



Mental Capacity Act 2005 Deprivation of Liberty Safeguards

Response to Consultation

February 2009

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The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009

Response to a consultation carried out by the the Department of Health. This information is also available on the Department of Health website:

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

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Introduction

This document is the post-consultation report for the consultation paper ‘Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Consultation on the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) and (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence (Amendment) Regulations 2009) which was published on 23 February 2009. The consultation covered one set of draft regulations for England: The Mental (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009.

This post-consultation report is published by the Department of Health. It covers:

- the background to the report;
- a summary of the responses to the report;
- a detailed response to the specific questions raised in the report; and
- the next steps following this consultation;

Further copies of this report can be obtained by contacting the **Project Management Team** at the address below:

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This report is also available on the Department's website at:

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

Background

A formal consultation on the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) and (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence (Amendment) Regulations 2009 set out draft regulations which sought to:

- confer power on the Care Quality Commission (CQC) for the purpose of monitoring, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards
- amend regulation 3 of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations

The consultation took place between 19 December 2008 and 30 January 2009. It invited comments and views on the regulations.

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) are a response to a European Court of Human Rights' judgement in October 2004 – the case of *HL v UK*. The Court found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment, and who had been admitted informally to Bournemouth Hospital, was unlawfully deprived of his liberty in breach of Article 5 of the European Convention on Human Rights.

The MCA DOLS remedy this breach of the ECHR and were inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007. The new provisions (found in schedule A1 to the 2005 Act) provide a framework for approving the deprivation of liberty of people who lack the capacity to consent to the arrangements made for their care or treatment (in either a hospital or care home) but who need to be deprived of liberty in their own best interests, to protect them from harm.

Twenty-nine responses were received, all of which were broadly in support of the regulations. A list of respondents is set out at Annex A. The responses were helpful and constructive. Many offered more detailed comments including requests for further clarification and suggestions about how the regulator should undertake the designated monitoring responsibilities.

The consultation paper asked a number of specific questions about the regulations. All respondents based their responses on these questions (although some included

general observations about monitoring activity and the nature of insurance and indemnity). The summary of responses that follows is framed around the questions that were asked in the consultation paper.

Responses received for each question

1. Do you support the proposal that power should be conferred on the CQC for the purpose of the monitoring of, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)?

Summary of responses

All respondents who commented on this issue agreed that the responsibility for monitoring the operation of the MCA DOLS should be conferred on CQC.

Consultation responses

Respondents sought further clarification about how CQC would undertake this role and also offered suggestions about how the regulator should discharge this new responsibility.

“...we believe this [MCA DOLS monitoring] should be integrated with their wider role of inspecting care homes against registration regulations and compliance criteria.”

“[We] can’t comment on how effectively it will do the job until more information is provided about how it will undertake its duties.”

Key concerns included:

- How will CQC integrate MCA DOLS activity into its broader role inspecting hospitals and care homes?
- The focus of the regulations is predominantly on the managing authority. Who scrutinises the supervisory body?
- What training will staff have to prepare them for their role as inspectors; as managers of a care home or hospital undergoing inspection?
- Inspectors need training in understanding particular needs of the client group so they can undertake their duties in an informed way
- “The CQC intends to pursue a strategy of risk-based targeted inspection and enforcement, and its methodology for assessing risk will be crucial to its effectiveness in monitoring and reporting on deprivation of liberty. As well as the assessment by CQC it is essential that there are rigorous procedures built into self-assessment.”
- “CQC must involve key stakeholders in the development of both their inspection methodology and the information they require as part of self-assessment.”

The Government’s response

We welcome the majority view that CQC should be responsible for operating the monitoring of the MCA DOLS.

We cannot comment on how the regulator will undertake its monitoring activities. The Health and Social Care Act sets out the legislative framework for the regulation of health and adult social care. It set out the functions of the Care Quality Commission clearly whilst giving it independence on how to deliver those functions. The high level regulatory requirements that providers of regulated services must meet will be set in secondary legislation and then regulator will have the freedom to develop the criteria by which it assesses compliance. The Commission will have the flexibility to make different provisions in different cases or different circumstances to reflect different services. This is to allow for the fact that, for example, measures to assure some issues in care homes may be very different from those required to assure the same issues in, say, acute wards.

2. Do you support the proposal to give the Care Quality Commission general powers to:

- **visit hospitals and care homes**
- **visit and interview people accommodated in hospitals and care homes**
- **require the production of, and inspect, records relating to the care or treatment of people accommodated in hospitals or care homes who are, or should be, deprived of liberty under the MCA DOLS.**

Summary of responses

Most respondents indicated their support for this proposal but with a number of provisos and specific recommendations for changes to the regulations and CQC activity. The one dissenting voice wanted to see enhanced powers for CQC in relation to MCA DOLS.

