judgment on the individual's overall ability.

## 7.4. When an urgent decision needs to be made

When an urgent decision is required, the individual's capacity to make the decision and their best interests must be assessed and clearly documented as soon as possible after the delivery of necessary care and treatment. Efforts should be made to keep the individual as informed as possible throughout the process, where appropriate.

The person responsible for arranging care, support, or treatment may proceed with the intervention if they reasonably believe the individual lacks capacity to consent and that it is in their best interests. The priority is to take immediate action to prevent serious harm and stabilise the individual beyond the point of crisis.

### 7.5. When the decision is not urgent

If the individual is likely to regain capacity, the decision should be delayed until they are able to make it for themselves.

### 7.6. Who should assess mental capacity?

Under the Mental Capacity Act 2005, capacity assessments may be conducted by any appropriate person following statutory criteria, rather than solely by psychiatrists or medical doctors. Typically, the assessment is carried out by the individual most directly involved at the time the decision needs to be made, particularly for routine day to day decisions or by the professional responsible for the proposed intervention.

As a result, different professionals may assess an individual's capacity for different decisions at different times. The determination of the most suitable assessor depends on the nature of the decision. For more complex decisions, specialist professionals may need to be involved in capacity assessments to ensure all relevant information, including risks and benefits, is properly explained in accordance with Principle 2 of MCA 2005. For example, the involvement of a Speech and Language Therapist or dietitian may be necessary to assess the risks and benefits of a particular decision.

The MCA 2005 is designed to empower health and social care professionals to conduct capacity assessments themselves, rather than relying on expert evaluations by psychiatrists or psychologists except in complex cases. Other factors indicating the need for additional professional involvement include:

- The gravity of the decision or its consequences.
- Disputes regarding a finding of incapacity.
- Disagreements between family members, carers, and/or professionals about an individual's capacity.

- Situations in which the individual expresses differing views to different people, potentially in an attempt to please them.
- Concerns about undue pressure or coercion affecting the individual or those around them.
- Potential legal consequences arising from a determination of incapacity.

### 7.7. Assessing Capacity – two stage test

When there is reason to question an individual's capacity to make a specific decision, a two-stage capacity assessment should be conducted. There must be a clear link between the diagnostic test and the functional assessment of the individual's ability or inability to make the decision.

### 7.8. The functional test -stage 1

An individual is considered unable to make a decision if they are assessed as being incapable of performing any of the following due to an impairment or disturbance in the functioning of their mind or brain:

**1. Understand the information relevant to the decision**

- Clearly define the decision to be made.
- Identify what constitutes "relevant" information, this includes the nature of the decision, the rationale for it, potential consequences of different choices, and the implications of making no decision at all.
- The person does not need to grasp every detail but must understand the key aspects of the decision.
- Assess understanding only after providing the necessary information in a clear and accessible manner, possibly requiring multiple explanations or alternative formats such as visual cues.
- Use concrete questions to test comprehension rather than subjective inquiries (e.g., "How do you feel about living here?").
- Ensure the person feels able to express uncertainty (e.g., saying, "I don't know" or "I'm not sure").
- Encourage them to provide a general explanation of what has been discussed.

- If responses are limited to “yes” or “no,” rephrase the question to verify genuine understanding rather than repetition.

**2. Retain the information**

- The person must retain information long enough to consider and process it for decision-making.
- The required duration will depend on the nature of the decision.
- Spontaneous recall is not necessary, nor is long-term retention beyond the point of decision-making—though this may have practical implications.

**3. Use or weigh the information as part of the decision-making process**

- Engage the individual in discussions about what matters most to them and how they reached their conclusion.
- Recognize that different individuals may prioritize different factors (e.g., valuing independence over physical safety).
- The MCA does not assess “lack of insight” as a criterion, and this term does not feature in the functional test or the Code of Practice.

**4. Communicate their decision**

- The individual must be able to communicate their choice in any form.

### 7.9. The diagnostic test – stage 2

**Does the person have an impairment of, or a disturbance in, the functioning of their mind or brain?**

- If *No*, the person **cannot** be deemed as lacking capacity.
- If *Yes*, the assessor must then establish whether the individual's inability to make the specific decision is caused by this impairment or disturbance.
- If the answer to this second question is *Yes*, the person **lacks capacity** to make this particular decision **at this point in time**.

Anyone asserting that an individual lacks capacity the Act must demonstrate, on the balance of probabilities, that the individual is unable to make the specific decision at the time it is required. This means proving it is more likely than not that they lack capacity to make that decision.

## 7.10. Supporting the person to make their own decisions

When supporting an individual in making a decision, consideration should be given to the following key points. The individual must be provided with all relevant information, including the risks, benefits, and consequences of the decision. The information should be tailored to their needs, striking a balance between providing enough detail to make an informed choice and avoiding excessive complexity that could cause confusion.

Under the presumption of capacity, those working with the individual must assume they have the ability to make their own decisions. Before concluding that someone lacks capacity, the assessor must take all practicable steps to support them in making the decision themselves. This includes addressing the following considerations:

- Has the individual been provided with all necessary information, including the risks, benefits, and consequences of the decision?
- Can the information be presented in a clearer or more accessible format to aid understanding?
- Are there optimal times of day or specific locations where the individual's comprehension and comfort are improved?
- Is it possible to postpone the decision to provide the individual with optimal conditions for decision-making?
- Can others assist the individual in making choices or expressing their views, such as an independent advocate, family member, or communication support professional?

## 7.11. Recording Assessments of Capacity

Comprehensive documentation must be completed for all capacity assessments and best interests decisions to ensure these comply with the requirements of the MCA. It is not sufficient to simply capture in the person's casenotes that they lack capacity to consent to their care and support and there was broad discussion about what might be in their best interest.

