NHS
Cornwall and
Isles of Scilly

Mental capacity act and deprivation of liberty safeguards policy

Date approved: 22 October 2025

NHS Cornwall and Isles of Scilly Integrated Care Board

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1. Introduction

This policy describes the ways that NHS Cornwall and Isles of Scilly Integrated Care Board (ICB) will implement its duties and responsibilities in relation to mental capacity and deprivation of liberty safeguards and includes the ICBs expectations for services from which we commission.

The Mental Capacity Act (MCA) 2015 consolidates human rights law for people who may lack the capacity to make their own decisions. It promotes the empowerment of individuals and the protection of their rights. The Act applies to anyone aged 16 years or over in England and Wales and is relevant for both care and treatment decisions. In 2022 the government provided an amendment to the Mental Capacity Act, however, these amendments were never implemented, the government at present time are considering reviewing the amendment again in the later part of 2026.

If the person is under 16 years old the Safeguarding of Childrens policy should be considered.
Child protection policy and procedure

This policy should be read in conjunction with:

- MCA code of practice
- MCA easy read guide
- Deprivation of Liberty Safeguards (DoLS) resources

The act is built on 5 statutory principles that guide and inform decision-making in respect of the estimated 2 million people who may lack capacity for decision making in some aspects of their life including their health care. (Social Care Institute for Excellence 2015).

The MCA 2005 key principles:

1. A presumption of capacity: every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. Support individuals to make their own decisions: people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. Right to make an unwise decision: people have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.
4. Best interest: anything done for or on behalf of people without capacity must be in their best interests.
5. Least restrictive option: anything done for or on behalf of people without capacity should be the least restrictive.

The MCA is the essential and required framework for both health and social care commissioners and practitioners, particularly when working with people who may be unable to, permanently or temporarily, make some or all decisions about their care and treatment.

Through a good understanding of the act, providers and commissioners can ensure that appropriate assessments of capacity are carried out and that decisions made on behalf of incapacitated people are in their best interests.

The act is part of a framework within which healthcare providers should be working to ensure they respect patients' dignity and human rights. This framework includes:

- Human Rights Act 1998
- MCA 2005
- Disability Discrimination Acts 1995 and 2005
- Equality Act 2010

The MCA is rights legislation. It protects the rights of all persons to make as many decisions about themselves for as long as possible. It places on staff a duty to help persons make decisions for themselves. If they cannot, it sets out a clear and robust process for determining whether patients have capacity and if they do not, how decisions should be made on their behalf.

The act lays down the firm principle that because a person cannot make a particular decision it does not automatically follow, they cannot make the next one required of them; therefore, the person's capacity is decision specific.

What is capacity

NHS England describes capacity as follows:

"Capacity means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that time."

Someone with such an impairment is thought to be unable to make a decision if they cannot:

- understand information about the decision
- remember that information
- use that information to make a decision
- communicate their decision by talking, using sign language or any other means

This is set out in the Mental Capacity Act 2005 and the MCA code of practice.

2. Purpose

To outline the responsibilities of Cornwall and the Isles of Scilly Integrated Care Board in applying the MCA code of practice. The policy ensures that as commissioners of services, these responsibilities are also adopted by those that we commission services from.

Cornwall and the Isles of Scilly Integrated Care Board, (the ICB) has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare and rights of adults at risk and young people, including for the purposes of the MCA, those people who are over the age of 16, and receive care, treatment and or services funded by the ICB by ensuring that:

- the services commissioned by the ICB provide safe, effective and high-quality care for vulnerable children and adults, including adults who lack capacity.
- the care commissioned by the ICB is compliant with the MCA 2005 and that providers fulfil their statutory responsibilities to people who access services.
- that all staff employed by the ICB are aware of and fulfil their responsibilities under the MCA, and that staff operate at all times in accordance with the statutory framework and the code of practice.
- that all staff employed by the ICB are aware of and fulfil their responsibilities under the deprivation of liberty safeguards and that their staff operate at all times in accordance with the statutory framework and the code of practice.
- that the ICB undertake yearly safeguarding adults and children's mandatory e-learning training which incorporates MCA training.

3. Integrated care boards

The ICB will need assurance that the Act is embedded in the work of commissioned organisations with their patients and will want to ensure that:

- as an organisation it fulfils all its duties relating to the act
- the MCA is embedded in all elements of the commissioning cycle
- its staff understand the importance of compliance with the MCA, as appropriate for their role
- assessing compliance and what needs to be done to achieve this is a key part of tendering and contract award
- ongoing compliance is monitored in detail through performance review and quality monitoring processes

Why the Mental Capacity Act 2005 is important to ICBs?

ICBs need to ensure that the services they are commissioning on behalf of local populations are being delivered in a way that both respects and applies the rights of

individual persons and, in particular, those who may not be able to make decisions on their own behalf.

In certain circumstances, failure to provide care within the framework set down by the act could be deemed to be unlawful. This could arise from noncompliance by ICB staff who have direct contact with patients and also by noncompliance when making commissioning decisions about individual packages of care.

As part of their authorisation process, ICBs are requested to have a lead for the MCA 2005, supported by training and policies. ICBs may need to demonstrate how they have discharged this duty.

As a commissioner, we are seeking evidence of an embedded cultural shift within organisations. Clinical engagement should be rights based. Decisions should be made on the basis that persons have a right to make their own decisions, and this should only be removed as the exception and only on clear evidence that the assumption of capacity be put aside and in accordance with the framework set down in the act.

4. Staff roles and responsibilities

The ICB is accountable to NHS England. The ICB has a clear line of accountability in relation to the delivery of its safeguarding duties. These are set out below:

Chief executive officer

The chief executive officer:

- is accountable to the ICB chair and board for the delivery of the ICB against the agreed financial plan. This includes safeguarding partnership strategies
- leads a positive culture of how the NHS responds to MCA compliance in Cornwall and the Isles of Scilly.
- assures themselves that their local safeguarding and MCA arrangements are effective. This includes systems of assurance for delivery against contracts

Chief nursing officer

The chief nursing officer is accountable to and reports to the chief executive officer.