Consultation responses

Recommendations for specific changes to the regulations were, as follows:

“[Regulations should] include a requirement for CQC to monitor the quality, standards and extent of the contractual and reviewing arrangements of local commissioners with regard to people who are subject to the Deprivation of Liberty Safeguards.”

“The CQC should be given powers to interview *both* adults who are accommodated and professionals involved in the care and treatment of adults who are or should be deprived of their liberty.”

“Regulations should require the CQC to instruct a managing authority to make an urgent application to authorise the deprivation of liberty in any case where CQC is of the opinion that deprivation of liberty is occurring.”

“CQC should also have the power to monitor those cases where authorisation of deprivation of liberty has not been granted because conditions have been outlined by the supervisory body in the care plan so that deprivation of liberty is avoided.”

Other recommendations for regulations sought greater powers for CQC in relation to the MCA DOLS.

- As people in scope of MCA DOLS lack capacity and may not be able to self-advocate, CQC should also be enabled to interview any IMCA other advocate, family member etc. to ensure the person's views are best represented.
- CQC should have a power to respond urgently if concerns are raised that a person is deprived of liberty without authorisation and raise the issue with the supervisory body.
- CQC should have a power to immediately require the managing authority to seek authorisation for deprivation of liberty. Regulations should require CQC to instruct the managing authority to make an application for an urgent authorisation in any case where CQC is of the opinion that an unauthorised deprivation of liberty is occurring.
- Supervisory bodies should be required to notify CQC of each authorisation; numbers of authorisations requested but not granted; each case where deprivation of liberty is not granted but conditions are imposed so that deprivation of liberty can be avoided.
- CQC should have a power to inspect records for individuals where deprivation of liberty has been turned down.
- CQC should have a power to make an individual inspection of a managing authority where it has been brought to their attention that a person may have been deprived of liberty without authorisation.
- Regulations should specify information and records should be provided by managing authorities prior to inspections of numbers and nature of authorisations and if any applications for authorisation were not granted CQC then need to see that care plan is being adhered to and no deprivation of liberty is occurring.
- Could the regulations specify that an inspection should be carried out either as a routine or special themed inspection on MCA DOLS?
- Regulations should give CQC a power to visit and monitor supervisory bodies, any of the various assessors and IMCA services on the provision of MCA DOLS processes and procedures.

Respondents also raised the following issues:

- Local commissioners should have a responsibility for monitoring local standards of care and treatment and should perhaps be included in CQC's remit.
- Monitoring imposes additional burden on managing authorities. No account is taken of this in RIA costings.
- Inspectors need to have teeth and not just function as overseers of the process.
- There are additional costs associated with training for inspectors.
- The inspection team must not function as an alternative DOLS police force.
- Training should be provided for inspectors to understand the particular needs of client groups.

The Government's response

Regulation 3 (b) gives the CQC the power to visit and interview persons accommodated in hospitals and care homes which covers all the people who respondents were anxious to see included in any proposed interview conducted by the regulator. There was therefore no need to explicitly give them the power to do so. We cannot in any case provided for the CQC to decide who it was appropriate to interview because this amounts to sub-delegation and we lack a specific power in the primary regulation-making power to enable this. We feel that CQC has sufficient power and scope to interview under the terms of the Health and Social Care Act.

The other recommendations for changes to the regulation went beyond the regulation-making power in the primary legislation.

Recommendations for CQC will be passed on to the regulator for their information but, as outlined under question 1 in our response, it will be for CQC to determine how it undertakes the monitoring of the safeguards and to set its own compliance criteria for this activity.

3. Do you support the proposal that supervisory bodies and managing authorities must disclose information requested by the Care Quality Commission within twenty-eight days?

Summary of responses

Most provider/professional organisations indicated support for the 28 day time frame. Only one dissenting voice suggesting the time frame should be longer (2 months).

Organisations representing the interests of service users and some MCA Local Implementation Networks strongly suggested that the timeframe was too long.

Consultation responses

Respondents made useful recommendations and raised a number of key issues, including recommendation for a specific change to the legislation:

- It must be a shorter timescale to protect vulnerable people particularly as the regulator will be investigating deprivation of liberty.
- The timeframe for disclosure of information should mirror the timeframe for the MCA DOLS assessment process.
- The timeframe needs to be more flexible. 28 days might be too long for some; too short for others. Organisations should be able to ask for an extension in exceptional circumstances. Give CQC a power to decide the period within which it is reasonable to require the information to be provided.
- It is assumed any system of notification introduced as part of regulation requirements will be subject to separate timescale linked to their responsibilities under the Health & Social Care Act.