For serious decisions where an individual may lack mental capacity, formal documentation is essential, particularly when there is potential for legal challenge. Evidence of the assessment must be clearly recorded in the individual's records, including concerns regarding the

individual's ability to consent or refuse care and support or a specific act or circumstances requiring a formal mental capacity assessment, such as:

- Decisions involving serious medical treatment or care and support needs
- Long-term accommodation changes
- Covert medication
- Clinically Assisted Nutrition and Hydration (CANH), e.g. PEG feed, medication etc
- Measures involving restrictions around contact, use of mobile phones, social media or internet
- Use of restraints
- When there are conflicting opinions between professionals, carers, or the individual about capacity
- Significant differences of opinion about the decision to be made

If the capacity assessment confirms that the individual has capacity, their care or treatment must be authorised through their informed consent, and a statement acknowledging this must be recorded in their case notes.

The Mental Capacity Assessment form template is available in Appendix 1, while the Best Interest template for BNSSG ICB decisions can be found in Appendix 2.

### 7.12. Reviewing mental capacity assessments

Decision-making abilities can improve over time, so regular reviews of mental capacity are essential. Capacity must be reviewed:

- During the development or review of a care plan
- At relevant stages within the care planning process
- Whenever a significant decision needs to be made or when the circumstances of the person changes.

These reviews ensure that care, support, and treatment are provided lawfully and in accordance with an individual's current capacity. If the person's condition remains unchanged, and the original capacity assessment remains valid for the specific decision, the care plan should reflect this accordingly.

### 7.13. Making Best Interest Decisions

Under the MCA 2005, if an individual is assessed as lacking capacity, any act or decision made on their behalf must be in their best interests. This applies regardless of whether the decision-maker is a family carer, paid care worker, attorney, court-appointed deputy, or healthcare professional.

As long as decisions or actions are made in the individual's best interests, whether relating to care, treatment, or other matters, the decision-maker or carer is legally protected from liability. Where such determinations on capacity and best interests are carried out an ICB employee, it is expected that they will be evidenced by appropriate documentation.

### 7.14. Exceptions to the Best Interests Principle

Certain circumstances override the general principle, including:

- Advance decisions to refuse treatment
- Specific cases involving research participation by individuals lacking capacity

Beyond these exceptions, the fundamental requirement remains: all acts and decisions must be made in the best interests of the individual who lacks capacity.

### 7.15. Determining Best Interests

Assessing what is in a person's best interests can be complex. The MCA 2005 requires decision-makers to follow specific steps when determining whether an act or decision serves the individual's best interests.

In cases where disagreements arise, as long as the decision-maker follows the correct process for assessing capacity and has taken all reasonable steps to establish the individual's best interests, legal protection should apply.

### 7.16. Best interest checklist and considerations

Section 4 of the MCA 2005 provides a checklist of factors to be considered when making a best interests decision for an individual lacking capacity. While this checklist serves as the foundation, additional individual factors may also be relevant.

**Steps to Determine Best Interests**

A person assessing best interests should:

1. Encourage Participation
    - Take all practicable steps to enable and encourage the individual to take part in the decision-making process.
2. Identify All Relevant Circumstances
    - Consider the factors the individual would have considered if they were making the decision themselves.
3. Understand the Individual's Views
    - Take into account:
        - Past and present wishes and feelings expressed verbally, in writing, or through behaviours.
        - Beliefs and values, including religious, cultural, moral, or political considerations that may influence the decision.
        - Other relevant factors they would consider if able to decide for themselves.
4. Avoid Assumptions
    - Do not assume best interests based on age, appearance, condition, or behaviour.
5. Assess Potential for Regaining Capacity
    - Consider whether the individual is likely to regain capacity (e.g., following medical treatment) and whether the decision can wait until then.
6. Decisions on Life-Sustaining Treatment
    - The decision must not be motivated by a desire to bring about the person's death.
    - Avoid assumptions about their quality of life.

Additional Considerations

When making a best interests determination, the decision-maker must:

- Review relevant written statements made when the individual had capacity.
- Determine the need for an Independent Mental Capacity Advocate (IMCA) in significant decisions, such as serious medical treatment or accommodation changes.

- Consult others involved in the individual's welfare, including:
  - Anyone the individual has named to be consulted
  - Carers, close relatives, and friends
  - Attorneys appointed under a Lasting Power of Attorney
  - Court-appointed deputies under the Court of Protection

A best interest determination must not be merely on the basis of:

- The individual's age or appearance
- A condition or aspect of their behaviour that could lead to unjustified assumptions about what might be in their best interests.

## 7.17. Decision maker

Under the MCA 2005, various individuals may be required to make decisions or act on behalf of someone lacking capacity to make a particular decision themselves. The person responsible for making the decision is known as the decision-maker, and they must ensure the decision is made in the individual's best interests.

**Identifying the Decision-Maker**

Careful consideration must be given to who holds this responsibility:

- If an attorney has been appointed under a Lasting Power of Attorney (LPA) to make such decisions, they will take on this role.
- If a Court of Protection-appointed deputy has the authority to make welfare decisions, they will act as the decision-maker.
- In the absence of a deputy or attorney, the decision-maker will be the person responsible for carrying out the proposed act of care or treatment.
- Under the MCA 2005, individuals can make an Advance Decision to Refuse Treatment (ADRT), which is a legally binding statement setting out specific treatments they wish to refuse should they later lose capacity to decide for themselves. If an ADRT is valid and applicable, healthcare professionals must respect the individual's decision, meaning no other decision-maker (such as a deputy, attorney, or clinician) can override it.

### 7.18. Disputes

Disagreements may arise regarding what constitutes best interests for an individual lacking capacity, such as conflicts between professionals and family members. Where disputes occur, staff should first seek local resolution using the following approaches:

- Involve an independent advocate to provide impartial support.
- Seek a second opinion on capacity and/or best interests.
- Hold a strategy meeting with all relevant parties.
- Consider mediation as a means of achieving consensus.
- Escalation to Legal Advice
- Ensure clarity of documentation and process at all points of contact, maintaining a comprehensive audit trail.

