Department of Health & Social Care

Proposed changes to the Mental Capacity Act 2005 Code of Practice and implementation of the Liberty Protection Safeguards

Submitted online 14/07/2022

About You

Are you responding as an individual or an organisation?

- An individual
- [x] An organisation

Organisation

What is your profession?

- NHS or health service delivery
- [x] Social care
- Government or Civil Service
- Education
- Other public sector
- Charity or third sector
- Private sector
- Student
- Retired
- Other

Where does your organisation operate?

- England
- Wales
- Scotland
- Northern Ireland
- [x] The whole of the UK

How would you describe the work of your organisation? Please limit your answer to approximately 100 words

The Homecare Association is a member-led professional association, with over 2,300 homecare provider members across the UK. Our members encompass the diversity of providers in the market: from small to large; predominantly state-funded to predominantly private-pay funded; generalist to specialist; live-in services to visiting services and from start-ups to mature businesses. Our purpose is to enable a strong, sustainable, innovative and person-led homecare sector to grow, representing and supporting members so that we can all live well at home and flourish in our communities.

Do you use or interact with the MCA or Deprivation of Liberty Safeguards in your role?

- Yes
- No

Name of your organisation (optional)

Homecare Association

Questions from Section 2 of the consultation document: 'Proposed updates to existing chapters that now include LPS guidance in the Code'

Section 2 covers chapters 3, 7, 10, 21 to 22, and 24 of the MCA Code of Practice. These chapters exist in the current MCA Code, but in the proposed new draft, include updates to the existing Code guidance **and** new guidance relating to the LPS.

Section 2 of the consultation document includes chapter-specific questions (1 to 3) about the new LPS guidance, which can be found throughout the section. These questions largely focus on the policy decisions that have been made during the development of the Code. Not all Code chapters have a corresponding question. The responses to these questions will be of particular interest to the Department of Health and Social Care (DHSC).

At the end of Section 2, there are also a set of broader questions (4 to 7) on the proposed updates to the existing guidance in the current Code. These questions relate to all the proposed updates to the existing guidance in the current Code listed in Section 1 and Section 2, so please consider all updates when answering. In the main, questions 4 to 7 do **not** relate to the LPS. The responses to these questions will be of particular interest to the Ministry of Justice (MoJ).

Please see Chapter 7 of the Code for help answering this question. (Chapter title: 'What is the role of the Court of Protection?')

1. **The Code states that applications to consider deprivation of liberty cases, only, should not generally be made to the Court. To what extent do you agree or disagree with the following statement? 'Responsible Bodies should not be routinely making applications to the Court, once LPS is implemented'**

    - Strongly agree
    - Somewhat agree
    - Neither agree nor disagree
    - Somewhat disagree
    - Strongly disagree

LPS: 16 and 17 year olds

Many 16 and 17 year olds who will be subject to an LPS authorisation will have complex special educational needs or complex additional learning needs and will therefore also have an Education, Health and Care (EHC) plan, in England, or Individual Development Plan (IDP), in Wales.

Practitioners and decision-makers involved in the LPS will need to understand how the LPS interacts with the special educational, health and care provision set out in the person's EHC plan, or additional learning provision set out in the person's IDP. Further information on EHC plans and IDPs can be found in the SEND Code of Practice or the Additional Learning Needs Code (these documents will not yet include guidance specifically relevant to the LPS).

For children who are looked after or otherwise supported by the local authority through children's services and subject to LPS arrangements in England, the LPS also interacts with the Children Act 1989. The LPS also interacts with other legislation, such as the Social Services and Well-being (Wales) Act 2014. It is important that decision-makers understand these interactions.

Please see Chapter 21 of the Code for help answering this question. (Chapter title: 'How does the Act apply to children and young people?')

2. **How clear is the guidance in the Code at explaining the interaction between the LPS and other relevant legislation and planning for 16 and 17 year olds?**

- Very clear
- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (300 words).

- Para 21.10 says that professionals can choose whether to apply the Children's Act 1989 or the Mental Capacity Act, but no reference is made to the Liberty Protection Safeguards until later, which could be confusing and give the impression that there is a choice with regards LPS.
- The Code of Practice is still quite technical for some people (including some 16 or 17 year olds) to manage, will there be additional information in easier to understand formats, perhaps including diagrams?

LPS: settling disagreements and disputes

Anyone, including the person, can challenge the proposed or authorised arrangements at any stage of the LPS process (including via the Court of Protection and via the Responsible Body). This is an important safeguard in the LPS process.

Please see Chapter 24 of the Code for help answering this question. (Chapter title: 'What are the best ways to settle disagreements and disputes about issues covered in the Act?')

3. How clear is the guidance in Chapter 24 at explaining how challenges relating to the LPS can be made, including deciding when to make an application to the Court?

- Very clear
- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (up to 300 words).

- The text is complex and covers multiple different types of challenge (not only in relation to the LPS). An extra flow chart, decision tree or table might be valuable – the one that is there (at 24.17) doesn't cover LPS specifically.

