Agenda for ACT 2026

9.00	**Conference registration and refreshments**
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9.50	**Strategic Commissioning Framework** Chris Scott, Director of Strategic Commissioning, NCC
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Norfolk County Council

Promoting Independence

#NorfolkACT2026

Workshops and Rooms

Workshop Name	Room
Quality Assurance Systems, Recording and Analysis	Sunningdale Suite
Mental Capacity Act	Eaton Suite
Safeguarding	La Fontaine
Behaviour Support: Brain, Behaviour, and Better Responses	Muirfield Suite
Strategic Commissioning Framework	Conservatory

#NorfolkACT2026

Achieving Care Together

Improving quality and sustainability in the adult social care market and key priorities for us all.

3 March 2026

Louise Brosnan

Assistant Director Quality & Brokerage
Norfolk County Council

Welcome & Housekeeping

#NorfolkACT2026

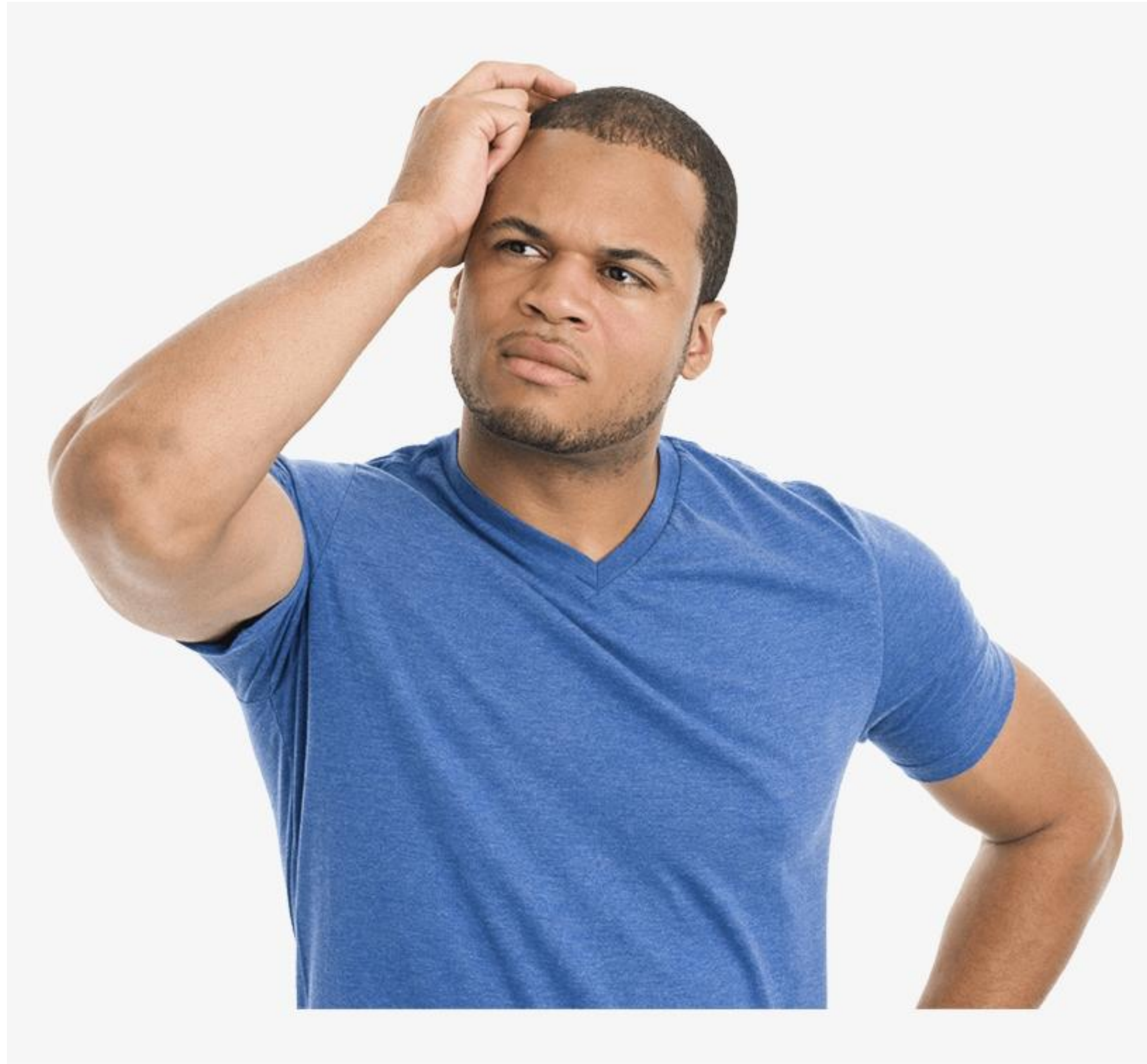
Introduction and Opening Remarks

Ian Wake
Executive Director of Adult Social Services

Norfolk County Council

Achieving Care Together

So, what is today about?

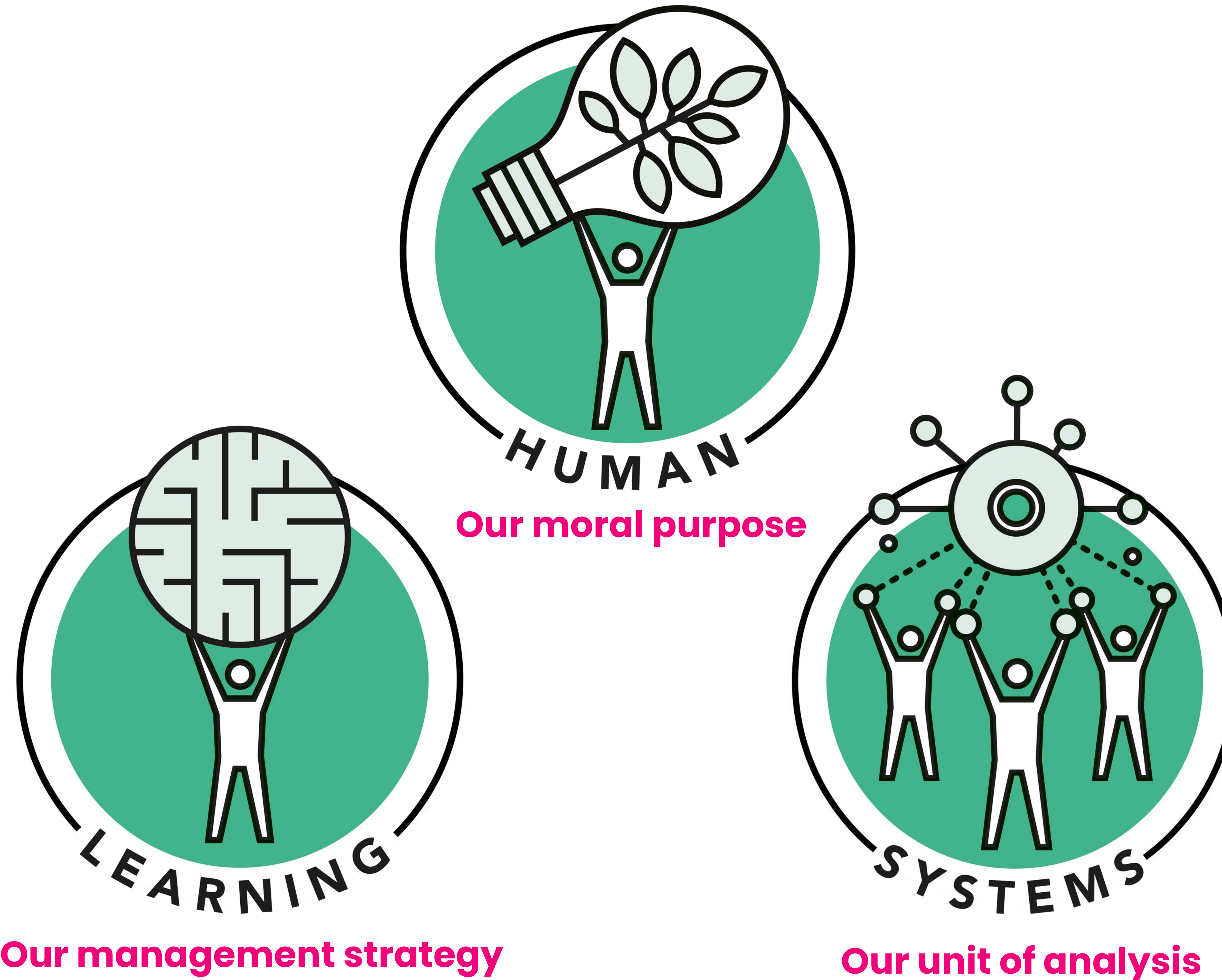


Achieving
Care
Together
2026

Inadequate | Requires Improvement | Good | Outstanding

Catherine's Story

Achieving
Care
Together
2026



www.humanlearning.systems

Adult Social Care Transformation Priorities

SIX NEW ASSD STRATEGIC PRIORITIES

01

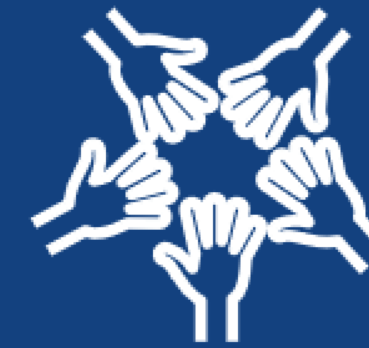
LEVERAGE THE POWER OF PEOPLE & COMMUNITIES TO PREVENT AND DEFLECT DEMAND

02

PROACTIVE PREVENTION THROUGH POPULATION HEALTH MANAGEMENT

03

IMPROVE THE QUALITY OF SOCIAL WORK PRACTICE BY ADOPTING A STRENGTHS & ASSET-BASED RELATIONAL APPROACH



04

INTEGRATE COMMUNITY CARE

05

TRANSFORM COMMISSIONING TO DELIVER BETTER CARE OUTCOMES & BEST VALUE

06

BUILD AN ASSD THAT IS FIT FOR THE FUTURE

Thank You

#NorfolkACT2026

Chris Scott

Director Strategic Commissioning & Care Markets
Norfolk County Council

Strategic Commissioning Framework

Hello and first an apology

Hello and first an apology

My commitment to you is that there will be communication in the form of emails and Vlogs that cover the following

