General
Medical
Council

GMC response to the Consultation on proposed changes to the Mental Capacity Act 2005 Code of Practice and implementation of the Liberty Protection Safeguards – England and Wales

2. Many 16 and 17 year olds who will be subject to an LPS authorisation will have complex special educational needs or complex additional learning needs and will therefore also have an Education, Health and Care (EHC) plan, in England, or Individual Development Plan (IDP), in Wales.

Practitioners and decision makers involved in the LPS will need to understand how the LPS interacts with the special educational, health and care provision set out in the person's EHC plan, or additional learning provision set out in the person's IDP. Further information on EHC plans and IDPs can be found in the SEND Code of Practice or the Additional Learning Needs Code (these documents will not yet include guidance specifically relevant to the LPS).

For children who are looked after or otherwise supported by the local authority through children's services and subject to LPS arrangements in England, the LPS also interacts with the Children Act 1989. The LPS also interacts with other legislation, such as the Social Services and Well-being (Wales) Act 2014. It is important that decision makers understand these interactions.

How clear is the guidance in the Code at explaining the interaction between the LPS and other relevant legislation and planning for 16 and 17 year olds?

• Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear

The guidance in the Code sets out other plans that may be in place or considered for a child with regards to their education and healthcare needs. We feel it is made clear to decision makers the importance of taking into account the age of the person and the length of time that any proposed arrangement which amounts to a deprivation of liberty will last as this will impact planning for 16 and 17 year olds and the appropriate legislative regime chosen.

The GMC is a charity registered in
England and Wales (1089278)
and Scotland (SC037750).

3. Anyone, including the person, can challenge the proposed or authorised arrangements at any stage of the LPS process (including via the Court of Protection and via the Responsible Body). This is an important safeguard in the LPS process.

How clear is the guidance in chapter 24 at explaining how challenges relating to the LPS can be made, including deciding when to make an application to the Court?

• Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear

As long as patients and those close to them have ready access to a process for the review of arrangements that would constitute a deprivation of liberty, it seems to us that a patient's rights will be appropriately centred. We note at Chapter 3 of the Code, the Responsible Body must publish information about the LPS process that is accessible and appropriate to the needs of the person which includes information about the right to challenge the arrangements and authorisation in the Court of Protection.

4. Are the principles of the MCA fully explained in the revised Code? Yes No

If you responded No, please specify the relevant paragraph and what you think it should say.

The Code sets out at paragraph 2.2, three aims of the statutory principles which quite rightly focus on what an individual should be able to do with appropriate support if necessary. We suggest that there should also be an aim to avoid decision-makers acting on biases or assumptions about the decision-making capacity of individuals with particular characteristics.

In the scenario at Principle 1, the example should include other practicable steps the son has taken to assist his mother to understand the decision she needs to make, such as providing her with access to written information or an appointment with an expert to explain more clearly, as currently the sons explanation may not be giving her all the information she needs. It is not clear if the son needs to or has conducted a capacity assessment. We note that, Ms A's son only has an LPA covering financial matters and needs a separate LPA to make medical care decisions. This distinction isn't always appreciated in healthcare settings and should be made clear in this scenario.

7. Do you have any other comments on the proposed updates to the existing Code guidance? Yes No

If you responded Yes, please specify the paragraph which your comments relate to, and your views on this).

We welcome the proposed updates to the MCA Code of Practice. The measures proposed in relation to the LPS promote a more streamlined and person-centred approach which is likely to make a positive impact on service provision and fairness. In particular, we support the emphasis on ensuring that a person is not assumed to lack capacity and is supported to make their own decisions and that where arrangements could amount to a deprivation of liberty the least restrictive intervention is used.

The introduction of the LPS is likely to be a significant change for health and care professionals for example the provisions extend to all settings such as private residences and 16 and 17 year olds and there is no longer the usual need for the Court of Protection to be involved but there will be the need to work with a Responsible Body instead. Ensuring that resources are allocated for, awareness raising campaigns, national training packages, and national guidance, will be vital to successfully embedding these measures in practice. [See our comments on Q 24]

8. How clear is the guidance in chapter 12 at explaining the meaning of a deprivation of liberty for practitioners? • Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear Please explain your answer if you wish.

