Ministerial foreword: Gillian Keegan MP

I am committed to delivering a fair health and care system for everyone that depends on the vital services that it provides. This includes the mechanisms by which we protect one of the most fundamental of our human rights: the right to liberty.

In some instances, it is necessary to deprive a person who lacks the relevant capacity of their liberty in order to deliver essential care or treatment to that person. This must be done with the greatest of care and respect for that person and their rights. The Deprivation of Liberty Safeguards (DoLS) were introduced with the aim of ensuring that safeguards apply when this happens in a care home or hospital.

However, the DoLS are overly complex and have struggled to provide the necessary protections since the Cheshire West Supreme Court ruling expanded the remit of the system. People have faced breaches of their human rights because of the authorisation backlog that has developed as a result of the bureaucracy of the DoLS and the expanded definition of deprivation of liberty.

The Mental Capacity (Amendment) Act 2019 made changes to the legislation which, once implemented, will repeal the DoLS and replace it with the Liberty Protection Safeguards (LPS). This new system will protect people aged 16 and above who are, or who need to be, deprived of their liberty to enable their care or treatment and who lack the mental capacity to consent to these arrangements.

The LPS is designed to be a simpler, more streamlined system which puts the person being deprived of liberty at the heart of the decision-making process. We want the LPS to be more integrated into everyday health and care planning, and to reduce the assessment burden for organisations administering the safeguards. New statutory roles and processes give greater weight to the wishes and feelings of people being deprived of liberty, and to the views of those that care for and about them. The LPS will provide specific protections when a deprivation of liberty happens in any setting, in England and Wales.

Acting on feedback from stakeholders, we have decided to merge the LPS guidance into the Mental Capacity Act 2005 (MCA) Code. The LPS scheme will therefore be fully informed by the principles of the MCA. Alongside the new Code, we are also publishing additional draft documents, which set out, in detail, how we think LPS should be implemented and operate. This includes 6 draft sets of regulations, information about workforce training, a proposed data specification for national reporting, and an updated impact assessment.

I would like to personally thank the experts, organisations and people who have or may have experience of the MCA who have contributed to the drafting of this guidance and our implementation work to date. The more feedback we receive, the better the final system will be. I therefore invite everyone, including those with expertise working in health and social care and, crucially, people who have or may have experience of the MCA to take part in this consultation. The government will carefully consider all the views that we receive, before making final decisions about how the LPS will be implemented.

I look forward to hearing from as many of you as possible.

Gillian Keegan, Minister of State for Care and Mental Health, Department of Health and Social Care

Ministerial foreword: Tom Pursglove MP

Our lives are full of decisions, ranging from those we make every day about things like what to wear or eat, to occasional and potentially life-changing decisions about issues such as how to manage an investment, what medical treatment to have, or where to live.

Since its implementation in 2007, the MCA has played an important role in empowering people who may need support to make these decisions, or who lack the capacity to do so and require others to make decisions in their best interests. The Act also enables people who have capacity to make arrangements to prepare for a time when they may lack capacity in the future. The Act’s Code of Practice has

been integral to this empowerment, setting out best practice for practitioners and offering practical guidance for all on how the Act operates on a day-to-day basis.

I am very aware that the Code is now over 13 years old, and that a lot has moved on since then – other legislation, case law, terminology, organisational structures, and good practice has developed over this time.

The time is therefore right to update the Code to reflect these changes, and I am very pleased to launch this consultation on a new draft Code with my colleagues, the Minister of State for Care and the Minister for Children and Families. We have worked closely together on this draft which, as well as updating the general mental capacity chapters for which I am responsible, incorporates new material specifically on the new LPS measures, which the Minister for Care will implement. We agree that embedding LPS guidance in the Code will help to align the new LPS practices with the overarching principles of the MCA and make it of maximum use to readers.

There has been a lot of work behind the scenes to get to this point. In 2019 the Ministry of Justice undertook a call for evidence, to gather initial stakeholder views on where the Code required updating. My officials have subsequently worked through these with a working group of experts from across sectors.

I would like to thank the many people who have selflessly contributed their time and expertise to the review already. This consultation is a vital step towards improving the Code further, and I would strongly encourage you to respond.

Tom Pursglove, Parliamentary Under Secretary of State, Ministry of Justice

Ministerial foreword: Will Quince MP

As Minister for Children and Families, my vision for all children and young people is that they achieve well and lead happy and fulfilled lives. The LPS will provide essential protections for 16 and 17 year olds who need to be deprived of their liberty as part of their care and treatment, and who cannot consent to these arrangements.

The courts have determined through case law that parents cannot consent to what would otherwise be a deprivation of liberty on behalf of their child once they reach the age of 16. This recognises that while parents have a key role in supporting decision-making for their child, it is paramount to keep the rights of the young person themselves at the centre, by ensuring specific legal authorisation is obtained.

The LPS is designed to put more emphasis on the perspective and experience of the person deprived of liberty, and the importance of the principle of acting in the best interests of the young person for care and treatment decisions. The scheme will include the introduction of an explicit duty to consult with the young person, and those interested in their welfare, to establish the young person's wishes and feelings about proposed arrangements. This will strengthen the voices of individuals involved, and their parents, carers and families.

I am aware that we are asking a lot of the children's workforce and that this will not be an easy and straightforward transition, but this change demonstrates the absolute necessity of protecting autonomy and human rights in line with the principles of the MCA.

Within the Department for Education, we are committed to working with our colleagues across government departments, the Welsh Government and the health and social care sector to ensure the system is prepared for successful implementation. Your responses to this consultation will be invaluable in ensuring this system enables us to protect the most vulnerable.

Will Quince MP, Minister for Children and Families, Department for Education

Introduction

Context

Mental Capacity Act 2005

The Mental Capacity Act 2005 (the MCA) is designed to protect and empower people who may currently lack the mental capacity to make their own decisions about their care and treatment. It also allows people who have capacity to make preparations for a time when they may lack capacity in the future.

The MCA applies in England and Wales. Parts of this consultation are applicable to both England and Wales, and other sections are applicable to England only. Further information on which parts of the consultation are relevant to Wales can be found in the consultation guidance subsection below.

Deprivation of Liberty

Article 5 of the European Convention on Human Rights (ECHR) guarantees the right to liberty and provides that no one should be deprived of their liberty on an arbitrary basis. Any deprivation of liberty must be carried out in accordance with a procedure prescribed by law and proper safeguards must be delivered.

A European Court of Human Rights judgment in 2004 – HL v United Kingdom – found that the English and Welsh legal system did not adequately protect people who lacked capacity to consent to their care and treatment arrangements as demanded by the right to liberty (Article 5).

The Deprivation of Liberty Safeguards (DoLS) were consequently introduced and came into force in 2009 through the introduction of new provisions added to the MCA by the Mental Health Act 2007. They intended to ensure that, in hospitals or care homes, where a person is being assessed for or under arrangements that amount to a deprivation of liberty and are unable to consent to those arrangements, they have access to the necessary safeguards.

In March 2014, the Supreme Court set out the ‘acid test’ for the meaning of an objective deprivation of liberty via the decision known as “Cheshire West”. This states that an individual who lacks the

capacity to consent to the arrangements for their care and treatment is objectively deprived of their liberty if they are:

1. subject to continuous supervision and control
2. not free to leave

Because of this judgment, the number of cases referred by hospitals and care homes to the DoLS process, in England, increased from approximately 14,000 in 2013 to 2014 to 264,000 in 2019 to 2020 creating a backlog of pending applications for local authorities.

Additionally, the House of Lords Select Committee on the MCA found in its 2014 post-legislative scrutiny report that the legislation was “bureaucratic” and “too complex” and that the safeguards were frequently not used at all. The Law Commission subsequently reviewed the DoLS. It recommended that the DoLS should be repealed and replaced as a matter of “pressing urgency”.

The government’s response to the Law Commission report was published in March 2018. The LPS were consequently introduced by the Mental Capacity (Amendment) Act 2019 (the MC(A)A).

The government had hoped to fully implement the LPS by April 2022. However, it is paramount that implementation of the LPS is successful so that the new system provides the safeguards that are needed. We recognise that without adequate time to prepare, implementation will not be a success. Given the impact of the COVID-19 pandemic on the sectors and professionals who will be called upon to implement these important reforms, we have had to reconsider our aim to implement the LPS by April. For more information on the implementation of the LPS, please see below.

