NHS
Central East
Integrated Care Board

Mental Capacity Act (2005) and Deprivation of Liberty Policy

2026-2027

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Contents

1. Introduction

This policy sets out the principles and requirements for Mental Capacity Act 2005 and Deprivation of Liberty within NHS Central East Integrated Care Board. It aims to ensure a consistent and effective approach that supports the organisation's objectives, complies with statutory and regulatory requirements and promotes best practice.

The Mental Capacity Act 2005 (MCA) hereafter referred to as 'The Act', came into force in 2007 and provides a legal framework for the care, treatment and support of people aged 16 years and over, in England and Wales, who are unable to make some or all decisions for themselves.

The Act is underpinned by 5 statutory principles.

The Act has introduced Lasting Power of Attorney (LPA) and Advanced Decision to Refuse Treatment (ADRT).

It is a criminal offence if a person who lacks capacity is ill-treated or wilfully neglected.

Deprivation of Liberty Safeguards (DoLS) was introduced into the Act in 2009 to protect people's rights under Article 5 of the European Convention of Human Rights (ECHR). DoLS provide a safeguard in cases where someone who lacks capacity and is subject to care and support which amounts to a deprivation of liberty.

2. Purpose and Scope

The purpose of this policy is to ensure that Central East ICB discharges its duty as commissioners and/or providers of healthcare services in compliance with the MCA 2005 by ensuring that robust systems are in place to safeguard and promote the rights of people who lack mental capacity.

ICBs have a statutory duty to ensure commissioned services comply with the MCA 2005 & DoLS 2009. And manage Courts of Protection Deprivation of liberty Safeguards (CoPDoLS) applications to make lawful care arrangements that amount to DOL.

This policy applies to all Central East ICB staff, Board members, volunteers, contractors, and others involved in commissioning, procuring, service design and policy-making processes.

3. Definitions

The Act does not define mental capacity but the lack thereof as:

"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 brain." (section2(1)).

MCA	Mental Capacity Act 2005
IMCA	Independent Mental Capacity Advocacy
Decision Maker	A professional who consults with others to decide on the best interest decision Code of Practice Written to support the understanding and application of the MCA
Best Interests	section 4 of the Act (supported by the Code of Practice) sets down how to decide what is in the best interests of a person who lacks capacity in any particular situation.
Lasting Power of Attorney (LPA) for health and welfare	This lasting power of attorney allows you to choose people to act on your behalf (as an attorney) and make decisions about your health and personal welfare, when you are unable to make decisions for yourself.

4. Policy Statement

Central East ICB is committed to safeguarding the rights and freedoms of people who lack mental capacity by ensuring compliance with all relevant legislations, case law and best practice in the tendering, commissioning, procurement and delivery of healthcare services.

Central East ICB will inform other joint commissioners of care or treatment services regarding non-compliance with the MCA where services are commissioned in conjunction with Central East ICB.

Central East ICB will inform the police if it has cause to believe a crime has been committed under section 44 of the MCA 2005 (the ill treatment or wilful neglect of an adult who lacks capacity).

All staff are expected to adhere to the requirements set out in this policy.

5. Roles and Responsibilities

The following have specific responsibilities in relation to this policy:

The Director of Safeguarding Complex Care/SEND has overall responsibility for:

Strategic direction and leadership, including ensuring that ICB processes comply with all legal and good practice guidance requirements in accordance with the MCA 2005.

Commissioning and providing services which demonstrate compliance with the MCA/DoLS legislation.

Ensuring that the MCA/DoLS legislation has a high profile throughout the ICB, and all ICB staff comply with The Act, including compliance within the tendering and contracting process.

The Deputy Director of Safeguarding Complex Care and SEND has overall responsibility for ensuring that:

MCA/DoLS is included in the job descriptions for posts being recruited to where staff are expected to work directly with persons affected by this legislation.

Compliance with this legislation forms part of personal development reviews of all staff working directly with the affected persons.

Conducive working environments are created within the ICB to promote embedding of this legislation into practice**.**

The Senior COPDOL Lead is responsible for:

Maintaining and reviewing this policy document based on statutory requirements and informed by evolving case law.