We understand that for a deprivation of liberty to arise, a person must be confined for more than a negligible period of time. Paragraph 12.10 sets out that if a deprivation of liberty does not arise because the time period is negligible, it is likely that the act is a restriction of liberty.

As explained at paragraph 12.6 restraint, which falls short of confinement will not attract protection against liability unless the individual taking action reasonably believes it is necessary and proportionate. With this in mind, we think that the last sentence of paragraph 12.10 should say ‘as long as the ***restriction*** is necessary and proportionate’ not *‘confinement’* as currently drafted which is confusing.

At paragraph 12.16, all the bullet point examples appear to suggest a situation in a domestic or private setting. While we recognise that these settings are most affected by the LPS and changes in the Code, it would be helpful if there was an example in a hospital setting.

The final sentence of paragraph 12.19 is not clear as we are unsure what is being conveyed and suggest the structure of the sentence is revised.

At paragraph 12.38 for completeness, it would be helpful for a scenario to be provided which does amount to continuous control.

On a general point, some of the scenarios are not in the right place in relation to the text introducing the scenario which makes reading the draft confusing at times but we are sure this will be rectified.

9. The Code sets expectations about how long key LPS processes should take to complete. Specifically, it states that the LPS authorisation should be completed within 21 days and that Responsible Bodies have five days to acknowledge an external referral. Do you think the timeframes set out in the Code are: • Too long • About right • Too short. Please explain your answer if you wish

We don't have the expertise to suggest a timeframe, however, we would like you to note the following. Registered medical professionals are eligible to and could be required to conduct capacity, medical and necessary and proportionate assessment and determination so the Responsible Body can decide if the authorisation conditions are met. We note that the suggested timeframe for completing the LPS authorisation process is within 21 days which suggests that medical professionals could potentially be required to carry out all three assessments within a shorter period in order for documents to be submitted for consideration of pre-authorisation and final authorisation. Given the current staffing issues with medical professionals and lack of resources across many organisations, we are concerned that this may be impractical, cause delays for individuals and place doctors under additional pressure.

Whilst we are not advocating for or against fixed time limits for completion of assessments, we note there is no obligation on any parties involved to adhere to the suggested timescales which means there is already the potential for any timescales to slip. Combined with the concerns above, this could lead to backlogs which could undermine the aims of the new LPS process. We feel it is important that the person subject of the process has their case dealt with as swiftly as possible. It will be essential for there to be sufficient resources and support in place to ensure

any timescales are met. There must be a balance in the need to take action quickly and properly, whilst taking care not to overburden a service already under pressure.

In about 2023/2024, we will be regulating anaesthesia associates and physician associates and wondered if it was your intention that they would be included as 'medical professionals' for the purposes of carrying out the assessments outlined and if so, could this be indicated in the Code?

10. The Code aims to support health and social care workers to integrate the LPS process into other health and care assessments and planning, as far as possible. How clear is the guidance in chapter 13 at explaining the interface between the LPS and other health and care assessments and planning? • Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear. Please explain your answer if you wish.

We understand that when engaging with a person, the professional has a responsibility to consider at the earliest opportunity, if any proposed plans for future care would amount to a deprivation of liberty so that they can decide ahead of time whether to trigger the LPS process and get authorisation. We feel it is important that where existing advance care planning processes are working well, the new LPS process should dovetail with, and not make these processes more burdensome. For example, where a capacity assessment is required for a person's care review and for continuation of a LPS, the same person may carry out the assessment for both purposes.

11. Is the guidance in chapter 13 on the authorisation, reviews and renewals processes clear?

• Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear Please explain your answer if you wish.

We understand that prior to an authorisation being given, a draft authorisation record should be completed which can be drafted by anyone who the Responsible Body identifies as best placed to do so, with the Responsible Body ultimately agreeing or not the draft. We would like to understand how a Responsible Body will identify who is best placed to draft the authorisation record and where the record will be kept. We also wonder if there is the potential for individuals to push back so they are not given responsibility to complete the draft authorisation record which could cause delay. The development of national guidance provides an opportunity to

clarify this and mitigate the possibility of action being passed between professionals. There could also be implications for medical professionals when it comes to the standards that we set for record keeping. We say in Good Medical Practice that clinical records must include the decision made and actions agreed, and who is making the decisions and agreeing the actions. It must be clear how it will be decided who the responsibility lies with for drafting the authorisation record and ultimately updating the clinical records.

