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LPS consultation and ‘go live’ planning

19 December 2022

Implementation date

The Mental Capacity (Amendment) Act 2019 eventually made its way through Parliament after much debate and controversy, practitioners have finally had sight of the draft Code of Practice and Regulations, though the date for implementation of the LPS remains unclear.

What we do know is that the joint consultation by the Department of Health and Social Care and the Ministry of Justice on the draft MCA Code of Practice (the Code) ran from 17 March 2022 and concluded on 14 July 2022 (having been extended by a week). The Government has indicated that it will be digesting the responses over the winter.

We await the publication of a final Code of Practice and Regulations which is now realistically not going to be ready before late Spring 2023.

The Regulations will be laid before Parliament for 40 days (to allow for parliamentary scrutiny) before they come into effect. If they pass through Parliament and come into effect, this will then trigger the rollout of the training for AMCPs, who are in effect taking over the role of the BIA. There will then be a further gap of at least 6-months between publication and implementation. Taking all of this into account, realistically LPS will hopefully be in place by October 2023 but it could easily be beyond that, as far as April 2024. It’s also important to remember too that when the LPS does come into force, there will be 1 year of transition where the DoLs and LPS systems will run alongside each other to allow time for all of the existing DoLs (both Court and Standard Authorisations) to be transferred over to LPS. It is good that progress is being made but we will all still be dealing with DoLs for some time to come.

Key points from the draft Code

Now we have had time to digest the code and respond to the consultation, here are some of the key themes gleaned from our analysis of the Code:

1. New responsibilities for ICBs

Clinical Commissioning Groups no longer exist and as of 1 July 2022 have been replaced with Integrated Care Boards and so that’s the first major change for the code that it refers to ICBs and not CCGs.

- ICBs will become the Responsible Body for all cases where the person is CHC funded meaning that they have to put the LPS in place, whereas before this would have been the role of the LA as the supervisory body.
- LPS apply in a much wider range of settings such as supported living placements, and this could mean that initially there is an increase in the challenges brought through the court as new points of law are clarified.
- This will be made more likely by the continuation of the right to challenge an LPS authorisation via the Court of Protection (now referred to as a s.21ZA) with non-means tested legal aid.
- In s.21A cases for CHC funded cases, the role of the ICB will become more complex as they will be both care manager and responsible body.

With all of these new duties will come the need for new systems and training requirements. All of which are things we would be happy to support with, so please do get in touch if that’s something your organisation could benefit from.

2. Reference to case law

A recurring point arising the consultation responses that we have seen is that the Code has disappointingly little reference to case law. The case study examples provided within the draft code were often found to be slightly confusing and didn't reflect the real-life examples from case law. It was felt that it would be of greater assistance to professionals if the code was consistent with the approach that has been taken by the Courts. For example, at paragraph 4.55, when referring to capacity 'to make decisions at limited periods', the Code could benefit from some specific examples such as the a maternity case, NHS Trust and others v FG ,where P had fluctuating capacity & restraint was required.

3. What is a DoL?

Chapter 12 of the Code has caused quite a lot of confusion due to the interpretation of what does or does not constitute a DoL and the seeming conflict between the code's definition and the 'acid test' from the Supreme Court case of Cheshire West, despite this case being referred to within the draft code.

- The case examples do not seem to properly apply Cheshire West, which gives rise to concerns that it could lead to an inconsistent application of the LPS reducing the protection for the vulnerable.
- It was felt by many that a statutory definition, though ruled out by the Code, would be helpful to avoid confusion.
- A specific example of the effect of the lack of clarity from the case examples (at paras. 12.21 – 12.30) is that it risks creating a scenario where many older people in care homes, who are extremely vulnerable, may actually fall outside of the LPS scheme and the protection that it offers.
- Nevertheless, the threshold for a referral into the LPS system importantly remains at arrangements that 'may' amount to a DoL (paras. 13.8 and 13.13), which somewhat mitigates the risk of people being excluded under the definition. Cross referencing of the 'may' threshold and clearer case examples could perhaps address some of the confusion within the chapter.
- There also needs to be more clarity around advance decisions for LPS – Paragraph 12.55 suggests that 'advance consent' is possible, which is inconsistent with the MCA that states that capacity is time a decision specific. This could be particularly problematic in situations where P changes their mind about treatment which requires physical restraint. The way in which the Code suggests 'advance consent' could apply, appears to mirror the statutory requirements for an advance decision to refuse treatment (ss.24 – 26 MCA 2005).

4. Timescales for assessments and authorisations

The timescales do not seem to consider the practical challenges of the work needed to carry out all the assessments and consultation which is required. For example, the Responsible Body has to acknowledge the referral within 5 days and the duration of the whole process (from referral to authorisation) should not exceed 21 days, save in 'exceptional circumstances' (para. 13.26).

These timescales seem to be more aspirational than realistic, especially when considered alongside the current wider challenges facing the health and care sector such as staff shortages. It's unfortunate that these challenges, which have been a significant contributing factor to the current DoLS backlogs (even before Covid), do not appear to have been considered when planning for the LPS. This could mean that we see a repeat of the same backlogs that LPS was aimed at reducing and the knock-on effect of people being deprived of the protection of the LPS, as well as further financial burden on public bodies if compensation is sought for unlawful DoL.

5. Ongoing monitoring

Paragraph 13.24 of the Code - it is unclear how each Responsible Body would appropriately monitor the person for the whole LPS process, including after authorisation. If there was reason for concern, it seems practical that this would be raised by way of a safeguarding concern and the LA who could inform the Responsible Body. This creates the potential for the LA to be the body who ultimately continue to oversee the LPS regime which was one of the aspects of the DoLS regime which LPS was going to change.

6. Who can be an AMCP?

Currently the list of eligible people who can become a AMCP is quite limited. You must be either a nurse, social worker, psychologist, SALT or OT and this could potentially exclude some existing BIAs and other health and social care professionals who have the relevant skills and experience to be effective AMCPS. A shortage of AMCPs will create significant practical challenges for implementation and complying with timescales.

In summary, there are 3 major areas where the final Code of Practice could be improved:

1. Improvements are required to ensure consistency with current case law,
2. The definition of what constitutes a DoL (Chapter 12)

3. The short timescales for the authorisation process, which will only add to the significant pressure that the sector faces.

Whilst there are a lots of positives to the new draft code including the flipping of the capacity test and the inclusion of 16 and 17 year olds under the LPS scheme, this is a complex area which has become more and more challenging in recent years. There is a risk that any positives could be overshadowed by the confusion caused by the apparent inconsistency which exists between the draft code and its interaction with case law and the relevant statutes such as the Mental Capacity Act.

Top tips for preparing for the go live date

- Look out for the final Code early next year which will set out the finalised principles we are working with.
- Ensure staff have good knowledge of the theory of the MCA and the practical application including its interaction with the Human Rights Act.
- Ensure staff have knowledge of the LPS both in general terms now and in more detail following the publication of the finalised Code.
- Talk to partner agencies (such as local authorities in the case of ICBs) to consider joint working and knowledge sharing in advance of implementation.
- Have clear systems in place in preparation for dealing with referrals, assessments and any other duties that your organisation under the new LPS regime and make sure your staff are trained and ready to use them!

In the meantime, ahead of any final code, please do get in touch for support with preparing for these changes including advice on individual cases, training on the LPS framework, the development of policies, workforce development and guidance on new responsibilities.

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