The Liberty Protection Safeguards

The LPS was introduced by the Mental Capacity (Amendment) Act 2019 to replace the DoLS as the system that authorises arrangements amounting to a deprivation of liberty in order to provide care or treatment to an individual who lacks the relevant mental capacity, in England and Wales. Though the LPS has the same overall purpose as the DoLS, the new system is different by design, in a number of ways.

The new system is designed to be more streamlined and will put the person at the centre of the decision-making process. The LPS will introduce an explicit duty to consult with the person, and those interested in their welfare, to establish the person's wishes and feelings about proposed arrangements. Those who are close to the person will also be able to provide representation and support to them via a new 'Appropriate Person' role. Otherwise people can be represented and, supported by an Independent Mental Capacity Advocate (IMCA) who will protect their rights throughout the process. Furthermore, the rights of people at the heart of the most complex cases will be considered and upheld by the new 'Approved Mental Capacity Professional' role.

The core principles of the MCA are at the heart of the proposed design for LPS. This will help to further align mental capacity awareness and practice across different settings and professions. LPS will extend to 16 and 17 year olds. This will streamline existing processes and improve access to safeguards for young people. For example, a decision from the Court of Protection will no longer be needed in every such case.

The LPS will cover a wider range of settings than just hospitals and care homes, providing protections to people receiving care or treatment, for example, in their own homes or in private and domestic accommodation. A decision from the Court of Protection will no longer usually be needed for deprivations of liberty that occur in these settings. This will make access to safeguards more straightforward, and quicker, for more people.

The new system has been designed to better integrate with other relevant legal frameworks. The aim is for LPS practice to become part of mainstream healthcare and social care assessments and planning, including the Care Act 2014 care and support planning. This integration will make the overall process more straightforward for the person and easier for local authorities by reducing duplication.

NHS bodies will now have a role in arranging assessments and authorising arrangements. This will help share the administrative burden and bureaucracy which has built up under the DoLS.

The number of assessments required to grant a deprivation of liberty authorisation will also be reduced from 6 to 3, and in some cases local

authorities will be able to renew authorisations without having to restart the process each time.

Executive summary

Code of Practice

The MCA was implemented alongside a Code of Practice which was designed to support the Act with practical, statutory guidance, explaining how the Act operates on a day-to-day basis and offering examples of best practice to carers and practitioners. The Code of Practice now requires updating for 2 key reasons.

First, there has been new legislation and case law, organisational and terminological changes, and developments in ways of working and good practice since the MCA came into force in 2007.

Second, the new LPS scheme means that changes are needed to the Code. It is important that professionals and practitioners understand and apply the principles of the MCA into the LPS process.

We have decided to produce one overarching Code of Practice to ensure the principles of the MCA are firmly embedded in the LPS from its introduction.

Any reference to ‘the Code’ in this consultation means the joint, draft Code of Practice published by the Ministry of Justice (MoJ) and the Department of Health and Social Care (DHSC). In preparing the Code for consultation we have:

- held a call for evidence
- engaged with professionals and practitioners
- sought views from over 100 stakeholders during the coproduction of the LPS sections of the Code
- met with people who may be affected by the LPS to ensure the Code reflected their experience. This included people with dementia, learning disabilities and acquired brain injury

The Liberty Protection Safeguards Regulations

The MC(A)A will be underpinned by 6 sets of regulations. These regulations must pass through the relevant Parliamentary procedure before the LPS can be implemented. They set out the legal requirements for:

- the criteria for appointment and the functions of an Independent Mental Capacity Advocate (IMCA)
- the criteria for training and approval of an Approved Mental Capacity Professional (AMCP)
- the powers of 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 the LPS
- the requirements for persons carrying out assessments and determinations, and the definition of a connection to a care home for those carrying out pre-authorisation reviews
- transitional arrangements to allow the LPS and the DoLS to run side by side during the first year of the LPS implementation
- the amendments to other legislation as a result of the MC(A)A

We are not required to consult on the regulations. However, we have decided to publish these with the consultation to seek views on the policy detail of each set of regulations. The drafting regulations are indicative of the policy intention only, and may change before the final version laid before Parliament. We are therefore not seeking comment on the formulation of the regulations.

Implementing the LPS

The implementation of the LPS is a large reform programme and will involve big changes for the health and social care system, and the people who rely on it. Key stakeholders in this system are expected to take a proactive role in ensuring readiness in line with the regulations, the Code and additional government guidance.

The government is committed to ensuring the sector is supported and prepared for this. In particular, bodies with statutory duties to authorise the arrangements (Responsible Bodies) and providers of care involving the LPS authorisations will need to understand the changes the LPS introduces in the lead-up to implementation. These organisations must have the right training and systems in place to

ensure they can carry out their functions effectively under the LPS once it goes live. We understand that this is a complicated area of law and practice, and more is needed to support implementation. The Code offers comprehensive, statutory guidance on LPS, but we think that more guidance, in other forms, will be needed. We will be publishing more guidance and are supporting implementation networks and the development of national training products for a wide range of audiences.

These plans are explained in more detail in Section 5 of this document, which also includes questions about implementation.

We have committed to an inclusive public consultation that will last 16 weeks. We expect that responses will be very detailed, and it will take time to work through those responses and ensure that we take them into account, in order to get LPS right. We intend to set a new date for LPS implementation when we publish the consultation response.

Consultation guidance

Scope

This consultation sets out the proposed updates to the MCA Code of Practice and introduces the LPS secondary legislation. It also covers workforce guidance related to the implementation of the LPS. This is a joint consultation published by DHSC and MoJ.

The LPS will apply to 16 and 17 year olds, and the Department for Education (DfE) has been involved in the development of this new system. All 3 departments will be working together to successfully implement the LPS.

The Code applies in both England and Wales. We therefore ask for stakeholders from both nations to respond to the sections of the consultation relating to the Code. The UK government will discuss any

outcomes of the consultation relating to Wales with the Welsh Government before taking any final decisions.

The Welsh Government is holding a separate consultation on certain aspects of the LPS design in Wales. This includes secondary legislation, specific to Wales, for: AMCPs, IMCAs, assessments and determinations, and monitoring and reporting. If you work in or engage with the Welsh health social care system, please respond to the Welsh Government consultation on specific issues covered by the draft, Welsh regulations. The UK government regulations for transitional provisions and consequential amendments apply to England and Wales. The other 4 sets of regulations only apply in England. The implementation products included in this consultation are also England only. The Welsh Government is developing its own workforce and data products.

Overview

This consultation document is split into 5 sections. This is to separate the various materials that are being consulted on and to make the document navigable for respondents who wish to provide feedback on individual documents, or on certain parts of the Code.

The new proposed Code is one overarching document which includes existing and updated guidance from the current Code and new LPS guidance. We understand that some respondents will have a particular interest in the broader MCA updates and others in the new LPS guidance.

In this consultation document, we have therefore split the Code chapters into 3 grouped sections:

- Section 1 covers the proposed updates to the existing chapters within the MCA Code of Practice
- Section 2 covers the proposed updates to the existing chapters that now include new LPS guidance
- Section 3 covers the new chapters which contain the LPS guidance only

Splitting the chapters into sections should help respondents provide feedback on the areas that they have most interest or experience.

It is worth noting that because these sections are grouped by their policy area, the chapters found in each section do not always reflect the chronological order of the chapters in the Code. Each section of this consultation document clearly explains which chapters it covers.

A detailed breakdown of what each section covers can be found below.

Section 1: proposed updates to the existing chapters in the Code

Section 1 covers chapters 4 to 6, 8 to 9,11, 23, and 25 to 26 of the Code. These chapters exist in the current MCA Code, but in the proposed new draft, include updates to the existing Code guidance. In the main, these chapters do not offer guidance about the LPS.

Questions on the proposed updates to the existing guidance in the Code can be found at the end of Section 2 and in Section 5. The responses to these questions will be of particular interest to MoJ.

Section 2: proposed updates to the existing chapters that now include LPS guidance in the Code

Section 2 covers chapters 3, 7, 10, 21 to 22, and 24 of the Code. 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 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 MoJ.

Section 3: 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.

Section 4: the draft LPS regulations

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

Section 5: putting the Code into practice and implementing the LPS

Section 5 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 interest to both DHSC and MoJ.

Responding to the consultation

The objective of this consultation is to ensure that the revisions to the Code best reflect developments in legislation and practice since it was published in 2007, and to make certain that the new LPS guidance in the Code and the LPS regulations are clear and deliver proper safeguards to those that need them. The Code aims to empower people to make decisions about their lives wherever possible and

protect their human rights while affording the greatest care and respect for them.