The Government’s response

We cannot give CQC discretion to determine the time taken for the disclosure of information, as the primary legislation did not allow these regulations to do this.

We have decided to remove the requirement altogether from these regulations and allow CQC to use other powers under the Health and Social Care Act. These also provide that failure to provide information when requested may constitute an offence.

4. Do you support the proposal that the Care Quality Commission should provide an annual report to the Secretary of State for Health as soon as possible after the end of each financial year? Do you have views on what this report should contain in respect of the monitoring of Schedule A1?

Summary of responses

All respondents said yes to the provision of an annual report, with most suggesting this should be part of a broader CQC annual report.

Consultation responses

Some respondents advocated that MCA DOLS (because of the nature of subject) should have its own separate report. Some respondents said that the model of the Mental Health Act Commission’s annual report might provide a good template. There was a suggestion that an interim report should be provided after 6 months to provide valuable information on the first year of implementation.

Detail proposals for what the report should contain were also advanced to include qualitative and quantitative data with many feeling that, as a minimum, the report should contain:

- An analysis of numerical data relating to the operation of MCA DOLS (including numbers of applications, authorisations and characteristics of the MCA DOLS “population”)
- The methodology used to monitor MCA DOLS during the period covered
- The activity that has taken place to monitor MCA DOLS during that period
- The findings of CQC, including both compliance with MCA and the Code of Practice and the experience of people who have been deprived of their liberty
- Other relevant development (eg. developing case law)

The Government’s response

We welcome the broad agreement in respect of the publication of an annual report but have decided that we should not have a separate requirement in these regulations but rather rely on the requirement in the Health and Social Care Act 2008 for the CQC to provide an annual report. This report will cover MCA DOLS. Most respondents set out their proposals for the content of the report and these useful recommendations will be passed to CQC for information to inform the development of plans for the annual reporting of the MCA DOLS. It will, of course, be for CQC to determine the scope, content and form of the report. We have included an additional requirement for CQC to report to the Secretary of State as

and when he may require, which will allow the Secretary of State to obtain information between annual reports if necessary.

5. Do you support the detail of the amendment to regulation 3 of the Mental Capacity Act (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 to include both insurance and indemnity cover for assessors?

Summary of responses

Some respondents declined to comment but among those responding there was broad support for the proposed amendment with one exception. The respondent asserts that doctors and patients should not be allowed to rely on discretionary indemnity for clinical negligence claims.

Consultation responses

Most respondents welcomed the proposals but further clarification was sought on the following issues:

- Will the proposed amendment allow for practitioners to be assessors if they are employed by LAs covered by a local authority scheme?
- Do the amendments allow assessors to carry out assessments for authorities by which they are not employed?
- Who provides cover for best interests assessors (BIAs) working across boundaries?
- What about an indemnity for registered managers?
- Does the proposal go far enough to cover all professionals who may act as BIAs who do not work for LA/PCT e.g. staff employed by a MH Trust or an Actute Trust?

The Government's response

The amendment to the Mental Capacity Act (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations does not water down the requirements for assessors in any way. It provides that MCA DOLS assessors are eligible to carry out assessments where they have in place an adequate and appropriate policy of insurance, indemnity arrangements or a combination of both. Under the existing regulations, only those assessors who have a policy of insurance in place will be eligible to carry out assessments. It was never our intention to prevent professionals with indemnity arrangements (rather than policies of insurance) from becoming assessors in this way.

Comments on the Impact Assessment

Summary or responses

Respondents observed that the IA shifts the cost impact of inspection to CQC. CQC will bear internal costs but provider organisations need to know how much resource to deploy in order to support a visit of inspection. Supervisory bodies will

incur management costs. CQC are asked to provide illustrative cost examples prior to 1 April.

Consultation responses

Key issues raised:

- The costs of monitoring should be borne by Government.
- If extra time needed by CQC to complete inspections extra funding should be provided.
- Legal aid for all cases should be on a non-means tested basis. Indeed anyone who the state authorises to be deprived of their liberty should not have to pay for their care home.

The Government response

It is unlikely that monitoring MCA DOLS activity in supervisory bodies and managing authorities will be a separate activity for CQC. This activity will be integrated into its broader remit as health and social care regulator.

General Comments

The Regulations focus exclusively on the role of the managing authority. Will CQC also examine how well supervisory bodies are implementing their role in respect of MCA DOLS including meeting assessment deadlines and working with care homes.

Regulations give CQC the power to monitor people subject to them but not to investigate whether people are unlawfully deprived of liberty and for whom no authorisation has been sought. Regulations should state that CQC should monitor where deprivation of liberty is occurring by no authorisation has been sought.

