Liberty Protection Safeguards Public Consultation – Closing Date 14th July 2022

Joint Response on behalf of ADASS, ADCS and the LGA

13th July 2022

About Us

The Association of Directors of Adults Social Services (ADASS) is a charity. Our members are current and former directors of adult care or social services and their senior staff, including principal social workers. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services, regardless of their backgrounds and status, and
- Promoting high standards of social care services.

The Association of Directors of Children's Services Ltd. (ADCS) is the national leadership organisation in England for directors of children's services (DCSs) appointed under the provisions of the *Children Act (2004)*. The DCS acts as a single point of professional leadership and accountability for services for children and young people in a local area, including children's social care and education.

The Local Government Association (LGA) is the national membership body for local authorities and we work on behalf of our member councils to support, promote and improve local government. We are a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems. The LGA also provides a range of practical support on a free of charge and/or subsidised basis, to enable local authorities to exploit the opportunities that this approach to improvement provides.

Introduction

ADASS, ADCS and the LGA have supported the LPS development work and are represented on the national steering group for LPS. We are committed to working with the Government and other partners to ensure that people who need their Article 5 rights safeguarded will benefit from the new scheme and that the policy objectives and intended effects, as outlined by government in the consultation draft Impact Assessment, are realised:

1. To create a new simplified legal framework which is accessible and clear to all affected parties.
2. To deliver improved outcomes for persons deprived of their liberty and their families/unpaid carers.
3. To provide a simplified authorisation process capable of operating effectively in all settings.
4. To ensure that the Mental Capacity Act 2005 (MCA) works as intended, by placing the person at the heart of decision-making and that it is compliant with Article 5 and 8 of the European Convention on Human Rights.
5. To provide a comprehensive, proportionate and lawful mechanism by which deprivations of liberty for young people aged 16 and 17 can be authorised.

The intended effects are to ensure increased compliance with the law, improve care and treatment for people lacking capacity and to provide a system of authorisation and robust safeguards in a cost-effective manner. ADASS, LGA and the LGA want to work with the Government and other partners towards these shared policy objectives. We offer the following feedback on the public consultation documents on that basis with some recommendations for change.

The Government has laid out its timetable for LPS implementation and reserves the right to decide when LPS should go live, once it has considered the responses to the public consultation. Councils and their local partners will want certainty on the implementation timetable. We are aware however, that there is a balance to be struck between implementing the new scheme as soon as possible, updating the Code in light of the consultation and making sure we learn from the past to get the LPS scheme right. As local government representatives on the national LPS steering group, we would like to work with the Government on both understanding the consultation responses and on assessing the best time to go live, taking into account other aspects of reform.

Ensuring the right funding, capacity and workforce to deliver on these shared ambitions are vital. We also want to continue to work with government on funding for the sector, and to this end, in addition to comments on the Impact Assessment in Part 2 below, will be offering to continue our work with the Government on developing an evidence base for the assumptions and calculations to be included in the final version of the impact assessment.

Part 1 – Comments on the Code of Practice and the Regulations

1. Updated guidance on existing MCA policy including the importance of MCA Principles

Recommendation 1) It needs to be clearly stressed that whilst the chapters included by Section 1 of the consultation document may not include new LPS guidance, the MCA principles are nevertheless **fundamental** to good LPS practice and to engaging well with the person at the centre and their families.

Recommendation 2) Chapter 6 should be reviewed to ensure clarity is provided on protection from liability in deprivation of liberty cases.

By implying in the consultation document that these chapters are separate from LPS, there are risks that practitioners who are new to LPS and the MCA will not look at them, and may be diverted away from really getting to grips with the MCA basics, particularly chapters 4 and 5. This is risky for those who have to implement LPS in front-line practice and have not routinely assessed capacity or made decisions in a person's best interests before, particularly children's staff, but also some adult social care and health staff. Staff working in LPS should also understand the law on LPA and deputies, as family members may have these roles and need to be supported to understand how they are dealt with in the LPS process.

In general, the principles of the MCA are explained, but see Section 2 below for the changes needed for 16- and 17-year-olds.

Chapter 6 should include an explanation of what protection staff have when carrying out arrangements that may amount to a deprivation of liberty but are not to enable life-sustaining treatment or a vital act (so s4B cannot be relied on), whilst awaiting a decision on authorisation

under the LPS from the Responsible Body. There is fear that without the continuation of the urgent authorisation option they may lose the protection they previously had under DoLS.

2. 16- and 17-year-olds

Recommendation 3) Paras 21.12 and 21.13 should emphasise that the Mental Capacity Act law and the five key principles apply to young people aged 16 and 17, rather than suggesting it "can" or "may" be used for young people.

Recommendation 4) An overview is required in Chapter 21 of how the LPS might impact on the different remits within Children's services, including young people leaving care and young people who may be moving from children's services to adults services.

Recommendation 5) It is also essential to have references to the legislative framework for under 18s and scenarios about 16- and 17-year-olds throughout the Code of Practice.

It is essential for Chapter 21 to clearly articulate how the whole legislative framework for children interacts with the MCA and LPS. This will be needed to support council children's services to enable the LPS process to be built into their front-line social work. It would be useful to have an overview of how this might impact on different areas/remits of children's services so that it is clear who a has a role within this guidance

Given the whole code (apart from specific identified exclusions) applies to 16- and 17-year-olds, it is therefore essential to demonstrate this by referring consistently and routinely to the Children Act 1989 and the Children and Families Act 2014, alongside the Care Act and the Social Services and Wellbeing Act throughout the code. The interface with children leaving care and associated law and regulations needs to be clearer.