Reviewing existing MCA related systems, identifying gaps, and highlighting areas for improvement to minimise risk of breach.

Formulating and ensuring access to tools and templates by staff to facilitate compliance with this policy.

Designing, delivering, and procuring staff training which is tailored to staff's roles and responsibilities in line with the Intercollegiate Guidance Roles and Competencies for Healthcare Staff (2024)

Collating relevant data, compiling and submitting reports on MCA related trends and performance to relevant committees/ boards and NHS Digital.

Engage with local Safeguarding Adults and Children Boards and board sub-groups.

Monitor the implementation of this policy document.

All Managers are responsible for ensuring that:

relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

All Central East ICB Staff are individually and collectively responsible for:

Compliance with this policy to ensure the rights conferred by the legislation are respected and upheld.

Understanding and implementing appropriate processes of seeking consent, assessing mental capacity, and supporting best interest decisions during their day-to-day work.

Maintaining contemporaneous and accurate records including robust mental capacity assessments, best interest decisions and care plans which reflect the MCA principles.

Identifying care plans where there are restrictions or restraints for people who lack capacity which may amount to a Deprivation of Liberty and ensuring the necessary legal processes are applied for the deprivation to be authorised.

Keep up to date with changes in statutory requirements which may trigger a review of or change in practice.

Identifying own training needs and notifying their Line Manager or Senior COPDOL Lead.

Attend available training which is commensurate with roles and duties.

6. Processes and Procedures

The following must be adhered to in order to comply with this policy:

MCA Principles

There are five key principles underpinning the Mental Capacity Act (2005) as follows

Principle 1 – **Presumption of capacity** - A person must be assumed to have capacity to make decision(s) unless it is established that they lack capacity to do so.

Principle 2 – **All practicable steps** must be taken to help a person to make a decision for themselves before treating them as unable to do so.

Principle 3 – **An unwise decision** - A person should not be treated as unable to make a decision merely because of making an unwise decision.

Principle 4 – **Best interests** - An act done, or decision made on behalf of a person who lacks capacity must be in that person's best interests.

Principle 5 – **Least restrictive** - anything done for or on behalf of a person without capacity should be the least restrictive of their basic rights and freedoms.

Assessing Mental Capacity

If there are any reasons to doubt a person's capacity and the person is over 16 years of age, a capacity assessment should be completed. The presumption of capacity is a rebuttal assumption meaning it can be overturned on the balance of probabilities if there is clear evidence of a mental impairment or disturbance that prevents an individual from understanding, retaining, or weighing information related to a specific, timely decision

Be professionally curious as to whether there are grounds to assess. The burden of proof sits with the health professional to evidence that the presumption of capacity is no longer applicable.

Responsibility for Assessing Mental Capacity

The responsibility for completing a mental capacity assessment lies with the person proposing the care/treatment or intervention for the individual at the time that the decision needs to be made.

A second opinion on the person's capacity might be sought for more complex decisions, impairments or disturbances but ultimately the conclusion as to whether a person has capacity for the specific decision or not, should be made by the person intending to carry out the intervention – also referred to as the 'Decision-maker.'

For all major decisions, a standardised mental capacity assessment form should be completed. If unable to be completed, detailed records including rationale must be added to the person's record.

Conducting Assessment of Capacity (Appendix 2 & 3)

The assessment should be approached from the standpoint of supporting the individual to make the decision at the time rather than conducting a 'test' on the individual (Principle 2). It is a single assessment with three parts.

Part 1 - Functional Assessment

Can the individual:

- **Understand** the information relevant to the decision to be made?
- **Retain** the information long enough to make the decision?
- **Use or weigh** that information as part of the decision-making process?
- **Communicate** their decision by any means?

An individual is unable to make the decision if they cannot meet ANY single element of the above **Proceed to Part 2**.

Part 2 - Diagnostic Assessment

Does the person have an impairment of or disturbance in the functioning of the mind or brain? **If yes, proceed to Part 3.**

If No, then it is highly like that the individual has capacity and is making an unwise decision. Provide relevant support to minimise/mitigate risk. Also consider coercion and control bearing in mind that an application to the High Court for its inherent jurisdiction might be needed.

This stage of the test is to establish why the person is unable to make the decision. The impairment does not have to be permanent or formally diagnosed.