- Adult Social Care Transformation (building on what Ian has shared already and what you will hear more about today)
- Commissioning Transformation including a link to the paper that is going to Adult Social Care and Public Health Select Committee on the 11th March.
- Approach to Appreciative Inquiry/ Learning visits – we are keen to spend more time with our providers listening and learning
- Engagement, co-design and co-production with our key stakeholders (including providers) – building on some excellent work that is already underway
- Noting various papers and decisions that have recently been approved by Cabinet

Today I am going to cover (and attempt to keep to time)

- Strategic Commissioning Framework and draft principles
- Learning visits
- And our Market Position Statement

But first a quiz....

If you include all types of support (including equipment, Short Term, Long Term etc) how many people were supported by Adult Social Care in 2024/25?

Answer A: Approx. 11,500

Answer B: Approx. 22,000

Answer C: Approx. 31,000

If you include all types of support (including equipment, Short Term, Long Term etc) how many people were supported by Adult Social Care in 2024/25?

Answer A: Approx. 11,500

Answer B: Approx. 22,000

Answer C: Approx. 31,000

What percentage of people aged 65+ in Norfolk live alone?

Answer A: 12.2%

Answer B: 28.8%

Answer C: 41.1%

What percentage of people aged 65+ in Norfolk live alone?

Answer A: 12.2%

Answer B: 28.8%

Answer C: 41.1%

What percentage of people with disabilities often feel lonely, compared to people without a disability?

Answer A:
3.1%

Answer B:
7.2%

Answer C:
11.2%

What percentage of people with disabilities often feel lonely, compared to people without a disability?

Answer A:
3.1%

Answer B:
7.2%

Answer C:
11.2%

How much is spent per day providing services across Adult Social Care?

Answer A: Approx £500k

Answer B: Approx. £1.5m

Answer C: Approx. £1.8m

How much is spent per day providing services across Adult Social Care?

Answer A: Approx £500k

Answer B: Approx. £1.5m

Answer C: Approx. £1.8m

Strategic Commissioning Framework

Possible Principles for Strategic C

A. Social Value
B. Equality, Diversity and Inclusion (EDI)
C. Co-Production, Co-design and Engagement
D. Human Learning Systems (HLS)
E. Prevention and Early Intervention
F. Place-based Integration
G. Ethical Commissioning
H. Risk-Positive Practice
I. Value for Money
J. Digital by Design

Possible Principles for Strategic Commissioning Framework

A. Social Value
B. Equality, Diversity and Inclusion (EDI)
C. Co-Production, Co-design and Engagement
D. Human Learning Systems (HLS)
E. Prevention and Early Intervention
F. Place-based Integration
G. Ethical Commissioning
H. Risk-Positive Practice
I. Value for Money
J. Digital by Design

a. Social Value
Commissioning will be used as a lever to deliver broader societal benefits, including tackling health and social inequalities, beyond service outputs. This includes:
- Creating employment opportunities, especially for disadvantaged groups.
- Promoting inclusion and reducing inequalities.
- Supporting environmental sustainability and climate action.
- Partners will be required to demonstrate how they contribute to social value, and Norfolk will embed social value metrics into procurement and performance frameworks.

b. Equality, Diversity and Inclusion (EDI)
Norfolk is committed to commissioning services that are inclusive, equitable, culturally competent, and accessible to all, proactively removing systemic barriers to participation and outcomes. This means:
- Ensuring services reflect the diversity of Norfolk's communities.
- Requiring providers to demonstrate equitable outcomes.
- Embedding inclusive practices in provider expectations and commissioning decisions.

1

Possible Principles for Strategic Commissioning Framework

c. Co-Production, Co-design and Engagement
People who draw on care and support will be actively involved in shaping commissioning priorities and service design. Norfolk will:
- Ensure that co-design and engagement activities are accessible to all, using diverse methods (e.g. translated materials, BSL, easy-read formats) and that this requires an investment of time and resources and will plan accordingly.
- Recognise the valuable expertise of lived experience and make sure it informs every stage of the commissioning cycle.
- Promote shared ownership of change through relational engagement.

d. Human Learning Systems (HLS)
Norfolk will work with partners, across the care system, to steward the market collaboratively, moving away from transactional relationships. We will ensure that learning cycles include feedback from diverse communities and are used to address inequalities in service access and outcomes This involves:
- Enabling partners to learn and adapt in real time.
- Focusing on relationships, and building trust
- Continuous improvement rather than rigid KPIs.
- Embedding Learning Cycles across system scales—from individual care settings to strategic governance boards.

e. Prevention and Early Intervention
Commissioning will prioritise upstream investment to reduce demand and improve outcomes. Prevention and early intervention will be tailored to the diverse needs of Norfolk's communities. Norfolk will:
- Invest in community-led initiatives that promote wellbeing.
- Commission services that prevent escalation of need.
- Support digital and relational models that enable independence.

f. Place-Based Integration
Commissioning will be aligned across health, housing, and social care systems to deliver joined-up support the ensures equitable access and outcomes for all communities, particularly those facing barriers to care. This includes:
- Developing integrated commissioning arrangements with health partners.
- Embedding locality-based models that reflect the unique needs of Norfolk's communities.
- Supporting the development of Integrated Neighbourhood Teams.

2

Possible Principles for Strategic Commissioning Framework

g. Ethical Commissioning (Real Care Deal)
Norfolk will ensure that commissioning decisions are transparent, fair, anti-discriminatory, and accountable. This includes being transparent with other commissioners to support shared objectives and mutual accountability. Which means:
- Using evidence-informed processes that reflect public values.
- Promoting ethical standards in procurement and provider relationships.
- Ensuring decisions are inclusive and open to scrutiny.

h. Risk-Positive Practice
Commissioning will support informed risk-taking to promote independence and innovation. Risk-positive practice will be implemented in ways that do not disadvantage marginalised groups and will be informed by diverse perspectives. Norfolk will:
- Encourage providers to take calculated risks that empower individuals.
- Avoid overly risk-averse models that limit choice and autonomy.
- Use relational approaches to manage risk collaboratively.

i. Value for Money
Resources will be used strategically to maximise impact and long-term sustainability, by actively managing the care market to ensure value for money, quality, and responsiveness to changing need. Norfolk will:
- Focus on outcomes rather than inputs.
- Ensure resources are allocated fairly and support the needs of all communities
- Use data and intelligence to inform investment decisions.

j. Digital by Design
Digital by design will ensure digital inclusion for all who want it, with targeted support for those with protected characteristics or at risk of digital exclusion. Technology will be used to support independence and choice, while strengthening human connection. Norfolk will:
- Commission digitally enabled care models, such as the Alcove Video Carephone.
- Ensure those who can support themselves with technology are enabled to do so.
- Provide human support for those who choose not to or are unable to use technology.
- Promote digital inclusion and ensure choice in care delivery.