Achieving these objectives requires a strong representation of views from across the sector, family carers and, most importantly, from people who have or may have experience of the Mental Capacity Act. We encourage anyone who has an interest in mental capacity, is affected by, or knows someone affected by, the proposed updates to the Code and the LPS to respond to this consultation.

The Code, this consultation document and the easy read materials have also been translated into Welsh.

Easy read

To make the contents of the Code easier to access for all audiences, we have produced 2 easy read summary booklets. One booklet is an easy read summary of the wider MCA guidance in the Code which is not directly relevant to the LPS. The other booklet is an easy read summary of the guidance in the Code which is specifically relevant to the LPS. These easy read summary booklets are based on the chapter summaries in the full Code.

Easy read summary booklet of the wider MCA guidance in the Code.

Easy read summary booklet of the LPS guidance in the Code.

To make the consultation easier to access for all audiences, we have produced an easy read consultation document.

This is a condensed version of this consultation document, which focuses on people's personal experiences rather than very specific policy questions. We think that having a different set of broader questions in the easy read consultation document will help people who have or may have experience of the Mental Capacity Act to tell us about their personal experiences and views. This feedback will help us to improve the Code and other guidance and ensure that it reflects real-life scenarios.

People who wish to respond to the easy read consultation questions can draw on the easy read summary booklets, or any of the other documents published, as points of reference. Anyone and everyone

who wants to respond to this consultation is free to respond to any question or questions, from either consultation document. We would like them to engage with the consultation in whatever way works best for them.

Duration

This consultation will run for 16 weeks from 17 March to 7 July 2022.

Enquiries

For any enquiries about responding to the consultation please contact lps.cop@dhsc.gov.uk.

How to respond

Please respond to this consultation by completing the online survey.

The survey will be available in Welsh.

An easy read survey with easy read questions will also be available. For more information on the easy read survey, please see the easy read consultation document.

The online survey allows respondents to save a draft response and return to the survey later. Using the online survey greatly assists in our analysis of the responses, enabling more efficient and effective consideration of the issues raised for each question.

We recommend that you:

- read this consultation document
- focus on the questions which cover areas that you have the most experience of or a particular interest in
- consider skipping questions if they are not relevant to you, or you do not have a view on them
- refer to the relevant documents or Code chapters referenced in the question
- respond to the questions using the online survey

Points to consider when responding to the consultation

Questions included in this consultation focus on the key issues identified through previous discussions with representatives from the

sector and people with health and care needs. The question styles vary in nature from broad questions covering the entire Code to questions relating to specific policy detail. When responding to a specific question, we ask that you keep your response related to the issue raised by the question. This will help ensure that the feedback you provide will be considered in context after the consultation period ends.

The Code provides guidance for a wide range of people, including professionals, the person, and their family and friends, but may not cover every possible situation that may be relevant. We ask that you keep this in mind when responding to the consultation. If you think that there is a key gap in the draft Code or that the Code could be better illustrated with an example scenario, you can provide this information at question 21.

To note, the Code and this consultation document refer to clinical commissioning groups (CCGs). The government has set out its proposals to replace CCGs with integrated care boards (ICBs), subject to the passage of the Health and Care Bill, which is currently undergoing Parliamentary scrutiny. The role of CCGs as the Responsible Bodies under LPS is tied to their commissioning role for Continuing Healthcare (CHC). As a core function of CCGs, we are expecting CHC to become the responsibility of the new ICBs, and therefore the Responsible Body function under LPS will also transfer to ICBs. We are continuing to work closely with the teams within DHSC that are leading the work on these reforms, and CHC overall, as this policy develops. This consultation document and the draft Code therefore reference CCGs, in line with current legislation.

You do not have to respond to all questions in the consultation.

All documents relating to this consultation can be found on the consultation page.

Data privacy

When responding to the questions, please avoid including information that will identify you, such as your last name. Responses that include information that could be used to identify you may be voided.

For more information, please see the privacy statement on the consultation page.

Section 1: proposed updates to the existing chapters in the Code

Section 1 covers chapters 4 to 6, 8 to 9,11, 23, and 25 to 26 of the Code. These chapters exist in the current MCA Code, but in the proposed new draft, include updates to the existing Code guidance. In the main, these chapters do not offer guidance about the LPS.

Questions on the proposed updates to the existing guidance in the Code can be found at the end of Section 2 and in Section 5. The responses to these questions will be of particular interest to MoJ.

Main updates to the Code

We have made various general edits across the Code to bring it up to date and ensure it reads well. These include:

- amendments to cross-refer to relevant legislation which has come into force since the MCA was implemented
- amendments referring to changes in practice since the MCA came into force, for example with regards to technological changes
- updates where other organisations' guidance, procedures or terminology have changed
- editorial changes to improve the clarity, structure, or consistency of the chapters
- revising scenarios and creating new ones
- changes to reflect good practice as outlined to us by stakeholders through the call for evidence, stakeholder working groups and the National Mental Capacity Forum

Some of the key proposed updates to each chapter are set out below.

Chapter 4: how does the Act define a person's capacity to make a decision and how should capacity be assessed?

Summary

1.1 Chapter 4 explains how the Act defines 'a person who lacks capacity to make a decision' and sets out a clear test for assessing whether a person lacks capacity to make a particular decision at a particular time.

Proposed updates

1.2 We have amended text to make clear the distinction between considering and assessing capacity. This aims to explain the presumption of capacity better, by balancing the twin challenges of not rushing into capacity assessments, but also not failing to assess capacity when there is reason to do so (paragraphs 4.5 and 4.6 of the Code).

1.3 We have changed the order in which the test of capacity assessment is set out, so that an assessor should firstly consider whether the person is able to make the decision, and if not, whether there is an impairment or disturbance in the functioning of the mind or brain causing their inability to make the decision. The aim of this change is to prevent automatic assumptions that the person cannot make a decision because of their condition (paragraphs 4.8 and 4.9).

1.4 We have added text to say that factors related to cultural background may influence a person's, way of thinking, behaviour or communication (for instance paragraphs 4.18, 4.31 and 4.82).

1.5 We have included new text providing guidance on 'executive functioning' and how this might affect the capacity assessment (paragraph 4.35 to 4.38).

1.6 We have included new text to provide guidance on how to approach decision-making when a person's capacity fluctuates (paragraphs 4.51 to 4.57).

1.7 We have added text to provide guidance on retrospective capacity assessments and how these situations differ from contemporaneous capacity assessments (paragraph 4.100 onwards).

Chapter 5: What does the Act mean when it talks about “best interests”?

Summary

1.8 Chapter 5 explains what the MCA means by acting in the best interests of someone lacking capacity to make a decision for themselves, and describes the checklist set out in the MCA for working out what is in someone’s best interests.

Proposed updates

1.9 We have added text to emphasise that deciding what is in a person’s best interests is only relevant after all practicable steps have been taken to support the person to make the decision in question (paragraph 5.1).

1.10 We have added text to clarify the relationship between best interests decision-making and assessing and meeting needs under other relevant legislation outside of the MCA (paragraph 5.8).

1.11 In light of the Supreme Court decision in Aintree v James, we have amended text to make clear that best interests encompass not just a person’s medical interests, but also their social and psychological interests (paragraph 5.10).

1.12 We have expanded text on ‘Who is the decision-maker?’ to help clearly identify who that person is and to avoid responsibilities being misunderstood (paragraphs 5.15 to 5.23).

1.13 We have amended text to make clear that a best interests decision is a decision between the options that are available (paragraphs 5.24 to 5.26).

1.14 As outlined in Aintree v James, we have clarified that if a life-sustaining treatment is not a treatment that is reasonable to give, the treating doctor cannot be required by the Act to provide it (paragraph 5.53).

1.15 Following the Supreme Court decision in Re Y and subsequent Court of Protection practice guidance, we have amended the guidance on when decisions regarding life-sustaining treatment must be brought to the Court of Protection, to say that this is only necessary when there is difference of opinion or the way forward is finely balanced (paragraph 5.59).

1.16 In line with case law, we have added further emphasis on the importance of taking the person's wishes and feelings into account. This includes clarifying that the person's wishes and feelings can be determinative in a best interests decision and that in cases where the decision is not one the person would have made, clear justification will be required (paragraph 5.68).

1.17 In light of Winspear v City Hospitals Sunderland, we have clarified that a failure to consult properly with someone interested in the person's welfare when it is practicable and appropriate to do so will mean that the decision-maker cannot rely upon the defence in section 5 (paragraph 5.88).

1.18 We have clarified that advance statements and Advance Care Plans should be considered as evidence of the person's wishes when a best interests decision is being made (though they are not legally binding) (paragraph 5.77).