The chief nursing officer acts as the executive lead for safeguarding and mental capacity, providing professional advice to the ICB board and the relevant committees, supported by the designated, named and lead professionals for safeguarding.

The responsibilities of the chief nursing officer are to:

- lead on supporting the chief executive and board for safeguarding people of all ages

- promote a positive culture of how the NHS responds to the Mental Capacity Act 2005 in Cornwall and the Isles of Scilly.
- is accountable for ensuring that the joint forward plan sets out how the ICB responds to the needs of people who lack capacity.
- ensure that all safeguarding functions are performed effectively and that there are effective assurance mechanisms in place
- lead the relationship with key safeguarding partners, to improve outcomes
- ensure the arrangements are in place for representation at safeguarding boards and partnerships, delegating attendance at the Cornwall and Isles of Scilly Safeguarding Adults Board executive group

Director of nursing

The director of nursing is accountable and reports to the chief nursing officer and deputises for them. They support the chief nursing officer, providing the ICB with the capacity to meet all the statutory duties in relation to the MCA. They also ensure that the accountable officer, directors, and governing body can access professional advice in relation to the MCA when required.

Head of nursing

The ICB head of nursing reports to the director of nursing and is accountable to the chief nursing officer.

The head of nursing is the lead designated professional and is responsible for leading and overseeing programmes of work in relation to domestic abuse to ensure the effective implementation of this policy.

The role is responsible for preparing submissions on a regular basis to the relevant ICB committees and preparing the safeguarding submission for the ICB joint forward plan.

The head of nursing represents the ICB at the SAB executive group.

MCA lead

The MCA lead reports to the head of nursing and is accountable to the chief nursing officer.

The MCA lead has a strategic professional lead role as a subject matter expert in their relevant fields of MCA and DoLS and is responsible for the implementation of the MCA work plan.

The MCA lead also oversees the work of the ICB's MCA team for those people that receive funding from the ICB, are deprived of their liberty and the deprivation of liberty needs to be authorised by the court of protection. The MCA lead oversees all the Court

of Protection cases that are appealing their deprivation of liberty (DoL) or who's level of restriction is higher than the remit for a Community DoLS application.

Designated, named, and lead safeguarding professionals

The designated, named and lead safeguarding professionals have a strategic professional lead role as subject matter experts in their relevant fields of safeguarding. They work across every aspect of health service contribution to safeguarding within all provider organisations commissioned by the ICB and across the health community and wider partners.

As clinical experts, the safeguarding professionals are responsible for enabling the implementation of the activities in this policy and ensuring that objectives are aligned with the objectives of local safeguarding boards and partnerships.

Head of continuing healthcare adults

This role is designed to implement and monitor the continuing healthcare (CHC) work programme. Part of the role is to ensure that an effective response is provided by the CHC team when a person funded by CHC is believed to lack capacity and provide assurance to the ICB about its response in accordance with this policy.

Head of continuing healthcare children

This role is designed to manage the programme of work relating to children who have complex needs and are in receipt of funding from the ICB. For those young people who are 18 and under, to ensure compliance with the MCA 2005.

CHC nurse assessors and coordinators

Expectation of the coordinators who are assessing a person for CHC eligibility and reviewing ongoing packages of care:

- be able to apply the MCA in accordance with their day-to-day work and evidence this in records
- recognise a deprivation of liberty
- check a DoLS authorisation is in place
- recognise a situation which may need escalation to the Court of Protection and to refer to the MCA lead

Mental health commissioning team

To ensure that the MCA's principles are considered in all commissioned care.

Mental health review team

Expectation of the coordinators who are reviewing people who are receiving inpatient mental health treatment outside of the ICB area;

- be able to apply the MCA in accordance with their day-to-day work and evidence this in records
- recognise a deprivation of liberty
- check the deprivation of liberty is authorised either under the Mental Health Act 1983 or that a DoLS authorisation is in place
- recognise a situation which may need escalation to the Court of Protection and to refer to the MCA lead

All staff

To have an awareness of the MCA and how to contact the MCA team with any queries. Maintain their competencies for MCA as appropriate to their role by completing their required adult and child safeguarding learning.

5. MCA training and supervision

The ICB will set out how all staff receive the correct training for MCA in an ICB safeguarding training strategy.

The training is required to promote the best practice by staff regarding the principles of the MCA.

Supervision can be provided by the MCA team in relation to the person's experience of implementing the act, this can be accessed by contacting the MCA lead.

6. Deprivation of liberty safeguards

The deprivation of liberty safeguards (DoLS) within the MCA provides a legal protective framework for those vulnerable or at-risk people who are deprived of their liberty and not detained under the Mental Health Act 2005 or any other legal process.

Article 5 of the European Convention on Human Rights states: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save... in accordance with a procedure prescribed in law."

The safeguards apply to people 18 years old and above; in hospitals and homes (whether privately or publicly funded) and their purpose is to prevent arbitrary decisions that deprive vulnerable people of their liberty. Local authorities currently have the responsibilities and powers to authorise the deprivation of liberty for people who are in hospitals and care homes. In the event of it being necessary to deprive a person of their

liberty the safeguards give them rights to representation, appeal and for any authorisation to be monitored and reviewed.

People can be deprived of their liberty in settings other than hospitals and care homes such as supported living, but in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations in such circumstances should be made to the court.

The MCA gives certain responsibilities to staff caring for people who lack the capacity to consent to their care and treatment to use restriction and restraint where it is in the best interests of the person and is necessary to prevent harm. If, however, that restriction and restraint move towards depriving that person of their liberty, it could be unlawful unless authorised by the relevant local authority following an assessment process determined in law.