3

Learning visits

And finally, a quick mention of the Market Position Statement

Our strategic aims and guiding approaches

Our six strategic aims for adult social care in Norfolk, and the national and local principles that shape how we work with the sector

The Norfolk picture

Explore the key factors shaping adult social care in Norfolk - including demographic trends, demand pressures, and benchmarking insights

Market shaping and transformation

How we're working with providers, people and partners to shape a sustainable, person-centred care market

Sector profiles and commissioning insight

73981/The-Norfolk-picture

How to work with us

Thank You for your time

Please do come and speak to me during the breaks or you can email at chris.scott@norfolk.gov.uk

#NorfolkACT2026

#NorfolkACT2026

Integrated Neighbourhoods

Ali Gurney

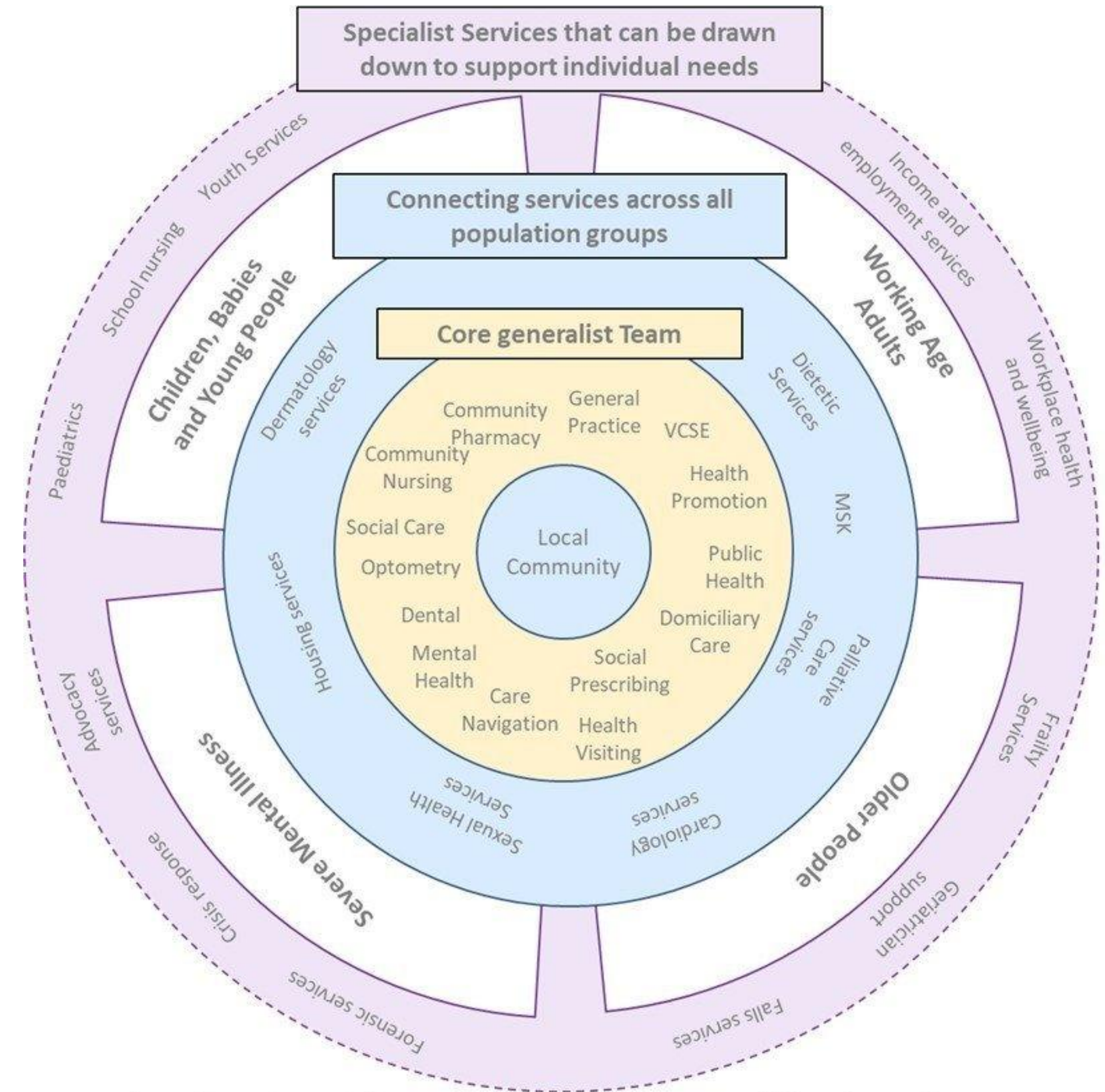
Assistant Director, Communities and Partnerships
Adults Social Care,
Norfolk County Council

Norfolk County Council

Promoting Independence

What Is Our Neighbourhood Health Plan?

- ➢A system-wide approach across Norfolk & Waveney.
- ➢Builds on strengths of local communities and providers.
- ➢Focuses on relationships, shared insight, early support, and working at the most local appropriate level.
- ➢Designed to reduce fragmentation and create a simpler, more joined-up experience.



*Specialist services are indicative and not exhaustive. These teams will flex and respond to the needs of individuals and groups within our populations.

Why We Are Doing This

- Wellbeing shaped by housing, income, connection, health and community.
- Current silos create handoffs, repeat assessments and delays.
- Neighbourhood health – relational and preventative support.
- Stabilises demand, supports independence, reduces crisis-led interventions.

Residents have told us they want to live independently, access support earlier, and feel confident in the care they receive.

How Neighbourhoods Work

- Reflect real communities based on PCN footprints, not rigid organisational boundaries.
- Teams form around what matters to residents.
- Expertise is pulled in, not referred out through multiple pathways.
- Shared understanding via neighbourhood profiles (data + lived experience + local insight).

The Shift to Working More at ‘Place’

- Decisions made closer to where people live.
- Partnerships at place bring health, social care, VCSE, housing and care providers as equal partners.
- Reduces duplication, speeds up problem-solving, uses local assets.

Prevent → Reduce → Delay

Prevent: wider determinants, early help in trusted local settings.

Reduce: spot early signs, rapid targeted support across partners.

Delay: sustain independence via reablement, falls prevention, meds optimisation, carers support.

Why This Matters for Providers

- Clearer and quicker access to support.
- Reduced duplication; fewer repeat referrals and assessments.
- Joined-up planning for residents with complex needs.
- Stronger relationships and earlier intervention.

What Integrated Neighbourhoods Mean in Practice

- Not a new team – shared capability across sectors.
- When you raise a concern, the neighbourhood pulls in the right practitioners.
- Wraparound support so issues are addressed earlier.

Early Focus Areas

- People with highly complex needs.
- People at risk of deterioration.
- Stronger focus on inequalities; co-design approaches with providers.

What Will Feel Different for You

- Single front-door feel and named neighbourhood contact point.
- Faster decisions, reduced handoffs.
- Transparent local priorities, pressures and assets.

Mentimeter link to follow

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Timeline & Next Steps

- Phased rollout across neighbourhoods.
- Start with early adopters, refine, then scale.
- Publish simple neighbourhood plans and continue co-design.

Contact
Ali Gurney, Norfolk County Council on
alison.gurney@norfolk.gov.uk

Thank You

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Promoting Independence

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Achieving Care Together 2026

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Physical activity, health, and confidence

Alex Devkota
Care England

Norfolk County Council

Promoting Independence

CARE ENGLAND
The voice of care

Care England

We speak with a unified voice for our members and the care sector. We are committed to supporting a united, quality-conscious, independent sector that offers real choice and value for money.
Our aim is to create an environment in which care providers can continue to deliver and develop the high-quality care that communities require and deserve.

- Discounts and free support
- White papers and policy research
- Guidance and collaborative research projects

Decaf

- Falls are the most common cause of injury-related deaths in people over the age of 75.
- Following a similar initiative by University Hospitals of Leicester NHS Trust (UHL) in which they noticed that many hospital patients were falling on the way to the toilet, Continence Nurse Specialist Sarah Coombes suggested switching to decaffeinated drinks to reduce bladder and bowel urgency in those with an overactive bladder or incontinence. Within three months, toileting-related falls in the hospital were down by 30%.
- People living in care homes are three times more likely to fall than those living at home; they are generally more frail, less mobile and have a higher prevalence of incontinence than the general population.
- Roughly 300 residents across Stow Healthcare's eight care homes were given the chance to blind taste-test caffeinated and decaffeinated drinks. Over 90% of residents chose to take part in the trial after being told about the potential health benefits of making the switch, with the choice of caffeine always available on request.
- Over six months between June – November 2023, falls associated with care home residents going to the toilet dropped by 35%.

SH

Taste the difference challenge!

What **decaffeinated** drink did you try?

Tea ☐ Coffee ☐

Can you tell it's not caffeinated?

Yes ☐ No ☐

What do you prefer?

Decaffeinated ☐ Caffeinated ☐

No preference ☐

Caffeine in tea and coffee can irritate the bladder and cause a need to rush to the toilet, and potentially increase your risk of falls. Knowing this, would you switch to decaffeinated tea or coffee?

Yes ☐ No ☐

Resident name:

Blind taste testing form, modified from UHL original

Improving health outcomes for care home residents

Decaffeination and falls prevention

A joint investigation by Care England and Stow Healthcare, in partnership with University Hospitals of Leicester NHS Trust

April 2024

Provide a list of the five most important points Summarise ...

BGF x Care England introduction

https://www.youtube.com/watch?v=adknf0jf2nI

Be Great Fitness reports

What do the sessions look like?

https://www.careengland.org.uk/wp-content/uploads/2026/02/Bailey-intro-video.mp4

&

https://www.youtube.com/shorts/oS49M7FHuYM

Maureen

- Maureen began the programme with severe deconditioning, disrupted sleep, poor nutrition, inactivity, and social withdrawal, all of which increased her risk of falls and health decline.
- A structured movement and wellbeing programme was introduced, combining gentle tailored exercises, assisted walking, routine-setting, and consistent staff reinforcement.
- Within the first months, Maureen became more alert during the day, stabilised her sleep pattern, improved hydration and nutrition, and started engaging in short social interactions.
- Over four months she gained confidence walking with a frame, resolved constipation without medication, participated in group activities, and showed improved mood and motivation.
- The intervention produced holistic benefits—better mobility, normalised routines, enhanced wellbeing, increased independence, and no falls—highlighting the value of integrated movement-based programmes in care settings.