Although Chapter 21 can emphasise matters that are important for, and specific to, 16- and 17-year-olds, it should not be the only chapter that includes scenarios about under 18-year-olds. This may inadvertently encourage staff who are known to be less familiar with the requirements of the Mental Capacity Act than those who work with adults, to only read Chapter 21.

There is a disappointing lack of examples and scenarios provided throughout the code about how it applies to 16- and 17-year-olds. These are needed as LPS is new to children's services so the more detail, the better, in order to ensure that arrangements that may amount to a deprivation of liberty are recognised and the process triggered appropriately. Representatives of council children's services (including principal social workers and practice leaders) have asked for a great deal of support to familiarise front-line staff with the Act and how it applies to 16- and 17-year-olds, including the Liberty Protection Safeguards, as well as clarity on how the Act does and does not apply to children aged under 16. Throughout the LPS chapters, there should be more scenarios that relate to 16- and 17-year-olds. Please **see Section 7**, below, on Scenarios.

Where there is a lack of available scenarios, the code authors should work specifically with children's social care and children's charities to seek out relevant scenarios about young people, as well as education and SEND colleagues. LGA and ADCS networks and regions could work with Government on this.

3. Definition Chapter

Recommendation 6) Clarity is needed on whether government's intent is narrow the definition of a deprivation of liberty.

The code does not state the intention to narrow the scope of the definition of a deprivation of liberty, in comparison to previous understanding of case law, although the impact assessment implies a change. Chapter 12 espouses the acid test, but then proceeds to interpret it differently from current understanding of case law. If this is the intention, it should be stated transparently.

There are concerns that some care homes are already asking if they can stop referring cases in for authorisation, based on the new definition suggested in the code, even though it is not yet the final published version.

The scenarios in the definition chapter should be re-drafted to illustrate how the authorisation conditions and the requirements of Schedule AA1 are met in each case and to demonstrate compatibility with case law. This will enable the scenarios to be a useful training resource for practitioners.

If the scope is narrowed as suggested by the interpretation included in the current draft of the Code, questions are also being raised about what to do about authorisations made in line with current case law. This includes working through what the sector might have to deal with, such as possible challenges in relation to historic cases, where it may be argued that people have been deprived unlawfully.

There is also some nervousness about the Chapter 12 proposal to extend Ferreira judgement (the so-called "Ferreira carve out") being extended to any setting where treatment is being given for a physical condition. In addition, whilst government guidance from 2015 was clear on advance consent for people at the end of life, there is some nervousness about extending this to other contexts as proposed in Chapter 12, particularly as this was considered and rejected by Parliament and was not included in the legislation. Whilst Codes of Practice are used to illuminate legislation rather than replace it, if there has been the suggestion that the advance consent concept is being re-introduced by the "back door", via the code. It is anticipated that the proposals in the definition chapter will be tested in court in due course and, if found to be unlawful, there are risks that the code would fall into disuse.

Since the Cheshire West judgement was published in Spring 2014, there has been a year-on-year growth in the number of applications, with subsequent delays and waiting lists. We welcome the recognition of the capacity impacts on councils and their local partners on this and we would welcome government support to manage this workload, whilst still delivering improved outcomes for persons deprived of their liberty and their families/unpaid carers, and placing the person at the heart of decision-making.

4. Keeping the Person at the Centre

Recommendation 7) Review the intended audience of the Code and ensure that either the Code includes guidance for the person at the centre, their families and friends or sign-posts them to other relevant national documents, including both easy-read and detailed guidance, that cover this requirement.

There is a general lack of information for the person, families and friends in the Code. There is also no consultation question about the roles that family or friends might take on, or the parts of the code relating to the subjects they might be most interested in (chapters 10, 15 or 17).

Whilst some may take the view that the Code of Practice is intended as a document for practitioners and professionals and not for the person or their families, para 19.29 suggests otherwise and points out that para 19.38 (non-professional decision makers) is for family members as well.

The availability of representation and support (whether from an Appropriate Person or an IMCA) is one of the key safeguards of the scheme. It is quite hard for some members of the public to understand regulations. The Code explains the regulations and legislation, and the consultation should in turn, invite comment on the Code chapter. The approach taken excludes families and the person at the centre of the process from the full consultation. Not everyone wants to engage with the easy-read consultation.

But the theme of "keeping the person at the centre" does not need to be lost in this way. If the code is only for paid practitioners, there needs to be another document written for families and Appropriate Persons, which could usefully cover:

- the role and responsibilities of the appropriate person
- the IMCA role in the LPS, including support to the Appropriate Person
- the purpose of consultation in the LPS process
- notifying the responsible body about a potential deprivation of liberty
- notifying the responsible body if there are changes in circumstances
- where to begin with challenging an authorisation via the court of protection

5. Process Timescales

Recommendation 8) Further work is required to ensure that the process is truly simplified in line with policy objectives.

Recommendation 9) As part of further work to provide an accurate evidence base for the impact assessment, it would be beneficial to schedule some pilot work to test out assumptions.

The process timescales included in the code include the aim of 5 days to acknowledge an external referral and 21 days to complete the process, in addition to the legislative requirement of giving or sending the authorisation record to the person and their representative within 72 hours of the authorisation decision. These timescales feel right in a fully-funded scheme. Due to the current level of pending cases, however, in both the DoLS scheme and the Court of Protection authorisation process, there are concerns that a high number of cases may be inherited from predecessor systems and require authorisation under the LPS in addition to new cases. The timescales may therefore not be achievable for some time, for many councils.

In addition to the number of cases to be processed under the LPS from day one, it has been argued that the number of tasks and inter-dependencies in the process (such as with GPs and other medical practitioners and IMCA services) might mean that council staff may not have full control of the achievable timescales. Other factors that may impact on timescales include other workload pressures, including the new care cap work, and the impact of being a net importer or exporter of cases (associated with the number of care homes and independent hospitals in the council area). As a new area of work for children's services, there is a view that the process may take longer initially whilst it is being embedded.

The impact assessment costings are based on assessment numbers, rather than how many registered professionals are required and available to operationalise the process in the required timeframes. Whilst capacity assessments and the necessary and proportionate (N&P) assessments can be done alongside needs assessments and care or treatment planning, respectively, requiring them to be completed by registered professionals needs a calculation of how many new posts will be required to do this. Some local authorities have followed a policy of changing their skill mix and employing a greater proportion of non-registered assessment and care planning staff compared to registered, to eke out their budgets. In those local authorities, they may have to reverse that previous policy because of LPS regulations.

It is not clear how the use of non-registered staff to do some of the work would reduce the workload of professionals. The assumptions about the number of previous or equivalent capacity and medical assessments that can be relied on have not yet been tested.

Because there is no news on the Government implementation timetable yet, or on funding for either implementation or new LPS burdens, Councils have no basis on which to plan their budgets and workforce strategically to prepare for LPS. Unless the process is simplified, it could take longer than 21 days, even if there were not a backlog.

6. Process – need for further clarity

Recommendation 10) The introduction of the LPS is a fundamental change of practice and scope for the mainstream, front-line staff that will take on the assessment, determination and consultation work. More attention should be given to the following points:

- Explanation to be given on how the LPS is supposed to work with assessment of needs and care planning. Many front-line staff in the professional groups listed in The Mental Capacity (Deprivation of Liberty: Assessments, Determinations and Pre-Authorisation Reviews) (England) Regulations 202X are not trained as BIAs and the training for competency group C needs the investment of much time and attention, to ensure that staff understand how to integrate the LPS capacity assessment into the needs assessment and the necessary and proportionate assessment into the consideration of care planning options and how the best interests decision about the proposed care, support or treatment should interface with the determination of necessity and proportionality.
- Chapter 13 and 16 are core to the training of Competency Group C, who will do the assessments and determinations, and will be required to understand the process in detail. This will include social workers, nurses and therapists, as well as any non-registered care and health staff that may contribute to all or part of the relevant assessments. This is an area where much training will be required for staff who have not previously practised as a BIA. There is not enough illustration of how it will be built into front-line assessment and care planning practice. Some staff are not familiar with the LPS policy intentions, so are still seeing the LPS process as a separate sequential process after the needs assessment and care planning. There is so much work to do on this.
- Some people are struggling with the distinction between “assessment” and “determination”, particularly in the case of the Necessary and Proportionate assessment and determination, and are understanding para 16.81 to mean that they cannot start the N&P assessment work until there is a best interests decision on the care or treatment to be enabled by the arrangements. This is not the case and would undermine the intention that the care planning and N&P assessment can be done together. It runs the risk that LPS is still seen as a “tag on”, that happens after assessment and care planning is complete, rather than integrating them together. It would also mean that necessity and proportionality would only

be considered for the one care planning option. The beginning of paragraph 5.8 may need further re-wording to avoid confusion in cases where needs assessment and care planning are undertaken under the Care Act 2014 for someone who lacks the capacity in relation to their care and support. A best interests decision would be needed under the Mental Capacity Act, about available care planning options, which have been considered to meet needs under the Care Act 2014.

- Some of the guidance is contradictory and it is not well connected with other chapters. It would be useful if it could be re-drafted with colleagues who are familiar with Care Act/Children's assessment practice to make sure that it rings true.
- More clarity is required on when the consultation should occur in both the review and renewal context. Also, more is needed on who is responsible for making the scheduled reviews happen. For example, should reviews be led by the LPS assessor or by the care provider?
- Chapter 16 does not clearly articulate what is meant by each of the terms “Equivalent assessment” and “Previous assessment”, although guidance in the bullets under paragraph 16.40 and 16.55 is helpful. Paragraph 16.55 refers to both without clearly using the two terms correctly in context. A general explanation of the two terms should be included, either at para 13.60, when first introduced, or at para 16.4, or both, to avoid confusion. Our understanding is that “previous” refers to previous assessments undertaken as part of the LPS process, and “equivalent” refers to assessments undertaken outside the LPS process, but in situations of sufficient similarity. The inclusion of more detail under each type of assessment is useful.
- At para 16.41, it refers to both previous and equivalent assessments that may have been carried out by someone who doesn’t meet the relevant regulations and states that it would not be possible to rely on them. This section could do with some re-work. For example, a previous LPS assessment would not have been acceptable the original time if the person didn’t meet the requirements in the regulations. But an assessment for another purpose could quite legitimately have been carried out by someone that didn’t meet the requirements in the LPS regs.
- The suggestion that other practitioners can contribute to some or all of the assessment and determination, including non-qualified people, as described in para 16.13, may add confusion/difficulty. There is no reference to the handover and to how a qualified person is to be accountable for this. If the professional has to supervise the unqualified worker, that doesn’t save the registered worker’s time, rather it increases their workload. More clarity is required on this.
- There is also a lack of clarity on the interplay between the pre-authorisation review and the authorisation.

7. Scenarios

Recommendation 11) Case law is particularly relevant to this area of law and will continue to evolve. To avoid the risk of the Code scenarios becoming out-of-date as case law evolves, consideration should be given to whether the scenarios should be included in a separate companion document, which can be updated without the need to lay it before Parliament. This should make it easier to maintain a case-law compliant scenario document as a partner document to the code.

Recommendation 12) More worked examples and scenarios are required in the key areas below:

- The code should include some scenarios in chapters 4 and 5 that relate to LPS. Chapters 2, 3, 4 and 5 and the relevant LPS chapters should give a clearer steer on the principle of inclusion and involvement so that people who may lack capacity should nevertheless be included in meetings about them wherever possible, as a general rule. The default should be that they are invited, rather than not being. Ministers, when debating the Mental Capacity (Amendment) Bill, were adamant that the implementation of LPS and the code should be co-produced. This would follow the principles of the report produced as part of the Valuing People programme by people with a learning disability called "Nothing about us without us" (March 2001). And yet, professionals often have meetings without the person being there themselves. This should not be the assumed norm, especially if the person is able to express themselves and their wishes and contribute to the discussion.
- More example scenarios are required on incorporating LPS assessments and determinations into mainstream needs assessment and care or treatment planning to demonstrate how it should work.
- There are gaps in understanding the power to include multiple settings in a single authorisation, and that this is only possible when the settings are known about and planned for, at the time of authorisation. This is a major change from the predecessor scheme, so would benefit from scenarios to clearly demonstrate this approach.
- More scenarios would be useful to give greater clarity on what constitutes a vital act or life-sustaining treatment.
- Further examples of scenarios of nurses, SALT and OT's doing assessments and determinations in their own context.
- Scenarios relating to 16- and 17-year-olds are needed throughout the code. As a matter of principle, in every place where there is an adult example, there should be a scenario relating to young people, to emphasise the relevance of all elements of the LPS (and also most of the MCA) to young people in this age group.
- In addition, there should be some scenarios relating the MCA and LPS to young people in all types of settings, including those who are fostered, those living with their family, those who are in mental health hospitals/Assessment and Treatment Units, those in acute hospitals, those in special schools and colleges, both day and residential schools and colleges, and those going through transitions to adult social care services.
- Scenarios need to be included about self-funders who may not have had any involvement from the local authority prior to needing arrangements that may amount to a deprivation of liberty.
- Scenarios for adults in acute hospital settings should be included.
- Scenarios in relation to "Discharge to Assess" and also people who are being discharged to a setting where a continuing healthcare (CHC) assessment can be undertaken are needed. Hospital discharge staff will need to consider mental capacity, best interests and the arrangements for the interim placement, if they might amount to a deprivation of liberty, rather than leaving it to those assessing the person in that interim setting.
- There is not enough guidance on variation, and scenarios could help illuminate what the Government have in mind with this concept.
- Examples/scenarios are required on variation and reviews, to provide clarity on when a variation can be used and on the interplay between a variation and review.
- In addition, scenarios are required to provide guidance on moving from one setting to another, both planned and unplanned.
- Scenarios are also needed to cover moving from one setting to another, both planned and unplanned.
- Scenarios would be useful to illustrate the difference in role between the pre-authorisation review and the authorisation.

- Scenarios would be useful to demonstrate how the LPS process should operate in independent hospitals, including independent sector mental health hospitals.
- Scenarios should be provided to demonstrate the interface between MHA and MCA/LPS in mental health hospitals, to build confidence in using the LPS in such circumstances and in the safeguards for individuals who are not covered by the Mental Health Act. These could helpfully include the option of the Responsible Body using their powers to refer a case to an AMCP for a pre-authorisation review, to offer independent scrutiny, even when the person is not expressing the view that they do not wish to reside there or have care or treatment there.
- Some scenarios of how the inspection or monitoring would be undertaken in non-regulated settings would be useful.
- More scenarios involving different settings would be useful, such as prisons, own homes, days services, taxis and ambulances, dentists, and GP practices.
- There should be scenarios to give examples of how a non-qualified person could work with a registered professional as part of the LPS process.
- Where scenarios are not offered as part of the responses to Question 21 in the public consultation, it may be useful to have a call for examples of specific circumstances. They may need to be drafted, as people may not have examples for new concepts.

8. References to Case Law

Recommendation 13) Insert footnote references to relevant case law/Court of Protection judgements, where relevant.

The code will be strengthened by clear references to relevant case law. Whilst individual cases do not need to be described in the text, references in footnotes are valuable, enabling practitioners to access the relevant judgement, to improve legal literacy. This also demonstrates that the content is based on case law and may improve confidence in the Code, particularly the definition chapter.

Judgements that could usefully be referenced in the LPS chapters include Cheshire West (which is mentioned), Bournewood (so that it is not taken out of context and mis-quoted), Ferreira and Neary, as would AJ v A Local Authority [2015] EWCOP 5, on issues to consider on the selection of a suitable person to provide representation for the person being deprived of their liberty, so that no conflict of interest prevents any challenge to the authorisation of that deprivation and the associated upholding of the person's article 5 rights.

Cases relating to deprivation of liberty should be included, including examples of application and interpretation of the acid test. Neary is referenced in the MCA chapters, but not the LPS chapters. In the mental capacity chapters, reference should be made to the JB case (A Local Authority v JB [2021] UKSC 52), in relation to the assessment of capacity and identifying which information is relevant to each matter/decision.

It is noted that Ministry of Justice chapters clearly reference relevant case law, whereas DHSC chapters do not. This is inconsistent and, as the topic of deprivation of liberty is frequently updated by case law, perceived by many as a weakness in the Code.

9. AMCP Role

Recommendation 14) Review Chapter 18 to explore the role of AMCPs undertaking pre-authorisation reviews in independent hospital settings, and to consider the practical implications of non-clinical professionals scrutinising arrangements proposed by clinicians.

Recommendation 15) Review Regulation 11 (3) in **The Mental Capacity (Deprivation of Liberty: Training and Approval as an Approved Mental Capacity Professional) (England) Regulations 202X** to include a minimum number of assessments that should have been completed, in addition to a minimum period of practice.

Recommendation 16) Transitional guidance should be developed to support the sector to ensure they are able to plan to have enough AMCPs for their organisation and their area.

For AMCPs undertaking pre-authorisation reviews in independent hospital settings where the local authority is the responsible body, AMCPs may need to challenge clinicians and may benefit from access to clinical and mental health expertise, or both, in some circumstances, in these settings (including independent mental health hospitals, when LPS is used instead of Mental Health Act detention).

There have been a number of questions in the LGA Q&A sessions about why the particular professionals had been picked for the AMCP role. There was a view that there may be other allied health professionals who may be skilled and able to undertake the AMCP role. If the Code and Regulations included that other registered allied health professionals could undertake the role this might enable those with competence and an interest to undertake this role.

The LGA is funded by DHSC to oversee the development of the BIA to AMCP Conversion course and Councils are to deliver it (either themselves or via training providers) for all BIAs. The regulations require that, in order to access the conversion course, BIAs must have "practiced for a year". It is not clear what is acceptable for this "practice" (for example, is a single assessment in the 12-month period enough?). We believe that it is most important to ensure experience and quality of practice, rather than simply the elapsed time since undertaking the BIA training. It would therefore be useful to include a reference to a minimum number of assessments to access the conversion course.

There is no suggested process for LAs to approve AMCPs in the Code or Regulations, so each LA will need to develop its own approach. It is noted that local authorities have the duty to ensure there are enough AMCPs for their area, but that whilst there may be enough AMCPs via the BIA conversion course route in local authority adult services, this route may not guarantee enough trained AMCPs in health or children's services, at least initially. Because the go-live date is not yet known, it is not clear whether there is time for NHS or children's services staff to complete a BIA course and achieve a full year of practice, and therefore to benefit from the conversion course. Some councils are apprehensive of the workload involved in offering practice opportunities and practice supervision to new BIAs in other organisations as well as their own. In the past, some have invested considerable time in health-employed BIAs only to find that their employers would not subsequently release them to do BIA work. Transitional guidance from Government would be useful to encourage prospective AMCP employers who wish to use this route to release staff and cover associated costs, including indemnity insurance. Clarity on the practice experience required, would support NHS and children's services employers to understand the need to release their staff for this work in the year prior to undertaking the conversion course.

10. AMCP Joint Team Proposal

Recommendation 17) The Government to review the model for joint AMCP teams.

More detail is required about how joint AMCP teams are expected to work. They could be joint within councils, across adults and children's services, joint across local government and NHS, or joint with other council areas, or a combination of all three. Key questions that require further information include:

- Is there any expectation of which type of agency should manage the joint team?
- How will authorisation be managed?
- How much is for local negotiation?

Where it is decided that NHS Trusts will have in-house AMCP Teams, and not to collaborate in joint teams, the Code suggests that local authorities would have to agree the NHS Trust's internal AMCP team structures. It is not clear why this is.

Para 18.71 refers to independence requiring an AMCP from a different "Line management chain". But this would be difficult if all AMCPs are in the same team.

11. Disputes and Challenges via the Court of Protection

Recommendation 18) Chapter 24 should be reviewed to take account of the following points:

- Para 24.32 states that any person or organisation can apply, without permission, to the Court of Protection when it relates to "the LPS", but it does not explain any more detail on what matters this might include. There are various points when an application might be considered, for example:
  - if steps are taken under s4B
  - if the Responsible Body triggers the LPS process or a referral is made to the Responsible Body
  - during the process of assessment, determination and consultation, including if the person's representative believes the arrangements do not amount to a deprivation of liberty
  - during the pre-authorisation review
  - at the authorisation decision stage
  - at any time during the authorisation period, including when a renewal is being considered or when the authorisation period has been extended by a renewal.
- The code doesn't state until 24.35 that although any person or organisation can apply, this comes with a cost (that is, any legal aid would be means tested, unless the person applying to the court is acting as the litigation friend for the person being deprived of their liberty). This should be stated up front in paragraph 24.32.
- The relevant paragraphs should be re-drafted and expanded to make clearer, particularly for family and friends:
  - what a litigation friend is
  - when someone would be a litigation friend for the person at the centre
  - when non-means-tested legal aid would be available to the person at the centre, the Appropriate Person, and any person bringing an application on behalf of the person at the centre, and therefore acting as litigation friend. This should include an explanation of rights in relation to both Schedule AA1 and s4B of the Act.
  - the fact that someone can apply to the court, and then choose not to continue as litigation friend and that the court can ask the Official Solicitor to take on this role.

- There is not enough detail about when a responsible body should apply to the court and we would wish to see further guidance on this.
- Some of the footnotes only include the Welsh local authority complaints guidance, such as footnotes 185 and 188. This should include the English equivalent as well.

12. Partnership Local Government/NHS and adults/children

Recommendation 19) Further exploration would be useful on options for partnership within the LPS.

The Consequential Regulations, which amend the **NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000,** enable the whole of Schedule AA1 to be included in partnership arrangements (Regulations 7 and 10). This suggests that anything within Schedule AA1 can be undertaken by one agency on behalf of another. This is in contrast with a strong policy thrust to share the role of Responsible Body across both councils and NHS bodies. If it is assumed that councils could or should take on all the LPS work, it starts to look like a hybrid between Option 1 (Fully operationalised DoLS) and Option 2 (new adjusted LPS) that has not been separately costed in the draft impact assessment.

It would be useful to consider the following points:

- If joint teams are used, can NHS Responsible Bodies abdicate all LPS responsibility back to councils (if the council agrees)?
- The code recommends a model of joint AMCP teams, but could usefully explore a wider range of partnership options, including legal clarity on the consequences of such partnership, for example:
  - If the council authorises arrangements on behalf of Health bodies (or vice versa), how should challenges via Court of Protection be dealt with?
  - Who does the data reporting, on behalf of each partner Responsible Body?
- The impact assessment could usefully include a consideration of the costs (for each responsible body) of managing such joint services (see the section on the Impact assessment, in Part 2, below)
- The Government should be informed by the sector to consider the required funding flows for different partnership models

13. The IMCA Service

Recommendation 20) Government to correct the contradiction between para 10.2 of the Code (that is LAs to fund IMCA services) and the Workforce Strategy (which states all Responsible Bodies to fund).

Recommendation 21) Further impact assessment work is required, post consultation, along with clarity on Government funding for new burdens in relation to IMCA service commissioning.

Recommendation 22) There are key issues that need to be jointly worked through in advance of implementation of the IMCA service including:

- Expectations of IMCAs in the code that are not required by the Regulations and do not routinely happen now. This includes the expectation for IMCAs to accompany the person to all meetings in the LPS process. There are questions about whether the expected approach

and associated IMCA time during the process is fully covered by the costings included in the current impact assessment.

- The requirement for a national transitional plan to support implementation in relation to the number of IMCAs required in each local authority. Independent advocacy services are run in the charitable sector. It is worth noting that rates of pay are fairly low and this can raise a major challenge in some areas for attracting enough applicants for these important roles, particularly in the quantities that will be needed for LPS.
- An IMCA-specific commissioning strategy may be required to attract people to the role. The code is not the right place for this, but if there continues to be an issue sourcing enough IMCAs, the LPS scheme may fail to deliver the policy objective of improved outcomes for people who may be deprived of their liberty. There are already concerns about where the IMCAs will come from (as well as the qualified social workers) even assuming enough funding is available. Whilst the IMCA service is referred to in the workforce strategy, it is also a commissioning matter for local authorities, as they have the duty under the Mental Capacity Act to ensure there are enough IMCAs for their area. Should the advocacy providers be predicting requirements, or commissioners, or both, working together with Government?
- The Government to build on the engagement with people with lived experience to date, using co-production approaches following the public consultation period, to ensure that this work is informed by the views of those who use the services and their representatives
- Existing IMCAs will also require conversion training to understand the change in role, as will people who have operated as RPRs or other types of advocate, who are prepared to retrain as IMCAs. There needs to be clear national support for this, supported by a coordinated prioritisation of both statutory and non-statutory advocacy.

14. Independent Hospitals

Recommendation 23) Exploration should be provided of how the process should work in independent hospital settings

There are unanswered questions about how the AMCP role should work in independent hospital settings, and also what the expectations are on both the clinicians in independent hospitals and the local authority Responsible Bodies in the LPS process.

In particular it would be helpful to have further clarity on who carries out the assessments, particularly the Necessary and Proportionate assessment, and whether it should it be social workers or can it/should it be clinicians in the independent hospital.

15. Other settings

Recommendation 24) More information is required on the application of LPS in settings other than care homes and hospitals, including non-regulated health and care settings.

The examples in the Code are mostly in care home and hospital settings. One of the key policy features of LPS is that it can be used in relation to any type of setting and also that an authorisation can cover multiple settings. This would be useful in both the definition chapter and also in the assessment and determinations chapter.

16. Life Sustaining Treatment or Vital Acts

Recommendation 25) More clarity should be provided on how the process works in the case of life-sustaining treatment or a vital act, including what constitutes a vital act.

More information is required about cover/liability. Note: Para 19.3 states that "the legal authority provided by s4B only applies to the steps needed for the life-sustaining treatment or vital act in question. It is not a 'continuous' or 'ongoing' power". This means that there is a risk of liability for those carrying out any arrangements between vital act carried out under s4B and the date of the authorisation decision. This is a major problem for care and treatment providers who are awaiting the authorisation decision, especially if there is a long delay, for example, if there are still backlogs and long waiting times for authorisation. Also, for any care or treatment that is not life-sustaining or a vital act, s4B cannot be relied on.

For responsible bodies, it will be important to understand whether s4B is being used to avoid applying for authorisation under the LPS. It will also be essential for those carrying out the arrangements to notify the responsible body when it relies on s4B to carry out steps either in an emergency or whilst awaiting a decision from the responsible body. The code proposes that the person carrying out the steps only needs to notify the Responsible Body the first time they rely on s4B. It is not clear, however, how long this would provide cover for.