When the LPS is authorised, the Responsible Body will agree to a schedule of reviews and will be responsible for deciding who is best placed to carry out the review e.g. an 'individual' who is sufficiently independent. Given that a medical professional is likely to have had involvement in carrying out at least one of the required assessments, we could conclude that a medical professional is unlikely to be considered as sufficiently independent. Paragraphs 13.44 and 13.45 explain what is required of an' individual' but it is still unclear who such an individual would be and how the Responsible Body will decide the allocation.

13. The Code sets out that previous and equivalent assessments can be used in the LPS process if it is reasonable to do so. This will help streamline the process and reduce the potential 'assessment burden' on the person when suitable assessments already exist.

- **Previous assessments are assessments carried out for an earlier LPS authorisation.**
- **Equivalent assessments are assessments carried out for any other purpose (for example, for a care plan).**

In cases where the person already has a previous or equivalent capacity or medical assessment, these may be used for the purposes of the LPS if it is reasonable to rely on it. However, a previous or equivalent assessment cannot be used for a necessary and proportionate assessment and determination.

How clear is the guidance in chapter 16 at explaining the use of previous and equivalent assessments for the purposes of the LPS? • Very clear • Somewhat clear • Neither clear nor unclear • Somewhat unclear • Very unclear Please explain your answer if you wish.

Our understanding of the rationale behind the use of previous and equivalent assessments for the purposes of the LPS is that where an assessment needs to be made of capacity or mental disorder the position is not necessarily going to change in between assessments and so there is no need to duplicate work already done to arrive at the same conclusions. What does need a new look is a decision about whether the arrangements in place that deprive a person of their liberty

continue to be ‘necessary and proportionate’. So, the intention is that individuals involved in a person’s care should continuously consider whether there is a less restrictive intervention.

For the first authorisation of arrangements amounting to a deprivation of liberty, paragraph 16.60 states a new ‘necessary and proportionate’ assessment and determination must be completed. Where an authorisation is to be renewed the previous assessment may be relied on. It is clear an ‘equivalent’ necessary and proportionate assessment and determination cannot be used to make a decision about a first authorisation of arrangements. Our understanding of the rationale behind this is that the evidence requirements in ‘equivalent’ assessments may not meet the same standards. Paragraph 16.60 states that ‘*at the point of renewal, if the Responsible Body is satisfied that this condition continues to be satisfied, it may be appropriate to use a previous necessary and proportionate assessment and determination’*. So for example the assessment used at first authorisation could be used for any subsequent authorisations. However, the consultation question suggests that a previous assessment cannot be used for a necessary and proportionate assessment and determination which is at odds with our understanding of the Code.

We support the proposals in that they appear to reduce the burden of assessment on both clinicians and patients, without reducing necessary safeguards. We think the factors set out in the Code are helpful, to assist the decision maker to determine whether it is reasonable to use a previous or equivalent assessment.

15. If the required conditions are met, as explained in chapter 19 of the Code, then the decision maker has the legal basis to take steps which deprive a person of their liberty in exceptional circumstances to provide life-sustaining treatment or a vital act. Section 4B is not a 'continuous' power, and only applies to those specific steps.

The Code sets out that the decision maker should inform the Responsible Body when section 4B is relied upon for the first time. It also provides guidance on when it may be appropriate for the decision maker to inform the Responsible Body about subsequent instances of the power being relied upon. For example, if the decision maker relies on the power a significant number of times within a short period.

Do you agree with the position set out in the Code, or do you think Responsible Bodies should be notified every time section 4B is relied upon?

• I agree that beyond the initial application of section 4B, decision makers should not have to notify the Responsible Body each time section 4B is been relied upon.

• I disagree with the Code.

Please explain your answer if you wish

We understand the rationale behind informing the Responsible Body of the first use of a s4B is to notify that a person's liberty has been deprived prior to an authorisation. We find it difficult to understand why second or subsequent uses of the s4B power for the same individual should not be reported to the Responsible Body given that the power is meant to be used in exceptional circumstances.