John

- An 81-year-old resident with dementia, John, had severe mobility issues, frequent falls, and exit-seeking behaviours that previously required emergency intervention.
- Before the programme, he was socially withdrawn, restless, and required constant staff supervision, which increased stress and limited his independence.
- A structured movement programme—including seated exercises, resistance bands, and gait-focused training—led to significant improvements in balance, gait, mood, and social engagement.
- Consistent reinforcement by care staff and participation in group activities reduced his restlessness and exit-seeking, eliminating emergency incidents and enabling safer independent movement.
- By the end of the programme, John showed better stability, confidence, and sociability, demonstrating how personalised physical activity interventions can enhance wellbeing, reduce falls risk, and support independence in high-risk care home residents.

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Promoting Independence
CARE ENGLAND The voice of care

Janet

- Janet (84) entered the care home after a long hospital stay following a fractured femur, during which she experienced severe inactivity, low mood, unstable diabetes, frequent UTIs, and declining mobility; a physiotherapy referral had been declined, leaving her without rehabilitation support.
- On arrival, she had very limited mobility, required a Sara Steady and two staff members for all transfers, spent most of her day in bed, and showed little motivation or willingness to engage socially or participate in activities.
- Initial in-house activity sessions used chair-based exercise, resistance bands, and confidence-building tasks, leading within weeks to improved postural control, standing tolerance, and reduced staffing needs for transfers.
- After joining an eight-week structured movement programme, Janet progressed from assisted standing to transfer practice with a walking frame, which led to gains in strength, balance, confidence, and daily participation; she began attending group classes, going on trips, and spending most of the day out of bed.
- By mid-programme, Janet had no further UTIs, her diabetes stabilised, her mood improved markedly, and she showed greater independence and social engagement—demonstrating the effectiveness of personalised, consistent physical activity in restoring function and confidence after prolonged inactivity.

Conclusions

- Structured, personalised movement programmes reversed or stabilised decline in residents previously considered high-risk, frail, or dependent—improving mobility, balance, continence, sleep, appetite, and overall wellbeing without medication changes.
- Behaviour and mood improved significantly, with marked reductions in agitation, distress behaviours, and social withdrawal, creating calmer, safer, and more predictable care environments for residents and staff.
- Staff experienced reduced stress and safer working conditions, as residents became more cooperative, stable, and independent in daily tasks such as transfers and personal care.
- Movement-led reablement demonstrated alignment with NHS priorities, including falls prevention, reablement, and healthy ageing, showing that regular activity can reduce clinical risks and ease system pressure.
- The case studies showed consistent patterns across diverse residents, proving that decline is not inevitable and that even individuals with dementia, advanced frailty, or post-hospital deconditioning can regain strength, confidence, and engagement through structured activity.

"These approaches… challenge the assumption that deconditioning is inevitable, showing instead that, with the right support, residents can rebuild strength, restore confidence, and maintain meaningful levels of independence and connection."

- Professor Martin Green OBE

Thank You

#NorfolkACT2026

Distress as Communication: The Brain Behind the Behaviour

By Kate Thubron
Director - Mindful Care Training and Consultancy

Mindful Care
Training & Consultancy

About

We specialise in training and consultancy to support the health and social care sector in providing excellent quality care. We specialise in three areas:

·***Dementia Care***
·***Wellbeing, Activities, and meaningful occupations***
·***Mindfulness, wellbeing and mental health support for care partners and health and social care staff.***

We provide training and support for NHS, Social Care, Care partners and the community in all areas of our specialties. From training to in house coaching, Quality Inspections, strategy writing and support, wellbeing and mental health support for care partners.

Health care Professionals, Mindfulness Practitioners, Dementia Coaches, Teepa Snow trainers, National Award winner, Previous Strategic and Operational Dementia Lead for a large care home company

Distress - What Do We Think Of First?

Mindful Care
Training & Consultancy

Agitation

Challenging behaviour

Escalation

Risk

“How do we manage it?”

“How do we fix it?”

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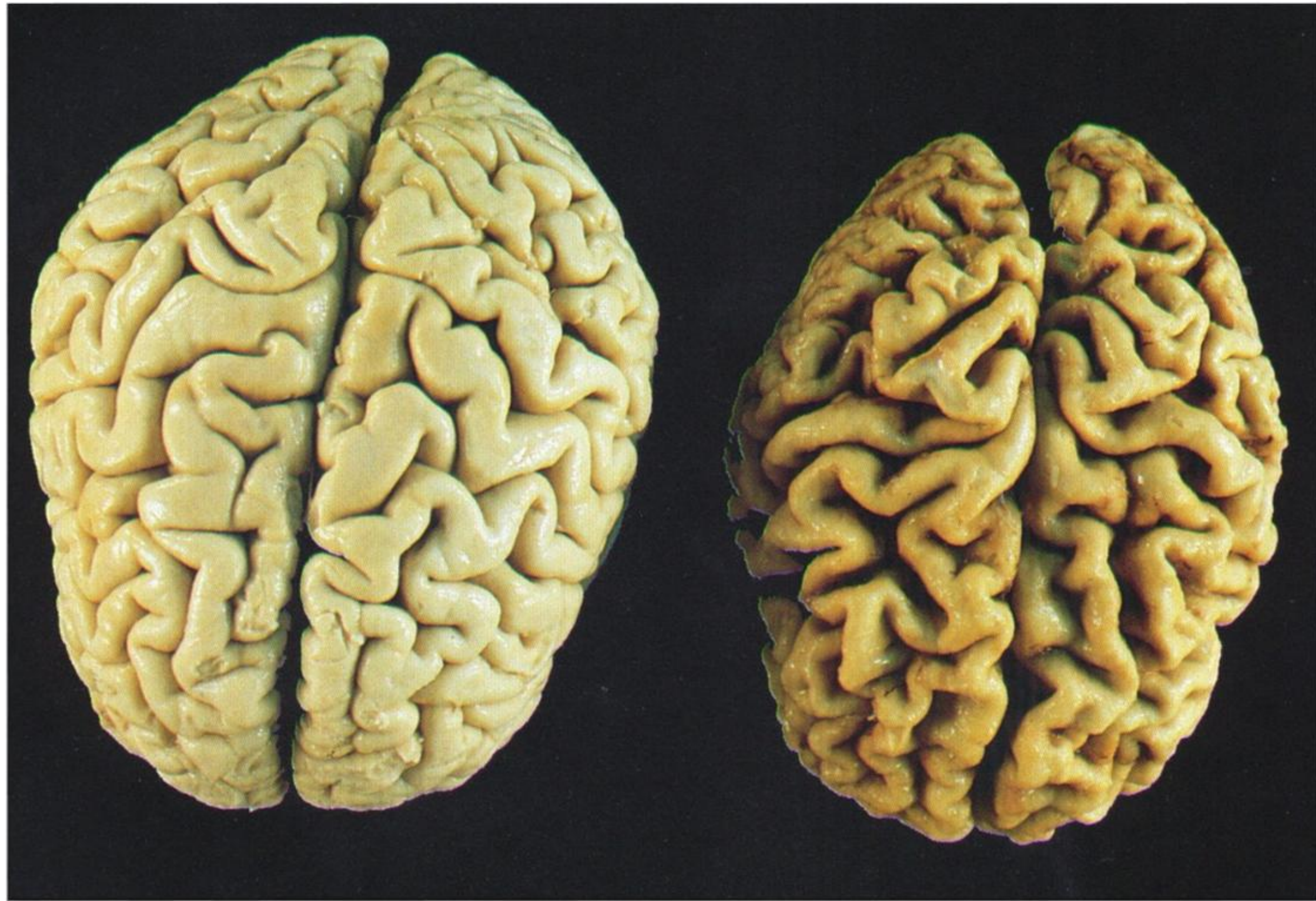
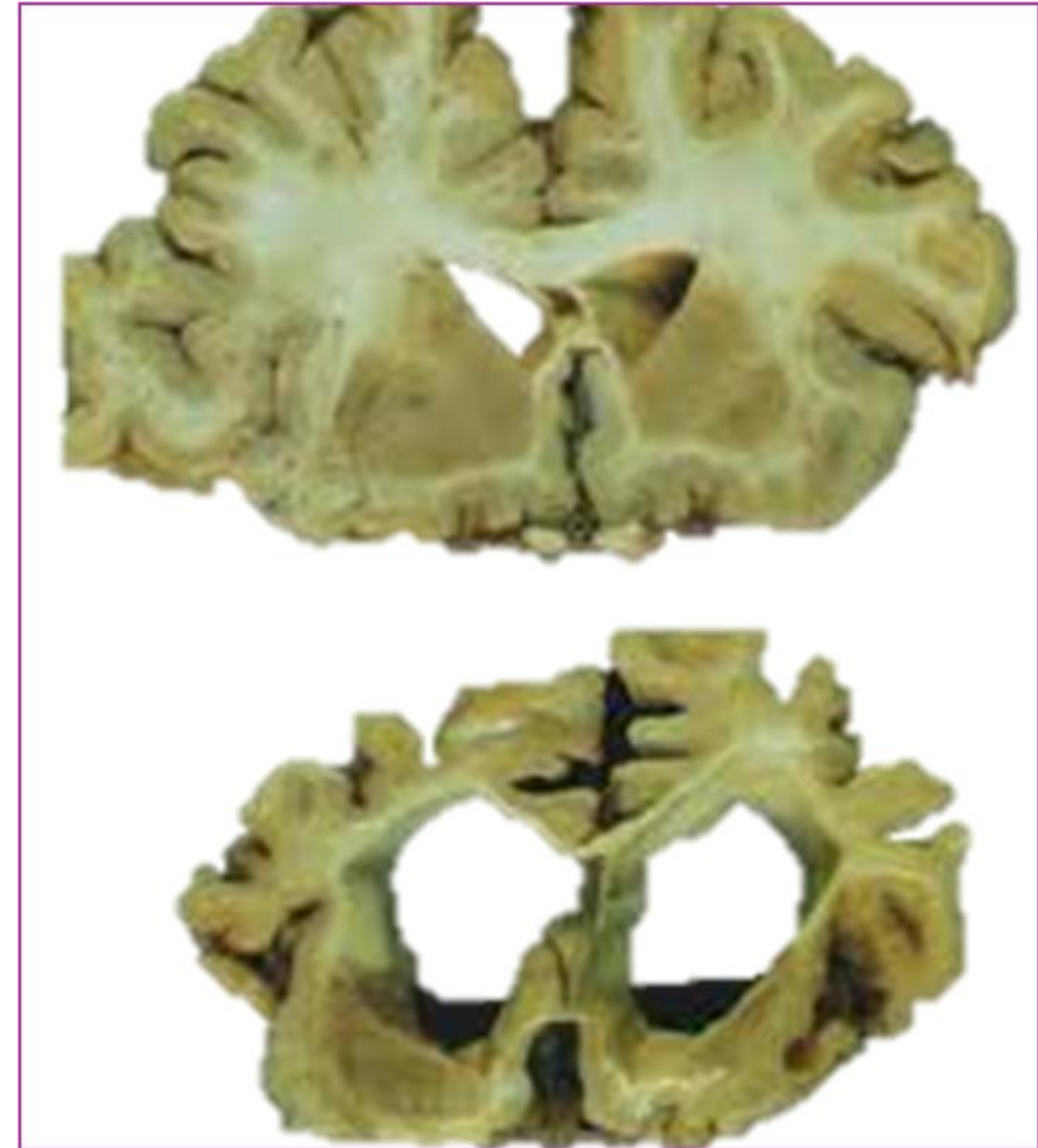
Training & Consultancy