Acid test

The UK Supreme Court made a ruling on the test for whether a deprivation of liberty is occurring. This only applies to people who do not have capacity to consent to their own care and treatment:

1. Is the person subject to continuous supervision and control?
2. Is the person not free to leave?

If the answer is yes to both questions, then it is almost certain that a deprivation of liberty is occurring, but every person must be considered individually.

Deprivation of liberty in domestic settings

The Supreme Court held that a deprivation of liberty can occur in domestic settings where the state is responsible for imposing such arrangements. This includes a placement in a supported living arrangement in the community. Where there is, or is likely to be, a deprivation of liberty in such placements, it must be authorised by the Court of Protection.

If the person is fully NHS funded by the ICB, then an application to the Court of Protection should be made by the ICB. If the person is joint funded, then a discussion with the other responsible commissioner will be necessary to decide whether a joint application will be made or whether one party will be the lead respondent in the application to the court. Please see The Court of Protection.

7. The Court of Protection

This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The court makes decisions and can appoint deputies to make decisions in the best interests of those who lack capacity to do so.

The Act provides for the Court of Protection to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The court also has the power to make declarations about whether someone has the capacity to make a particular decision. The court has the same powers, rights, privileges, and authority in relation to mental capacity matters as the High Court. It is a superior court of record and can set precedents (set examples to follow in future cases).

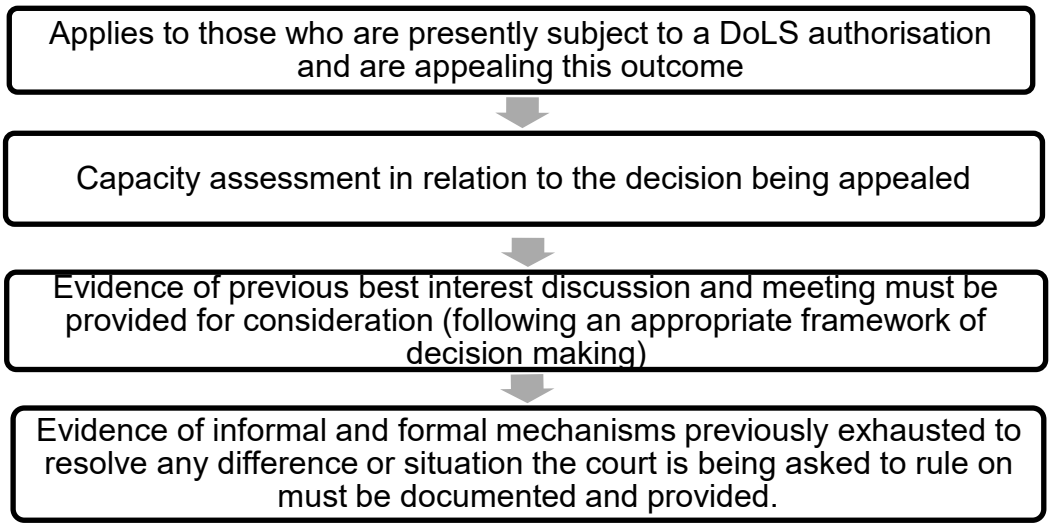
The Court of Protection has the powers to:

- Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions and appoint deputies to make decisions for people lacking capacity to make those decisions
- Decide whether a lasting power of attorney (LPA) or enduring power of attorney (EPA) is valid; and remove deputies or attorneys who fail to carry out their duties and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid

Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian. Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are also available from the Office of the Public Guardian.

The ICB must be assured that all informal and formal internal mechanisms have been exhausted before making any application to the Court of Protection. However, where an application is required, this must not be delayed.

Process for consideration when use of the Court of Protection is required

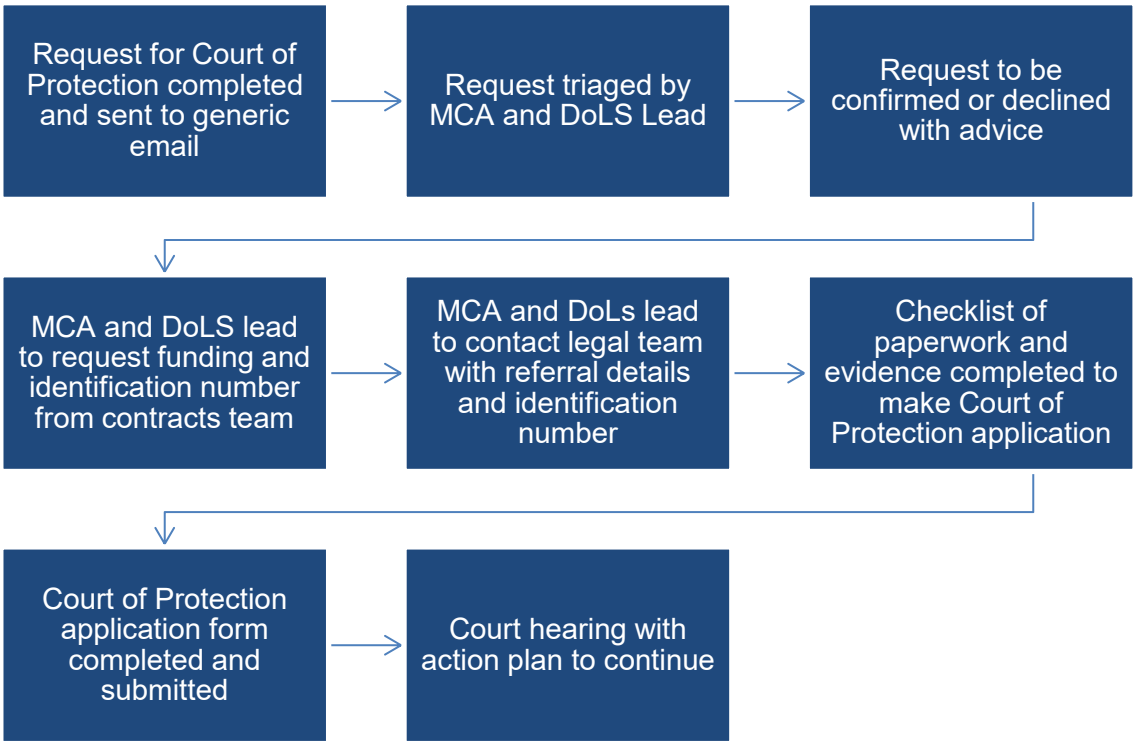


The flow chart above describes the following steps that need to be followed:

1. Applies to those who are presently subject to a DoLS authorisation and are appealing this outcome.
2. Capacity assessment in relation to the decision being appealed.
3. Evidence of previous best interest discussion and meeting must be provided for consideration (following an appropriate framework of decision making).
4. Evidence of informal and formal mechanisms previously exhausted to resolve any difference or situation the court is being asked to rule on must be documented and provided.

Early conversation with the lead for MCA and Court of Protection must be had to alert the ICB of the above activity. Once all the above have been exhausted and completed, then the ICB will seek legal support to present the case to the Court of Protection.

Flowchart for Court of protection



The flow chart above describes the following steps that need to be followed.

1. Request for Court of Protection completed and sent to generic email: ciosicb.mentalcapacity@nhs.net.
2. Request triaged by MCA and DoLS professional lead.
3. Request to be confirmed or declined with advice.
4. MCA and DoLS lead to request funding and identification number from contracts team.

5. MCA and DoLS lead to contact legal team with referral details and identification number.
6. Checklist of paperwork and evidence completed to make Court of Protection application.
7. Court of Protection application form completed and submitted.
8. Court hearing with action plan to continue.

8. Supporting the person to make decisions

It is important to consider the following when supporting persons to make decisions:

- Does the person have all the information they need to make the decision?
- Have they been given information on all the alternatives available to them?
- How does the person communicate? People can communicate in a variety of ways, including non-verbal. Consider if they need an interpreter or specialist equipment/adapted information leaflet such as easy read.
- Have you considered what time of day is best for the person to make a decision?
- Is there a particular place where the person feels most comfortable?
- Would they like someone with them to support with this, such as a family member or carer or independent advocate?

It is essential not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person to understand.

What happens in an emergency?

In an emergency situation, urgent decisions will have to be made, and immediate action taken in the person's best interests.

In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies. However, even in emergency situations, healthcare staff should try to communicate with the person and keep them informed of what is happening.

9. When is a capacity assessment required?

The legal starting point is the presumption that a person aged 16 and above has mental capacity. Evidence to the contrary needs to be gathered to establish mental incapacity before decisions can be made and actions taken on behalf of the adult in best interest. It is also important that the person who does an assessment can justify their conclusions.

An assessment of capacity should be completed at any time where there is a concern that the person may not be able to make an informed decision. This may be at the point when seeking consent for a non-invasive procedure like taking a person's blood

pressure, or for an invasive treatment such as treatment of a pressure sore or insertion of a catheter. It is essential that staff appropriately assess capacity and evidence this for all decisions when it is felt that there is doubt regarding the person's capacity.

For significant decisions such as invasive treatments, with risk of side effects, it is advised that a formal assessment is completed using the assessment of capacity form (appendix 1). If you choose not to use any of the templates provided you must ensure you evidence your assessment and how the decision was reached. It is not acceptable to just record that a capacity assessment was completed and the outcome of this.

10. Who undertakes the assessment of mental capacity?

The practitioner who assesses a person's capacity to make a decision will usually be someone who is directly concerned with the decision and the person at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

More complex decisions may require more formal assessments. A professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist, nurse or social worker. However, the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity – not the professional, who is there to advise.

Two stages of testing for Mental Capacity

"A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help him to do so without success" (MCA 2005).

Mental capacity may fluctuate, and it is important to undertake the test at a time of optimal functioning, for example being sensitive to the effects of drugs. A person's mental capacity may be recovered with appropriate care and treatment, meaning that follow-up assessments may be required.

The test of mental capacity, as laid out in the MCA 2005, has 2 clear stages.

Stage 1

Does the person have an impairment or disturbance of the functioning of the mind or brain sufficient that the person lacks capacity to make that particular decision?

The impairment or disturbance of the functioning of the mind or brain, for example (this is not an exhaustive list):

- effects of alcohol or drugs
- all categories of mental illness including depression

- delirium
- head injury
- dementia
- learning disability
- brain injury

Stage 2

In order to establish the answer to the above question in stage 1, you must assess the following. Can the patient communicate, understand, retain and balance (CURB):

1. Communicate their decision (whether by talking, using sign language or any other means). Ensure you make it clear how you have tried to promote communication.
2. Understand the information relevant to the decision (what is being proposed and why it is being suggested). This should be done in a simple and jargon freeway. The person needs to demonstrate they understand the salient points.
3. Retain the information (for long enough to process the information and make an effective decision).
4. Balance or weigh that information as part of the process of making the decision. Can they appreciate the benefits, risks, and alternatives of pursuing or not pursuing the option(s) suggested?

If all of the above are achieved, then the person must be regarded as having the mental capacity to make his or her own decision. It should be noted that the quality or reasonableness of the person's decision is not a factor. People have the right to make decisions that others may consider to be unwise.

If the person fails even one part of the test, then they must be regarded as lacking mental capacity for this specific decision. Staff must ensure that they act in the person's best interest.