If local resolution is not possible despite all reasonable efforts by the decision-maker, discussions should take place with line management to determine whether legal advice is required. The Court of Protection has jurisdiction to resolve disputes related to capacity and best interests, and an application may be necessary in some cases to achieve resolution.

### 7.19. How to document a best interest decision

Best interests decisions must be appropriately recorded using the Best Interest Decision recording template as seen in Appendix 2. While it is not always necessary to hold a formal Best Interests Meeting, the decision must always be documented to ensure clarity, accountability, and compliance with the MCA 2005. Where competing rights or complex issues are involved, it is advisable for the decision-maker to complete a Welfare Balance Sheet, as outlined in Appendix 3.

### 7.20. Care and Treatment: Section 5 and Best Interests Decision-Making

Under Section 5 of the MCA 2005, carers, healthcare professionals, and social care staff are granted protection from liability when carrying out necessary actions in connection with care or treatment for individuals lacking capacity. These acts must be undertaken in the individual's best interests, ensuring that interventions comply with legal and ethical principles. While Section 5 provides a framework for lawful action, it should not be relied upon in cases of disputes over capacity or best interests, where formal legal processes may be necessary.

**Best Interests Considerations in Care and Treatment**

Decisions regarding restrictions on mobile phones, internet, and social media, contact and correspondence, Clinically Assisted Nutrition and Hydration (CANH), Positive Behaviour Support Plans, and covert medication must align with the best interests framework, as reinforced by emerging case law. The MCA 2005 does not define "care" or "treatment," but case law has established principles governing how restrictions and interventions must be applied lawfully. Separate determinations on capacity and best interests are required for the following matters, in addition to the overall assessment of capacity and best interests regarding care, support, and/or residence matters (this list is not exhaustive):

- Restrictions on communication (phones, internet, social media, and correspondence) must be proportionate, justified by specific risks, and regularly reviewed to avoid unduly limiting autonomy.
- Restrictions on contact must be assessed case by case, considering potential risks while ensuring the individual's rights to family and social connections.
- CANH is a broad term referring to medical interventions that provide nutrition and fluids to individuals who cannot eat or drink normally. This can be delivered through various methods, including nasogastric tubes, intravenous hydration, and PEG feeding. CANH decisions require careful medical, ethical, and legal assessment and regular reviews, ensuring alignment with the individual's previously expressed wishes and quality of life considerations. Additionally, case law (*NHS NW London ICB v AB & Ors, [2024] EWCOP 62 (T3)*) reinforces that **ICBs must actively engage in CANH decisions rather than being passive bystanders**. The expectation is that the ICB ensure compliance with legal and ethical standards, facilitate multidisciplinary discussions, and support decision-making processes to safeguard the rights and interests of individuals lacking capacity. There is an expectation by the Court of Protection that there is:
    - Proactive and regular positive consideration of whether CANH is in a person's best interests where the person is in Prolonged Disorders of Consciousness (PDOC); and
    - Where the ICB is the commissioner of a placement/PoC, there is a positive duty on it to ensure that the above review is undertaken.

- Positive Behaviour Support Plans must prioritise the least restrictive approach, ensuring interventions are justifiable, necessary, and tailored to individual needs.
- Covert medication requires rigorous justification, with courts emphasising transparency, necessity, and safeguards to uphold human rights. All decisions concerning covert medication must adhere to the best interests framework under the MCA 2005, ensuring that interventions are proportionate, thoroughly assessed, and subject to regular review involving all interested parties to protect the individual's autonomy and dignity.

It is the responsibility of the relevant ICB case managers either to make best interests determinations on matters such as restrictions on mobile phone, internet, and social media use; contact and correspondence; Clinically Assisted Nutrition and Hydration (CANH); Positive Behaviour Support Plans; and covert medication, or to ensure that such determinations are made by the appropriate individuals. They must contribute to the best decision-making process on these matters and ensure that all such decisions are documented in writing. The case managers are also responsible for ensuring that these decisions are reviewed in line with the MCA 2005 and evolving case law, to confirm that they continue to reflect the person's wishes, feelings, and best interests.

**Applying Section 5 in Best Interests Decision-Making**

Actions related to personal care, mobility, communication, and medical interventions must be carried out in accordance with Section 5, but where a best interests decision involves complex restrictions, additional scrutiny is required. Multidisciplinary input, family consultation, and formal documentation are crucial, particularly where significant liberty-limiting measures are involved. Where disputes arise, decision-makers should seek local resolution, mediation, or legal guidance, including potential Court of Protection applications in complex cases.

## 7.21. Limitations of Protection from Liability

Professionals are protected from liability under Section 5 of the MCA 2005, provided they can demonstrate that:

- They have taken appropriate steps to assess capacity.
- They reasonably believe that the individual lacks capacity.

- They can evidence that a best interests assessment has been carried out and that the act is in the individual's best interests.

However, Section 5 does not provide a defence in cases of negligence, whether arising from acting improperly or failing to act where necessary.

Additionally, Section 6(5) clarifies that any act depriving a person of their liberty cannot benefit from protection under Section 5.

### 7.22. Enduring / Lasting Power of Attorney (LPA) and Court appointed deputies

A power of attorney is a person (donee) legally appointed by a donor to make decisions on their behalf. There are several types of power of attorney, so it is essential to confirm the specific type and request evidence of its validity.

Enduring Power of Attorney (EPA)

- EPAs were established before 2007 to enable attorneys to manage a donor's financial affairs.
- They remain valid if registered with the Office of the Public Guardian.
- Registration is required when the donor has lost or is losing capacity to make financial decisions.
- EPAs cannot be used while the donor retains mental capacity to make their own financial decisions.
- EPAs do not grant attorneys authority over health and welfare decisions.