Part 3 – Causative Nexus

Is the inability to make the decision linked to the impairment of or disturbance in the functioning of the mid or brain?

An individual is deemed to lack the capacity to make the decision if they cannot meet part 1 and part 2 and part 3 is positively established.

7. Best Interests Decision-Making Process

Where a person is assessed as lacking capacity to make a specific decision and in the absence of any pre-existing legal authority, the decision must be made by the person proposing the intervention, also known as the Best Interest Decision-Maker

Follow the Statutory Best Interests Checklist when making best interest decisions

For complex decision(s), a meeting involving the relevant people (including family and any interested parties to the case) should be convened or the people could be consulted by other means to decide what is in the person's best interests.

A Court of Protection (CoP) application must be made immediately where there is a professional dispute about a person's best interests, and an attempt to resolve it has failed.

The ICB should not mediate family dispute about best interest. In such cases, an application to the CoP should be made immediately.

For all CoP applications, contact the ICB's Senior COPDOL Lead and legal provider.

In emergency situations urgent medical treatment can be given under best interests to a person who lacks mental capacity, except where there is a current and valid Advanced Decision to Refuse Treatment (ADRT) or a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) if relevant.

A written record should be kept of the decision-making process including steps taken to support the person assessed as lacking capacity and the best interest process.

Relevant Forms

MCA assessment and Best Interest form

Best Interest checklist and Best Interest Meeting Agenda Template

Legal Authority to Make Decisions

If a person has been assessed as lacking capacity to make a specific decision, it should be ascertained if there are valid pre-existing arrangements providing legal authority for deciding on behalf of the person lacking capacity such as Lasting Power of Attorney (LPA), Advance Decision to Refuse Treatment (ADRT), Court Appointed Deputy.

Lasting Power of Attorney (LPA)

This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. LPA can be made for:

- Property and Financial Affairs LPA regarding financial and property matters. This can come into effect while the donor still has capacity if the LPA says they can and the donor gives permission.
- Health and Welfare LPA regarding decisions about health and welfare. Only comes into effect when there is a lack of capacity. It must be registered with the Office of the Public Guardian.

An LPA can only act within the remit of their authority as documented in the LPA document.

Where there are more than one LPA, they could be authorised to make decisions severally (separately) or jointly (in agreement) thus attention must be paid to the LPA documentation for further details.

An Enduring Power of Attorney (EPA) which was previously used prior to the MCA remains effective for Finance & Property decisions only. Only EPAs made and signed before October 1, 2007, can still be used

Practitioners must be assured that the LPA is valid and any restrictions are considered.

To ascertain whether a person has a registered LPA, a search can be done with the Office of Public Guardian (OPG).

8. Advance Decision to Refuse Treatment (ADRT)

A person may have expressed verbally or documented an advance decision to refuse specific treatments when they had capacity. These should be recorded in the persons file where there is knowledge of them. These may also be logged with the person's GP.

ADRT's are legally binding if made in accordance with the Act and must be followed.

For an ADRT relating to life-sustaining treatment to be valid, it must

- be in writing,
- contain a specific statement, which says "*this decision applies even though my life may be at risk"*
- signed by the person or nominated appointee and in front of a witness
- signed by the witness in front of the person. The person witnessing should not be someone who is likely to benefit from the person's death.

16yrs and 17yrs old cannot make ADRT.

A relevant Lasting Power of Attorney can override an advanced decision to refuse treatment if the LPA is made **after** an advanced decision to refuse treatment.

9. Court Appointed Deputy

The Court of Protection (CoP) can appoint someone to make specific decisions on behalf of the person who lacks capacity to do so where there is no LPA in place. They can be appointed to act for property/finance or health and welfare decisions.

Any concerns about validity of these arrangements can be verified with the Office of the Public Guardian via email or telephone – 0300 456 0300

10. Other legal bodies

Independent Mental Capacity Advocate (IMCA)

An IMCA referral MUST be made when a person has been deemed to lack the capacity for a particular decision at that time and the person has no family or friends willing and able to support them.

An IMCA is not a decision maker for a person who lacks capacity but instructed to support the person who lacks capacity and represent their views and interests to the decision maker; equally, they are not mediators between parties in any dispute.