No opportunity to comment on how CQC will discharge its duties.

CQC should have a defined remit that covers communication with carers and relatives. They should be informed of visits and given an opportunity to meet with CQC.

Next Steps

The Regulations will be published and CQC will adopt formal responsibility for all its duties, including MCA DOLS monitoring, from 1 April 2009. CQC replaces the Healthcare Commission, CSCI and the Mental Health Act Commission.

CQC has been operating in shadow form since October 2008 and has been working closely with DH in relation to developing the MCA DOLS monitoring duties.

CQC has advised that it intends to undertake MCA DOLS monitoring following a number of key principles;

- That the focus of CQC’s monitoring needs to be on the experience of people with limited capacity - when deprivation of their liberty is being considered or authorised - and on their quality of life;
- That the monitoring role needs to be distinct from CQC’s wider role as a regulator of health and adult social care provision and from the role of councils and PCTs who have a local duty to “regulate” the authorisation of deprivation of liberties by providers;
- That the way that CQC monitors therefore needs to be proportionate and not duplicate what happens under other duties;
- That wherever possible, the practical implementation of CQC’s monitoring duties should dovetail with its other duties of inspection and assessment – so that the burden of the tasks is minimised on those regulated and assessed and is carried out cost effectively for the regulator;
- That CQC should rely on the DH defined data returns from councils and PCTs to provide statistical context for its monitoring role and should avoid making additional demands for data wherever possible.

CQC is now finalising its monitoring proposals following the recent ending of consultation on the relevant regulations and DH’s response to this consultation. It intends to talk urgently with key stakeholders about these proposals before they are concluded.

It is likely, depending on the sector and whether the agency is a managing authority (care homes and hospitals) or supervisory body (councils and PCTs), that the dates for implementing some aspects of the monitoring will be phased in during the year and will also be subject to ongoing review with stakeholders.

As a minimum, CQC will be publishing detailed guidance for its staff and for care services on the implications of the Mental Capacity Act and the DoLs safeguards.

CQC’s Board will sign off the monitoring proposals in mid March for publication by 1 April 2009.

Annex A - List of Respondents

1. David Bond, Strategic Development Officer, Lancashire Adult and Community Services Directorate
2. Claire Mallet, Mental Health Network, NHS Confederation
3. Claire Churchill, Policy Administrator, Royal College of Psychiatrists
4. Anna Passingham, Senior Policy and Communications Officer, Counsel and Care
5. Ann Mackay, Director of Policy, ECCA
6. Ed Collins, Project Manager - Mental Capacity Act Deprivation of Liberty Safeguards, Adult and Community Services
Durham County Council
7. Mental Health and Disability Committee, The Law Society
8. Pat Stewart on behalf of North East LIN
9. Pennine Care NHS Foundation Trust
10. Patrick Sullivan, Director of Nursing, Lancashire Care NHS Foundation Trust
11. Lorraine Currie, Mental Capacity Act Implementation Officer, Disability Resource Centre, Shropshire Council
12. Alexina Weston, Head of Professional Practice (Nursing), Colchester Hospital University NHS Foundation Trust
13. Dave Shields, LIN lead for the LA from Leeds Adult Social Care/ Peter Scanlon, lead Programme Manager for MCADoLS in Leeds NHS
14. Pat Clow, Mental Capacity Act Project Manager, Newham PCT
15. Heather Blow, Head of Deprivation of Liberty Safeguards, NHS Lincolnshire
16. Sue MacMillan, Mental Health Act Commission
17. Paul Greening, Mental Capacity Act Manager, Dorset PCT
18. Jenny Goodall and Richard Webb, Co-chairs, ADASS Mental Health Drugs and Alcohol Policy Network, Association of Directors of Adult Social Services
19. Alison Waller, Director of Children, Family and Adult Services, East Riding of Yorkshire Council
20. Robert Keys, Mental Health Law Manager, North East London NHS Foundation Trust
21. Jane Harriman, Deputy Director of Standards and Engagement, Sheffield PCT
22. Dennis Little, MCA & DOLS Coordinator, Southend on Sea Borough Council, on behalf of Southend Local Implementation Network for DOLS
23. Allan James, Chair of Cambridgeshire MCA Implementation Group
24. David Congdon, Head of Campaigns and Policy, Mencap
25. Emmet Perry, Senior Manager – Adult Safeguards, Essex County Council on behalf of the Essex Local Implementation Network
26. Age Concern and Help the Aged (joint response)
27. Mary Lou Nesbitt, Head of Governmental and External Relations, The Medical Defence Union
28. Ciara Brannigan, External Relations Manager, Medical Protection Society (MPS)

29. Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing