14 July 2022

Written submission to the consultation on proposed changes to the Mental Capacity Act Code of Practice and implementation of Liberty Protection Safeguards

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

Introduction

Under the new Liberty Protection Safeguards (LPS), deprivations of liberty need to be authorised in advance by the 'responsible body', which for hospitals will usually be a manager in the trust that runs the hospital. This provision will allow the NHS, rather than local authorities, to make decisions about patients and service users, resulting in a more efficient and clearly accountable process because patients are most likely to be onsite or in touch with NHS services at the time they require these provisions.

NHS trusts and foundation trusts have shared high-level feedback with us on a number of areas of the draft code of practice and implementation of LPS, as set out below. Alongside this, it will be important for the Department for Health and Social Care (DHSC) and the Ministry of Justice (MoJ) to engage with trusts directly for more operationally-focused views and evidence to finalise the MCA code of practice and plans for LPS implementation. It will also be important for the government to continue to work closely with health and care organisations to develop a robust and achievable plan for implementation. Other demands being placed on the system, and the capacity of health and care staff to deliver what is required, need to continue to be carefully considered as this work progresses.

Implementation of Liberty Protection Safeguards

Workforce training

Trusts have shared positive feedback with us on the suggested Training Framework: it appears similar to their local draft training plans. Trusts expect that they will need to provide tailored local LPS training delivering programmes, part of which will include specialist face to face training for staff in key roles with more direct involvement in LPS. One trust has also flagged that the development of local systems, including the necessary updates to patient clinical information systems, will require staff with a variety of specialist skills including in the MCA, LPS and IT software programming. Trusts would welcome a national LPS training programme being made available to support and complement their work here.

Meeting additional costs

Providers need to be appropriately resourced to deliver the new provisions, with potential additional costs arising as a result of:

- Administration: there will be increased costs relating to the new administration of the process. This includes developing and implementing new policies and procedures, governance frameworks, and administrative systems to ensure compliance with the new legislation.
- Staff workload: costs will be incurred as clinicians will be required to undertake assessments and pre-authorisation reviews. Trusts have highlighted there may be a possibility to utilise community staff to carry out the necessary and proportionate assessment as part of their care plans and risk assessments.
- Recruitment: new roles and teams will be needed to ensure delivery, in particular to allow for clinician assessments and pre-authorisation reviews.
- Legal challenges: trusts may face increased legal and insurance costs given the broad spectrum of the criteria for objection.

Any additional funding will need to be in place within enough time to ensure that it can be appropriately planned into trust budgets.

Monitoring and reporting

Trusts have highlighted the importance of a national standard pro forma for completing information monitoring bodies require, in order to guide the format of local LPS forms. They would also welcome this being produced in a format that can be completed and submitted electronically. This would be helpful and give consistency for quality assurance, and would also support quick reporting.

There has been some concern expressed that the reporting process appears more complex than the current notification arrangements under the Deprivation of Liberty Safeguards (DoLS). One trust has suggested an alternative approach could be to require the Responsible Body to notify the monitoring body once the outcome of a "triggered" LPS process is known, which would include triggers for a renewal process, and to send an updated, linked, notification to the monitoring body to advise the LPS has ended in cases where the LPS is authorised. One trust has also fed back to us their concern that regulations stating information needs to be sent "at least once every 6 months" is ambiguous and would welcome clarity on how this is intended to work in practice.

Data and digital

Improving data is a critical enabler to the wider system changes, and it is right that trusts and national bodies prioritise working together to make further progress on data collection and data quality to give a better understanding of use of the Act that can then enable better commissioning and the provision of services more broadly.

Trusts will need to set up or adapt fit for purpose systems to record, monitor and report on the use of the Act. To assist with this, it would be helpful for the government to prioritise making decisions around data monitoring and national documentation as early as possible. We are also keen for trusts to have clarity on digital strategy and funding (recognising the revenue and capital implications) in order to support their ability to invest in digital ways of working. For many, this will mean investing in core infrastructure to make things easier for staff: from improving wi-fi coverage to fixing slow log in times.

Interface with the Mental Health Act

The lack of clarity around the interface between the Mental Health Act 1983 (MHA) and the MCA has been a longstanding cause for concern for trusts. The MCA reproduces the notoriously complex and poorly understood interface between DoLS and the MHA. Whereas disputes over that interface currently take place within a local authority, under LPS, the same dispute would arise between a hospital manager and a local authority. It is essential that the new MCA code provides clarity around who will resolve such disputes, and how, under the new system. More broadly, there must be clear guidance, including through the MCA code of practice, to support practitioners when making decisions on the correct legal frameworks to apply.

When we sought feedback from trusts about reforming the MHA, a number of trusts suggested that the demarcation between the two Acts should be based on the nature and purpose of the detention,

so that all those being detained in hospital for assessment or treatment for a mental disorder receive MHA safeguards. One trust believed that the existing nuanced case law position would ensure more appropriate options for patients than an unsuitable, artificial simplification.

We welcome that the government is going to assess the impact of LPS before introducing reforms to the MHA to ensure that any gaps can be addressed.

Proposed changes to the Mental Capacity Act Code of Practice

Independence of assessors

Some trust leaders have raised concerns that the current proposals in the draft code for all three assessments to be carried out by different individuals could create significant challenges for trusts given current operational and workforce pressures. There also seems to be a lack of clarity as to whether these individuals need to be from different teams, wards or hospitals, and it will be important to address this ambiguity in the final code.

An alternative approach suggested by one trust is that pre-authorisation reviews be undertaken by a person independent of the treatment team in order to balance the practical considerations of operating the new system. The involvement of an approved mental capacity professional (AMCP) where someone is objecting to their deprivation of liberty would remain to provide critical independent scrutiny and oversight.

Another suggestion put forward is that the independent review of the patient's circumstances and care plan would be provided at the pre-authorisation review stage, which must be carried out by someone who is independent of the care team or an AMCP, with further review by the senior manager who reviews and signs the final authorisation.

AMCP out of hours service

It is right that a Responsibility Body must ensure there is a mechanism for an LPS referral to be submitted at any time. However, some trust leaders have raised questions about the requirement for Responsible Bodies to deliver an AMCP duty service for out of hours referrals and the benefit of such a service, given the level of additional finance and resourcing this would require, when the draft code allows for the LPS assessment and authorisation process to be completed within 21 days.

One trust's view is that, where someone needs to be deprived of their liberty on an emergency basis out of normal working hours, that Mental Capacity Act assessments, best interests decisions and least restrictive care arrangements are sufficient to manage these situations until daytime services are available to conduct LPS processes. The trust believes it is also unlikely that all the assessments and consultations required for the authorisation process would be possible to complete robustly out of hours.

Trusts we have received feedback from stressed the importance of AMCPs, and Independent Mental Capacity Advocates (IMCAs), remaining centrally commissioned by integrated care boards (ICBs) or local authorities as this would be the most efficient and effective approach in terms of cost and time. It will be important to clarify if this is the expectation. If it is not, one acute trust raised concerns about the likelihood of there being a limited number of referrals to AMCPs within their trust and so there is a risk ACMPs employed by the trust will have little exposure to the process, which would an issue as these roles need to have expert knowledge, skills and be up to date with case law.

Guidance for acute trusts

We would welcome more references to, and guidance for, acute trusts and case studies relating to acute care in the code, especially given many will need to set up entirely new arrangements as the Responsible Body. Guidance for patients sedated and ventilated in intensive care units has been highlighted as a particular area that would be helpful.

Acute trusts have also highlighted that they are often only responsible for a person's care provision for a very short time, and the majority are discharged within 21 days, and so further guidance for trusts in these circumstances would be welcome.

Transferability and portability of LPS from one care setting to another

Concerns have been raised by trusts about the apparent lack of portability of LPS between different settings, with the code indicating that if care provision is not similar, then a new LPS process will need to be triggered (for example, in cases of admission from community with an LPS to an acute hospital).

More clarity would also be welcomed by trusts regarding transfers from one care provider to another. One trust highlighted the considerable amount of time they take putting 'Transport Plans' together for patients who lack capacity to consent to discharge, usually to a care provider, but are objecting strongly to that discharge – there is currently no legal framework to cover that gap between one provider and another.

Emergency powers

The current drafting of the code states that an emergency LPS is not a "continuous" power and only provides authority for discrete, one-off, positive acts of physical restraint that amount to a deprivation of liberty. Concerns have been raised about the usability of the emergency power in practice if this approach remains in the final version.

Article 5 scope

Concerns have been raised about the amount of people who would be out of Article 5's scope if the code stays as currently drafted, and the apparent contradiction between this and the Cheshire West judgement, which made it clear that trusts and clinicians should "err on the side of caution" when it comes to applying Article 5 and give people the protection of the statutory safeguards when in doubt.

Clarity and accessibility

It will be critical to the useability of the code to have an executive summary, quick and clearly signposted summaries at the beginning of each chapter, easily navigable digital versions, and the development of an easy-read version as well as other resources and guidance that are more accessible and work for different audiences.

One specific suggestion has been shared with us by a trust about setting out the detail of chapter 6 in a table so that it is clearer, more precise and user-friendly. Each row of the table would be for the different people using the Act and columns of the table should include: what assessments need to be conducted and records need to be made; under what scenarios can a plan based on an assessment by someone else be worked to; and what are the personal responsibilities in the aforementioned scenarios.