- Care providers may need guidance about what would happen to care arrangements whilst a dispute is underway.
- It might be valuable to refer here to guidance about how to raise complaints/concerns about LPS not being in place where it potentially should be – the focus seems to be more on challenging existing authorisations.
- The text rightly raises the concern that someone may be reluctant to make a complaint or challenge arrangements (including in Court). In some cases this might be in relation to feared worse treatment / being seen as a trouble maker / a risk of victimisation. It is possible that professionals might also be concerned about victimisation when handling complaints (potentially from decision makers such as commissioners). Does this merit further policy consideration? Could this chapter outline what protections should be in place for bona fide complainants? Has consideration also been given about whether the process could be used in an intentionally vexatious way and how to manage this?
- Consideration should also be given around mentioning how health and social care professionals can raise concerns about systemic failings with LPS in particular authorities.
- The Code says: “Information about how to make a complaint should be included within the information that Responsible Bodies publish and be available through care providers”. We note that, whilst care providers will have complaints policies in place, they may be dependent on the Responsible Body publishing information about making complaints in relation to the LPS process, which they can refer to.

Questions on the proposed updates to the existing guidance in the current MCA Code

Questions 4 to 7 relate to the proposed updates to the existing guidance in the current MCA Code. These questions relate to **all** the proposed updates to the existing Code guidance listed in Section 1 and Section 2 of the consultation document, so please consider **all** updates when answering. In the main, these

questions do not relate to the LPS. There are also further questions on the whole Code in Section 5 of the consultation document.

4. **Are the principles of the MCA fully explained in the revised Code?**

    - Yes
    - No

    If you responded no, please specify the relevant paragraph and what you think it should say (up to 250 words).

5. **Do any of the updates to the existing guidance in the Code, as listed in Section 1 and Section 2, require further expansion or revision?**

    - Yes
    - No

    If you responded yes, please specify the relevant paragraph, and what you think it should say (up to 250 words).

6. **Have there been any significant developments in case law or practice which the revised Code does not address but which you feel it needs to?**

    - Yes
    - No

    If you responded yes, please specify the relevant paragraph and what you think needs to be added (up to 250 words).

7. **Do you have any other comments on the proposed updates to the existing Code guidance?**

    - Yes
    - No

    If you responded yes, please specify the paragraph which your comments relate to, and your views on this (up to 500 words).

Questions from Section 3 of the consultation document: 'The new chapters which contain LPS guidance in the Code'

Section 3 of the consultation document covers chapters 12 to 20 of the Code. These chapters do **not** exist in the current MCA Code, and offer new guidance about the LPS in the new, proposed MCA Code.

Section 3 of the consultation document includes chapter-specific questions (8 to 16) about the new LPS guidance, which can be found throughout the section. These questions largely focus on the policy decisions that have been made during the development of the Code. Not all Code chapters have a corresponding question. The responses to these questions will be of particular interest to DHSC.

LPS: deprivation of liberty

Please see Chapter 12 of the Code for help answering this question. (Chapter title: 'What is deprivation of liberty?')

8. How clear is the guidance in chapter 12 at explaining the meaning of a deprivation of liberty for practitioners?

- Very clear
- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (300 words)

- The guidance is substantially different for people in their own homes (the consent criteria is less onerous and 'freedom to leave' is treated differently).
- It would be helpful for some further examples to be included about where LPS does apply in a person's own home – particularly for older people. Constant supervision and control is likely to prove difficult to delineate.
- It may be relevant to consider whether a person who is living with their family is free to leave and live somewhere else if they wished to.

- We would like to see an example or two explicitly covering live-in careworkers working in private residences in addition to visiting homecare.
- 'State imputability' (12.76) – para 13.19 implies that care providers are expected to inform authorities if care they are providing privately could amount to a deprivation of liberty – if that is correct, could that be referenced here?
- The guidance mentions locking people into their own homes from the deprivation of liberty perspective but does not acknowledge other risks associated with locking a person in their own home (e.g. fire risks).
- We are concerned that the case of Jake where someone is constantly locked in and under at least a notable degree of control does intuitively feel like a deprivation of liberty – so if it isn't what is?
- Re 12.35: some cases could tip into situations of control if support is reduced due to finances or staff shortages. Does the Code of Practice need to encourage commissioners to be alert to this?

LPS: timeframes in the LPS process

The Code sets expectations about how long key LPS processes should take to complete. Specifically, it states that the LPS authorisation should be completed within 21 days and that Responsible Bodies have 5 days to acknowledge an external referral.

Please see Chapter 13 of the Code for help answering this question. (Chapter title: Chapter: What is the process for authorising arrangements under the Liberty Protection Safeguards?

9. Do you think the time frames set out in the Code are:

- Too long
- About right
- Too short

Please explain your answer if you wish (300 words).

- It is desirable for the process to be completed reasonably quickly to uphold people's rights.
- The Code of Practice says that the time frame proposed "is to ensure that the person is not left in potentially unlawful and/or unsafe

arrangements". The implication is that care providers might be expected to provide unsafe or unlawful care in at least some circumstances while LPS is being processed or because an application is taking a long time.

- If care is commissioned by the public sector and cannot be provided in a certain way until an LPS authorisation is granted (and section 4B is not applied) then commissioners may need to be prepared to temporarily commission alternative care packages whilst applications are being processed to provide care that is as safe as possible while not depriving someone of their liberty. This may come at an increased cost. It would be unacceptable for commissioners to push the financial and regulatory liability onto a private care provider and/or put the individual at risk because they are taking a long time to process the application.
- If providers are asked to deliver unsafe care they may hand care packages back.
- A primary concern with DoLS has been that applications have not been processed within the statutory timeframes and that has left care providers at risk of liability. Only 24% of DoLS applications were processed in 21 days and almost 120,000 DoLS applications remained unprocessed at the end of 2020-21 (NHS data). What will happen to these? And what action will the Government take if a similar situation emerges with LPS? While the processes are designed to be faster, the scope has expanded. Alzheimer's Society estimate 61% of people with dementia live in the community and many families lock doors to try to keep people safe from wandering. This could lead to a significant number of referrals.

LPS: Interface with other health and care planning

The Code aims to support health and social care workers to integrate the LPS process into other health and care assessments and planning, as far as possible.

Please see Chapter 13 of the Code for help answering this question. (Chapter title: Chapter: What is the process for authorising arrangements under the Liberty Protection Safeguards?

10. How clear is the guidance in chapter 13 at explaining the interface between the LPS and other health and care assessments and planning?

- Very clear

- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (300 words).

- Care providers will typically undertake their own needs assessments and risk assessments on accepting a new care package. These will be reviewed frequently and could give rise to concerns that trigger an LPS process. These assessments will be in addition to the statutory assessments undertaken by social workers or health professionals and it is the statutory assessments that are more likely to be combined with the LPS assessments.
- It would be helpful for providers (and possibly others) to be able to talk through cases and receive some initial first-line expert advice on whether a situation is borderline in terms of falling into the LPS process or not before the provider applies to trigger an LPS review. Where will this advice come from and is there funding for it?
- It is unclear how this process will interact with the Government's proposals to develop the use of digital care planning in social care. Could digital care plans reduce the additional paperwork required by the LPS process?
- It is important that LPS concerns arising from informal or self-funded care are treated with an equal priority to those arising in care commissioned or delivered by the public sector.
- There are 13.6 million informal carers (Carers UK) as well as an estimated 1.5 million who have unmet care needs (Age UK). The number of people potentially covered by these regulations will be multiple times higher than DoLS and many of these people may not have care assessments in place.

LPS: authorisations, reviews and renewals

Please see Chapter 13 of the Code for help answering this question. (Chapter title: Chapter: What is the process for authorising arrangements under the Liberty Protection Safeguards?"

11. Is the guidance in chapter 13 on the authorisation, reviews and renewals processes clear?

- Very clear
- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (300 words).

- Would an LPS review be required if a person was moved from one care provider to another by a commissioner (e.g. due to a package being handed back) even if the care package being provided by the new provider is essentially the same and in the person's own home?
- Greater clarity should be provided on the distinction between the 'conditions for authorisation' and 'authorisation conditions'. Also greater detail on what the 'conditions for authorisation' (13.37) might be and what they could include, and why they might be imposed.
- Would there be an opportunity for parties other than the Responsible Body (or possibly AP) to, for example, challenge the capacity or necessary/proportionate assessment other than by taking the whole case to the Court of Protection later? Can details be provided on this?
- The authorisation is sent to the person, the AP or IMCA (13.68)– is it up to the individual or their AP to share this with the care provider who might need to implement the arrangements? Would they not require evidence of the authorisation in order to implement such arrangements?
- 13.99 focuses on place rather than care arrangements, this fails to take account of people receiving care in their own homes.

LPS: the care home manager role

The government has decided not to implement the role of the care home manager (outlined above) in the LPS, having heard a range of concerns raised by stakeholders about this role.

12. Do you agree that the care home manager role should <u>not</u> be implemented?

- Yes, I agree that it should **not** be implemented
- No, I disagree

LPS: assessments and determinations

The Code sets out that previous and equivalent assessments can be used in the LPS process if it is reasonable to do so. This will help streamline the process and reduce the potential 'assessment burden' on the person when suitable assessments already exist. Previous assessments are assessments carried out for an earlier LPS authorisation. Equivalent assessments are assessments carried out for any other purpose (for example, for a care plan).

In cases where the person already has a previous or equivalent capacity or medical assessment, these may be used for the purposes of the LPS if it is reasonable to rely on it. However, a previous or equivalent assessment cannot be used for a necessary and proportionate assessment and determination.

Please see Chapter 16 of the Code for help answering this question. (Chapter title: 'What are the Assessments and Determinations for the LPS?')

13. How clear is the guidance in chapter 16 at explaining the use of previous and equivalent assessments for the purposes of the LPS?

- Very clear
- Somewhat clear
- Neither clear nor unclear
- Somewhat unclear
- Very unclear

Please explain your answer if you wish (300 words).

- The use of existing assessments as described, and where appropriate, would be welcome if this speeds up the process providing they are accurate.
- Family members or careworkers who have day to day contact with a person may wish to challenge the outcome or use of an assessment as part of the process. The guidance in Chapter 16 isn't clear about how family members or social care professionals would do this (unless they are an AP), if, for example, they wanted a second professional opinion about someone's capacity during or in response to the LPS process (other than by going to the Court of Protection as in Chapter 24). The focus is largely on whether the Responsible Body would accept the assessment. Can other parties complain to the Responsible Body about the use or outcome of an assessment if they think it is significantly unrepresentative of the situation? Is it solely the Appropriate Person who could challenge an assessment? Can the guidance make this clear, if so? This section of the Code or Practice feels mostly aimed at the Responsible Body, but may be referred to

by others who will want to clearly understand what input they can have in the process and at what stages.