1.19 We have introduced text on 'future care plans' drawn up for a person who lacks the relevant capacity, emphasising that it should help inform a best interests decision and that those involved in drawing it up should follow the best interests decision-making principles of the MCA as far as possible to ensure that the plan can help inform the decision robustly (paragraphs 5.95 and 5.96).

1.20 We have included new guidance on recording best interests decisions about care and treatment (paragraphs 5.102 to 5.108).

1.21 We have included new guidance on recording property and affairs decisions made by attorneys and deputies (paragraphs 5.109 to 5.111).

Chapter 6: what protection does the Act offer for people providing care or treatment?

Summary

1.22 Chapter 6 explains how the MCA protects people who provide care or treatment for someone who lacks the capacity to consent to the decision or action being taken.

Proposed updates

1.23 We have linked to new guidance in the best interests chapter on recording best interests decisions. This aims to ensure that the decision-maker has considered all the matters necessary to be able to rely upon the defence in section 5 of the MCA (various, including paragraphs 6.42 to 6.44).

1.24 We have included new guidance on decisions to restrict a person's contact with others (paragraphs 6.20 to 6.22).

1.25 We have set out guidance, linked to the Court of Protection and best interests chapters, regarding when the court should be asked to make a healthcare or treatment decision (various, particularly paragraphs 6.32 to 6.37).

1.26 We have updated guidance on making payments for goods and services (paragraphs 6.86 to 6.91).

Chapter 8: what does the Act say about the Lasting Powers of Attorney?

Summary

1.27 Chapter 8 explains how people who wish to plan ahead for the possibility that they might lack the capacity to make particular decisions for themselves in the future are able to grant Lasting Powers of Attorney (LPAs) to named individuals to make certain decisions on their behalf, and how attorneys appointed under an LPA should act.

Proposed updates

1.28 We have added guidance on who cannot be a certificate provider (paragraph 8.11).

1.29 We have provided information on cancelling an LPA (paragraph 8.12).

1.30 We have added guidance on the implications of appointing attorneys jointly or jointly and severally (paragraphs 8.19 to 8.23).

1.31 We have added guidance on who the LPA should be provided to once registered (paragraph 8.28).

1.32 We have added text to clarify the status of foreign powers of attorney in England and Wales (paragraph 8.30).

1.33 We have included guidance on how someone can check the validity of an LPA (paragraph 8.38).

1.34 We have added further guidance on instructions and preferences in an LPA (paragraphs 8.32 to 8.33).

1.35 We have clarified the limits on the types of decisions an attorney can make, including various care and treatment decisions and the creation of a will (paragraphs 8.45, 8.62 to 8.63 and 8.69 to 8.74).

1.36 We have set out what should happen if an attorney feels unable to make a care or treatment decision (paragraph 8.65).

1.37 We have set out an attorney’s role in the preparation of a care plan for the donor (paragraph 8.66).

1.38 We have updated guidance on when attorneys can make gifts or similar payments on the donor's behalf (paragraphs 8.49 to 8.59).

1.39 We have set out what should happen when a decision needs to be made that relates to both the donor's personal welfare and their property and affairs (paragraphs 8.78 to 8.81).

1.40 We have added text to say that factors related to cultural background may influence a person's way of thinking, behaviour or communication (for instance paragraphs 4.18, 4.81 and 4.84).

Chapter 9: what does the Act say about deputies?

Summary

1.41 Chapter 9 describes the role of deputies appointed by the Court of Protection to act and make decisions on behalf of someone who lacks capacity to make those decisions and explains how they are supervised.

Proposed updates

1.42 Following the decision in Re Lawson, Mottram and Hopton (appointment of personal welfare deputies), we have amended text on the appointment of personal welfare deputies to reflect the court's approach to determining whether one should be appointed, and the need to balance protecting the person with promoting their autonomy (paragraph 9.13).

1.43 We have added text to clarify what should happen if there is a conflict of interest, including where the deputy is a family member or a professional deputy. This includes when an application to the court may be required (various, including paragraphs 9.17 and 9.39 to 9.43).

1.44 We have amended text to provide clearer guidance on when deputies may delegate tasks (paragraphs 9.46 and 9.47).

1.45 We have added text providing guidance on when deputies may use the person's funds to make gifts or family care payments (paragraphs 9.58 and 9.59).

1.46 We have added information regarding how the Office of the Public Guardian (OPG) supervises deputies, including the OPG's role in provision of security (paragraphs 9.58 to 9.67).

Chapter 11: what does the Act say about advance decisions to refuse treatment?

Summary

1.47 Chapter 11 explains the procedures that must be followed if someone wishes to make an advance decision to refuse medical treatment to come into effect when they lack capacity to refuse the specified treatment.

Proposed updates

1.48 We have amended the text to add clarification on considering whether an application to the Court of Protection is required in the case of doubt about existence, validity or applicability of an advance decision to refuse treatment (paragraphs 11.62 and 11.78 to 11.81).

1.49 We have added text to clarify how advance statements and advance care plans differ from advance decisions (paragraphs 11.82 and 11.83).

Chapter 23: what means of protection exist for people who lack capacity to make a decision for themselves?

Summary

1.50 Chapter 23 describes the different agencies that exist to help make sure that people who lack capacity to make a decision for themselves are protected from abuse and neglect.

Proposed updates

1.51 We have included a table highlighting different types of abuse (paragraph 23.5).

1.52 We have set out additional legislation and safeguarding procedures that those working with people who lack capacity should be familiar with (paragraphs 23.6 to 23.9 and 23.37).

Chapter 25: what rules govern access to information about a person who lacks the relevant capacity?

Summary

1.53 Chapter 25 summarises how the laws about data protection and freedom of information relate to the provisions of the MCA.

Proposed updates

1.54 We have restructured the beginning of the chapter to set out how someone can see information on behalf of someone else when they have capacity, followed by situations in which someone may or may not be able to see information on behalf of someone else when that person lacks the relevant capacity (paragraphs 25.1 to 25.12).

1.55 We have clarified that an attorney or deputy can ask to see information concerning the person they represent if it helps them make the decisions that they have the legal authority to make (paragraphs 25.13 to 25.18).

1.56 We have added text to clarify that the disclosure of information by a professional to others, as part of the process of working out someone’s best interests, is likely to be lawful if it is required for the

professional to consult meaningfully. We have also clarified that disclosure of information to statutory advocates is likely to be lawful if it is required for the advocate to discharge their statutory functions (paragraphs 25.21 to 25.25).

1.57 We have included text setting out the right that the OPG and IMCA have to access health records under the MCA (paragraphs 25.25 to 25.27).

Chapter 26: how does the Act affect research projects involving a person who lacks the relevant capacity?

Summary

1.58 Chapter 26 provides guidance on how the MCA sets out specific safeguards and controls for research involving, or in relation to, people lacking capacity to consent to their participation.

Proposed updates

1.59 We have amended the chapter to make clear that the specific research provisions of the MCA apply when involving a person who lacks capacity, but that the general provisions of the MCA are also important. Researchers must follow the principles of the MCA when involving someone with an impairment or disturbance in the functioning of their mind or brain, including supporting them with decision making and assessing their capacity if required (paragraphs 26.7 to 26.8).

1.60 We have added reference to the Data Protection Act and General Data Protection Regulation (GDPR) to make clear that researchers must comply with the safeguards they contain when processing personal data (paragraphs 26.17 and 26.73).

1.61 We have clarified that the decision for someone to participate in research is not a best interests decision, but that researchers use the research provisions in the MCA to follow the person’s wishes and

feelings when deciding whether the person should take part (paragraphs 26.16 and 26.27, 26.67).

1.62 We have included further guidance on the role of the consultee, including clarifying that the role of the consultee is not to provide consent to researchers, but to advise the researcher about whether the intentions of the research are in accordance with what they think the person lacking capacity would have wanted. It is the researcher's responsibility to make the final decision (paragraphs 26.40 to 26.62).

Section 2: 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 Code. 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 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 but there is space at question 20 to add any further thoughts. The responses to these questions will be of particular interest to 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 MoJ.

Chapter 3: how should people be helped to make their own decisions?

Summary

2.1 Chapter 3 explains how the MCA makes sure that people are supported to make their own decisions as far as possible. It also explains the importance of keeping the person at the centre of the decision-making process throughout the LPS and how this can be done. It also explains information rights, outlining what information is available to the person's Appropriate Person and IMCA in the LPS process.

Proposed updates to the existing guidance

2.2 Reflecting the United Nations Convention on the Rights of Persons with Disabilities principles of supported decision-making, we have strengthened wording to place more emphasis on supported decision-making and empowering people to make their own decisions, while remaining within the ambit of the MCA (throughout chapter).