Notification on each occasion will alert the Responsible Body to the fact that a person is being deprived of their liberty and in order to make sure that the care of that patient is properly scrutinised without delay, it would seem to us counterproductive if subsequent emergency use isn't reported. Reporting will ensure they have all relevant information to decide whether to shorten the process for making a timely authorisation decision and may also be relevant to the arrangements under consideration.

We acknowledge the provision for decision makers to inform the Responsible Body of the significant use within a short period of time or where the act of restraint was significant, of s4B, but this is concerning for a number of reasons:

- It rests entirely with the decision maker to judge whether to do this after the initial application of s4B

- What amounts to significant use within a short period of time or significant restraint is subjective. Without definitions and guidance in place, this is likely to lead to the Responsible Body being inconsistently informed about the use of s.4B.
- Oversight is key given the risk that s.4B could undermine the LPS authorisation process and the monitoring function of a Responsible Body, if it is frequently used to deprive a person of their liberty without the appropriate authorisation having been given.

18. The Code and the LPS regulations outline which professionals can carry out each of the three assessments and determinations under the LPS. It also outlines the requirements these professionals have to meet. The professionals who can complete a capacity or necessary and proportionate assessment and determination are:

• a medical practitioner • a nurse • an occupational therapist • a social worker • a psychologist • a speech and language therapist

Medical assessments and determinations may only be carried out by a registered medical practitioner (including GPs and psychiatrists) or a registered psychologist who meets the conditions of these regulations.

Do the assessments, determinations, and pre-authorisation reviews regulations enable the right professionals to carry out assessments and determinations?

Yes No

Please explain your answer if you wish.

As we regulate doctors, our response is limited to 'medical practitioners' who are authorised to undertake all three assessments and make a determination. Assessing capacity is a core clinical skill for registered doctors which doesn't necessarily require specialist input (e.g. by a psychiatrist). A doctor should be able to draw reasonable conclusions about a person's capacity during a dialogue with them. We say in our Decision, making and consent guidance that a doctor should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision (paragraph 82). We advise that where it is believed that a patient may lack capacity to make a decision, capacity must be assessed using the test set out in the relevant legislation, taking account of the advice in the relevant guidance. If a doctor finds it difficult to judge whether a patient has capacity to make a decision, they should seek support from someone who knows the patient well, for example, another member of the healthcare

team or someone close to the patient (paragraph 84). In complex cases where a doctor believes they're unable to make a judgement, they should seek specialist input from psychiatrists, neurologists, speech and language therapists or liaison nurses (paragraph 85).

We support the reference in the regulations to medical professionals rather than being prescriptive and specifying qualifications and experience. As outlined above, much is likely to depend on the decision that needs to be made and the ability to choose an appropriate medical professional to match individual circumstances which we hope will reduce delays in providing care. We note that the professionals listed in the regulations are those we suggest in our guidance a doctor may wish to refer to.

As referred to at question 9, we will be regulating anaesthesia associates and physician associates from about 2023/2024 and the overarching legal term for them and doctors will become 'medical professional'. You may wish to consider making provision now for new roles to be added and new terminology to be introduced.

20. The Code will be an important resource that will used by many different groups of people to understand the LPS process. For example:

• It will be especially important that chapter 3 (How should people be helped to make their own decisions?), chapter 15 (What is the role of the Appropriate Person?), and chapter 17 (What is the LPS consultation?) of the Code are understood by the person and their family and friends to ensure they remain at the centre of the decision-making process.

• Chapter 3 (How should people be helped to make their own decisions?), chapter 10 (What is the Independent Medical Capacity Advocate service?), chapter 13 (What is the overall LPS process?), chapter 16 (What are the assessments and determinations for the LPS?), chapter 17 (What is the LPS consultation?), and chapter 18 (What is the role of the Approved Mental Capacity Professional?) will be of particular importance to practitioners and people involved in the person's care.

• 16 and 17 year olds, and their parents and carers, will need to understand the guidance in chapter 13 (What is the overall LPS process?) and chapter 21 (How does the Act apply to children and young people?).