**Lasting Power of Attorney (LPA)**

- Introduced under the MCA 2005, LPAs can be made by a person aged 18 or over while they retain capacity.
- LPAs must be registered with the Office of the Public Guardian before they can be used.
- LPAs can cover property and affairs, health and welfare, or both.
- Unless stated otherwise, a property and affairs LPA (once registered) can be used before the donor loses capacity for financial decisions.
- A health and welfare LPA (once registered) can only be used when the donor lacks capacity for a specific decision.

- The donor may place restrictions on a health and welfare LPA, particularly regarding life-sustaining treatment.
- A health and welfare LPA cannot override an advance decision made by the donor after the LPA was appointed.

**Court-Appointed Deputies**

- If a person no longer has capacity to appoint an LPA, the Court of Protection may appoint a deputy to make decisions.
- Deputies may be appointed for individual decisions, property and affairs, or health and welfare, subject to court-imposed limitations.
- Deputies are supervised by the Office of the Public Guardian.

**Responsibilities and Safeguards**

- Where an attorney or deputy is appointed for a relevant decision, they must determine what is in the person's best interests.
- LPAs must comply with the Code of Practice and act in the donor's best interests.
- Attorneys and deputies may consent on behalf of the individual in line with their appointed powers, but cannot consent to decisions that constitute a deprivation of liberty.

**Safeguarding and Disputes**

- If misuse of power by an attorney or deputy is suspected, safeguarding procedures should be followed.
- Concerns may also be referred to the Office of the Public Guardian, which can apply to the Court of Protection to remove an attorney or deputy.
- Disagreements between professionals and an LPA or deputy regarding best interest decisions do not always constitute a safeguarding concern.

## 7.23. Independent Mental Capacity Advocates (IMCA)

An Independent Mental Capacity Advocate (IMCA) is a statutory advocate appointed under the MCA 2005. An IMCA must be involved in certain serious best interests decisions when a person lacks capacity and has no appropriate unpaid person (such as a family member or friend) who is willing or able to be consulted.

Statutory IMCA involvement: An IMCA must be instructed for decisions relating to:

- Serious medical treatment provided by the NHS.
- Long-term moves into care settings (e.g. care homes or hospitals):
    - More than 28 days in a care home.
    - More than 8 weeks in hospital.

Discretionary IMCA involvement: An IMCA may be instructed at the discretion of the decision-maker for:

- Reviews of care or accommodation arrangements, particularly in cases involving ongoing or long-term care decisions.
- Adult safeguarding enquiries, even where family or friends are available, if they are not appropriate to consult.

The appropriateness of family or friends to be consulted must be considered carefully. If their involvement may be detrimental to the individual's welfare or they do not act in the person's best interests, they may be deemed inappropriate.

An IMCA would not usually be instructed:

- Solely due to disagreements about what is in a person's best interests.
- Merely because of disputes between professionals and family members.

IMCA involvement despite the presence of family/friends: An IMCA may still be instructed even where family or friends are involved, if:

- The person is subject to safeguarding investigations.
- The person is under a Deprivation of Liberty Safeguards (DoLS) authorisation.
- There is a need to support a DoLS representative.

**Role of IMCAs**

An IMCA does not make best interests decisions. Instead, they provide relevant information, represent the person's views and wishes, and support their rights in the decision-making process. If necessary, an IMCA can challenge decisions on the individual's behalf.

It is important to note that IMCAs are not mediators between conflicting parties. Their role is solely to represent the person who lacks capacity, ensuring that their rights, preferences and best interests are central to the decision-making process.

### 7.24. Excluded decisions

Under the MCA 2005 certain decisions are explicitly excluded from being made on behalf of an individual who lacks capacity. These "excluded decisions" are outlined in sections 27 to 29 of the Act and include:

- Making a will
- Making a gift (unless the person has a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering into marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office
- Proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state.
- Cases involving organ or bone marrow donation by a person who lacks capacity to consent.
- Cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.

Decisions beyond the scope of the MCA 2005 may require determination by the Court of Protection or other legal bodies, depending on the nature of the issue.

### 7.25. Information sharing for those who lack capacity

When a person lacks capacity to consent to the sharing of their personal information, individuals with a Health and Welfare Lasting Power of Attorney (LPA) or court-appointed deputyship for health and welfare have the same right of access to the person's information as the person themselves.

If there is uncertainty regarding a person's authority to access information, their legal documentation should be reviewed, and verification can be sought through the Office of the Public Guardian by submitting an OPG100 search.

A person holding Finance and Property LPA or deputyship does not automatically have the right of access to health-related information. However, their legal role may indicate a sufficiently close relationship, enabling them to act on the individual's behalf (e.g., making a complaint). Health-related information may still be shared if it is in the person's best interests.

If a person lacks capacity and does not have a Health and Welfare LPA or deputy, a best interests decision must be made regarding information sharing.

- This decision should consider:
    - The person's known wishes.
    - The views of others involved in their care.

Any shared information must be relevant and proportionate to the specific circumstances, with a record of what was shared and why.

### 7.26. Commissioned services and contracts

The ICB is responsible for commissioning high-quality health services across BNSSG and has a particular duty to protect individuals who are less able to protect themselves from harm, neglect, or abuse. The ICB must ensure that all health organisations with which it contracts for commissioned services have robust strategies and concrete measures in place to comply with statutory responsibilities under the MCA 2005 and deprivation of liberty frameworks, in accordance with the evolving legal landscape.

### 7.27. Restraint and Restriction

Restraint and restriction refer to:

- The use of, or threat to use, force to compel a person to act against their will.
- Limiting a person's liberty of movement, regardless of whether they resist.