11. Lack of capacity

Anybody who claims that a person lacks capacity should be able to demonstrate this.. They need to be able to show, on the balance of probabilities, that the person lacks capacity to make a particular decision, at the time it needs to be made. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

Please use appendix 1.

12. What if a person cannot communicate?

Sometimes there is no way for a person to communicate. This will apply to very few people, but it does include:

- people who are unconscious or in a coma, or those with the very rare condition sometimes known as ‘locked-in’ syndrome who are conscious but cannot speak or move at all

If a person cannot communicate their decision in any way at all, the Act says they should be treated as if they are unable to make that decision.

13. Record keeping and professional liability

The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity to consent, provided that you:

- have observed the principles of the MCA
- have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question
- reasonably believe the action you have taken is in the best interests of the person

It is important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity, reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person’s best interests.

You can use the templates provided in appendix 1 and appendix 2 to record assessments of capacity and best interest decisions.

14. Best interest

When a person has been assessed as lacking capacity in relation to a specific decision, health and social care staff must ensure that any decision made on behalf of the person is made in best interest.

When making a best interest decision staff must consider the following areas below.

Regaining capacity

It may be appropriate to delay the decision to allow further time for additional steps to be taken to restore the person’s capacity or to provide support and assistance which would enable the person to make the decision themselves.

Encouraging participation

The person must be permitted and encouraged to participate as fully as possible in any act done for him or her and any decision affecting him or her. Time must be taken to try to seek their views. A trusted relative or friend, or an independent mental capacity

advocate (IMCA), may be able to help the person to express wishes or aspirations or to indicate a choice between different options.

The person's feelings and wishes

The person making the decision must consider so far as is reasonably ascertainable, the person's past and present wishes and feelings; the beliefs and values that would be likely to influence their decision if they had capacity; and the other factors that they would be likely to consider if they were able to do so. This also includes specific views that may have been set out in an advance directive, communicated informally to relatives and carers or formally in the lasting power of attorney.

The views of other people

The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; anyone engaged in caring for the person or interested in their welfare; anyone that is a lasting power of attorney. You may also need to consult with other professionals involved in the person's care.

Do not make assumptions

The individual making the decision must not make any assumptions about the person based on age, condition, appearance or behaviour.

Please use appendix 2.

15. Who is the decision maker?

Under the Mental Capacity Act 2005, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves.

It is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity. Decisions relating to a person's social care needs may need to be made by a social worker, however, a decision relating to a person's treatment would be made by the person prescribing that treatment. For example, a pressure sore or insulin injection would be made by the clinician prescribing the insulin or dressing at that time. The person delivering the treatment would need to ensure that it remains in the person's best interest at the time of delivery. Equally a decision relating to a person's ability to consent to an emergency hospital admission may need to be made by a paramedic or GP.
The table below is an indicative guide how a response should relate to the level of complexity of the decision to be made.

Decision level	Decision maker	Recording
Simple: Informal day to day decisions such as what to wear, eat, where to go.	Formal carers in consultation with the person, their family, and friends.	Brief notes in care log record. Record any decisions the person is able to make for themselves, and what is known about their likes or dislikes.
Complex: Withdrawal or refusal of serious medical treatment	GP, NHS consultant or doctor or consultant nurse who knows the person best and who can provide information about the risks and choices in consultation with the person, their family, and friends	Record decision and rationale in medical records.
Complex: Permanent change of accommodation, for example going into residential care for 8 weeks or more	Case worker or CHC team manager who knows the person best and is able to offer the options or choices in consultation with the person, their family, and friends	Record capacity assessment and best interest decision and rationale in case notes

If a lasting power of attorney (or enduring power of attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority. Enduring powers of attorney predate the Mental Capacity Act 2005 and will still carry legal status but were only applicable to financial decisions.

16. What should I do if there is a dispute about best interests?

Family and friends may not always agree about what is in the best interests of an individual. If you are the decision-maker, you will need to clearly demonstrate in your record keeping that you have made a decision based on all available evidence and taken into account all the conflicting views.

If there is a dispute, the following things might assist you in determining what is in the person's best interests:

- get a second opinion
- hold a formal or informal case conference
- go to mediation

- seek advice from MCA lead who may then seek legal advice and make an application to the court of protection for a ruling
- seek legal advice in urgent circumstances
- an application could be made to the Court of Protection for a ruling

17. Independent mental capacity advocate

An IMCA is a specific type of advocate that has to be involved if there is no-one appropriate who can be consulted. An IMCA is not the decision-maker, but the decision-maker has a duty to take into account the information given by the IMCA.

An IMCA will only be involved if:

- the decision is about serious medical treatment provided by the NHS
- it is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home,
- a long-term move (8 weeks or more) to different accommodation is being considered, for example, to a different hospital or care home

An IMCA may also be instructed on behalf of a person lacking capacity for:

- care reviews, where no-one else is available to be consulted
- safeguarding adult cases, whether family or friends are involved

Duties of the IMCA include:

- supporting the person who lacks capacity and represent their views and interests to the decision-maker
- obtain and evaluate information
- as far as possible, ascertain the person's wishes and feelings, beliefs and values
- ascertain alternative courses of action
- obtain a further medical opinion, if necessary; and prepare a report for the person who instructed them
- if an IMCA disagrees with the decision made, they can also challenge the decision-maker

If you have any questions about IMCA services in Cornwall please contact The Advocacy People. Telephone: 0330 440 9000 or email The Advocacy People.

18. Governance

Governance of the safeguarding process is defined in the NHS England Safeguarding Accountability and Assurance Framework 2024.

The reporting and recommendations to the relevant ICB committee responsible for quality (as the committee with delegated authority for quality) are prepared through the ICB safeguarding assurance meeting. The ICB is accountable for all duties and responsibilities through its board and joint peninsula committee, to which the finance, performance and quality committee reports.

19. Quality assurance and monitoring

Where review is necessary due to legislative change, this will happen as soon as practicably possible.

The ICB has systems in place for quality assuring the safeguarding governance systems within provider organisations from which they directly commission services.

Contract leads and providers should raise concerns if they are concerned about compliance.

20. Update and review

All policies and similar documents must be dated when approved and a review date also included. This will usually be 3 years unless there is an indication to the contrary. It is the responsibility of the author (or nominated officer) to be aware of influencing factors and to initiate reviews promptly within the 3 years if appropriate.

21. Polices referred to in this document

- Child protection policy and procedure (icb.nhs.uk)
- Adult safeguarding policy (icb.nhs.uk)

- Adult Safeguarding: Roles and Competencies for Health Care Staff Second Edition Published July 2024.
- Care Act 2014
- Care Act 2014 statutory guidance.
- Cornwall and Isles of Scilly Adult Safeguarding Board policies and procedures
- Human Rights Act 1998
- NHS England Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework 2024.
- Office of the Public Guardian: Mental Capacity Act Code of Practice

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Mental Capacity Act
Assessment Decision Record

Appendix 1.

Name:		
NHS number:	**Hospital number:**	
DoB:	**Date:**	**Time:**
Address:		
Details of the decision to be made:		
The following steps have been taken to support the person to make the decision in question: (Where you have made reasonable adjustments, please create a reasonable adjustments digital flag for the person or add them to an existing flag)		

The following people supported the person when their capacity was being assessed: (Examples would be family carer, IMCA, learning disability liaison nurse)
Information relevant to the decision in question:
The relevant points for this decision are:

Mental Capacity Act
Assessment Decision Record

Assessment criteria

A. Can the person understand the information relevant to the decision?	**Yes**	**No**
(Set out details of your discussion and findings)		

B. Can the person retain that information?	**Yes**	**No**
(Set out details of your discussion and findings)		
C. Can the person use or weigh that information as part of the decision-making process?	**Yes**	**No**
(Set out details of your discussion and findings)		
D. Can the person communicate their decision, whether verbally or using sign language, gestures or any other means?	**Yes**	**No**
(Set out details of your discussion and findings)		

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Mental Capacity Act
Assessment Decision Record

Assessment criteria

E. Does the person have an impairment or disturbance of the functioning of their mind or brain?	**Yes**	**No**
Please state the identified impairment or disturbance:		
F. If your assessment indicates the person cannot make the specific decision in question at this specific time because of impairment or disturbance of the functioning of the mind or brain, please give your findings and reasons. Is capacity to make this decision likely to return and could the decision be delayed until this time?		
In my opinion (name) *does / does not (*delete as appropriate) have the capacity to make the above decision at this time. (In the event that the answer to any of the questions in A to E above is 'no' due to an impairment or disturbance in the functioning of the mind or brain, the person should be considered to lack capacity to make the decision in question at the date and time stated.)		

If the person is assessed as not having capacity to make this decision, you must make a best interests decision in respect of the decision in question and record this decision and the reasons for it.	
Signed	**Date**
Name (in capitals)	
Job title	

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Cornwall and Isles of Scilly

Form for recording mental capacity assessment best interest decision making Appendix 2.

Name:			
NHS number:		**Hospital number:**	
DoB:	**Date:**	**Time:**	
Address:			
Details of the decision to be made:			
Has the person's capacity to make this decision been assessed? (If **no**, an assessment must be completed before a best interests decision is undertaken). If **yes**, the best interests decision can only be undertaken if the person lacks capacity to make this particular decision).		**Yes**	**No**

Does the person have a written lasting power of attorney that is valid and relevant to this decision, or a court-appointed deputy for health and welfare? (If **yes**, the attorney or deputy is the decision-maker and their decision should be followed, as long as they are acting in the person's best interests).	**Yes**	**No**
Has the person made an advance decision that covers this decision? (Where the decision relates to the provision of life-sustaining treatment and the person has made a valid advance decision to refuse such treatment, generally that advance decision must be respected. Where there is any uncertainty, further guidance and possibly legal advice should be sought).	**Yes**	**No**

Provide the information requested in A to E below (for guidance refer to section 4 of the MCA 2005 together with MCA Code of Practice principle 2 and chapter 3 as appropriate).

A. Provide details of how the person has been encouraged and assisted to participate in the decision. If they have not been able to participate, please explain why.
B. Set out all the factors considered relevant to the decision.

C. Set out what you know about the person's wishes (both their past and present wishes and feelings) in respect of this decision.

D. Confirm whether the person might regain capacity and if so whether the decision can be delayed.

E. Explain how you have used the information in A to D above to reach your mental capacity decision.

(For guidance refer to the MCA Code of Practice – principle 2; paras 2.6–2.8 and chapter 3 as appropriate)

I have consulted the following relevant people in coming to my decision (state who they are in relation to the person):

Their views were:

It was not practicable/appropriate to consult* (delete as appropriate) include detailed reasons (include in here for example LPAs and deputies).

Independent mental capacity advocate (IMCA)

i. *A referral to the IMCA service is not necessary as I have been able to consult relevant individuals under the best interests checklist or the decision needs to be taken on an urgent basis.

Reason for urgency: ii. *A referral has been made to the IMCA service and I have taken the IMCA's view into account.

* delete where appropriate

Details of decision made and reasons for this decision (reference balance table appended to this form):

Details of individuals to be informed:
I confirm that I have not based my assessment solely on the person's age, appearance, condition or behaviour.

Signed	**Date**
Name (in capitals)	
Job title	

For joint decisions:

Signed	**Date**
Name (in capitals)	
Job title	

Signed	**Date**
Name (in capitals)	
Job title	
Signed	**Date**
Name (in capitals)	
Job title	

Option 1 [insert details of what this option is]

Intended benefits	Potential risks

Option 2 [insert details of what this option is]

Intended benefits	Potential risks

Add more balance tables if there are more than 2 options.

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Appendix 3: Court of Protection triage tool

Triage for Court of Protection application

Question	Answer
Name of person and Broadcare number if known	
Name of person providing information and email address	
Funding stream in place or applied for (CHC, joint, section 117)	
Is the person already in placement or has a discharge plan to move to placement? Please give details	
Brief outline of background and level of restriction, for example 2:1, locked doors, restraint, medication	
What is the Court of Protection being asked to authorise?	
Family members, close friends or legal representative involved?	
Any previous Court of Protection involvement?	
Which commissioning manager has agreed to the Court of Protection proceedings?	

Notes and additional items

Reason or outcome required for Court of protection application:

Click or tap here to enter text.

Appendix 4: Checklist for documents required index

1. Consideration as to whether the application needs to be urgent
2. Medical evidence stating that “P” suffers from unsound mind.
3. Medical evidence that “P” lacks the capacity to consent to arrangements: Court of Protection.
4. Dated copy of “P’s” care or support plans from provider and agency.
5. Emergency or contingency care or support plan.
6. Statement of best interest: best interest meeting minutes.
7. An annex recording any relevant wishes and feelings expressed by “P.”
8. Additional court papers for evidencing LPA, EPA and deputy allocation.
9. Identified litigation friend or rule 3A representative.
10. Completed and signed application: Court of Protection 11.

Appendix 5: Glossary

Reference	Abbreviated term
Mental Capacity Act	MCA
Independent mental capacity advocate	IMCA
Lasting power of attorney	LPA
A personal welfare LPA is for decisions relating to health and personal welfare.	LPAHW
A property and affairs LPA is for decisions relating to financial matters.	LPAF
Enduring power of attorney	EPA
Deprivation of Liberty Safeguards	DoLs

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Appendix 6: Impact assessment

Name of policy, service or decision to be assessed: MCA and DoLS policy
Department or section: Safeguarding and quality
Date of assessment: 02/10/2025
Person(s) responsible for the assessment: Rebecca Bartlett
Is this a new or existing policy? Existing

General background information

Reason for undertaking full impact assessment: Three yearly review

Describe the aims, objectives and purpose of the policy, service change or development:
To ensure the ICB has processes in place to comply with the Mental Capacity Act 2005 and to achieve the best outcomes for people protected by this act.

Anticipated timetable for decision: Less than 1 month

What areas will this impact? Cornwall and Isles of Scilly

Which of the strategic objectives apply to this full impact assessment? Other - improve care experience and improve health and well being

What are the commissioning arrangements? Other – cover whole of Cornwall and Isles of Scilly in all aspects of practice

What are the contractual implications for the policy or service change? All staff and commissioned services should comply with this policy

Who implements the policy or service? CIOSICB

Who benefits or is intended to benefit from this policy or service? All service users especially people who are unable to make decisions about their care and treatment or need support to do so. All staff will benefit from access to policy and guidance

What health and social care outcomes are achieved or wanted from this policy or service? Reducing health inequalities

How will this be monitored? Multiple sources

What factors or forces could contribute or detract from the outcomes? service pressure can affect impact

Who are the main stakeholders in relation to the policy or service? All staff and safeguarding partners

Is there clinical evidence for effectiveness of the policy or service? Yes - national

Does this policy or service link to health and social care overall strategy for the next 5 years and current direction of travel for integrated communities? Yes

Engagement

How have you engaged stakeholders in gathering or testing the evidence available? policy based on national findings from public enquiries and legislation and local system policy

What is the experience of individuals who access the service? Multiple – impact of the policy on safeguarding children is largely positive but due to the nature of the issues involved outcome can be mixed.

How have you engaged stakeholders in testing the policy or service proposals? Based on multi-agency policy which is developed by stakeholders

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

Impacts

Access to services

Aspect	+ or – impact	Details and plans to minimise negative impact
Ability of people to access the service	positive	Not applicable
Eligibility of people to receive the service	positive	Not applicable
Longer term sustainability of the service	positive	Not applicable
Reducing health inequalities	positive	Not applicable
Waiting times to receive service	positive	Not applicable

Quality of services

Aspect	+ or – impact	Details and plans to minimise negative impact
Choice for members of the public	positive	Not applicable
Clinical performance or outcomes	positive	Not applicable
Cohesion with wider services	positive	Not applicable
Operational effectiveness	positive	Not applicable
Statutory NHS targets	positive	Not applicable

Members of the public and carers

Aspect	+ or – impact	Details and plans to minimise negative impact
Carer experience	positive	Not applicable
Psychological	positive	Not applicable
Privacy and dignity	positive	Not applicable
Public care journey and pathway	positive	Not applicable
Public care standards	positive	Not applicable
Public experience	positive	Not applicable
Public safety	positive	Not applicable

Wider community

Aspect	+ or – impact	Details and plans to minimise negative impact
Cohesion with community strategy	positive	Not applicable
Community safety, crime, and disorder	positive	Not applicable
Environment, including climate change	positive	Not applicable
Information management	positive	Not applicable
Local economy	positive	Not applicable
Rural isolation	positive	Not applicable
Safeguarding*	positive	Not applicable
Social care	positive	Not applicable
Technology	positive	Not applicable
Transport	positive	Not applicable

* For safeguarding, consider the Care Act 2014 6 key principles: empowerment, prevention, proportionality, protection, partnership, and accountability.

Wider system partners

Has consideration been given to sharing with all appropriate meetings, groups or organisations?