The Changing brain





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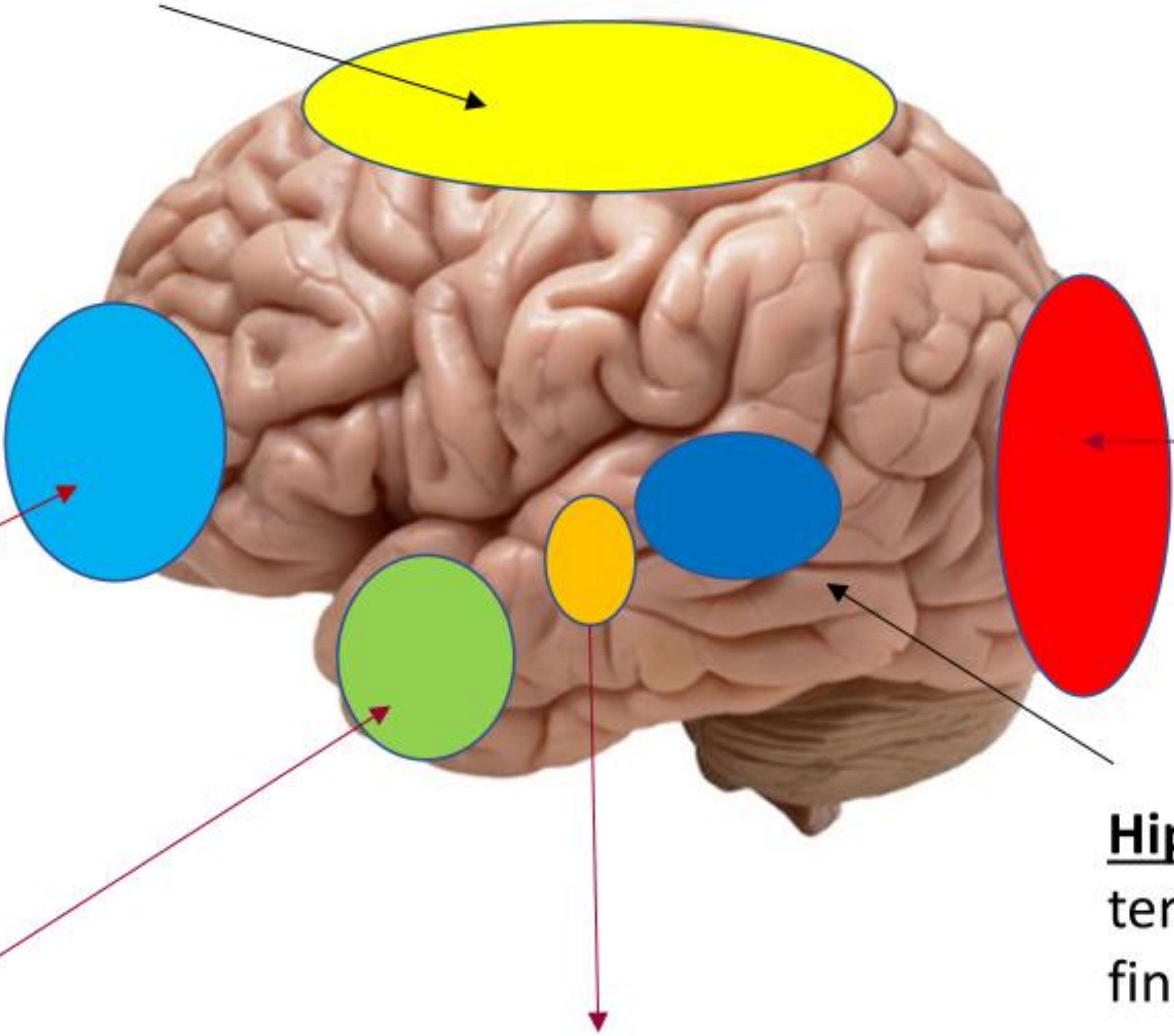
The Beautiful brain

Functions of the brain

Cerebral Cortex- Sensory motor and movement



Frontal Lobe
(Seeing it from some else's point of view, aware of what is socially acceptable and what is not), reasoning, weighing up decisions, sequencing, initiating and terminating- reverse the way we were developed

Occipital Lobe- vision

Temporal Lobe
LEFT – Language, vocabulary, comprehension of speech
RIGHT – Chit Chat, Music, Rhythm, Swear words, racial slur,

Hippercampus – Short term Memory and finding your way.

Amygdala – Emotions, helps trigger fight or flights
Very vulnerable to vascular traumas – (Vascular dementia)

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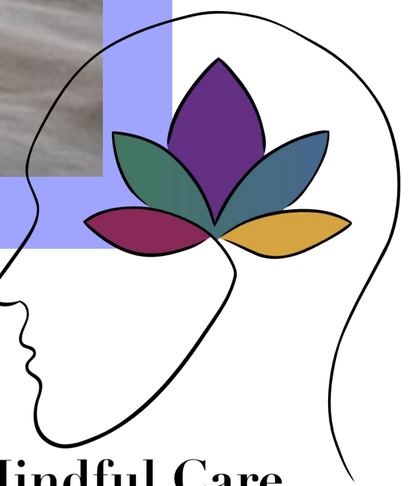
What is the brain experiencing?

What has changed for this person?

What need is unmet?

What emotion sits underneath this?

<u>Distress is communication.</u>



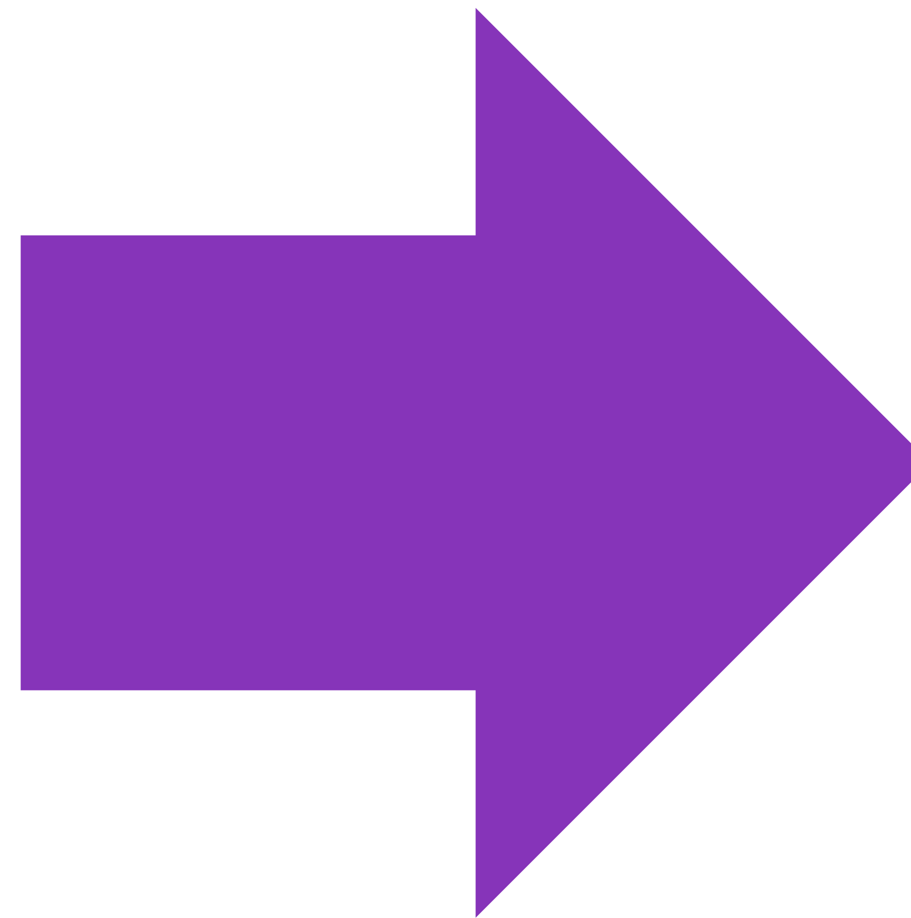
Is This Dementia — Or Is This Human?