• Responsible bodies, including local authorities, NHS trusts and clinical commissioning groups, will need to understand the principles of the MCA outlined in chapter 2 (What are the statutory principles and how should they be applied?), as the principles of the MCA are integrated throughout the LPS. They will also need to, in particular, understand the guidance in chapter 7 (What is the role of the Court of Protection?), chapter 10 (What is the Independent Medical Capacity Advocate service?), chapter 13 (What is the overall LPS process?), chapter 14 (What is the role of the Responsible Body?), chapter 16 (What are the assessments and determinations for the LPS?), and chapter 24 (What are the best ways to settle disagreements and disputes about issues covered in the Act?).

From your perspective, how clear is the LPS guidance in the Code and is there anything that you feel is missing? Please reference specific groups of people and chapters in your response.

Our overall impression of the LPS guidance in the Code is that it is clear and comprehensive and aligns with Good Medical Practice and our explanatory guidance Decision making and consent. We believe the updated Code will be a practical and useful document for doctors, other professionals, persons and their supporters to refer to when making arrangements for the care and treatment of a person that will amount to a deprivation of liberty.

We note that in the information provided for the Welsh consultation, there is a helpful flowchart titled 'My LPS journey' which we suggest should be replicated for England. Professionals working

in services where they are time poor will need and will benefit from easy to digest guidance or other resources to navigate the Code.

There is still a lack of understanding about what to do when a patient whose capacity is affected by a learning disability refuses treatment and we feel that there could be a case study included to highlight this. When a doctor attempts to treat a patient and further assessment is indicated before providing treatment, the doctor must not allow the patients learning disability to overshadow any other potential diagnosis. They must not avoid carrying out an investigation they would usually do because the learning disability may make a physical examination more complicated. They should also consider whether difficult and non-cooperative behaviour is a sign of distress and how they can help manage it.

A doctor should establish with the patient if they have the capacity to consent to a physical examination so a decision can be made about appropriate treatment by explaining why an examination needs to be carried out. This may include communicating with the assistance of a third party such as a relative or carer. Where it is concluded that a person does not have capacity for example, the person understands an examination needs to be carried out but not why, a decision should be made about what is in the best interests of the patient, taking into account any views about the patients preferences. If a doctor concludes that an examination would cause avoidable distress, then other options should be explored.

It's particularly important that healthcare staff do not interpret, without further reflection, a patient's non-co-operation as a valid refusal of treatment: if the patient does not have the capacity to consent, the patient then also does not have the capacity to refuse. In those circumstances, which are unusual, a decision must be made based on the patient's best interests or overall benefit. We would refer you to the case study on our website covering this point which we hope you will find helpful.

24. The Training Framework describes the core skills and knowledge relevant to the LPS workforce and presents learning outcomes for each workforce competency group across five subject areas.

Does the Training Framework cover the right learning outcomes? Yes No Please explain your answer if you wish.

Promoting excellence sets our standards for providers of medical education and training. It states that education organisations must have systems to check that education and training comply with all relevant legislation and we expect that NHSE/HEE will engage them. We regularly check

through our quality assurance processes that standards are met but it is the responsibility of undergraduate and postgraduate training organisations to deliver an education incorporating up to date legislation around the Mental Capacity Act.

For the majority of doctors not currently in training, responsibility lies with them and their employers to ensure they remain current with health legislation as part of CPD.

Our Generic Professional Capabilities Framework sets out the essential capabilities which underpin professional medical practice and are fundamental to all postgraduate training programmes. The framework, alongside *Excellence by design* details the standards all postgraduate curricula in the UK must meet. On page 17, under Domain 3: Professional Knowledge, we say, "*Doctors in training must be aware of their legal responsibilities and be able to apply in practice any legislative requirements relevant to their jurisdiction of practice, for example: - mental capacity and deprivation of liberty safeguards".*

The Generic Professional Capabilities have now been embedded in most, but not all, postgraduate speciality curricula, with others in the process of being updated. It will take some time for the impact of our requirements in *Outcomes for graduates* and Generic Professional Capabilities to become evident but they still remain valid and doctors must know whatever legislation is current.

In Outcomes for Graduates paragraph 7g , we say, "Newly qualified doctors must be able to recognise and identify factors that suggest patient vulnerability and take action in response to..explain the application of health legislation that may result in the deprivation of liberty to protect the safety of individuals and society".