Go to MCA resource page on intranet for local IMCA contact details.

The Office of the Public Guardian (OPG)

The OPG exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Deputies; and providing reports to the COP, as requested.

The OPG can be contacted to find out if someone has an LPA or Deputy acting for them. This can be an attorney under a Lasting Power of Attorney, an attorney under an Enduring Power of Attorney (pre 2007) or a court appointed Deputy. You need to complete form 'OPG 100' to search the register. This is a free service.

Send your completed form to: Office of the Public Guardian

customerservices@publicguardian.gov.uk and write 'Registers' as the subject.

Further information regarding the Office of the Public Guardian can be found by the following link: https://www.gov.uk/government/organisations/office-of-the-public-guardian

The Court of Protection (CoP)

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

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.
- Appoint Deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether an LPA or EPA is valid; and remove Deputies or Attorneys who fail to carry out their duties,
- Hear cases concerning any objections to register an LPA.
- Authorise a deprivation of liberty and hear s21A challenges.

Further information regarding the Court of Protection can be accessed via https://www.gov.uk/courts-tribunals/court-of-protection

For all CoP applications, contact the ICB's COPDOL Lead and legal provider.

11. Prolonged Disorders of Consciousness (PDOC) -

PDOC refer to persons who are in a vegetative or minimal state of consciousness.

Where the ICB might be funding care for these persons, the following must be completed:

Care must be reviewed annually

Best Interest decision should focus on whether it is in the patient's best interests and therefore lawful to continue to give rather than withdraw certain treatments e.g. clinically assisted nutrition and hydration (CANH). See Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67.

In cases where professionals and family agree to withdraw treatment, a CoP application is not necessary.

However, in cases of dispute, an application to the CoP must be made immediately as per Hayden J in NHS South East London Integrated Care Board v JP & Ors [2025] EWCOP 8

12. Disputes

The ICB **must not** mediate family dispute about a person's best interests as this is likely to occlude the nature of the best interest inquiry and delay court applications.

When there a professional dispute regarding a person's capacity and or best interests, a second opinion on capacity and best interests should be sought immediately and if not resolved, contact Senior COPDOL Lead to discuss CoP application.

Court of Protection proceedings must be issued promptly and there must be a robust and collaborative approach between appropriate providers and commissioners.

13. Restraint

Section 6(4) of the Act states that someone is using restraint if they:

- Use force or threaten to use force to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not have protection from liability unless the following two conditions are met:

1. The person taking action must reasonably believe that restraint is necessary to **prevent harm** to the person who lacks capacity, and
2. The amount or type of restraint used and the amount of time it lasts must be a **proportionate** response to the likelihood and seriousness of harm.

Staff should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person's care what action they think is necessary to protect the person from harm.

If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible and consideration should be given as to whether the restraint used, could be classed as a deprivation of the persons liberty whereby a legal authorisation will be required.

Interface between the Mental Capacity Act and the Mental Health Act (MHA)1983 amended 2025

The interface between the two Acts is relevant when a person with a mental disorder is unable to or willingly consent to care or treatment.

For mental disorders that meets the criteria for assessment and treatment under the MHA, the MCA framework cannot be used.

For mental disorders that do not meet the criteria for assessment and detention under the MHA, the person's mental capacity to consent to the proposed treatment should be assessed.

Where someone is supported by the Mental Health Act and they have physical care, and treatment needs consideration must be given to the need to assess under the MCA to provide physical care and treatment.

If a patient is already detained in hospital under s3 (and most other MHA sections) they cannot be detained under DoLS.

A patient on s17 leave, conditional discharge, Community Treatment Order (CTO) or guardianship can also be detained under DOLS if that does not conflict with the MHA provision.

A patient on s17 leave, conditional discharge or CTO should be recalled rather than detained under DoLS

A patient under guardianship, or a person who is not detained but meets the s2/ or s3 criteria of the MHA ,who objects to psychiatric hospital admission, should not be detained under DoLS.

Under the MHA 2025, the Mental Health Tribunal can authorise a conditional discharge of a mental health patient with conditions that amounts to DoL. In such case, a CoP application is not needed.