LPS: Approved Mental Capacity Practitioners (AMCPs)

To ensure the independence of AMCPs, the Code provides a suggested model for a central AMCP team.

Please see Chapter 18 of the Code and Set 1 of the LPS regulations, 'The Mental Capacity (Deprivation of Liberty: Training and Approval as an Approved Mental Capacity Professional) (England) Regulations', for help answering this question (Chapter title: 'What is the role of the Approved Mental Capacity Professional (AMCP)?').

14. Do you have any suggestions for how the model, as set out in chapter 18 of the Code, could be improved?

- Yes
- No

If you selected Yes, please provide suggestions for how this model could be improved (300 words).

- Chapter 18 focuses on whether the person objects to the place rather than the care provided, which might be inappropriate wording for people who are cared for in their own homes.
- It is important that AMCPs understand the substantial differences between care provision in hospital or residential settings and in people's own homes.
- 18.12 reads "the senior manager or practitioner will need to decide, based on the individual circumstances of the case, whether is appropriate to allocate an AMCP to a case referred by the Responsible Body they are employed by." Should the guidance not be stronger regarding this – it is vital that there is impartiality. There should be clearer criteria about checking impartiality. For example, having recently worked in a team that is referring a case should also be considered; as well as personal connection to the individual etc.

- Similarly, the Code of Practice suggests that AMCPs may authorise cases on behalf of a Responsible Body in some cases but gives no guidance about when this might be appropriate and when not.
- Should there be clearer guidance about the governance arrangements for AMCP teams? Could the team's location, security of funding or managerial reporting lines impair their impartiality, for example?
- Is it worth saying more about how to determine how many will be needed and then ensure there are enough AMCPs, and measures that can be taken if there are not enough? The guidance on this in 18.6 is vague but could be critical to effective implementation.

LPS: section 4B

If the required conditions are met, as explained in chapter 19 of the Code, then the decision-maker has the legal basis to take steps which deprive a person of their liberty in exceptional circumstances to provide life-sustaining treatment or a vital act. Section 4B is not a 'continuous' power, and only applies to those specific steps.

The Code sets out that the decision-maker should inform the Responsible Body when section 4B is relied upon for the first time. It also provides guidance on when it may be appropriate for the decision-maker to inform the Responsible Body about subsequent instances of the power being relied upon. For example, if the decision-maker relies on the power a significant number of times within a short period.

Please see Chapter 19 of the Code for help answering this question. (Chapter title: 'What is Section 4B, and how is it applied?')

15. Do you agree with the position set out in the Code, or do you think Responsible Bodies should be notified every time section 4B is relied upon?

- I agree that beyond the initial application of section 4B, decision-makers should not have to notify the Responsible Body each time section 4B is been relied upon
- I disagree with the Code

Please explain your answer if you wish (300 words).

- Suggest that the examples in 19.5, 19.15 and 19.22 should be formatted as scenarios.

- In at least some cases with homecare we think that the ‘decision-maker’ for LPS section 4B might be the commissioner rather than the provider.
- There would need to be clear communication between the commissioner and the provider about the section 4B justification and arrangements, this should be mentioned in the Code.
- Cases where restraint isn’t involved but there could be constant supervision and control to ensure someone is safe might be harder to identify. Could you give a scenario related to the application of section 4B in relation to constant supervision and control?
- It is important that the term ‘vital act’ is clearly explained in guidance, training and scenarios.

LPS: monitoring and reporting on the operation of the LPS

In order to provide reassurance that the LPS are being operated correctly, it is important for there to be an effective mechanism for monitoring the use of the safeguards.

The main aspect of state oversight under LPS will be provided by Responsible Bodies who will have responsibility to scrutinise and authorise deprivations of liberty. However, international human rights law (the Optional Protocol to the Convention on Torture) requires there to be further independent oversight of how the scheme is operating.

To meet these obligations in England, the proposed monitoring and reporting design places a duty on the Care Quality Commission (CQC) and Office for Standards in Education, Children's Services and Skills (Ofsted) to monitor and report on the operation of LPS for adults and young people deprived of liberty in any setting. CQC will be responsible for those over the age of 18, whilst Ofsted will be responsible for those aged 16 and 17 years old.

The LPS regulations and chapter 20 of the Code together set out the statutory duties and overarching design for LPS monitoring and reporting. As the bodies responsible for monitoring LPS in the regulations, CQC and Ofsted will be expected to plan for and implement this design in practice.

Please see Chapter 20 of the Code and Set 4 of the LPS regulations, ‘The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) (England) Regulations’ for help answering this question. (Chapter title: ‘How is the LPS system monitored and reported on?)

16. To what extent will chapter 20 and the Monitoring and Reporting regulations deliver effective oversight of the LPS?

- Fully effective oversight of the LPS
- Somewhat effective oversight of the LPS
- Neither effective nor ineffective oversight of the LPS
- Somewhat ineffective oversight of the LPS
- Fully ineffective oversight of the LPS

Please explain your answer if you wish (300 words).

- N.B. we have not reviewed these regulations as legal professionals and are commenting on the policy intent only.
- In many cases it seems that consideration of LPS would be wrapped up into the CQCs day to day inspection activity. If there is a Deprivation of Liberty where the care is not CQC regulated (e.g. it is in a family home with unpaid care or personal assistants) how will this be monitored?
- How can care providers raise issues if they think there are systemic failings in a Responsible Body?
- How will the CQCs new risk-based inspection approach prioritise services where there might be LPS considerations? (Perhaps one for the CQC rather than the Code of Practice, but providers need to understand this through one route or another).