- Fear
- Loss of control
- Confusion
- Overstimulation
- Pain
- Loneliness

When the brain feels unsafe:

The emotional brain takes over
Logic reduces
Fight / Flight / Freeze increases
Processing slows
Sensory input overwhelms

This is not dementia.
This is being human.



Now imagine:

Not understanding where you are
Not recognising people
Not processing language properly
Living in constant uncertainty

The stress response becomes more frequent.
Distress is often the brain trying to protect itself

Distress – What Do We Think of Now?

- Not behaviour
- Not something to fix
- Not something to label

But…

- The human brain
- A stress response
- A human response
- A brain needing safety
- Brain changes on top of this

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Training & Consultancy

Achieving Care Together 2026

- **What is this brain experiencing right now?**
- **And what would safety look like for this person?**

Because when we support the brain, we support the person.

Thank you

Any Questions?

info@mindful-care.co.uk

www.mindful-care.co.uk

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Norfolk County Council

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Mental Capacity and Best Interests

Achieving Care Together

March 2026

Siân Davies

Barrister, 39 Essex Chambers

Capacity

1. Basic principles
2. Fluctuating capacity
3. Complex capacity issues
4. Overlapping areas

Capacity: the three questions

- Please don't follow what the Code of Practice says: it is WRONG: *A Authority v JB* [2021] UKSC 52: instead, three questions in this order

  (1) Is the person able to make a decision? If not:

  (2) Is there an impairment or disturbance in the functioning of the person's mind or brain? If so:

  (3) Is the person's inability to make the decision because of the identified impairment or disturbance?

What makes a good capacity determination? (1)

AMDC v AG & Anor [2020] EWCOP 58

a. An expert report on capacity is not a clinical assessment but should seek to assist the court to determine certain identified issues.

b. The letter of instruction should, as it did in this case, identify the **decisions** under consideration, the **relevant information** for each decision, the need to consider the **diagnostic and functional elements of capacity**, and the **causal relationship** between any impairment and the inability to decide. It will assist the court if the expert structures their report accordingly. If an expert witness is unsure what decisions they are being asked to consider, what the relevant information is in respect to those decisions, or any other matter relevant to the making of their report, they should ask for clarification.

c. It is important that the parties and the court can see from their reports that the expert has understood and applied the presumption of capacity and the other fundamental principles set out at section 1 of the MCA 2005.

What makes a good capacity determination? (2)

d. In cases where the expert assesses capacity in relation to more than one decision,

i. broad-brush conclusions are unlikely to be as helpful as specific conclusions as to the capacity to make each decision;

ii. experts should ensure that their opinions in relation to each decision are consistent and coherent. (*B v A Local Authority* [2019] EWCA Civ 913)

e. An expert report should not only state the expert's opinions, but also explain the basis of each opinion. The court is unlikely to give weight to an opinion unless it knows on what evidence it was based, and what reasoning led to it being formed.

f. If an expert changes their opinion on capacity following re-assessment or otherwise, they ought to provide a full explanation of why their conclusion has changed.

g. The interview with P need not be fully transcribed in the body of the report (although it might be provided in an appendix), but if the expert relies on a particular exchange or something said by P during interview, then at least an account of what was said should be included.

What makes a good capacity determination? (3)

h. If on assessment P does not engage with the expert, then the expert is not required mechanically to ask P about each and every piece of relevant information if to do so would be obviously futile or even aggravating. However, the report should record what attempts were made to assist P to engage and what alternative strategies were used. If an expert hits a "brick wall" with P then they might want to liaise with others to formulate alternative strategies to engage P. The expert might consider what further bespoke education or support can be given to P to promote P's capacity or P's engagement in the decisions which may have to be taken on their behalf. Failure to take steps to assist P to engage and to support her in her decision-making would be contrary to the fundamental principles of the Mental Capacity Act 2005 ss 1(3) and 3(2).

Capacity: a diagnostic pause

It does not matter if you cannot give a diagnosis: *North Bristol NHS Trust v R* [2023] EWCOP 5, the question is whether there is impairment, it need not be diagnosed or conclusively diagnosed

Avoiding ‘silos’

- *B v A Local Authority* [2019] EWCA Civ 913

‘The Judge's flawed conclusion followed from his approach in analysing B's capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them’

- *Lancashire & South Cumbria NHS Foundation Trust & Lancashire County Council v AH* [2022] EWCOP 45 – good example of expert report considering interaction

The threshold cannot be set too high

DY v A City Council & Anor [2022] EWCOP 51

> *In the final analysis, their arguments relied heavily on the fact that DY makes contradictory statements about his need for care and supervision, that he was inclined not to think things through and that fact that he can overestimate his abilities. In doing these things, DY is no different from many people who do have capacity. People with capacity can make unwise decisions and act on impulse.*

Hoarding

- *AC and GC (Capacity: Hoarding: Best Interests)* [2022] EWCOP 39 – relevant information
  - Volume of belongings and impact on use of rooms
  - Safe access and use
  - Creation of hazards
  - Safety of building
  - Removal/disposal of hazardous levels of belongings

- See also *A Local Authority v X* [2023] EWCOP 64

Fluctuating capacity

- Not a concept expressly addressed or provided for in the MCA 2005, although it is referred to in the Code of Practice
- Is it really fluctuating capacity at all?
- Outside court, always a question of reasonable belief (s.5) or longitudinal DoLS determination
- Where you need to go to court, and the need for solutions to be practical and workable: *A Local Authority v PG & Ors* [2023] EWCOP 9

Relevance of belief to capacity

Is it necessary, for a person to have capacity, for them to believe an objectively verifiable medical consensus as to consequences of having, or not having, treatment?

Re Sudiksha Thirumalesh (dec'd) [2024] EWCA Civ 896

…in order to understand and/or to use and weigh up the relevant information, ***Sudiksha's belief as to her prognosis and the likelihood of her receiving effective nucleoside treatment was relevant, but not determinative as to whether she was able to make a decision under section 3 and therefore satisfy the functional test [emphasis added]***

Relevance of insight to capacity

CT v London Borough of Lambeth & Anor [2025] EWCOP 6 (T3) (Theis J)

Context was capacity to decide on hospital discharge, potentially to be street homeless.

Theis J made clear that lack of insight is also not a shortcut to a conclusion that there is a lack of capacity. Doing so was held to have blurred the lines between the diagnostic and functional aspects of the capacity test.

Insight is not irrelevant, but is to be considered in the overall context of the functional test.

Executive capacity

- Distinction between a clinical phenomena (and in some cases a research question) and how it relates to the MCA: *Warrington Borough Council v Y & Ors* [2023] EWCOP 27

- Need to explain how a person's difficulties with executive functioning mean that they cannot make the decision for purposes of the MCA

- If this is not explained, then it's not a capacity determination

- Suggest a key question is whether the person is aware of their own deficits – can they understand (or use and weigh) the fact that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete situations

  => How can you reach a conclusion without triangulation between talking to the person and seeing them in action?

- Executive Dysfunction and the MCA webinar: NMCF Events - Essex Autonomy Project

Internet and social media

- Relevant information: *Re A* [2019] EWCOP 2

- Asking why the internet and social media are being used – exploration, contact, something else? *Re EOA* [2021] EWCOP 20

- Being sensible about risk: Re AA (Capacity: Social Media and Internet Use) [2021] EWCOP 70

  Whilst I entirely respect and understand the opinion of Dr Ince, on the basis of the evidence, I reach a different conclusion from him. In the absence of any evidence, for many months now, of AA putting himself at risk of harm in his use of the internet and social media, I am satisfied that there is insufficient evidence for me to conclude that he lacks capacity to make decisions in respect of his use of the internet and of social media.