For restraint to be lawful, the MCA 2005 requires that:

- it is in the person's best interests

- It is necessary to prevent harm to the person who lacks capacity.
- It is a proportionate response, considering both the likelihood and severity of harm.

The level of restraint must correspond to the harm being prevented, rather than the intended outcome of the intervention.

- Only the minimum restraint for the shortest possible duration should be used to prevent harm, which may include psychological as well as physical harm.
- Restricting liberty does not necessarily require force, but it must be distinguished from deprivation of liberty.
- Restricting movement is not the same as depriving a person of their liberty.
- No individual has the authority to deprive another of their liberty under the MCA Code of Practice, unless authorised through a lawful process, such as a DOLS authorisation or a Court of Protection order.

## 8. DEPRIVATION OF LIBERTY

Deprivation of liberty refers to detention or confinement that goes beyond individual restrictions or isolated instances of restraint. The UK Supreme Court clarified in 2014*(Cheshire West and Chester Council v P [2014] UKSC 19)* that a person is deprived of liberty if three key conditions are met:

1) Under Continuous Supervision and Control

- A person is subject to continuous supervision and control if others must know their location and monitor their actions at all times for their safety.
- This principle is sometimes referred to as the "acid test."

2) Not Free to Leave

- According to the 2015 Law Society Guide, a person is not "free to leave" if they cannot come and go as they wish—whether with or without assistance—unless permitted by decision-makers.
- The key factor is not whether the person actively tries to leave, but what would happen if they attempted to do so.

3) No Valid Consent to the Arrangements

- A person who lacks capacity to make a decision cannot provide valid consent to any arrangement that results in deprivation of liberty.

The right to liberty is a fundamental human right, and deprivation of liberty can only be lawfully authorised through a legal procedure that includes a right of appeal to a court. Best interest decision-making under the MCA 2005 does not provide sufficient legal authority for depriving someone of their liberty. The MCA's protection from liability does not extend to unlawful deprivation of liberty.

## 8.1. Deprivation of Liberty Safeguards (DoLS)

In some instances, care or treatment in hospitals and care homes may be provided under conditions so restrictive that they unavoidably deprive the individual of their liberty, potentially breaching their rights under Article 5 of the European Convention on Human Rights (ECHR). This occurs when the individual lacks capacity to consent to the measures being taken and when those measures—implemented in their best interests—are necessary to ensure their safety and well-being.

To lawfully provide care and treatment in such circumstances, the care provider must obtain legal authorisation, ensuring compliance with Article 5 ECHR and safeguarding the individual's rights. In hospital and care home settings, the Deprivation of Liberty Safeguards (DoLS) under Schedule A1 of the Mental Capacity Act 2005 provide the legal framework for authorising the deprivation of liberty of individuals aged 18 or over who lack the mental capacity to consent to their care or treatment arrangements.

The DoLS framework, established under the MCA 2005, ensures that individuals in care homes and hospitals receive care in a manner that does not inappropriately restrict their freedom.

Paragraph 345 of the National Framework for Continuing Healthcare states that 'when an individual is in receipt of NHS Continuing Healthcare and lacks the mental capacity to consent to their accommodation or care and support arrangements, the Integrated Care Board (ICB) must ensure that the commissioned arrangements are lawful and compliant with the Mental Capacity Act 2005.'

Funded Care practitioners must ensure that the care provider applies to the relevant Supervisory Body (local authority) for a Deprivation of Liberty Safeguards (DoLS)

authorisation, which may be submitted up to 28 days before placement commences or, if not obtained in advance, as soon as possible after admission.

Where a Funded Care practitioner believes that a care provider is not acting on their concerns or failing to submit an application for a DoLS authorisation, they should escalate the matter by making a third-party referral to the relevant Supervisory Body, in accordance with para 9.3 of the DoLS Code of Practice.

### 8.2. Deprivation of Liberty in Community Settings (Community DoL)

For individuals receiving Funded Care in their own homes or tenancy-based accommodation (e.g., supported living), the DoLS do not apply. Instead, the ICB, as the primary funding authority, must submit an application to the Court of Protection to obtain authorisation for any arrangements that constitute a deprivation of liberty.

Paragraph 346 of the National Framework for NHS Continuing Healthcare states that 'where an individual who lacks the relevant capacity is in their own home, including tenancy-based accommodation, and is subject to restrictions that may constitute a deprivation of liberty, authorisation cannot be obtained using the Deprivation of Liberty Safeguards (DoLS) process, instead the Court of Protection must grant authorisation. In such cases, because the ICB is the primary funding authority, it is responsible for ensuring that the appropriate legal process is followed.

Where packages of care in the community meet the threshold of the acid test established in the *Cheshire West* ruling, the practitioner or their line manager must inform the ICB DoLS team, ensuring cases are appropriately triaged for submission to the Court of Protection.

The Court of Protection typically authorises deprivation of liberty for up to 12 months in Community DoL cases. However, where changes to the care plan result in greater restrictions and have been implemented as a matter of urgent necessity, the ICB must apply to the Court for an urgent review of the existing order. This application must be made on the first available date following implementation of such changes. It is therefore essential that Funded Care case managers promptly inform the ICB DoLS team as soon as care plan changes are proposed or implemented, ensuring timely legal authorisation and compliance with statutory safeguards.

The Court of Protection will appoint a Rule 1.2 Representative, whose duty is to monitor the implementation of the care plan and report any concerns to the court. Therefore, the Funded Care case manager must ensure that the Rule 1.2 Representative is consulted on all matters related to the detained person's care arrangements, with such consultations properly documented. The Rule 1.2 Representative will have a formal role in the review of the detained person's care arrangements and holds ongoing responsibilities for their monitoring.