Deprivation of Liberty (DoL)

Article 5 of the Human Rights Act 1998 states that, '*everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law.'*

In P v Cheshire West and Chester Council [2014] UKSC 19 the Supreme Court set out the grounds in which someone is deprived of their liberty, known as the 'acid test'. These are:

- *the person is subjected to continuous supervision and control; And*
- *the person is not free to leave. (The person does not have to actively be trying to leave)*

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation, or an authorisation obtained via the appropriate legal process. Such authorisation should be obtained via the MCA 2005 and The Deprivation of Liberty Safeguards 2007 (DoLS) or by an application to the Court of Protection (COP). Where the individual requires care and treatment related to a mental disorder the Mental Health Act 1983 (MHA amended in 2007) should be utilised.

For persons in hospitals and care/nursing homes, DoLS authorisation is done by the Local Authority (Supervisory Body). For those in ICU, consider the Ferriera judgement when seeking assurance on DoLS authorisation.

ICB staff should seek assurance from care providers (Managing Authority) that all fully NHS Funded individuals in nursing homes who meet the criteria for deprivation of liberty have had DoLS authorisation.

For fully NHS Funded individuals in a community setting, such as an independent living scheme, a person's own home, an adult placement or foster placement, where a potential Deprivation of Liberty may be occurring, then the following process should be followed:

- Review the care package to see if any restrictions could be removed to negate a deprivation.
- Complete a mental capacity assessment on the person's capacity to consent to the care arrangements.
- Complete and document a best interest decision if the person has been assessed as lacking capacity.
- If the person has mental capacity to consent to their care arrangements, the person should sign a consent form agreeing to the care arrangements.
- If they lack mental capacity to consent to their care arrangements, the case manager should refer person to the COPDOL Team who will initiate the COPDOL11 authorisation process.

ICBs are not regulated by the CQC, therefore do not have to notify the CQC when a COPDOL is authorised. If the person is cared for by a regulated care provider, then it is the provider's duty to notify the CQC.

Where a person is subject to a Deprivation of Liberty Authorisation dies, the case manager or reviewing officer must notify the Supervisory Body or authorising Court.

Any unauthorised deprivations will carry with it a potential risk of litigation and financial risk to the ICB. Such a risk should be included on the Risk Register and an action plan to address the risk reviewed on a regular basis.

Statutory and National Guidance

This policy has been developed with reference to the following statutory and national guidance:

- *European Convention on Human Rights 1950*
- *Human Rights Act (1998)*
- *Equality Act (2010)*
- *Care Act (2014)*
- *The Mental Capacity Act 2005 (Amended 2007 and 2019)*
- *The Childrens Act (2004)*
- *Mental Health Act (1983), amended 2025*
- *A Local Authority v JB [2021] UKSC 52 case law which confirms to start assessment with functional element.*
- *R (Ferreira) v HM Senior Coroner for Inner South London [2017] EWCA Civ 31*
- *Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67*
- *Prolonged disorders of consciousness following sudden onset brain injury: national clinical guidelines. 2020-03_RCP_PDOC_guidelines.pdf*

Stakeholder Engagement Record

8.1 The following stakeholders were engaged in the development / of this policy:

Role/Group	**Date of Engagement**	**Summary of Feedback**
[CEICB safeguarding team]	[n/a]	[This policy has been developed by merging the MCA policies from the three formal ICBs. The three formal ICBs' policies were developed with stakeholders' engagement from their various locality therefore from implication, this policy has been developed with stakeholder engagement.]

Accessibility Statement

This policy is available in alternative formats upon request, including large print, Braille and translated versions, to ensure accessibility for all staff and stakeholders.

Implementation Plan

Development and Consultation: [.]
Dissemination:. . [All ICB staff should be made aware of this policy and guidance through various communication channels. The policy should be published on the ICB's internal website.]
Training: [All staff are required to undertake relevant training and safeguarding supervision commensurate with their duties and responsibilities as outlined in the Intercollegiate Document 'Adult Safeguarding: Roles and Competencies for Health Care Staff' and the ICB document 'A Learning Approach to Adult Safeguarding'. Staff requiring support should speak to their line manager in the first instance.]
Monitoring: [To be monitored via the relevant governance structure]
Review: [This policy will be reviewed in 3 yearly or sooner if there is a change in legislation, case law, or organisational structure that impacts on the operationalisation of the policy]
Equality, Diversity, and Privacy: See Appendices
Associated Documents: [CEICB Safeguarding Policy]
References: [*Adult Safeguarding: Roles and Competencies for Health Care Staff 2024*

A Local Authority v JB [2021] UKSC 52 case law which confirms to start assessment with functional element.