  Even if I am wrong in coming to that conclusion and I ought to find that he does lack capacity, I am entirely satisfied that it is not in his best interests for the daily checks to be undertaken of his electronic devices because:

  (a) they deliver no evidence of any value and afford no protection to AA; and

  (b) it is contrary to AA's wishes that those checks are undertaken, which causes him some distress and/or at least uneasiness.

- And more help: Online safeguarding, capacity and rights to participation – in conversation with Professor Andy Phippen – Mental Capacity Law and Policy

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Sex

ZX (Capacity to Engage in Sexual Relations) [2024] EWCA Civ 1462

The Court of Protection clarified that the approach to be followed when assessing capacity for the purposes of the Mental Capacity Act 2005 s.2 and s.3 was as prescribed in Local Authority v JB [2021] UKSC 52, [2022] A.C. 1322, [2021] 11 WLUK 315.

Neither PN (Capacity: Sexual Relations and Disclosure), Re [2023] EWCOP 44, [2023] 10 WLUK 229 nor Local Authority A v ZZ [2024] EWCOP 21, [2024] 4 WLUK 160 had changed that approach.

The Judge had taken into account history of sexual offences, conduct which was not by itself indicative of a lack of ability to understand/ retain/ weigh information about consent - and might be indicative of ability to do so but having chosen not to. Also, a causative nexus was required, and had not been found in this case.

Final declaration set aside, interim declaration made, and case remitted.

Capacity / vulnerability

- Listening carefully to the person caught in the middle: *Re RK (Capacity; Contact; Inherent Jurisdiction)* [2023] EWCOP 37

- Expanding incapacity? *An NHS Trust v ST & Anor* [2023] EWCOP 40

- The line between capacity and vulnerability: 39 Essex Chambers | Mental Capacity Guidance Note - Inherent Jurisdiction - 39 Essex Chambers | Barristers' Chambers

- Interpersonal influence and decision-making capacity – in conversation with Kevin Ariyo – Mental Capacity Law and Policy

BEST INTERESTS

*‘The omnipresent danger in the Court of Protection is that of emphasising the **obligation to protect** the incapacitous, whilst losing sight of the fundamental principle that the promotion of **autonomous decision making** is itself a facet of protection’.*

Hayden J, *LB tower Hamlets v NB & AU* [2019] EWCOP 27

Best Interests and risk

- *AH, Re (Re Best Interests)* [2023] EWCOP 1 – DoLS, diabetes and the desire to be at home

> *In the end, if M remains confined in a home she is entitled to ask "What for?". The only answer that could be provided at the moment is "To keep you alive as long as possible". In my view that is not a sufficient answer. The right to life and the state's obligation to protect it is not absolute and the court must surely have regard to the person's own assessment of her quality of life. In M's case there is little to be said for a solution that attempts without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable.*

Best interests and risk

London Borough of Lewisham v SL & Anor [2025] EWCOP 51 (T3)

SL lived with her parents, and was a highly vulnerable young woman with a history of absconding and risk of sexual abuse.

LA had been seeking an alternative placement. However this search was causing stress to SL and the parents favoured a six month pause. Initially that was opposed by the LA but by the time of this hearing it was agreed this was the best option.

Theis J, the Vice President therefore agreed the plan, though noting it was not without risk. The judgment includes observations as to how the search for a more permanent placement could be undertaken.

The Court of Protection (& Autonomy?)

– Do we have the balance right?

– What are the barriers to promoting autonomy/positive risk taking in social work practice?

1. Is your capacity assessment tight enough

2. Taking proper account of what is important to P

Promoting autonomy in BI decision making

3. Risk assessment and risk planning

4. BI decision making which overlaps areas of capacity

Go back to capacity

- Are you drawing capacity assessment tightly enough?
- Are you catching areas of capacity in 'catch all' assessments?
  - What is the 'matter' requiring a decision?
  - Can the decision be broken down to promote autonomy?
  - People usually more willing to tolerate risk in themselves than others…

BI from P's perspective

- Standing in the shoes of P – how often is lip service just paid to this?
  - What was important to them?
  - What was their tolerance to risk – how did they live their lives before lack of capacity?
  - What are the views of friends/family/carers?
  - Consider not just wishes and feelings now, but what their views would have been likely to be before lack of capacity?

(section 4 (6)(7) MCA 2005)

BI from P's perspective

86 … Unless they now express contrary wishes, or there are other overriding considerations, where possible one must seek to enable them to live their remaining days in a way consistent with those wishes, beliefs and values. The Mental Capacity Act 2005 is an enabling Act designed to help, where practicable, those without capacity to live the life they wish or would wish to live if they still had capacity

London Borough of X v MR, PD and AB [2022] EWCOP 1

Positive risk taking

- If BI outcome P would wish for is risky, can the risk be managed?
  - Up to date risk assessments?
  - Graded plan/positive risk taking plan?
  - Regular review?
  - BI decision utilising risk assessments?
  - Proper recording (to address liability concerns)
  - Very high risk plans can be put to court for approval.

3. Complex case

- Care planning around cases where P has capacity in an area that overlaps with area of incapacity?

- Re sex and contact – see *A Local Authority v TZ* (No 2) [2014] EWCOP 973

- Think about how one can apply the core aspects of a ‘TZ Care Plan’ to other areas of capacity which overlap with incapacity.

- Where intervention/orders are sought which intrude on area of capacity – consider application to High Court LC & Anor [2018] EWCOP 30.

- Usually – at the point that the dispute crystalises.

DEPRIVATION OF LIBERTY

What is a deprivation of liberty?

Article 5 ECHR:

- Objective element: confinement to restricted space for non-negligible period of time –
- Subjective element: either cannot or will not give valid consent
- Imputable to the state

The objective element

- *Birmingham City Council v D* [2017] EWCA Civ 1695
  - Meaning of freedom to leave

- *A Local Authority v AB* [2020] EWCOP 39 and *Re AEL* [2021] EWCOP 9
  - Continuous supervision and control, the 'true powers of control' and the 'policy of caution'

- And can include the use of medication (covert or otherwise) to sedate the person to control their behaviour: *Re AG* [2016] EWCOP 37

The subjective element (1)

- The information relevant to the decision: *A PCT v LDV* [2013] EWHC 272 (Fam)

- If you are to say a person has capacity to consent to what would otherwise be a deprivation of their liberty, they must be given and be able to understand, retain, use and the information relating to the restrictions upon them

The subjective element (2)

- 16 and 17 year olds: *Re D* [2019] UKSC 42
  - Where 16/17 year old confined and cannot consent, parents cannot seek to consent on their behalf
  - I.e. apply 'acid test', ask whether young person can consent, and then, if they cannot, they are deprived of their liberty

  => Application under MHA (where relevant) or court order will be required

- https://www.mentalcapacitylawandpolicy.org.uk/deprivation-of-liberty-and-16-17-year-olds-shedinar/

What is a deprivation of liberty? Imputability to the state

- *Re D* [2019] UKSC 42

  it is clear that the first sentence of article 5 imposes a positive obligation on the State to protect a person from interferences with liberty carried out by private persons, at least if it knew or ought to have known of this

If it is a deprivation of liberty?

- DoLS: 18 and over, care homes/hospitals
- MHA: in-patient admission for assessment/treatment of mental disorder
- Court order:
  - ‘Community DoL’
  - High Court inherent jurisdiction (?)

"Community DoL"