Many people have asked about what s4B does and does not cover, and the period for which s4B can be relied on. Whilst saying at paragraph 19.3 that it is not a continuing power, this still doesn't give clarity on when it should be challenged because the steps have been used over too long a period. There are many who worry that with the Ferreira carve out and the s4B option, some acute hospitals believe they will not have to seek authorisation under the LPS at all.

17. MHA/MCA interface

Recommendation 26) Review Chapter 22 of the Code (the MHA/MCA interface chapter) and the impact assessment in the light of the changes to the definition of a mental disorder.

Recommendation 27) Ensure that Chapter 22 of the Code (the MHA/MCA interface chapter) underlines the safeguards available to individuals who have an LPS authorisation in relation to a mental health hospital to reassure professional who fear the loss of safeguards for people excluded from the definition of a mental disorder for treatment by the MHA changes.

It is proposed in both this code and the MHA reform proposals that the interface between the MHA and MCA will be unaffected, and that objection alone would not be used to dictate whether the framework of the MHA or the MCA should be used to authorise detention/deprivation of liberty for a person who lacks capacity to consent to hospital treatment for a mental disorder. There are clear views expressed by some that the MHA provides more safeguards than the MCA for people in this situation. But this is not supported by this code.

The Government has also indicated that the definition of a mental disorder for the purposes of detaining someone for treatment under the Mental Health Act (s3) will change, and that a person with a learning disability or autism will only be included in the definition if they also have a co-occurring mental health condition. This has implications for the LPS as it uses the MHA definition of a mental disorder. Will the LPS Code need to stipulate that it is the definition used for s2 of the Mental Health Act rather than for s3? There is the suggestion that any arrangements to enable treatment that would amount to a deprivation of liberty would need to be authorised under the LPS if the person lacks the capacity to consent. Under the current

authorisation conditions, if the person is no longer to be classed as having a mental disorder, the Deprivation of Liberty could not be authorised under LPS either.

It will be important to reflect on the proposed changes to how a learning disability or autism will be handled, that is, not a mental disorder for the purpose of detention for treatment (MHA s3), in Chapter 22. It is anticipated that this will result in more cases coming into the LPS scheme, affecting numbers and therefore the impact assessment and new burdens. Will this require consequential amendments to the MC (A) A 2019 (and the MCA itself)? Code paras 16.43 and 16.44 may need revising to explain how the definition of a mental disorder under the MHA.

Projected figures for this need to be included in the impact assessment and need to be taken into account to inform workforce planning. This will be relevant to local authorities as responsible bodies for independent sector mental health hospitals.

18. Monitoring and Reporting

Recommendation 28) Provide more detail on how the LPS will be monitored in non-regulated settings.

Recommendation 29) Provide clarity on the distinction between regular reporting of the NMDS and the requirement to report to CQC and Ofsted and how this is expected to work.

It is not yet clear how the oversight of non-regulated settings will work. The Code would benefit from a much wider range of example scenarios in settings other than care homes and hospitals. This should include prisons, day services, transport (taxis, non-NHS ambulances), supported living services, owner occupier and rented, both where family carries out the arrangements and where paid staff carry out the arrangements, plus settings such as GPs, dentists, opticians, audiologists.

Also, there is no data on life-sustaining treatment or vital acts, but there is reference, for example in para 19.26, to circumstances where “care providers, IMCAs or an Appropriate Person” could become concerned about the inappropriate reliance on s4B. With no data about this, it will not be a straightforward matter to provide evidence to the monitoring bodies on the use of s4B, or for them, in turn, to monitor its use.

The code and the Regulations do not provide enough clarity on the role of the NMDS in supporting Responsible Bodies to notify CQC and Ofsted. A number of councils have asked if there are two duties, one to report on the NMDS and one to report directly to CQC and Ofsted. The text on this needs to be re-drafted to ensure that it is clearly understood.

Part 2 Comments on Other National LPS Documents

In parallel to responding to the consultation, we would welcome further joint work with government on the other national documents, as also crucial to implementation:

Draft Impact Assessment

ADASS, LGA and ADCS intend to send a separate, more detailed critique of the impact assessment in due course and hope that DHSC will take up their offer of continued work on evidence gathering to ensure that the impact assessment is evidence-based and accurate. This

is crucial for the success or failure of the LPS and will inform the Government's New Burdens assessment – so it must be accurate and evidence-based. The annual DoLS data for 2021/22 is due to be published in August 2022, and this will enable another year of data to be built into any trend analysis.

The current draft impact assessment estimates that Option 1 (fully-funded and operationalised DoLS) would be more expensive than Option 0 (the current status quo of a partially implemented DoLS scheme) and that Option 2 (LPS) would be less expensive than Option 0, but would have higher transitional costs. The impact assessment acknowledges that there are some unknowns which are not costed in Option 2 and cites at 23.4 the cost of renewals as an example. We suspect that there are a number of other costs that are either missing or under-estimated in Option 2, including, for example, the costs of reviews during the authorisation and renewal periods, backfill costs for training Competency Group C, the costs of the proposed AMCP team management). It is believed that the training costs are still under-estimated for Option 2.

In addition to under-estimated costs identified for Option 2, another issue which could suggest that estimated savings may be unrealistic is over-estimated costs in Option 0 (which would carry through to Option 1). This would include the figure (£1,358) for "completed but not granted" applications, which assumes that cases where very little work is done due to a death or change of circumstances, cost the same as cases where the full process is followed prior to a decision being taken not to authorise. Further sophisticated analysis would enable a truer picture of costs of the status quo.