2.3 We have added text prompting professionals to be aware of the risk of coercion or undue influence from someone who is supporting a person either to make a decision or to express their views as part of the process of best interests decision-making (paragraph 3.18).

New guidance for the LPS

2.4 It is essential that the guidance in the Code supports professionals and others to keep the person at the centre of the LPS process and decision making related to the LPS. Although the Code cannot provide step by step guidance for every scenario, it aims to highlight the core principles set out in the MCA that must be followed throughout the LPS process. These include taking all practicable steps to support the person to make the decision.

2.5 We spoke to people who have or may have experience of the MCA, with a range of backgrounds, about the best ways to help them feel involved in the process and things that practitioners should know when working with someone who lacks the relevant mental

capacity. This has heavily informed the guidance in this chapter of the Code.

Chapter 7: what is the role of the Court of Protection?

Summary

2.6 Chapter 7 describes the role of the Court of Protection, established under the MCA, to make decisions or declarations in cases where there is no other way of resolving a matter affecting a person who lacks capacity to make the decision in question.

2.7 It also explains how the person, their Appropriate Person, IMCA, or anyone else can apply to the Court, for example to challenge an LPS authorisation under section 21ZA of the MCA or the use of the legal authority provided by Section 4B of the MCA.

Proposed updates to the existing guidance

2.8 For clarity, we have separated the previous Court of Protection and court-appointed deputies chapter into 2 separate chapters.

2.9 We have updated and restructured the description of the Court, including the description of its powers to make decisions and declarations, as well as decisions and declarations it cannot make (paragraphs 7.3 to 7.17).

2.10 We have updated sections providing guidance on when cases must or may go to the Court, both for property and affairs and health and welfare cases. This update follows the Supreme Court decision in Re Y and subsequent Court of Protection practice guidance (paragraphs 7.18 to 7.30).

2.11 We have added new text explaining the obligation to consider how long is reasonable to spend seeking to reach agreement before applying to the Court, to ensure delay does not adversely affect the person’s welfare (paragraph 7.30).

2.12 We have included guidance on who should bring an application to the Court, how they can make an application and how the Court will deal with the case (paragraphs 7.42 to 7.57).

New guidance for the LPS

2.13 Applications can be made to the Court of Protection relating to certain aspects of an LPS authorisation under section 21ZA of the MCA. Additionally, an application could be made in relation to the LPS assessment process or the use of section 4B.

2.14 One of the key aims of the LPS is to streamline the authorisation process and reduce the reliance on the Court of Protection. The LPS will aim to achieve this by enabling all cases to be considered by a Responsible Body, rather than requiring certain cases to be considered by the Court. The introduction of the role of the Approved Mental Capacity Professional will also mean that where arrangements are contrary to the person's wishes and feelings, additional oversight will be provided.

Question 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

Chapter 10: what is the Independent Mental Capacity Advocate (IMCA) Service?

Summary

2.15 Chapter 10 describes the role of IMCAs appointed under the MCA to help people who lack capacity to make certain significant decisions and sets out when they should be instructed. It explains the responsibility of local authorities and local health boards in Wales to ensure enough IMCAs are available to meet the demands in their area.

2.16 The chapter also describes the IMCA role under the LPS.

Proposed updates to the existing guidance

2.17 We have included text on the interface between IMCAs and other types of advocacy, including the statutory duty to instruct an advocate under other legislation such as the Care Act (paragraphs 10.118 to 10.121).

2.18 Under the MCA, IMCAs are instructed by organisations now termed ‘the organisation instructing the IMCA’ (paragraph 10.61). This is to differentiate between organisations who appoint IMCAs under the LPS, which are termed ‘Responsible Bodies’.

2.19 In line with clarifications made to the chapter regarding disagreements and disputes, we have clarified guidance on when the IMCA disagrees with the decision-maker and when they have concerns not directly related to compliance with the MCA (paragraphs 10.66 to 10.73).

New guidance under the LPS

2.20 The role of the IMCA under the LPS is to represent and support an individual, or support an Appropriate Person, throughout the LPS authorisation process and while the authorisation is in force. While IMCAs also have a role under sections 37, 38 and 39 of the MCA, the focus of this section of the consultation document is specifically on the role of IMCA services in the context of the LPS.

Chapter 21: how does the Act apply to children and young people?

Summary

2.21 Chapter 21 explains those parts of the MCA which can apply to children and young people and how these relate to other laws affecting them.

2.22 It also explains how the LPS will apply to 16 and 17 year olds and outlines the use of Education, Health and Care Plans (EHC Plans) in England, and Individual Development Plans (IDPs) in Wales, and how they interact with the MCA.

Proposed updates to the existing guidance

2.23 We have referred to additional legislation which adults supporting 16 and 17 year olds should be familiar with (paragraphs 21.3 to 21.4).

2.24 We have clarified the legal frameworks available for decision-making in relation to 16 and 17 year olds, explaining that professionals can choose which regime to apply, but should be clear as to which one they are using (paragraphs 21.1 to 21.20).

2.25 We have added text to clarify the inter-relationship between the Family Court or Family Division of the High Court and the Court of Protection, as well as between Special Educational Needs and Disabilities (SEND) Tribunals and the Court of Protection (paragraphs 21.22 to 21.25).

New guidance for the LPS

2.26 Unlike DoLS, the LPS will apply to any person aged 16 or over. In Re D it was held that that parental consent cannot authorise arrangements which amount to a deprivation of liberty on behalf of their child aged 16 or 17 who lacks the relevant mental capacity. This chapter sets out guidance on the interaction between the LPS and specific issues and legislation relating to young people.

Question 2

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.

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).

Chapter 22: what is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

Summary

2.27 Chapter 22 explains how the MCA relates to the Mental Health Act 1983 (MHA), including the interface between the LPS and MHA.

Proposed updates to the existing guidance

2.28 We have updated the chapter to account for updates to the MHA including guardianship (throughout, particularly paragraphs 22.11 to 22.17).

2.29 We have updated the chapter to account for amendments to the MHA including Community Treatment Orders (CTOs) (throughout, particularly paragraphs 22.18 to 22.22).

2.30 We have included new text regarding Independent Mental Health Advocates (paragraphs 22.49 to 22.51).

New guidance for the LPS

2.31 The guidance set out in the Code explains how decision-makers should make decisions to use the LPS or MHA to deprive the person of liberty in hospital for treatment of a mental disorder. This follows the decision in AM v SLAM. It also sets out how the interface should be applied in the community.

2.32 The government published a white paper and undertook a public consultation on reforming some aspects of the MHA that are relevant to the MCA and the LPS. The government has now responded to this consultation, and does not intend to implement any changes to the interface between the MCA and the MHA at this time.

Chapter 24: what are the best ways to settle disagreements and disputes about issues covered in the Act?

Summary

2.33 Chapter 24 examines the various ways that disputes over decisions can be made under the MCA. This includes how the LPS authorisations can be challenged. The chapter explains who can challenge an LPS authorisation and provides advice on applications that can be brought to the Court of Protection.

Proposed updates to the existing guidance

2.34 We have updated the descriptions of advocates to reflect better their role in representing the person who lacks the relevant capacity in a disagreement (paragraphs 24.6 to 24.9).

2.35 We have clarified the difference between a dispute about what is in a person's best interests and a complaint about the provision of a service to a person who lacks capacity (paragraph 24.17).

2.36 We have condensed information, on formal and informal ways of complaining about the care or treatment of someone who lacks capacity, into a table (paragraph 24.17).

2.37 We have added text to set out the importance of striking a balance between using the methods for resolving disputes or disagreements in the chapter and applying to the Court of Protection where needed (paragraph 24.22).

New guidance for the LPS

2.38 The LPS has been designed to ensure compliance with Article 5 of the European Convention of Human Rights – the right to liberty. Being able to challenge the LPS process or the arrangements is an important safeguard of the person's rights. Anyone, including the person, can challenge the proposed or authorised arrangements at any stage.

2.39 This chapter provides guidance for decision-makers to determine whether to make an application to the Court in respect to either section 4B or an LPS authorisation. The guidance focuses on the person's Article 5 human rights and how to decide whether an application should be made to the Court, even if the person themselves does not have the capacity to decide if something is wrong or does not wish to make an application. The Code also discusses other ways to resolve disputes about the LPS process sets out that Responsible Bodies should have a complaints procedure in place.

Question 3

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.

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).

Questions about updates to the existing guidance in the 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, 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.