Questions from Section 4 of the consultation document: 'The LPS regulations'

Section 4 of the consultation document covers the LPS regulations and includes questions (17 to 19) about them. The responses to these questions will be of particular interest to DHSC.

LPS: AMCP training regulations

Please see Set 1 of the LPS regulations, 'The Mental Capacity (Deprivation of Liberty: Training and Approval as an Approved Mental Capacity Professional) (England) Regulations', for help answering this question.

17. The purpose of the AMCP regulations is to ensure that there are an adequate number of trained AMCPs with the required skills and knowledge to carry out this role. Will the AMCP regulations achieve this?

- Yes
- No

Please explain your answer if you wish (300 words).

- N.B. We are commenting on the policy intent only and not on the legal drafting so have not commented yes or no in terms of the effect of the regulations.
- In terms of supply of AMCPs we would be more concerned about factors other than those mentioned. For example, how this fits with the person's day to day job, the availability and appropriateness of the actual training from Social Work England and if there is appropriate reward for those taking on the roles reflecting the additional training and responsibility.

LPS: assessments, determinations, and pre-authorisation reviews regulations

The Code and the LPS regulations outline which professionals can carry out each of the 3 assessments and determinations under the LPS. It also outlines the requirements these professionals have to meet. The professionals who can complete a capacity or necessary and proportionate assessment and determination are:

- a medical practitioner
- a nurse
- an occupational therapist
- a social worker
- a psychologist
- a speech and language therapist

Medical assessments and determinations may only be carried out by a registered medical practitioner (including GPs and psychiatrists) or a registered psychologist who meets the conditions of these regulations.

Please see Set 2 of the LPS regulations, 'The Mental Capacity (Deprivation of Liberty: Assessments, Determinations, and Pre-Authorisation Reviews) (England) Regulations', for help answering this question.

18. **Do the assessments, determinations, and pre-authorisation reviews regulations enable the right professionals to carry out assessments and determinations?**

- Yes
- No

Please explain your answer if you wish (300 words).

We do not generally feel that domiciliary care staff or managers (who do not fall into these categories) should be undertaking these roles, but they may be otherwise involved in supporting the process.

It is possible that some OTs, speech and language therapists and community nurses will feel like the standard professional training that they receive does not necessarily equip them to deal with legal questions of this nature.

LPS: Independent Mental Capacity Advocates (IMCA) regulations

These regulations amend the regulations for IMCAs who act under the MCA. They provide the provisions for appointing and the functions of IMCAs under the LPS.

IMCAs are given functions under the LPS, for example, to represent and support the person to participate in the process, ascertain their wishes and feelings, and make representations to the Responsible Body on the person's behalf. In some circumstances, IMCAs will also support the person's Appropriate Person to represent and support the person. IMCAs are also given functions to support the person, or their Appropriate Person, once an authorisation is in place and where appropriate to challenge the authorisation.

Please see Set 3 of the LPS regulations, 'The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) (Amendment) (England) Regulations', for help answering this question. These regulations should be read alongside 'The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006', which Set 3 of the LPS regulations amend.

19. **Do the IMCA regulations allow for IMCAs to carry out their full functions effectively under the LPS?**

- Yes
- No

Please explain your answer if you wish (300 words).

We consider this a question for people with legal drafting experience.

Questions from Section 5 of the consultation document: 'Putting the Code into practice and implementing the LPS'

Section 5 of the consultation document covers the entire MCA Code and documents and questions (20 to 25) related to the implementation of the LPS. The responses to these questions will be of particular interest to both DHSC and MoJ.

LPS: putting the Code into practice

The Code will be an important resource that will used by many different groups of people to understand the LPS process. For example:

- it will be especially important that chapter 3 (how should people be helped to make their own decisions?), chapter 15 (what is the role of the Appropriate Person?), and chapter 17 (what is the LPS consultation?) of the Code are understood by the person and their family and friends to ensure they remain at the centre of the decision-making process
- chapter 3 (how should people be helped to make their own decisions?), chapter 10 (what is the Independent Medical Capacity Advocate service?), chapter 13 (what is the overall LPS process?), chapter 16 (what are the assessments and determinations for the LPS?), chapter 17 (what is the LPS consultation?), and chapter 18 (what is the role of the Approved Mental Capacity Professional?) will be of particular importance to practitioners and people involved in the person's care
- 16 and 17 year olds, and their parents and carers, will need to understand the guidance in chapter 13 (what is the overall LPS process?) and chapter 21 (how does the Act apply to children and young people?)
- Responsible Bodies, including local authorities, NHS trusts and clinical commissioning groups, will need to understand the principles of the MCA outlined in chapter 2 (what are the statutory principles and how should they be applied?), as the principles of the MCA are integrated throughout the LPS. They will also need to, in particular, understand the guidance in chapter 7 (what is the role of the Court of Protection?), chapter 10 (what is the Independent Medical Capacity Advocate service?), chapter 13 (what is the overall LPS process?), chapter 14 (what is the role of the Responsible Body?), chapter 16 (what are the assessments and determinations for the LPS?), and chapter 24 (what are the best ways to settle disagreements and disputes about issues covered in the Act?)