Reviews need explicit consideration in the impact assessment. In the table on page 53, it states that, for Option 2 (LPS), the % of authorisations leading to a review will be 0% of cases, which is not the case. Reviews are not separately costed, and seem to be grouped together with N&P assessments, although it is not clear why.

There are currently waiting times for both DoLS authorisations and Court of Protection authorisations, and it will be important to give further thought to how these will be reduced in the run up to LPS, and to develop transitional guidance on handover of cases to NHS responsible bodies that may have been partially processed under DoLS, and also handover to CCG/ICBs and local authorities of cases awaiting authorisation through the Court of Protection. These handover transitional matters are not the subject of any of the public consultation documents but are relevant to all types of responsible body.

Some other areas where further exploration of the data and costs would be useful, include:

- analysis of the current split of initial authorisation applications versus renewals
- whether each local authority is a net importer/exporter of cases (for example where there is one or more independent hospitals or a high number of cases placed in care homes or supported living from outside the area) and out-of-county work (where there may be few, or no, care homes in district) – this will impact on both workforce and IMCA commissioning and provision costs
- costs associated with travel, especially for rural areas
- costs associated with managing a joint LPS service
- commissioning requirements for IMCAs vs RPRs,
- potential costs of additional care act work for self-funders (not always required under DoLS)
- arrangements with s12 doctors in DoLS vs GPs in LPS and whether there are to be any charges to local authority or NHS responsible bodies, or if the costs will be covered by the NHS GP contract

- understanding the impact of definition changes
- workforce costs associated with the transition (including restructure, redeployment, staff consultation, job evaluation)
- IT systems development estimates

Sufficient information must be provided by Government on funding to be made available for LPS implementation as well as for ongoing new burdens. This must be provided in good time to enable budget planning, not only for the financial year that LPS will go live, but also for the pre-live preparation and training period. In considering the timetable for implementation, the government should also allow time for councils to plan for workforce changes, any required restructure or redeployment, IT systems development, operational procedure development and training.

Workforce Strategy and Training Framework

These documents provide a starting point for councils and other responsible bodies to start planning for LPS. The proposed changed definition and potential narrowing of scope suggested by the code and impact assessment makes it difficult, however, to base predictions of required staffing levels on trended data on DoLS and Court of Protection cases. More clarity, more work with, and more support for the sector will be required to enable preparation and planning, including calculations of how many more professionals may be required to fulfil the requirements of The Mental Capacity (Deprivation of Liberty: Assessments, Determinations and Pre-Authorisation Reviews) (England) Regulations 202X. For adult social care, this will also need to take into account workforce planning to support other government initiatives, such as increased assessment staffing required for the care cap changes.

There needs to be more acknowledgement in both the workforce strategy and the impact assessment of potential restructure, redeployment, job evaluation and staff consultation that some councils may need to undertake.

Paragraph 18.2 of the Code states that AMCPs will "normally be employed by a Responsible Body", but it is not clear what is expected in relation to the use of staff outside the proposed AMCP team arrangements, including the use of agency or self-employed staff. Clarity would be useful on commissioning of staff to undertake LPS tasks, including:

- Assessments
- Determinations
- Consultation
- Pre-authorisation reviews
- Authorisations
- Reviews

As mentioned above under the IMCA Service, in addition to estimating the commissioning costs of an increased IMCA service, planning will be required to estimate how many additional IMCAs may be required in each local authority area, and where they will come from.

Draft National Minimum Data Set, Notification Duty and Draft Template forms

The intention to mainstream the LPS work into assessment and care planning tasks means that the National Minimum Data Set will need to be built into every-day assessment and care planning recording systems. Whilst some councils have built the DoLS data systems into

assessment and care planning systems, others have maintained separate IT systems for their DoLS services. In children's services, this will be a totally new requirement. Considerable work will be required to ensure the required recording will be possible in councils from Day one. Note: many council children's services still have separate IT systems for children's social care and education. The average cost estimated in the impact assessment of £10k per responsible body to amend recording systems to accommodate LPS (and in councils that includes both adults and children's services) may be an under-estimate of the cost of this.

The notification duty requiring responsible bodies to submit national data "at least once every 6 months" represents a new burden for both adults and children's services. This needs to be properly costed in the impact assessment and national funding identified for this.

The Government has announced that template forms will be published separately from the public consultation, but for information and comment. It will be important to review these along with IT systems providers to identify the systems development work and subsequent, associated staff training that will be required to ensure effective recording to meet the requirements.

Interface with other government initiatives

It is of paramount importance that DASSs and DCSs are able to build LPS implementation into their work programmes alongside other government initiatives as part of Adult Social Care reform and Children's services changes and mental health reform. This includes the need to consider how LPS aligns with other aspects of reform, including both the timing of implementation and an understanding of the impact of the various initiatives on the same workforce. This includes the work towards the care cap and inspection of Adult Social Care, as well as Children's Social Care and SEND reviews. There will be workforce and training implications for each, as well as budget implications.

Further Engagement

Throughout the development of the LPS, including the period when the Mental Capacity (Amendment) Bill was making its way through parliament, our members have engaged with government departments to offer their expertise and experience. All three of our organisations have been active members of the DHSC-led national LPS steering group. We would like to take this opportunity to offer to continue to work with the government following the public consultation period to ensure the final version of the LPS scheme, when implemented, is as informed as possible by operational and strategic expertise in the relevant subject matter.

If you have any questions regarding this submission, please do not hesitate to contact Hilary Paxton, Senior Adviser/Programme Manager, Local Government LPS Implementation Support Programme, on 07464 652917 or hilary.paxton@local.gov.uk.