Question 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).

Question 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).

Question 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).

Question 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).

Section 3: the new chapters which contain LPS guidance in the Code

Section 3 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 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 but there is space at question 20 to add any further comments. The responses to these questions will be of particular interest to DHSC.

Chapter 12: what is a deprivation of liberty?

Summary

3.1 Chapter 12 introduces and explains what is meant by a deprivation of liberty.

3.2 The LPS can only be used to authorise arrangements that give rise to a deprivation of liberty. The courts have confirmed, in a number of cases, that a deprivation of liberty has 3 elements:

1. the objective element: confinement in a restricted space for a non-negligible period of time
2. the subjective element: the person has not validly consented to that confinement, and
3. the state is responsible for the detention.

3.3 The leading domestic legal case on the objective element of deprivation of liberty is the Supreme Court decision known as Cheshire West. This case set out the ‘acid test’ which states that for a person to be deprived of their liberty they must be; not free to leave, and under continuous supervision and control. The chapter explains what each element of this test means and how, when considered together, they may indicate whether somebody is being deprived of liberty.

Question 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

Chapter 13: what is the process for authorising arrangements under the Liberty Protection Safeguards?

Summary

3.4 Chapter 13 covers the various stages in the LPS process and outlines the different organisations and individuals that may be involved. The aim of this chapter is to provide practical and accessible guidance for everyone involved in the LPS process. The chapter also explains how the LPS integrates with other health and care assessments and planning.

3.5 This chapter describes some aspects of the LPS briefly, because they are covered in more detail, in other chapters. It describes other aspects of the LPS, that are not covered elsewhere, in more detail.

Time frames in the LPS process

Question 9

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.

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).

Interface with other health and care planning

3.6 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. This means that, for example, if the person's care or treatment is being arranged under a different legal framework, the LPS assessments and reviews can be carried out alongside the person's main health or care assessment or review

processes. This will help avoid repeat assessments and avoid unnecessary deprivations of liberty.

Question 10

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.

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).

Authorisations, reviews and renewals

3.7 Chapter 13 also covers the process for LPS authorisations, reviews and renewals. Decisions about the detail of these processes and who completes each of these roles are for the Responsible Body. However, this chapter sets out the practical elements of the process which will need to be carried out.

Question 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).

The care home manager role

3.8 As originally conceived, the LPS care home manager role would mean that in some cases, care home managers could carry out some preparatory work for an authorisation, including commissioning the assessments for someone in their care home. The Responsible Body would then review the relevant documentation and following a pre-authorisation review, consider whether an authorisation should be given.

3.9 The government has heard representations from across the sector, both for and against the role of the care home manager in the MC(A)A. Some care home managers told DHSC they would not have time to carry out this role and others argued there could be a conflict of interest for care home managers in such cases. The government has considered its position very carefully and has decided not to implement this aspect of the MC(A)A for now.

3.10 Staff who care for the person every day and know them best will, alongside the person's family and friends, still play a vital role throughout various stages of the LPS process. For example, they should be consulted when an authorisation is being considered. The government will keep the case for the care home manager role under review as LPS is implemented and beds in.

Question 12

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.

Do you agree that the care home manager role should not be implemented?

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

Chapter 14: what is the role of the Responsible Body?

Summary

3.11 Chapter 14 describes the responsibilities of a Responsible Body in the LPS process and provides information on how to decide which organisation is the Responsible Body in different settings. It also sets out the role of the Responsible Body when someone is placed in arrangements in another area or nation within the UK.

3.12 The Responsible Body must determine whether to authorise arrangements for a person's care or treatment when the arrangements will give rise to a deprivation of liberty. The Responsible Body must also arrange the assessments and carry out other steps leading up to the authorisation decision and have continued oversight of any authorised arrangements.

3.13 Under the DoLS, care homes and hospitals seek authorisations from local authorities to enable them to deprive a person of their liberty. However, under the LPS, alongside local authorities, CCGs, NHS trusts, in England, and local health boards in Wales will also act as the Responsible Bodies. This will help streamline health and care processes for the person, enabling organisations that are responsible for the person's care or treatment to also oversee the LPS process.

Chapter 15: what is the role of the Appropriate Person?

Summary

3.14 Chapter 15 explains the Appropriate Person role as set out in the MC(A)A. It also outlines who can be an Appropriate Person, and the role of the Responsible Body in appointing an Appropriate Person.

3.15 The Appropriate Person is a voluntary role, usually carried out by someone who is close to the person. It is designed to provide representation and support for the person within the LPS process. This is a key role in securing the person's views, wishes and feelings about their health and care arrangements and ensuring that the person is at the centre of the decision-making process. If no individual is suitable to undertake the role, then the Responsible Body will, in

most cases, appoint an Independent Mental Capacity Advocate (IMCA).

Chapter 16: what are the assessments and determinations for the LPS?

Summary

3.16 Chapter 16 explains the 3 assessments that must be completed in order to determine whether the authorisation conditions have been met. These are:

- the capacity assessment and determination on whether the person has the relevant mental capacity to consent to the arrangements
- the medical assessment and determination on whether the person has a mental disorder
- an assessment and determination on whether the arrangements are necessary to prevent harm to the person and proportionate in relation to the likelihood and seriousness of harm to the person

Previous diagnosis and equivalent assessments

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

3.18 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 and determination cannot be used for a necessary and proportionate assessment and determination.

Question 13

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.

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).

Chapter 17: what is the LPS consultation?

Summary

3.19 Chapter 17 explains consultation as part of the LPS process. The guidance in this chapter explains how best to work with the person. It is based on advice and input from people who have or may have experience of the MCA.

3.20 The LPS has been designed to keep the person at the centre of the decision-making process. The consultation stage of the LPS is critical to this. Decision-makers should consult the person and certain others, as far as is practicable and appropriate, to ascertain the

person’s wishes and feelings as they relate to the person’s care and treatment arrangements.

3.21 The Responsible Body must carry out the consultation during the assessment process of an initial authorisation, when a variation for an authorisation is being considered, and when an authorisation is being considered at the renewal stage. Approved Mental Capacity Professionals will also consult with the person and certain others when they carry out the pre-authorisation review.

Chapter 18: what is the role of the Approved Mental Capacity Professionals?

Summary

3.22 Chapter 18 covers the Approved Mental Capacity Professional (AMCP) role as set out in the MC(A)A. This chapter explains the role of the AMCP, recommends a potential model for an AMCP service, and explains the responsibilities of local authorities in approving AMCPs and ensuring sufficient AMCP availability for their area.

3.23 AMCPs provide an additional layer of scrutiny and enhanced oversight of the LPS process for people who need it most. In certain circumstances, an AMCP will carry out the pre-authorisation review and may draft the authorisation record. In some cases, an AMCP should also carry out the review of the arrangements.

3.24 This chapter explains the circumstances in which a case must be referred to an AMCP. Certain other cases may be referred. As suggested by stakeholders, the chapter provides some principles that Responsible Bodies should consider when deciding which other cases to refer. The chapter includes some examples of these type of cases.

Question 14

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

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 19: what is Section 4B, and how is it applied?

Summary

3.25 Chapter 19 provides guidance for decision-makers on the legal authority provided by section 4B of the MCA and the circumstances in which it may be appropriate to rely on it. Unlike the DoLS, there is no emergency authorisation process under the LPS, and Responsible Bodies will not have to administer separate standard and emergency authorisation processes.

3.26 The chapter provides definitions and examples of vital acts and life-saving treatments. It also provides information about who should be informed when section 4B has been relied upon, and what records should be kept.

Question 15

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.

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).

Chapter 20: how is the LPS system monitored and reported on?

Summary

3.27 Chapter 20 explains how the LPS will be monitored and reported on by the relevant bodies in England and Wales. 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.

3.28 The proposed monitoring and reporting of the LPS has been designed to streamline reporting and to reflect the expanded remit of the LPS to cover, for example, private settings and 16 and 17 year olds.

3.29 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 CQC and 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, while Ofsted will be responsible for those aged 16 and 17 years old. In Wales, the bodies will be the Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW). In respect of education settings, the function is also performed by Estyn. These bodies will be referred to collectively for the purposes of LPS as ‘monitoring bodies’.

3.30 The monitoring bodies will be responsible for monitoring and reporting the operation of the LPS in all settings including where there is no regulated activity being provided. This includes people’s private homes (although most authorisations will not apply in these settings).