R (Ferreira) v HM Senior Coroner for Inner South London [2017] EWCA Civ 31

Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67

Prolonged disorders of consciousness following sudden onset brain injury: national clinical guidelines. 2020-03_RCP_PDOC_guidelines.pdf]

Appendix 1: Equality Impact Assessment

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Mental Capacity Act and Deprivation of Liberty Policy
Date of assessment:	24/02/2026
Screening undertaken by:	Linda Katte- MCA Lead and Karen McCulloch – MCA Lead

Protected characteristic and inclusion health groups.	**Could the policy create a disadvantage for some groups**	**If Yes - are there any mechanisms already in place to mitigate the**

Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	in application or access no? (Give brief summary)	potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	The Policy will positively impact on vulnerable adults age 16+. It sets out the procedures which staff are required to adhere to empower and support individuals to make their own decisions.	
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	The Mental Capacity Act is in place to uphold individual's rights and freedoms and linked to The Human Rights Act 1998. This policy sets out to address any discrimination relating to disability in line with legislation. The policy allows for scrutiny of care packages where restrictions may be in place that may amount to a deprivation. If so, an authorisation to make lawful that care package will be put in place and will further protect the individual.	
Gender reassignment The process of transitioning from one gender to another.	The policy sets out to address any discrimination relating to Gender reassignment in line with current legislation.	
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	This policy sets out to address any discrimination relating to marriage and civil partnership in line with current legislation.	

Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.	This policy sets out to address any discrimination relating to Pregnancy and Maternity in line with current legislation
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	This policy sets out to address any discrimination relating to race in line with current legislation.
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	This policy sets out to address any discrimination relating to race in line with current legislation.
Sex A man or a woman.	This policy sets out to address any discrimination relating to sex in line with current legislation.
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	This policy sets out to address any discrimination relating to race in line with current legislation.
Carers Individuals within the ICB which may have carer responsibilities.	This policy does not impact on any working arrangements. Carers are consulted as part of any mental capacity process, to establish the views of the actual individual concerned. (Not the views of the carer)

Please summarise the improvements which this policy offers compared to the previous version or

position.

Has potential disadvantage for some groups been identified which require mitigation?

Yes / No – (If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken.)

No – The Mental Capacity Act 2005 and The Mental Capacity (Amendment) Act 2019 is in place to empower individuals and uphold their rights and freedoms. The Government have their own EQIA completed for the legislation also. The overall aim is to ensure individuals are supported to make informed decisions where possible and if unable to, evidence is documented, and decisions made in the persons best interests using a checklist that evidence that the persons wishes and feelings are given primacy and where their wishes are not followed full justification in the documentation is essential.

Appendix 2: Data Protection Impact Assessment

Screening questions to determine if a full DPIA is required. Guidance on handling personal and sensitive data.

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via ***(insert email address once confirmed)***

A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Mental Capacity Act and Deprivation of Liberty Policy
Date of assessment:	24/02/2026
Screening undertaken by:	Linda Katte- MCA Lead and Karen McCulloch – MCA Lead

Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1. Will the policy result in the processing of personal identifiable information / data? This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	Yes
2. Will the policy result in the processing of sensitive information / data? This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	Yes
3. Will the policy involve the sharing of identifiers which are unique to an individual or household? e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	Yes
4. Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information? **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any persons. Re-identification is remotely possible, but very unlikely.	No
5. Will the policy result in organisations or people having access to information they do not currently have access to?	No
6. Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?	No
7. Does the policy result in the use of technology which might be perceived as being privacy intruding? e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8. Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?	No

	Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	
9.	**Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?**	No
10.	**Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive?** e.g., personal email, text message etc.	No

Appendix 3: MCA Decision Making - Policy Flowchart