20. From your perspective, how clear is the LPS guidance in the Code and is there anything that you feel is missing (up to 1,000 words)? Please reference specific groups of people and chapters in your response. (Do not include information in your response that could be used to identify you, such as names.)

- The Code of Practice is not clear enough about how, when and by whom decisions are made about whether a Deprivation of Liberty is, in fact, taking place or proposed (such as application of the acid test and details in Chapter 12). It needs to be more clear how this relates to the LPS process in Chapter 13 and the three assessments in Chapter 16. Initial decisions (13.20) may be made about whether the case amounts to a Deprivation of Liberty at the submission of a case (i.e. gatekeeping). If the case proceeds it is likely this would be further explored in the necessary and proportionate assessment, which will be checked at pre-authorisation review and authorisation. This needs to be spelled out more clearly including detail about how these decisions will be recorded and communicated (presume initial decisions on whether there is a Deprivation of Liberty would be fed back at 13.25 but this isn't clear). It needs to be clear how this could be challenged and how the case might be closed at different stages in the process if it is decided that a deprivation of liberty is not occurring/proposed. For example, the authorisation conditions at 13.54 don't mention consideration of whether the arrangements amount to a deprivation of liberty and the authorisation record at 13.36 doesn't suggest its necessary to explain why the circumstances are considered to amount to a Deprivation of Liberty. Is this right? It seems likely this could be one of the main points of contention.
- A number of elements within the LPS guidance are left to the discretion of the Responsible Body. However, many care providers will be working nationally and will be dealing with multiple Responsible Bodies, sometimes in one area, sometimes across the whole country (for example, live-in care providers who provide careworkers across the UK and may only have one client in that area). Standardisation of some processes (including complaints processes) would be preferable in terms of communication, understanding and managing participation in the process. It will be much harder for national care providers to communicate with people about their rights, the process and complaints procedures if this differs across the country – or even within an area depending on

whether care is provided by NHS CHC or not. We note that a standard set of forms has been circulated and hope that Responsible Bodies do not significantly vary these.

- We suggest that additional guidance is added to the Code of Practice about what to do if there are long delays with the LPS process.
- There is a tendency throughout to frame people's objection as to a place rather than to a service – this language is likely to be inappropriate for care in a person's own home.
- It is important that what is meant by 'vital act' is clearly understood by practitioners with regards section 4B; including how to record decisions. Will a template form be provided?
- Further explanation is needed about what constitutes a deprivation of liberty in a person's own home (also discussed in scenarios section below).
- The Code of Practice remains a lengthy and technical document and we believe that additional accessible documents should be drafted for target audiences that explain the key elements of the process and legislation, including something for careworkers and something for people who use care and support services and their families.
- It would be helpful if the CQC produced some accessible information for care managers explaining how the LPS will interact with care providers' other regulatory responsibilities and for this to be communicated to all registered care providers.
- There are several aspects that remain somewhat unclear should someone be being deprived of their liberty but cared for by family members at home - how would known cases be monitored, for example?
- Should the Code of Practice refer to (i.e. not necessarily to include in full in this document) best practice guidance in closely related cases, for example, say more about best practice where people are found to have capacity; or where there is some level of control but not constant supervision and control; or regarding the risks of locking people in?
- There may well be family disputes around who the Appropriate Person should be, the guidance suggests that the decision rests with the Responsible Body. 15.34 notes the need for Responsible Bodies

to have ‘channels’ to challenge decisions about who can be an Appropriate Person. This is quite vague. Responsible bodies should also support the resolution of family disputes of this nature as an ongoing dispute could create problems further along in the process.

- An additional resource covering the sector-specific key points for the various social care settings might be welcome (e.g. specific guidance on day care, supported living, extra care housing, shared lives, homecare, live-in homecare, personal assistants etc.).
- Should 14.68 include a duty to provide information about complaints processes as well as information about the Court of Protection?

Scenarios in the code

We would be grateful for suggestions and drafts of new scenarios on the following topics, based on your own experience of best practice. In particular, for:

- chapter 2 – application of the MCA principles by emergency services
- chapter 3 – best practices for keeping the person at the centre of the LPS decision-making process
- chapters 4 and 5 – assessing capacity and/or best interests decisions in the context of culturally sensitive decision-making
- chapter 7 – a court makes a decision around a person’s online contact or use of social media
- chapter 8 – gift-giving under a Lasting Powers of Attorney on behalf of a donor who lacks the relevant capacity, demonstrating the more complicated considerations of taking into account the donor’s circumstances, their wishes and whether the gift is considered appropriate under the MCA
- all guidance relevant to the LPS

21. Is there any part of the Code where an existing scenario requires updating or a new scenario or best practice example is required to help illustrate the policy?

- Yes
- No

If you responded yes, please provide examples (up to 1,000 words).

- While the Code says that scenarios “should not in any way be taken as templates for decisions that need to be made in similar situations”, it is questionable if this is realistic. Scenarios are likely to be one of the key ways that people begin to understand the principles being

described and it is inevitable that they will be used in training so they will influence decision making on the ground. This makes it crucial that they are clear.