3.31 The powers that the monitoring bodies can be given in regulations to discharge this duty are limited to those set out in the MC(A)A. The draft regulations for England accordingly provide discretionary powers for CQC and Ofsted to visit settings where authorisations apply (with permission, as there is no power of entry), meet with the person the authorisation applies to (with their consent), meet any individual caring for them or interested in their welfare, and request records about the deprivation from the Responsible Body or the setting that it applies in.

3.32 The LPS regulations and chapter 20 of the Code together set out the overarching design for LPS monitoring and reporting. In England, as the proposed bodies responsible for monitoring and reporting on the LPS in the regulations, CQC and Ofsted will be expected to plan for and implement this design in practice. CQC and Ofsted will have existing statutory powers which in some cases may be relevant to how they monitor and report on the LPS in practice. In Wales, there will be a national monitoring and reporting strategy.

3.33 Under the proposed LPS regulations, Responsible Bodies will have a duty to provide regular notification data on key LPS processes and milestones, rather than in real time (as applies for care home and hospital notifications, under the DoLS). This will help ensure broader compliance with notification duties (which will apply to a smaller number of organisations) and the consistency of notifications to the monitoring bodies. It will reduce the possibility of multiple notifications being received from different providers. This will also reduce the administrative burden for care homes and hospitals, compared to the DoLS.

Question 16

To what extent will chapter 20 and the Monitoring and Reporting regulations help ensure the monitoring bodies deliver effective oversight of the LPS? See Section 4 for more information on the Monitoring and Reporting regulations.

- 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).

Section 4: the draft LPS regulations

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

It is not a legal requirement to consult on draft regulations, but we have decided, in this instance, to publish the full text for consultation to give stakeholders an opportunity to read alongside the Code of Practice. The regulations will be available on the consultation page. The regulations are indicative of the broad policy intention and we are seeking views on that intention. The drafting of each set may change before being laid in Parliament, we are therefore not seeking comments on the formulation or wording of the regulations.

Set 1: The Mental Capacity (Deprivation of Liberty: Training and Approval as an

Approved Mental Capacity Professional) (England) Regulations

4.1 These regulations set out the criteria for AMCP training, the criteria for an individual to be approved as an AMCP, and the criteria for continuing approval. The key aspects of these regulations are that:

1. only certain professionals can act as an AMCP
2. AMCPs will need to undertake either a conversion course, if already a best interest assessor (BIA), who has been practising for a certain period of time, or initial training. They will also need to meet other criteria, such as having appropriate indemnity, in order to be approved as an AMCP
3. AMCPs will need to complete 18 hours of further training each year, at higher education level, and have carried out their functions as an AMCP to an appropriate standard for their approval to continue. There are some exceptions to this, for example, if the AMCP is suspended from their professional register or where a pause in their approval is agreed with the relevant local authority.
4. Social Work England will approve the initial training and further training in England. Social Work England will be able to set standards for the training they approve, may charge fees for this approval and will consult on these rules ahead of implementation
5. DHSC will approve and fund the development of the conversion training

4.2 To approve the conversion course, DHSC will use the LPS training framework that has been published alongside the consultation.

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).

Set 2: The Mental Capacity (Deprivation of Liberty: Assessments, Determinations, and Pre-Authorisation Reviews) (England) Regulations

4.3 These regulations set out which professionals can carry out each assessment and determination. Only doctors and psychologists can carry out medical assessments. Doctors, social workers, nurses, speech and language therapists, psychologists and occupational therapists can carry out all other assessments and determinations.

4.4 Additionally, the professionals set out above must meet general eligibility requirements such as having adequate insurance, having the relevant skills and experience, and having no financial interest in the person's case.

4.5 These regulations also set out the description of a prescribed connection to a care home, which applies to anyone undertaking a pre-authorisation review. This prevents an individual from carrying out a pre-authorisation review, including where this is carried out by an AMCP, if the arrangements are being carried out in a care home and the individual has a connection with that care home. This is to protect the person and their human rights.

Question 18

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.

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).

Set 3: The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) (Amendment) (England) Regulations

4.6 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.

4.7 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. They are also given functions to support the person once an authorisation is in place and where appropriate to challenge the authorisation.

4.8 A new element of the LPS is the role of the Appropriate Person, and in some cases an IMCA will also support this role. These regulations set out the functions for the IMCA to support the Appropriate Person.

Question 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).

Set 4: The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) (England) Regulations

4.9 These regulations place a duty on CQC and Ofsted to monitor and report on the operation of LPS in England. Wales will place a duty on their proposed monitoring bodies via their own regulations. They provide CQC and Ofsted the powers to:

- visit settings where an LPS authorisation is taking place
- access records relating to the care and treatment of the person
- meet that person
- meet anyone caring for them or with an interest in their welfare

They also provide a duty for both CQC and Ofsted to regularly report on the operation of the LPS.

Please see question 16 in Section 3 which asks about the proposed monitoring and reporting of the LPS, as set out in both the Code and the Monitoring and Reporting regulations.

Set 5: The Mental Capacity (Amendment) Act 2019 (Commencement, Transitional, and Saving Provisions) Regulations

4.10 These regulations commence the provisions within the Mental Capacity (Amendment) Act 2019, which will implement the LPS. They also allow for the DoLS provisions to remain in place for a year after implementation. No new DoLS authorisations can be given after the LPS is implemented, but the transitional year will allow for those under an existing DoLS authorisation to continue to access those safeguards until their authorisation ends.

Set 6: The Mental Capacity (Amendment) Act 2019 (Consequential Provisions) Regulations

4.11 These regulations amend other legislation that is affected by the MC(A)A.

Section 5: putting the Code into practice and implementing the LPS

Section 5 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 interest to both DHSC and MoJ.

Code contents and structure

5.1 The Code is a long document that includes technical advice on how to use the MCA, including the LPS. It is important that this document holds all the key guidance for practitioners and staff

working in the LPS system as well as informal carers and the person themselves. However, the Code presented for consultation is still a working draft, and we recognise that we can do more to make it accessible to different audiences. We therefore welcome comments on the structure and presentation of the document, as well as the technical content.

5.2 We think that one of the best ways to improve accessibility is through case scenarios. The LPS chapters as drafted do not include many case studies or scenarios. We are working on these for the final version of the Code, and are keen for these to be informed by real life examples and practice, as much as possible. We therefore welcome scenarios from the sector to illustrate points in the Code.

5.3 The following questions are aimed at improving the accessibility and usability of the Code.

Question 20

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?)

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.)

Question 21

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

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 include here (up to 1,000 words).

Products relating to the implementation of the LPS

This section explains our proposed implementation plans in more detail and asks questions about implementation products.

5.4 The implementation of the LPS is a large reform programme and will mean big changes for the health and social care system, and the people who rely on it. Key stakeholders in this system are expected to take a proactive role in ensuring readiness in line with the regulations, the Code and government guidance.

5.5 The government is committed to ensuring the sector is supported and prepared for this. In particular, bodies with statutory duties to authorise the arrangements (Responsible Bodies) and providers of care involving the LPS authorisations will need to understand the changes the LPS introduces in the lead-up to implementation. These organisations must have the right training and systems in place to ensure they can carry out their functions effectively under the LPS once it goes live. We understand that this is a complicated area of law and practice, and more is needed to support implementation. The Code offers comprehensive, statutory guidance on LPS, but we think that more guidance, in other forms, will be needed. We will therefore be publishing more guidance and are supporting implementation networks and the development of national training products for a wide range of audiences.

Impact assessment

5.6 Alongside this consultation, we have published an updated draft version of the impact assessment for our proposed design for LPS.[footnote 1] Unlike previous published versions, this now takes account of policy details set out in the draft regulations for the LPS. This is not a final assessment of the impact of LPS, because final decisions about the design of LPS will be informed by this public consultation. However, it constitutes the government's assessment of the design of LPS, that is proposed for consultation. We invite all stakeholders and partners, who will be called upon to implement and operate the LPS, to look closely at the impact assessment and offer us feedback on it.

5.7 In the LPS, the government aims to design and implement a system that is ultimately simpler and more efficient to run, than DoLS. Once fully implemented, we believe that most organisations with statutory roles under the DoLS and then the LPS will see efficiencies. However, we understand that all organisations with roles under the LPS will incur implementation costs in transitioning to the new system. Some organisations will take on new roles, and others will see their roles changed or expanded. As we weigh up responses to the public consultation, we will also be considering the arguments for different types of additional funding, for a diverse range of delivery partners.

Question 22

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.

Do you agree with the estimated impact of the LPS, as set out in the assessment?

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly 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 (300 words).

Workforce

5.8 LPS will bring changes to services and for staff caring for people who may need to be deprived of their liberty. The creation of new Responsible Bodies will also bring changes for staff working within these organisations, as it will give these organisations new roles and responsibilities.