Aspect	+ or – impact	Details and plans to minimise negative impact
Care homes	positive	Not applicable
Cornwall Council	positive	Not applicable
Cornwall Partnership NHS Foundation Trust	positive	Not applicable
Council of the Isles of Scilly	positive	Not applicable
Domiciliary care providers	positive	Not applicable
E-zec Medical Transport	positive	Not applicable
Hospice providers	positive	Not applicable
Kernow Health CIC	positive	Not applicable
NHS 111 (Vocare and Kernow Health CIC)	positive	Not applicable
Out of hours primary care	positive	Not applicable
Primary care	positive	Not applicable
Royal Cornwall Hospitals NHS Trust	positive	Not applicable
South Western Ambulance Service NHS Foundation Trust	positive	Not applicable
University Hospitals Plymouth NHS Trust	positive	Not applicable
Other system partners - please specify and add lines as necessary	positive	Not applicable

Financial aspect

Aspect	+ or – impact	Details and plans to minimise negative impact
Implications for individual or carer	positive	Not applicable
Implications for local authorities	positive	Not applicable

Aspect	+ or – impact	Details and plans to minimise negative impact
Implications for Cornwall and the Isles of Scilly Integrated Care Board	positive	Not applicable
Implications for other NHS commissioning organisations	positive	Not applicable
Implications for GP practice	positive	Not applicable
Implications for primary care network (PCN)	positive	Not applicable
Implications for surrounding practices	positive	Not applicable
Implications for NHS provider organisations	positive	Not applicable
Implications for peninsula	positive	Not applicable
Implications for private sector	positive	Not applicable
Implications for voluntary sector	positive	Not applicable

Anticipated climate of opinion

Aspect	+ or – impact	Details and plans to minimise negative impact
Clinical opinion	No impact	Not applicable
Colleagues	No impact	Not applicable
Local community	No impact	Not applicable
Media	No impact	Not applicable
Political	No impact	Not applicable

Protected characteristics

What is the differential impact on people from the perspective of race, nationality and/or ethnic origin? Does this have a positive or negative impact on people who have a black, Asian and minority ethnic (BAME) background? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of sex? Does this have a positive or negative impact on people who identify as male, female, or intersex? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of disability? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of sexual orientation? Does this have a positive or negative impact on people who identify as heterosexual, lesbian, gay, bisexual, pansexual, or asexual? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of age? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience. This policy is specifically aimed at protecting people who are protected by the Mental Capacity Act 2005 but can be applied in any care setting or environment.

What is the positive or negative differential impact on people from the perspective of religion or belief? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the positive or negative differential impact on people from the perspective of marriage and civil partnership? This is particularly relevant for employment policies. How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of gender re-assignment? Does this have a positive or negative impact on people who identify as trans or transgender, non-binary or gender fluid? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

What is the differential impact on people from the perspective of pregnancy and maternity? Does this have a positive or negative impact on people who are pregnant, breast feeding mothers, or those on maternity leave? How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Other identified groups. How will any negative impacts be mitigated?

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Human rights

How have the core human rights values of fairness, respect, equality, dignity, and autonomy been considered in the formulation of this policy, service, or strategy? If they haven't, please review this document and amend to incorporate these values.

This in included in the content of the policy.

Which of the human rights articles does this document impact?

The right:

☒ to life
☒ not to be tortured or treated in an inhuman or degrading way
☒ to liberty and security
☒ to a fair trial
☒ to respect for home and family life, and correspondence
☒ to freedom of thought, conscience, and religion
☒ to freedom of expression
☒ to freedom of assembly and association
☒ to marry and found a family
☒ not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention
☒ to peaceful enjoyment of possessions

What existing evidence (either presumed or otherwise) do you have for this?

safeguarding is intrinsic to promoting human rights and ensuring prevention of discrimination and harm.

How will you ensure that those responsible for implementing the policy are aware of the human rights implications and equipped to deal with them?

Governance is in place to ensure the policy is embedded in practice and this includes promoting human rights

Social Value Act 2012

The ICB is committed and obliged to fulfil the requirements of the public sector Social Value Act 2012. This act requires the organisations to consider how services commissioned or procured might improve the economic, social, and environmental wellbeing of an area. Please describe how this will support and contribute to the local system, wider system, and community.

Aspect	+ or – impact	Details and plans to minimise negative impact
Economic: promote skills, tackle worklessness, maintain employment, increase volunteer hours to support the community and promote inclusion	Positive	
Environmental: support local, reduce congestion	Not applicable	
Inclusion of small medium size enterprises (SMEs) in the process and supply chain	Not applicable	
Social: reduce anti-social behaviour, tackle exclusion by promoting inclusion including to vulnerable groups	Positive	

General public sector equality duties

Describe how the policy contributes towards eliminating discrimination, harassment, and victimisation.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Describe how the policy contributes towards advancing equality of opportunity.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Describe how the policy contributes towards promoting good relations between people with protected characteristics.

This policy promotes equity in service provision and seeks to ensure all are safe from abuse and neglect regardless of background or experience.

Any other impact not identified above?

No

Summary

If the differential impacts identified are positive, explain how this policy is legitimate positive action and will improve outcomes, services and/or the working environment for that group of people.

Promotion and adherence to this policy will ensure staff are confident to uphold the rights of those who are protected by the Mental Capacity Act 2005. This will be monitored via a robust governance structure.

Explain what amendments have been made to the policy or mitigating actions have been taken, and when they were made.

Updated to ensure take into account changes in practice and legislation.

If the negative impacts identified have been unable to be mitigated through amendment to the policy or other mitigating actions, explain what your next steps are using the following full impact assessment action plan.

None identified

Responsible person: Rebecca Bartlett, MCA Professional Lead

Timescale for completion: 1 month

Issues to be addressed: Not applicable

Action required: Not applicable

Action taken: Not applicable

Comments: Not applicable

This impact assessment should accompany the policy or service change documentation through the sign off process.

Completed by: Rebecca Bartlett
Date: 02/10/2025

Agreed by (committee): Executive Team
Date: 22/10/2025