An application to the Court of Protection to authorise deprivation of liberty requires supporting documentation, including a capacity assessment, an up-to-date care plan and a best interests document (not an exhaustive list). Where relevant, additional documents such as PRN medication protocols, Positive Behaviour Support (PBS) plan, and CCTV protocols may also be required. It is therefore essential that Funded Care practitioners ensure these documents are scrutinised and reviewed when accepting cases from local authorities or conducting Funded Care reviews to ensure applications to the Court of Protection are submitted in a timely manner to maintain compliance with statutory requirements.

### 8.3. Deprivation of Liberty in the community of 16- and 17-year-olds

For 16- and 17-year-olds who lack the capacity to consent to their care arrangements but do not fall within the scope of the Mental Health Act 1983, the appropriate procedure is to apply to the Court of Protection for authorisation of any deprivation of liberty. This requirement will remain in place until the Liberty Protection Safeguards (LPS) are implemented.

It is the responsibility of the public body acting as the lead commissioner for the young person's care or treatment to submit the application to the Court of Protection, ensuring compliance with statutory safeguards.

### 8.4. Deprivation of Liberty and end of life care

Hospices, which provide specialist palliative and end-of-life care, are generally considered to fall within the scope of hospitals under the Care Standards Act 2000. Consequently, DoLS may apply in these settings, although their application requires careful and individualised consideration in accordance with the acid test established by the Supreme Court in *Cheshire West* (2014), regardless of whether the setting is a hospice or another care environment.

In palliative or end-of-life care, where a person has capacity to consent to their care and treatment (including any associated restrictions), a DoLS authorisation or alternative legal framework is not generally required. Valid, informed consent can provide a lawful basis for the care arrangements, even if the individual subsequently loses capacity—provided the care remains within the scope of the original consent and there is no objection.

However, a DoLS authorisation, or in future an LPS authorisation, may be required in the following circumstances:

- There are significant changes to the care or treatment from what the person originally consented to;
- The person loses capacity and subsequently objects to the care arrangements;
- It is no longer appropriate to rely on the original consent, and the individual meets the criteria for a deprivation of liberty under the *Cheshire West* test.

All staff involved in the care of individuals who may lack capacity must adhere to the MCA 2005 Code of Practice and the DoLS Code of Practice. Where there is any doubt regarding an individual's capacity, the validity of consent, or whether a deprivation of liberty is occurring, practitioners should seek timely professional supervision where necessary.

### 8.5. Children under the age of 16

Although the MCA 2005 does not apply to individuals under the age of 16, the ICB has positive obligations under Article 5 of the ECHR to uphold the right to liberty for people of all ages. This includes ensuring that any deprivation of liberty is carried out lawfully and in accordance with appropriate legal procedures.

Where the ICB directly funds the care or treatment of a child, it must assess whether the care arrangements could amount to a deprivation of liberty. If so, the ICB must work in collaboration with the relevant local authority children's services to ensure that appropriate authorisation is obtained.

Additionally, the ICB must seek assurances from commissioned providers of services for children, confirming that they have considered whether the care arrangements may constitute a deprivation of liberty and have taken steps to ensure that any necessary legal safeguards are in place.

### 8.6. Court of Protection

The Court of Protection is a specialist court, established under the MCA 2005, responsible for making decisions on financial and welfare matters for individuals who lack the capacity to make such decisions themselves. It holds authority equivalent to the High Court and has the power to set legal precedents.

BNSSG ICB may need to engage with or apply to the Court of Protection, particularly when it is funding an individual's care or treatment. For example, the ICB may be involved in proceedings challenging a DoLS authorisation issued by a local authority. Where an individual receiving a package of care fully funded through Funded Care is deprived of their liberty in a setting other than a care home or hospital, the ICB is responsible for submitting an application to the Court of Protection. This must be done through the Community DoL process or via a section 16 welfare application under the Mental Capacity Act 2005. The ICB must exhaust all informal and formal internal mechanisms before proceeding with an application to the Court of Protection.

## 9. TRAINING AND SUPPORT

BNSSG ICB is committed to providing training and support to its employees to ensure they understand and effectively implement the Mental Capacity Act and statutory duties under the Deprivation of Liberty frameworks. This includes access to training, standard forms, guidance documents, and professional development opportunities.

An MCA training matrix exists to provide clarity and support to this expectation. All staff are required to undertake the E-learning for Healthcare (elfh) MCA e-learning programme and patient facing staff should undertake additional training in line with individual roles and identified within the Personal Development Plan.

All ICB patient facing staff in the Chief Nursing Office Directorate are required to undertake Level 3 face to face MCA and DoL training commensurate with their function and teams within they work as a minimum.

Available training includes:

- E-learning for Healthcare MCA, DoLS, restraints modules.
- Face-to-face, one-day training on assessing capacity (level 3).

- Face-to-face, half-day training on DoL procedures (level 3).

The ICB will ensure that all employed staff (temporary and permanent) participate in MCA and DoLS training that is relevant and proportionate to their role as per the MCA training matrix, meeting the requirements for service commissioning. ICB Staff compliance with MCA and DoL training will be monitored by their line manager and overseen by the employees' Directorate. Training compliance is also shared with the Outcomes, Quality and Performance Committee through the Safeguarding Reports. The Head of Safeguarding (all age) will have full visibility of the compliance records. Persistent non-compliance with training will be reported to the Chief Nursing Officer and Chief People Officer and managed via the appropriate disciplinary policy.

Legal support for Court of Protection applications will be available in accordance with ICB protocol.

## 10. EQUALITY AND HEALTH INEQUALITIES IMPACT ASSESSMENT (EHIA)

An EHIA has not been completed for this policy.

## 11. IMPLEMENTATION, MONITORING AND REVIEW

The implementation of this policy will be monitored through regular audits and reviews. Feedback from employees, healthcare providers, patients, and carers will inform ongoing improvements. The policy will be reviewed in three years or in response to significant legislative changes.