5.9 To help prepare the workforce for implementation and make them aware of these changes, we have considered the recommended training requirements for staff working across services and have proposed 6 ‘workforce competency groups’ (from A to F) for staff working in the LPS process. This intention for these groups is to enable training to be targeted at the different parts of the workforce, depending on how much they need to know about LPS, once it begins.

5.10 Workforce competency group A covers staff in health, care, education or other settings, who may in the course of their work encounter a person who might lack the capacity to consent to arrangements that may give rise to a deprivation of their liberty. We suggest that these staff will benefit from ‘awareness raising’ about the MCA and the LPS. Workforce competency groups B to D cover specific groups of staff working with the LPS process, from identification and referral through to authorisation and pre-authorisation review. Workforce competency groups E and F refer to those with certain specific statutory roles under the LPS (that is, IMCAs and AMCPs).

National support to prepare the relevant sectors for LPS

5.11 To support the implementation of the LPS in England, the government is committed to establishing 3 workforce implementation support programmes:

- a local government implementation programme – this programme was proposed by the Local Government

Association (LGA) and Association of Directors of Adult Social Services (ADASS), with support for this proposal provided by the Association of Directors of Children's Services (ADCS)
- a social care providers implementation programme – lead organisations Skills for Care (SfC) and the Social Care Institute for Excellence (SCIE)
- a health implementation programme – lead organisations involved will include NHS England and Health Education England (HEE)

5.12 These programmes are intended to:

- raise awareness of the LPS and support different sectors to prepare for implementation, including via regional implementation networks
- gather feedback from relevant sectors to inform the design of national guidance on the LPS
- develop high quality, national training materials that organisations can draw on as they prepare their staff for LPS

5.13 These programmes will not allocate funding to organisations who will be training their staff, in preparation for the LPS, including organisations with statutory roles, like Responsible Bodies.

5.14 For IMCAs, we expect that training will be provided by expert advocacy organisations that are already delivering this for other advocacy functions under the MCA. We expect that IMCAs will undertake training that meets the requirements of City & Guilds national independent advocacy qualification.

5.15 With AMCPs, training will depend on whether candidates are new starters or wish to convert from the role of best interest assessor (BIA) under the DoLS. Social Work England will be responsible for approving training courses that will be developed by Higher Education Institutes for new AMCPs. Meanwhile, for BIAs that wish to convert to AMCPs, training will be delivered by local authorities and approved by the Secretary of State for Health and Social Care. To support the sector in delivering this conversion training LGA and ADASS have been developing a high-quality, training support package.

5.16 Further details about the workforce support that we are putting in place to support the implementation of LPS in England is set out in

our draft LPS workforce and training strategy, published with this consultation, available on the consultation page. This strategy should be used by stakeholders to support their plans for implementation. It covers:

- workforce planning
- the learning, development and training on offer
- what different organisations and sectors can do now, to begin preparing for LPS

5.17 In support of the strategy, we have also developed a draft LPS training framework, which makes recommendations about subject areas that LPS training should cover. It covers recommended learning outcomes within each subject area for each of the workforce competency groups.

5.18 The LPS training framework subject areas and learning outcomes will also provide training providers with a consistent set of standards that they can use to develop training courses and materials.

5.19 We welcome feedback on the draft strategy and training framework.

Question 23

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.

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).

Question 24

The training framework describes the core skills and knowledge relevant to the LPS workforce and presents learning outcomes for

each workforce competency group across 5 subject areas. Does the training framework cover the right learning outcomes?

- Yes
- No

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

Monitoring, notification data and reporting

5.20 In England under the DoLS, 2 distinct data flows facilitate ‘national oversight’ of the system. First, hospitals and care homes must provide almost real-time data about authorisations directly to CQC, the relevant regulator. Second, supervisory bodies (local authorities in England) provide annual data to NHS Digital (NHSD), to facilitate an annual Official Statistics overview of the DoLS.

5.21 Under the LPS, we propose to simplify notification data requirements by merging these 2 notification processes. Under the proposed design for the LPS, Responsible Bodies will have a statutory duty to regularly provide notification data on LPS authorisations to the bodies with statutory responsibilities for monitoring LPS (monitoring bodies) to enable them to carry out their monitoring role. In England, we are proposing that these bodies will be CQC (for adults) and Ofsted (for 16 and 17 year olds).

5.22 Under the LPS, we propose that the notification by Responsible Bodies is every 6 months for the first year of the LPS, moving to a more frequent submission, likely quarterly, from the second year. This should give Responsible Bodies some time and space to concentrate on implementation overall, before data is first due to monitoring bodies. Responsible Bodies will need to collect LPS data from day one of implementation, to submit for the first notification after 6 months. In this time period, CQC and Ofsted will still have a general legal duty to monitor on the operation of the LPS and will be expected to exercise their powers in response to concerns.

5.23 As with DoLS, we also plan to publish official statistics for LPS in England via NHSD to provide transparency on the operation

of LPS and link with other health and social care statistics. We are working closely with NHSD on these plans. We expect this report to be based on the same data flow that enables monitoring bodies to do their role, too (the duty for Responsible Bodies to regularly provide notification data on LPS authorisations to the monitoring bodies).

5.24 Although the proposed notification to the monitoring bodies is a new requirement on Responsible Bodies, the streamlined approach will be more efficient overall. It will facilitate standardisation of LPS notifications to the monitoring bodies, and Responsible Bodies' broader compliance with statutory notification duties.
For CQC and Ofsted, more consistent and reliable data will enable them to target their resources more effectively and with more assurance. Streamlining data notifications via Responsible Bodies instead of providers will reduce the possibility of multiple notifications being received from different providers (given LPS can apply in more than one setting). This will also reduce the administrative burden for care homes and hospitals, compared to the DoLS.

National support on LPS data

LPS National Minimum Data Set

5.25 In order to standardise the collection and submission of notification data from Responsible Bodies to the Monitoring Bodies and NHSD in England, a national minimum data set for LPS will be used – the LPS National Minimum Data Set (LPS NMDS). The draft LPS NMDS is available on the consultation page. The data set has been developed by considering the requirements for national level reporting by the monitoring bodies and government, what questions will need to be answered, and deriving the data items from them.

5.26 The recommended data set covers operational aspects of the LPS process (how many, how long, decisions made etc), demographics and equalities, and outcomes for the person who has been deprived of their liberty. This latter element is not currently captured by the DoLS data set. We think it is important that this changes under LPS, to better monitor how the new scheme is working for the people deprived of liberty.

5.27 The data set will collect person identifiable information such as NHS number and date of birth. This will facilitate longitudinal analysis of individuals subject to LPS authorisations and also across Responsible Bodies. The use of the NHS number will also enable analysis of information across health and social care data sets to track a person's interaction and pathway through other parts of the health and social care system.

5.28 The minimum frequency and content of the notification needed by monitoring bodies will be set out in the regulations. However to ensure consistency of notification across all Responsible Bodies, the administration of the LPS NMDS – the full list of data items (including those needed to administer the notification data scheme such as the LPS Episode Reference ID), frequency and timing of submission, method of submission – will be subject to national agreement and published in advance of the start of LPS to ensure Responsible Bodies have time to update their local IT systems accordingly. For local authorities, approval will be sought via the Single Data List Gateway Group and for adult social care and health bodies (NHS trusts, CCGs), approval will be sought via the Data Alliance Partnership.

5.29 We aim to publish a set of template forms for operational use. The templates will not be mandatory but will be provided to encourage consistency of information required by Responsible Bodies. They will enable the recording of the LPS assessment information which will be required operationally for authorisation, but which will not all be reported at a national level. The templates have been kept to a minimum, covering key points in the process when information needs to be transferred from one party to another. They do not cover every single data item in the NMDS, as some items will be collected separately.

The LPS notification data system

5.30 The government is proposing to fund the development of a national notification data system that will facilitate the transfer of data between Responsible Bodies and the monitoring bodies/NHSD in England. In practice, this will enable notification data to flow from local authorities, CCGs and hospital trusts to CQC, Ofsted and NHSD at the frequency required. The intention is to reduce burden for Responsible Bodies by establishing a digital system that is automated

where possible. DHSC is working with
NHSX, CQC, Ofsted and NHSD to consider the optimum solution for a data system. The aim is that Responsible Bodies only need to submit data to one system which the monitoring bodies and NHSD can access.

Question 25

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.

Are there further data items needed in the LPS NMDS to provide effective oversight of the LPS?

- Yes
- No

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