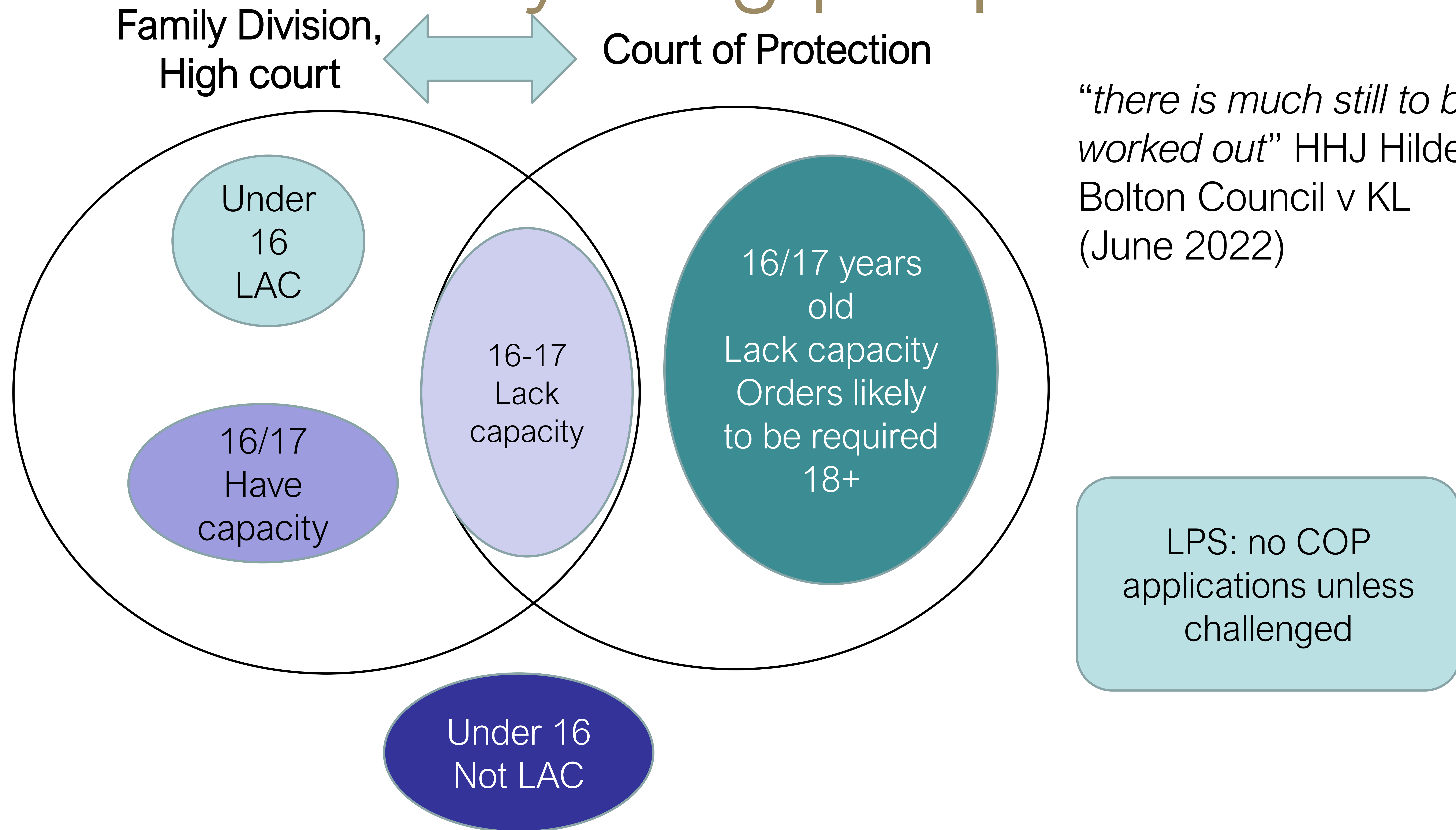
- *Re X (Deprivation of Liberty)* [2014] EWCOP 25 and [2014] EWCOP 37
- The process for judicial authorisation of deprivation of liberty falling outside DOLS because of nature of placement (or age)
- The 'irreducible minimum' for compliance with Article 5(1)(e) ECHR
- COPDOL11, Practice Direction (PD11A) and model order
- https://www.39essex.com/judicial-deprivation-liberty-authorisations/
- Remember tenancy agreements (and is it a tenancy at all?)
- Choosing a representative

DOLS and public protection

DY v A City Council & An NHS Trust [2022] EWCOP 51

> …it is strongly in DY's best interests not to commit further offences, or place himself at risk of further criminal sanctions. In my judgment this falls squarely within the meaning of the qualifying requirement in paragraph 16 schedule A1, 'to prevent harm to the relevant person'. That this harm would come about by his harming others does not detract from this

Deprivations of liberty for children and young people



"*there is much still to be worked out*" HHJ Hilder – Bolton Council v KL (June 2022)

LPS: no COP applications unless challenged

Common issues

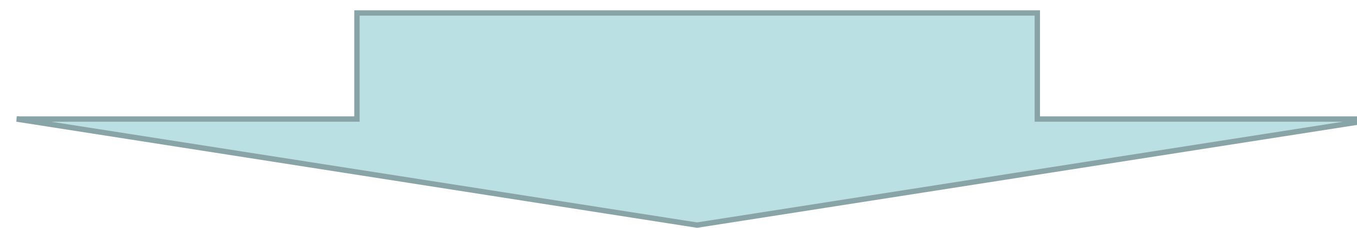
Scarcity of secure accommodation places

Too few registered children's homes

(Ofsted fast track)

Tier 4 beds – deemed inappropriate and short term

Limited availability of community based therapy



Least worst option is sanctioned

Rubber stamp?

36. This case, as do many others involving the care of children with complex needs, calls into question the court's role. Very often the court is told that there is only one place where the child can be accommodated. The court's role is therefore very limited. There are no real choices for the court to make. The court cannot direct that placements shall be made available. The court is not a regulator and cannot inspect potential placements or oversee care regimes. On the other hand, even when there are no other placement options, the court does not merely provide a rubber stamp for the restrictions sought, and there are decisions to be made about the extent of the restrictions that are necessary and proportionate and in a child's best interests. However, the courts, like the parties, continue to be confined by the consequences of what Lord Stephens called a "scandalous lack of provision" for which it appears that there is no end in sight.

J, Re (Deprivation of Liberty: Hospital) [2022] EWFC 121 (12 October 2022) – Poole J – October 2022

Applications in the COP

- COPDOL 11 – use to start but will probably be called in – Bolton v KL
- Procedural safeguards (joinder, LF, notification, judicial scrutiny, Rule 1.2 Rep)
- Likelihood that DOLs will be required post 18
- "*Experience since December 2019 has shown that, with the benefit of robust scrutiny by fully informed representatives of P, some of the applications relating to deprivation of liberty of 16/17 year olds throw up very worrying issues in transitional arrangements and in respect of restraint; but others can be finalised by consent quickly*".

Worrying issues

- Restraint
  - Frequency
  - What steps have been taken – PBS
  - Goes to what is the least restrictive
- Chemical restraint
  - Frequency
  - Safeguards/ monitoring
  - Goes to what is the least restrictive
- Transitional arrangements

“Swift resolution” cases

- Features of cases capable of swift resolution:
  - Front loading of evidence
  - Detailed care planning;
  - Involvement of a range of professionals;
  - Evidence of lack of capacity;
  - Clear and detailed consideration of the different restrictions

Mobile phones and DOL

- *Manchester City Council v CP & Ors* [2023] EWHC 133 (Fam)
- Article 5 – physical liberty
- Restriction of mobile phone and other devices is an Article 8 issue
- *It is important that the court be careful not to allow its jurisdiction to make orders authorising the deprivation of a child's liberty by reference to Art 5(1) to spill over into authorising steps that do not constitute a deprivation of liberty for the purposes of Art 5(1), particularly where those steps might constitute breaches of different rights, which breaches fall to be evaluated under different criteria* (para 50)
- Restraint to remove devices is a different matter

DoLS and contact/visiting

- **DoLS does not authorise limitations on contact/visiting**

- Who has the authority to impose restrictions on who the person has contact with (remotely or in person) or others visiting them? And on what basis?

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39 Essex resources on mental capacity

https://www.39essex.com/our-thinking/mental-capacity-resource-centre/

Any questions?

Provider Journey of Mental Capacity Assessments

Tegan Ithell

Registered Care Manager

www.sense.org.uk

sense

connecting sight, sound and life

Agenda for ACT 2026

Time	Session
9.00	**Conference registration and refreshments**
9.25	**Welcome & Housekeeping** Louise Brosnan, Assistant Director Quality & Brokerage, NCC
9.30	**Introduction/ Opening Remarks** Ian Wake, Executive Director of Adult Social Services, NCC
9.50	**Strategic Commissioning Framework** Chris Scott, Director of Strategic Commissioning, NCC
10.10	**Integrated Neighbourhoods** Ali Gurney, Assistant Director – Communities and Partnerships, NCC
10.30	Refreshments and networking
10.55	**Health, physical activity, confidence of clients** Alex Devkota, Senior Policy Officer, Care England
11.15	**Distress as Communication: The Brain Behind the Behaviour** Kate Thubron, Founder, Mindful Care
11.35	Short break
11.45	**Understanding Mental Capacity Act** Sian Davies, Barrister, 39 Essex Chambers

Time	Session
12.05	**Provider journey of improvement, Mental Capacity Act** Tegan Ithell, Registered Manager, SENSE
12.20	**Q&A session**
12.50	Lunch, networking and market stalls
13.40	Go to workshop
13.50	**Workshop 1**
14:35	Go to workshop 2
14.45	**Workshop 2**
15.30	Refreshments
15:40	**Summary of conversation** Cllr Alison Thomas
15:55	**Closing remarks** Louise Brosnan, NCC
	Refreshments available for further networking

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Workshops and Rooms

Workshop Name	Room
Quality Assurance Systems, Recording and Analysis	*Sunningdale Suite*
Mental Capacity Act	*Eaton Suite*
Safeguarding	*La Fontaine*
Behaviour Support: Brain, Behaviour, and Better Responses	*Muirfield Suite*
Strategic Commissioning Framework	*Conservatory*

Cllr Alison Thomas

Cabinet Member for Adult Social Care,
Norfolk County Council

Summary of conversations

Louise Brosnan

Assistant Director Quality & Brokerage
Norfolk County Council

Closing remarks

Thank you for attending.

Please scan the QR code or follow the link in your delegate pack to submit your feedback for this conference.
All feedback is important to us in shaping future events.