By adhering to this policy, the BNSSG ICB seeks to uphold the rights of individuals who may lack capacity, ensuring that they receive care and treatment that is in their best interests and respects their dignity and autonomy.

### 11.1. Implementation Plan

| Target Group | Implementation or Training objective | Method | Lead | Target start date | Target End date | Resources Required |
|---|---|---|---|---|---|---|
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| All ICB Staff | Raise awareness of revised MCA and DoL policy to all staff and ensure that this is also shared as a standalone policy | Through 'Have we got news for you' or The Voice | Faye Kamara and the MCA Lead | Oct 2025 | Dec 2025 | None |
| Funded Care Teams | Walkthrough of the policy during the Funded Care Team meeting | Introduce and highlight key aspects of the policy to colleagues | MCA Lead | Oct 2025 | March 2026 | None |
| Patient facing staff in CNO directorate | Establish links between frontline practice, MCA/DoLS training, and the policy. | By referencing key aspects of the policy during level 3 MCA and DoL training. | MCA Lead | Oct 2025 | On going | None |

### 11.2. Review history

| Version | Review date | Reviewed by | Changes required (if yes please summarise) | Changes approved by | Approval date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## 12. COUNTERING FRAUD, BRIBERY AND CORRUPTION

The ICB is committed to reducing and preventing fraud, bribery and corruption in the NHS and ensuring that funds stolen by these means are put back into patient care. During the development of this policy document, we have given consideration to how fraud, bribery or corruption may occur in this area. We have ensured that our processes will assist in

preventing, detecting and deterring fraud, bribery and corruption and considered what our responses to allegation of incidents of any such acts would be.

In the event that fraud, bribery or corruption is reasonably suspected, and in accordance with the Local Counter Fraud, Bribery and Corruption Policy, the Safeguarding Team will refer the matter to the ICB's Local Counter Fraud Specialist for investigation and reserve the right to prosecute where fraud, bribery or corruption is suspected to have taken place. In cases involving any type of loss (financial or other), the ICB will take action to recover those losses by working with law enforcement agencies and investigators in both criminal and/or civil courts.

## 13. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

The following documents were used to assist with the development of this policy:

- Mental-Capacity-Guidance-Note-Capacity-Assessment-May-2025_0.pdf
- https://www.39essex.com/wp-content/uploads/2025/05/Mental-Capacity-Guidance-Note-Best-Interests-May-2025_0.pdf
- Department of Health and Social Care, Ministry of Justice, Department for Education, and Welsh Government (March 2022) Draft MCA Code of Practice
- BNSSG ICB Confidentiality and Security of Information Policy
- BNSSG ICB Records Management Policy
- BNSSG ICB Information Governance Policy
- BNSSG ICB Safeguarding Adults Policy

# 14. APPENDICES

## 14.1. Appendix 1

**MENTAL CAPACITY ASSESSMENT**

| **Service User Details** | |
|---|---|
| **Name** | |
| **Address** | |
| **DOB & Age** | |
| **NHS Number** | |
| **Caretrack ID** | |

| **What has prompted this assessment:** (include summary of background information) |
|---|
| |

| **What is the specific decision that needs to be made?** (Any assessment of capacity must be time and decision specific.) |
|---|
| |

| **Is it appropriate to delay the decision to see if the person will regain capacity?** (Tick most appropriate) | |
|---|---|
| • **Yes** | |
| • **Not likely to regain capacity** | |
| • **Not appropriate to delay** | |
| | |
| Evidenced by: | |

| **Were all practicable steps taken to maximise the person's capacity to make the decision?** (Document what action was taken e.g consideration of time of day or location of the assessment, use of an interpreter, use of pictures etc) |
|---|
| Evidenced by: |

| **Relevant Information** (Please set out the relevant information which the person would need to understand, retain, use and weigh to make the decision) |
|---|
| *The relevant information for care and support decisions includes the following. Please provide details on the following;*<br>• *What the decision is*<br>• *The reason the decision needs to be made*<br>• *What are the areas where the person requires support from others to meet his/her care needs*<br>• *What are the options or choices?*<br>• *The consequences of each option or choices (if there are any)*<br>• *The consequence of making the decision*<br>• *The consequence of not making the decision* |

**STAGE 1 – FUNCTIONAL TEST**

| **a) Can the person understand the relevant information relating to the decision?** (include salient information here) | **Yes** | **No** |
|---|---|---|
| | | |
| Evidenced by: | | |

| **b) Can the person retain the information in their mind (long enough to make the decision)?** | **Yes** | **No** |
|---|---|---|
| | | |
| Evidenced by: | | |

| **c) Can the person use or weigh the information as part of the decision-making process?** | **Yes** | **No** |
|---|---|---|
| | | |
| Evidenced by: | | |

| d) Can the person communicate their decision? | Yes | No |
|---|---|---|
| | | |
| Evidenced by: | | |

**STAGE 2 – DIAGNOSTIC TEST**

| **Is there an impairment of or disturbance in the functioning of the persons mind or brain?** (Specify what this is) | |
|---|---|
| | |
| **Is the impairment:** (tick the most appropriate) | |
| • **Temporary** | |
| • **Permanent** | |
| • **Fluctuating** | |
| Evidence for this: | |

**OUTCOME OF ASSESSMENT:**

| **Does this service user have the capacity to make the decision in question at the time of the assessment?** (In order to establish that someone does not have the mental capacity to make a particular decision the assessor must have a **reasonable belief** (i.e. on the balance of probabilities) that they lack mental capacity. If the answer is 'YES' to **all** the above questions in the functional test, the person must be assessed to have the mental capacity to make the decision themselves, even though it may be considered an unwise decision.<br><br>If 'No' is indicated in any of the four areas above this indicates that the person lacks capacity to make this decision. Evidence the outcome below by giving rationale for your decision and demonstrate that the person's inability to make the decision is because of the impairment or disturbance in the functioning of their mind or brain.) | Yes | No |
|---|---|---|
| | | |
| [Evidence causative nexus and conclusion]: | | |

| | |
|---|---|
| **Name of the assessor** | |
| **Signature of the assessor** | |
| **Designation** | |
| **Date / Time** | |
| **Contact details** | |

| | |
|---|---|
| | |

Note:

- If the service user is assessed as lacking capacity to make the decision, you must now complete a Best Interests decision.
- IMCA required? Yes □ No □ If yes, please make a referral to an Advocacy/IMCA Service (If the decision is about a change of accommodation and the service user is considered to be 'unbefriended' then you must make a referral to the IMCA service)

### 14.2. Appendix 2

## Best Interests Decision

| 1. SERVICE USER DETAILS | |
|---|---|
| **Name** | |
| **Address** | |
| | |
| | |
| **DOB & Age** | |
| **Caretrack ID** | |

| 2. Details of capacity assessment | |
|---|---|
| Date of the capacity assessment in relation to this decision | |

**Outcome of the capacity assessment:**
(Please note best interests cannot be used for people who have capacity to make their own decisions. A best interest decision can only be made once the person has been assessed as lacking capacity for the decision in question and evidence is provided in accordance with the best interests checklist.)

| |
|---|
| |

| 3. What is the decision being considered?<br>(Note: An act or decision made for or on behalf of a person who lacks the relevant mental capacity must be done, or made, in his/her best interests. ) |
|---|
| |

| 4. Is there a valid Lasting Power of Attorney/Enduring Power of Attorney or a Court of Protection Deputy? (If yes, they will be the decision maker/s) |
|---|

| | |
|---|---|
| Yes | No |
| If yes, name of the individual/s: | |
| Has the decision maker verified the LPA/EPA/Deputyship?<br><br>(A copy of LPA/EPA/Deputyship or OPG100 search result is required to ascertain whether an LPA/EPA/court appointed deputy is in place) | Yes/No |
| Date LPA/EPA registered: | |

**5. Will the person regain capacity if the decision-making is delayed?** (tick most appropriate)

| | |
|---|---|
| • Yes | |
| • Not likely to regain capacity | |
| • Not appropriate to delay | |

Evidence: (If the person will regain capacity, state when this might be and defer decision-making unless it's not appropriate to delay)

**6. Is there a valid and applicable Advance Decision to Refuse Treatment (ADRT)**

| | |
|---|---|
| Yes | No |
| Details of this: | |
| Is there an Advance Care Plan or statement regarding this decision | Yes/No |
| Details of this: | |

**7. Details of people consulted as part of the decision-making**

| Name | Relationship | Consulted – Yes/No | If No, provide reasons |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**8. Relevant Circumstances**
(Try to identify all the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity to make this decision.)

**9. What are the available options?**
(Consider all available options and list the advantages and disadvantages of the proposed actions having regard to medical, welfare, social, emotional and any ethical aspects of the proposed measures. Where the choice is being made on behalf of the person, that choice can only be between options which are actually available to them)

| |
|---|
| **Option 1:**<br>**Benefits:**<br>•<br>•<br>•<br>•<br>•<br>**Burdens:**<br>•<br>• |
| **Option 2:**<br>**Benefits:**<br>•<br>•<br>**Burdens:**<br>•<br>•<br>•<br>• |
| **Option 3:**<br>**Benefits:**<br>•<br>•<br>**Burdens:**<br>•<br>•<br>•<br>•<br>*(If no alternative arrangement other than Option 1 is being considered, please state why)* |

| **10. Views of the person in relation to this decision**<br>(What are the person's past and present wishes and feelings relevant to the proposed decision. Does the person have any beliefs and values relevant to the proposed measures (e.g. religious or cultural factors) that would be likely to influence the decision? Evidence what steps you have taken to ensure that you have encouraged and enabled the person, who lacks capacity, to take part in the decision-making process. ) |
|---|
| |

| **11. Views of interested parties:**<br>(e.g. family, friends, carers, professionals involved, IMCA, Lasting Power of Attorney, Court of Protection Deputy etc.) |
|---|

| |
|---|
| |

| **12. Document what decision has been made in the person's Best Interests**<br>(Outcome of the best interests process: Having considered all the relevant circumstances and views of all interested parties, please now document the outcome of your decision, how it was reached, reasoning behind the decision and why this is in the person's best interests.<br><br>In having a reasonable belief that you are acting in the person's best interests, you need to complete the above assessment with necessary detail pertaining to the decision using the information available and gathered at the time of the decision made.) |
|---|
| |
| **13. Any disagreements regarding the decision, give details if any** |
| |

| **14. Details of the decision maker** | |
|---|---|
| Name of the decision maker | |
| Signature | |
| Designation | |
| Date | |

**14.3. Appendix 3**

# Welfare Balance Sheet

**Name of the service user:**
**Proposed intervention/action:**

| HEALTH/MEDICAL | WELFARE | SOCIAL | EMOTIONAL | ETHICAL |
|---|---|---|---|---|
| Advantages / Benefits | Advantages / Benefits | Advantages / Benefits | Advantages / Benefits | Advantages / Benefits |
| | | | | |
| Disadvantages / Burdens | Disadvantages / Burdens | Disadvantages / Burdens | Disadvantages / Burdens | Disadvantages / Burdens |

| | | | | |
|---|---|---|---|---|
| | | | | |

It is worth referring to these five areas when undertaking welfare balance sheet analysis;

**Health/Medical Aspects**
Not just the outcome, but what will be the burden and benefit of the treatment?

**Welfare Aspects**
How will this impact (for better or worse) on the way the person lives their life?

**Social Aspects**
What will this do to the person's relationships etc?

**Emotional Aspects**
How will this person feel or react?

**Ethical Issues**
Are there any specific ethical issues that require separate consideration?

**********