- We would like to see an example or two explicitly covering LPS in relation to live-in careworkers working in private residences. They are required to be there all the time – what would amount to constant supervision and control in live-in care?
- In Chapter 12 we'd like to see some examples of scenarios where older people are living in their own home and have visiting homecare services where they are deemed to be deprived of their liberty (there are some dementia cases where people are in their own home but in these people are deemed not to be deprived of their liberty).
- The guidance mentions locking people into their own homes from the deprivation of liberty perspective but does not acknowledge other risks associated with locking a person in their own home (e.g. fire risks). We are concerned that this might encourage poor practice.
- We are concerned that the case of Jake where someone is constantly locked in and under at least a notable degree of control does intuitively feel like a deprivation of liberty. The case examples are likely to be highly influential. As its written, this case example might deter people from referring cases where a person is locked in. Is that intended?
- Suggest that the examples in 19.5, 19.15 and 19.22 should be formatted as scenarios.
- The concept of 'vital interests' in section 4B is likely to be really key for training and implementation and is potentially vague. We would like to see more examples about when this would and would not apply.
- It might be helpful to have some scenarios relating to young people and the LPS in Chapter 21.
- There are no LPS scenarios in Chapter 24, only ones about the MCA

LPS: Impact Assessment

The Impact Assessment constitutes the government's assessment of the costs and benefits of the LPS, including the Code and regulations, as proposed for consultation. Please provide feedback on the Impact Assessment for the LPS, including on its assumptions, coverage and conclusions.

Please see the Mental Capacity (Amendment) Act (MC(A)A) Impact Assessment for help answering this question.

22. Do you agree with the estimated impact of the LPS, as set out in the Assessment?

- Fully agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Fully disagree

Please explain your answer and provide feedback on the Impact Assessment for the LPS, including on its assumptions, coverage and conclusions if you wish. (600 words)

Firstly, we are concerned about the capacity of the sector to implement these changes whilst also managing other substantial reforms in social care.

Secondly, we think significantly more thought needs to be given to how to manage the backlog of DoLS applications during the transition.

Thirdly, we are concerned that the Impact Assessment considerably underestimates the cost of training as it omits the cost of training managers of homecare services and care staff providing care in people's own home (and Allied Health Professionals, which we do not cover further below, but who may need substantial additional training)..

According to Skills for Care's figures, we estimate the cost to the homecare sector of training registered managers and careworkers at mean wage rates, using the training times in the Impact Assessment (para 23.43) estimated for raising awareness (2.5 hours) and identification and referral training for managers (5 hours in total) respectively, to be approximately £12.5 million in England. This is calculated as follows:

Staff who will need LPS training - independent sector only in CQC, non-residential services

Number providing direct care: 495,000. This figure includes careworkers, senior careworkers, personal assistants and support and outreach.

Mean hourly pay for those providing direct care: £9.46.

Cost of 2.5 hours training per worker - £23.65

Total estimated cost £11,706,750

Number of registered managers: 9,600.

Mean hourly pay for registered managers: £15.92.

Cost of 5 hours training per manager - £79.60

Total estimated cost £764,160

Care worker and manager training total £12,470,910.

Information drawn from Tableau visualisations on Skills for Care website. These relate to England only, estimates for 2020-21.

Applying a 5.66% uplift for Wales, this amounts to £ 13,176,763 for England and Wales.

This figure omits travel time going to and from training, which employers will have to meet, costs of assessing competency and administrative costs of maintaining training records, extra costs of training on both the MCA and LPS during the one-year transition period, ongoing costs of keeping up to date with LPS caselaw in the future, training of other roles within homecare organisations, like safeguarding leads, and staff training on the different LPS processes designed by each local authority and ICB.

Also, the section on training care home managers seems to envisage training one manager per care home, in para 23.41 of LPS implementation: draft impact assessment. This is impractical and fails to take account of staff rotas, holidays and sick leave. In both care homes and homecare organisations, more than one manager will need to be trained.

We note the intention to provide some free training. However, the homecare sector will unable to absorb the cost of staff time undertaking LPS training without additional funding. Fuel costs, the rising cost of living and wage costs are all impacting on the financial stability of homecare providers – see Fuel costs hit homecare hard and Shortage of homecare and unmet need – impact of cost of living and removal of COVID-19 grants. The sector requires ring-fenced grant funding, paid direct to homecare providers.

The impact statement also does not seem to cover the business costs the homecare sector will incur in identifying and making individual deprivation of liberty referrals, contributing to assessments and consultations, care planning and data capture by Responsible Bodies and the Care Quality Commission, who may require homecare organisations to submit regularly/monthly data to them on LPS.

In theory these costs should be met by commissioners of homecare (local authorities and ICBs), but our experience is they will not be recognised in fee rates paid to providers. Further, CQC registered domiciliary care agencies (there are currently 7,795) will incur higher CQC fees if these include the cost of regulating LPS compliance, as anticipated in the Impact Assessment, leading to further financial pressure on the sector. Given most care is provided to public sector commissioners, these costs should be covered by Government and are unlikely to be recognised by local authority commissioners, so should be covered directly.

LPS: Workforce Strategy

The Workforce Strategy aims to support local, regional and national employers with their preparation for implementing the LPS in England. It offers advice on the workforce planning that will need to take place and the learning, development and training that is being made available ahead of implementation.

Please see the Workforce Strategy for help answering this question.

23. Will the Workforce and Training Strategy help your organisation prepare for the implementation of the LPS?

- Yes
- No

Please explain your answer if you wish (300 words).

- We would like to see an accurate estimate of the likely number of applications for authorisation from the community, including where people are deprived of their liberty while living at home. We do not think this necessarily corresponds to the current number of applications to the Court of Protection. We further consider it is wider than estimates of those with moderate or severe dementia or who have a learning disability living at home. We regard it as critical that Responsible Bodies are well trained on this aspect of LPS so they can respond to multiple requests for authorisation from homecare providers and provide advice to them on when a referral is needed.
- We note that Responsible Bodies have considerable freedom to design their own system for processing LPS authorisations. Homecare providers who operate nationally will find it difficult to make LPS referrals if there is a different system in each local authority and Integrated Care System where they operate, though the use of templates could be of assistance if they are universally adopted by Responsible Bodies.
- Homecare providers sometimes experience issues when care is transferred from local authority to CCG, or vice versa. It is essential that training covers how to achieve a smooth transfer, including a change of Responsible Body if needed.
- We would like LPS training to be fully portable, so a careworker or registered manager trained in one organisation, does not have to repeat training when they change jobs. For this reason, it is critical that standards of training and assessing competence are consistently high so homecare organisations have confidence in training previously received by new recruits.
- We would like to see LPS Competency Group A training integrated with established training in the social care sector, the Care Certificate, and both Competency Groups A and B integrated with Registered Manager Level 5 training.

LPS: Training Framework

The Training Framework describes the core skills and knowledge relevant to the LPS workforce and presents learning outcomes for each workforce competency group across five subject areas.

Please see the Training Framework for help answering this question.

24. Does the Training Framework cover the right learning outcomes?

- Yes
- No

Please explain your answer if you wish (300 words).

- As mentioned above, we would like assurances that LPS training and assessment of competency will be consistently high standard and training portable, so a careworker or registered manager trained in one organisation, does not have to repeat training when they change jobs. There would be merit in both MCA and LPS training being incorporated in established training within the social care sector, like the Care Certificate, at Competency Group A level, and for Competency Groups Level A and B incorporated into Registered Manager Level 5 training.
- The Training Framework refers to identifying a deprivation of liberty. This is the crux of the LPS process. It will be important for the definition of deprivation of liberty, and Scenarios in the Code of Practice, to be clear and unambiguous on whether there is/is not a deprivation of liberty in different cases as both will be used extensively for training purposes.
- We trust the Skills for Care and Social Care Institute for Excellence (SCIE) free training will amply cover LPS issues from the perspective of homecare providers, and deprivation of liberty in people's own home.
- We are concerned about the timing of plans to launch the training, as the roll out of training in homecare will take some considerable time. The workforce is a mobile one and there is less opportunity for group training than for staff in care homes.
- We consider the free training should be launched at the earliest possible opportunity, particularly if there is any delay in publication of the regulations and code of practice. We would like to see adequate publicity about the availability of and timetable for the issue of free resources so providers are not pressed into buying alternative training, unless this is their choice, and can plan the roll out to their managers and staff and adaptation of their own training.
- We are concerned that some existing training on DoLS can be overly complex and that for LPS careworkers will require a succinct summary of key points that they need to understand and apply.

LPS: National Minimum Data Set

Responsible Bodies will need to notify CQC and Ofsted of LPS referrals and authorisations in their area in order to enable them to monitor and report on the

scheme. NHSD will need this data to publish official statistics for the LPS. The LPS NMDS will provide a standardised data set to ensure consistent and quality submission of this data.

The data set has been developed via extensive stakeholder engagement and should capture data required to monitor and oversee the operation of LPS at a national level and does not preclude local systems capturing additional data for local use.

Please see the LPS National Minimum Data Set for help answering this question.

25. Are there further data items needed in the National Minimum Data Set to provide effective oversight of the LPS?

- Yes
- No

Please explain your answer if you wish (300 words).

Data item 6. Location ID reference for the current or proposed setting included in the proposed or authorised arrangements, needs to include specific fields to capture data concerning:

1. Those receiving care at home from providers who are CQC-registered
2. Those receiving either unregulated care, like care provided by a personal assistant, or care from a family member at home.

It is important there is not a catch-all non-regulated/other setting field in the National Minimum Data Set because policymakers must be able to identify if the two categories above are using the LPS provisions in the manner intended in the Code of Practice and regulations.

The consultation did not ask about data collection outside the LPS National Minimum Data set. In order for Responsible Bodies to complete their returns, they may well require regular/monthly returns from homecare providers in their area, with attendant time and cost for our sector. CQC may require LPS data from regulated homecare providers too. To minimise the effect of this, we trust any data required will be integrated into existing data collection processes.

Before you submit your response

We have a few questions we would like to ask to help us improve future consultations.

How satisfied are you with the consultation process?

- Very satisfied
- Satisfied
- Somewhat satisfied
- Disappointed

How did you hear about the consultation?

- Social media
- Received an email from Department of Health and Social Care
- Word of mouth (family, friend or colleague)
- Direct communication from a third sector organisation or regulatory organisation
- Broadcast news (TV or radio)
- GOV.UK or other government website
- Newspaper (online or print)
- Website (non-government)
- Trade magazine
- Other

What could we do to improve your experience of the consultation survey? (300 words)

The submission form does not allow the use of hyperlinks, which could be useful to reference sources.

Some of the word limits seemed overly short and some of the questions seemed to be quite legally specific.