HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Oral evidence: The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards, HC 890

Wednesday 28 March 2018

Written evidence from witnesses:

- **Betsey Lau-Robinson**, Head of Safeguarding Adults, the Mental Capacity Act & Prevent, University College London Hospital
- **Stephen Chandler**, Director, Adult Social Services, Somerset Council

Watch the meeting

Members present: Ms Harriet Harman (Chair); Fiona Bruce; Ms Karen Buck; Alex Burghart; Baroness Hamwee; Baroness Lawrence of Clarendon; Jeremy Lefroy; Baroness O'Cathain; Baroness Prosser; Lord Trimble; Lord Woolf.

Questions 9–17

Nicholas Paines QC, Commissioner, Law Commission; **Tim Spencer-Lane**, Lawyer, Law Commission; **Betsey Lau-Robinson**, Head of Safeguarding Adults, the Mental Capacity Act & Prevent, University College London Hospital; and **Stephen Chandler**, Director, Adult Social Services, Somerset Council gave evidence.

Q9 **Chair:** Thank you very much for joining us and agreeing to give evidence from your position of considerable expertise both in the actual field and from the Law Commission perspective. We are really grateful that you have come. Anything to do with deprivation of liberty is very high on our agenda, this being the Joint Committee on Human Rights. Anything that deals with vulnerable people and their rights is very high on our agenda. As you know, we are a Joint Committee, which means we are half Lords and half Commons. We start with questions from Margaret on the Lords side.

Baroness Prosser: The first question we have for you is aimed at both Stephen and Betsey as persons from outside the field of law. I

think all of us would agree that people who lack mental capacity should not be deprived of their liberty without proper safeguards. Do you think we are currently achieving that? If you think we are not, can you tell us why?

Betsey Lau-Robinson: I represent University College London at Euston Road. From the acute perspective, by and large we are safeguarding people with the capacity and resources that we have, but my honest answer is that we could improve. We have systems and processes in place, but it is recognised that right across England and Wales awareness of the Mental Capacity Act is still quite low. I believe that fundamental to deprivation of liberty is a strong and deep understanding of how to apply the Mental Capacity Act. Those are the fundamentals. There is a lack of understanding and awareness across the board, and a lot of work still needs to be done.

Baroness Prosser: Do you think there is any room in the work that you do to help deepen and widen that understanding?

Betsey Lau-Robinson: We do mandatory training. We offer three levels of training for all staff, from front-line non-clinical staff right up to clinical staff, who deliver care to patients and are involved in decision-making. The types of instances where we apply deprivation of liberty are when patients who come in need serious medical treatment, and lack capacity either temporarily or permanently. We have to apply the safeguards and deprive them of their liberty in order for us to deliver treatment and for discharge planning. If an older person who has self-neglected and has a cognitive impairment comes in and they are not safe to go home, a decision will be made as to whether they will be deprived of their liberty when they go to a care home, for example. Those are the kinds of decisions that we make every day for our patients.

Baroness Prosser: If I understood your first comments correctly, you are saying that there is room for improvement among the people who have to make those decisions at different levels.

Betsey Lau-Robinson: Absolutely. There are different layers. Most of the senior people involved in care get it right, by and large, but there is still a big population who do not quite understand how to apply the principles. That is why it is crucial that senior people are there to advise. I am heartened that most organisations have knowledgeable people in place as advisers, but there can always be more of us.

Stephen Chandler: As most people know, I am the director of social services in Somerset, but I am also happy to talk on behalf of the Association of Directors of Adult Social Services.

We absolutely support the context of enabling people to have as much choice and control as possible over their care and support arrangements. Your question is whether we are keeping everybody safe. Clearly, in the context of the Mental Capacity Act we are not able to meet the demand within the timescales that have been set out. You could then ask whether

those for whom we are not able to meet it are at risk. It is not a simple case of taking that step, because the people we are talking about are in care establishments—care homes, nursing homes or hospitals—so they will be under the care of professionals.

We have some of the most passionate advocates working for and supporting the individuals referred to us for consideration under the current scheme. Our struggle is often to keep them motivated when they see a backlog of individuals who still need to have their cases considered.

Q10 **Baroness Prosser:** As you know, there is a statutory code of practice under which applications are expected to be processed within 21 days, but currently 70% of those applications do not meet that standard. That is pretty serious. One in 10 took more than a year to complete. Can you tell us why you think that is? Does it mean that the current system is seriously not working?

Stephen Chandler: Most people accept that the current system is not working, hence the Law Commission's review and this Committee's interest. Prior to the Cheshire West decision, we were meeting the majority of referrals, but the exponential increase in referrals following the Cheshire West case has meant that local authorities are not able to meet the increased demand. The data is there. We are not talking about a relatively small increase; they are ten and twentyfold increases. There is an increase both in the number of referrals we get and in the time it takes to do the multiple assessments to ensure that the decisions we take ultimately are the right ones. It is important that we do that work proportionately and safely.

People say to me, as I think you have said, that the law says that we must do that. Directors of social services do not have disregard for the law, but we are constantly balancing competing demands. We have invested significant additional resources in teams of staff who carry out that activity on our behalf, but it is a difficult balance. We have tried to help staff and systems by providing guidance on thresholds, and how to decide who is the most important, but Mental Capacity Act leads up and down the country are taking really difficult decisions each and every day. To be clear, we would not be here if the current scheme was working well.

Chair: If the time limits are there to make sure that if there is a wrong deprivation of liberty it is addressed expeditiously, because obviously deprivation of liberty is serious, how can it not be a problem if it is going so far over time? Surely that must be a major issue.

The other thing I want to ask about is the appeals rate. Although there are no statistics on rates of appeal under the scheme, apparently the best estimate puts the rate of appeal at less than 1% of people subject to a deprivation of liberty authorisation. That is just making the appeal, let alone having any appeal granted.

Does that not show that there is no challenge in the system and it is just chugging along?

Stephen Chandler: I refer back to something Betsey said about awareness. When the Cheshire West clarification on the law was made, and a significant increase in referrals came through, it was because the health and care system recognised that the law now said that a number of groups of individuals needed to be considered in the context of the Mental Capacity Act. That included lots of people who were in long-term stable care arrangements and for whom the process of going through the Mental Capacity Act would make little or no difference to the way their care and support was arranged day to day.

In practice, what happens now is that the local authority receives an application from a care provider on the basis of either a change in somebody's needs, or sometimes following a CQC inspection, when the inspector says, "Have you made the local authority aware that the following restrictions are in place?" The Mental Capacity Act lead will then look at the detail and make a decision, on the balance of the information, as to whether that referral gets priority over the list of referrals already in the system.

For some people, that care and support arrangement has been stable and in place for many, many years, and they inevitably fall down the priority list. Should something change in a person's care arrangements—their health may change, their needs may change or the environment they are in may change—clearly the Mental Capacity Act lead will review it again.

Just because somebody gets prioritised down the list does not mean that nothing happens with them. Mental Capacity Act leads review the lists on a week-by-week basis to see if anything has changed, but it is a really difficult balancing act that Mental Capacity Act leads do on our behalf and local authorities do every day.

Chair: People who have been prioritised down the list, which is a prioritisation you do not necessarily want to be subject to, are basically being detained outside the law.

Stephen Chandler: Yes.

Chair: What do you think about the appeal system, and the fact that the number of appeals is just 1%? Does that not show that it is completely defunct?

Stephen Chandler: I do not think anyone involved in the system would say that it is working. People are genuinely saying that we need something to replace it and we need it now.

Q11 **Ms Karen Buck:** How do you think the Law Commission's recommendations will help to address the problem, and, picking up on the evidence you have just heard, how will those particular issues be addressed?

Nicholas Paines: I am very happy to talk about our recommendations. I do not know where you would like me to start.

Ms Karen Buck: Could you start by responding to the evidence you have just heard, the analysis of the problems being experienced and how you think the recommendations may help to address them?

Nicholas Paines: What Betsey and Stephen said accords entirely with the evidence we heard from consultees and stakeholders during the consultation phase and throughout the life of the project. The current system had already been criticised by a House of Lords Select Committee as not fit for purpose. Almost at the same moment as that report was released, the Cheshire West decision was handed down, and an already unfit-for-purpose system was suddenly loaded with a manifold increase in cases requiring to be processed under it.

We looked at the old deprivation of liberty safeguards. I call them old; they have been around since 2007 or 2008. We looked at those, talked to people in the sector about what they found to be the deficiencies, studied what the House of Lords Select Committee had said about the deficiencies and set about consulting on what would be a better scheme, offering greater protection and, at the same time, being less inefficient and easier to operate. We like to think we have achieved that.

Shall I tell you a bit about the specific objectives we set ourselves?

Ms Karen Buck: Yes, please.

Nicholas Paines: A fundamental objective was a scheme that complied with Articles 5 and 8 of the human rights convention. We also wanted to make the new scheme fit better with the ethos and values of the Mental Capacity Act. Indeed, our terms of reference from the Department of Health specifically asked us to do that. We would have done it anyway.

We wanted to see better compliance with the existing provisions of the Mental Capacity Act about decision-making on behalf of people who have impaired capacity; in particular, we wanted more effective protection for the group of people in whose cases deprivation of liberty was being considered. As I mentioned, we wanted a scheme that was more efficient, more proportionate to the needs of the cases that arise, less cumbersome to operate and cheaper for the taxpayer at the end of the day.

Ms Karen Buck: It would be very helpful if you could just explain a little more about how that proportionality will work in practice, particularly given what we have just heard about the experience of local authorities trying to deal with the volume of cases.

Nicholas Paines: Stephen referred to the time taken to do the assessments required by the existing deprivation of liberty safeguards. Six assessments are required at the moment. A deprivation of liberty safeguard order can apply only to a single place of residence of a person. It is a simple yes/no answer to the question of whether the person should or may be deprived of their liberty.

We took a radically different approach. Starting with the human rights convention, a decision to move somebody from their home to a care home or some other setting engages Article 8: the right to respect for their private and family life. That is irrespective of whether they are going to be deprived of their liberty in the new setting. Article 8 is always present. If deprivation of liberty is being contemplated, Article 5 is engaged as well. Article 5 was our main focus, but not our exclusive focus. We wanted a system that better protected people's private life rights in decisions to move them from home to somewhere else taken in a lawful and proportionate manner.

The existing Mental Capacity Act dates from 2005. The deprivation of liberty safeguards were bolted on to it three years later. The original 2005 Act was designed very much to achieve Article 8 compliance where decisions are made on behalf of people who may not have the capacity to make them for themselves. It is fair to say that it was a Law Commission product, for which I can take no credit because it was many years before I turned up there. It was ground-breaking.

It started by setting out five principles. I will mention some of them: the presumption that a person has capacity; the requirement that you do not treat a person as not having capacity unless you help them make their own decision and have not succeeded; when you have to take a decision for somebody else you must have regard to their best interests; and you must take a decision that achieves what you are trying to achieve in the manner that is least restrictive of the person's rights and freedoms. We all think they are very important principles.

When you have to take a so-called substituted decision, one taken on behalf of somebody else in their best interests, the Act tells you that you must encourage the person to participate, and you must consider their wishes, feelings, beliefs and values. Those principles apply to any decision where a person may lack capacity, or lacks capacity, and that is even before you get to the question: should we deprive them of their liberty, and is that justifiable? It seemed to us that those principles could be better applied than they have been.

> **Ms Karen Buck:** There will be quite a lot of additional questions to probe that further, but it is a very helpful beginning. Tim, do you want to add anything on the question of summarising how the Law Commission's proposals will deal with the problems we have heard about?

Tim Spencer-Lane: I will add two things to what Nicholas said. One is that we tried to focus existing resources on cases where we felt they could add most benefit. Essentially, we felt that those were cases where people were objecting to care and treatment arrangements that would lead to a deprivation of liberty. We felt that a better use of existing assessment resources would be to have extra safeguards in those cases.

Other cases, where there is no doubt that the arrangements are in the person's best interests, and there is no question that the person does not

agree with them, or is not happy with them, can be signed off much more straightforwardly.

The other big change is that you would no longer have to go to the court to get an authorisation. All cases that fall outside the deprivation of liberty safeguards at the moment have to go to court, which is a complete waste of money.

Chair: Would you remind everybody which cases fall outside the deprivation of liberty scheme?

Tim Spencer-Lane: The deprivation of liberty scheme applies only to hospitals and care homes; it has nothing at all to say about deprivation of liberty in supported living arrangements, shared lives arrangements, domestic settings and family settings. In all those settings, deprivations of liberty occur. If a local authority or a CCG comes across such a case, the expectation is that they should take it directly to the court for an authorisation, if that is in the person's best interests.

When we went to consultation, we found that that rarely happens in practice. Local authorities are struggling to deal with existing deprivation of liberty cases, so those cases are put at the bottom of the priority list. Under our scheme, you could authorise those arrangements in a much more straightforward way, without wasting resources and having to go to court.

Ms Karen Buck: That is very helpful.

Stephen Chandler: Back in 2013, when the Cheshire West decision was made, approximately 20,000 referrals were made to local authorities. In the last recorded year, 2016-17, that had increased to 217,000, so the scale of increase is phenomenal. Even in the year 2016-17, there was still an 11% increase on the previous year.

To go back to one of your questions to me about local authorities' effectiveness in dealing with those cases, we increased our ability to process them by 45% between 2015-16 and 2016-17. We worked closely with the Law Commission on its proposal. It has been a really good example of working together to try to find a solution that works for everyone.

Chair: The business of going from 20,000 to 217,000 referrals still leaves out all the people Tim described who are in a bit of a no man's land at the moment.

Tim Spencer-Lane: Even those huge figures are just the tip of the iceberg, because they do not take into account people who are deprived of liberty outside hospitals and care homes. We do not know what is happening with those cases, which is very concerning.

Chair: Currently, they are, de facto, outside legal protection.

Tim Spencer-Lane: Very possibly. There are streamlined court processes to try to deal with them, but the evidence suggests that they apply to only a tiny number of cases.

Chair: Your proposals would deal with more people than are currently being dealt with, because you include all those who are in

the categories you mentioned, such as supported housing and family care, but there would be a two-tier system. Are you sure that even a two-tier system will be able to deal with the situation without costing a fortune just in the authorisation process for all the people who are not yet even properly visible to the system?

Tim Spencer-Lane: It is hard. We tried to cost it and look at numbers, but the figures are not there. We did some research with ADASS to try to look at the cases that we felt should be prioritised, which are cases where the person clearly objects. That research indicated generally that at the moment probably just over 25% of cases involve an objection to the care and treatment arrangements. Extrapolating that across the sector takes us back pre-Cheshire West to somewhere near the numbers that local authorities would be expected to deal with through the additional safeguards. If that is right, and it is a big if, we think it is just about manageable.

Q12 **Baroness Lawrence of Clarendon:** Stephen and Betsey, do you think the Law Commission's proposals for liberty protection safeguards strike the right balance between protecting human rights and providing a scheme that can be implemented without excessive bureaucracy and cost?

Betsey Lau-Robinson: I sit in many forums across London and with NHS England. Most of our colleagues agree that they strike the right balance. There are obviously some who disagree. The liberty protection safeguard would, from the acute perspective, improve administration. One of the challenges, especially since the Cheshire West case and increased scrutiny through the acid test, was that the bureaucratic process resulted in long delays in applications being granted.

From our trust's perspective, for example, in 2016 we had a 90-day delay in applications being granted, but the trust put systems in place and employed extra admin staff to monitor and track local authorities, because we are a tertiary referral base, and we reduced it to five this year. That is pretty incredible. We think that the liberty protection safeguards will definitely help the process, because they give acute hospitals their own system to manage the new two-tier arrangement.

Chair: I hate talking about bureaucracy, because it is people doing work under systems laid down by Parliament, and they are trying to do it in the public interest. Do I gather from what you said that you have had to increase your bureaucracy to deal with the hold-ups in the authorisation bureaucracy and, therefore, you find your way through it by bulking out your bureaucracy?

Betsey Lau-Robinson: That is one perspective. We realised that there was a delay in putting through patients' applications and that was a breach of their human rights. We had sent the application through but they had not been assessed.

Chair: You had to employ people to chase it up.

Betsey Lau-Robinson: In order for us to mitigate risk, we employed extra admin staff to chase up the paperwork and when the assessors would be coming in. It is very bureaucratic. Junior doctors and multidisciplinary staff have to complete the forms and send them off, and it takes 14 days for assessors to come in.

By and large, they never meet the 14 days. Because of capacity issues, best-interest assessors and Section 12 doctors generally do not meet that deadline. They are given only a very small window to assess the patient. We constantly have to play catch-up. In order for us to mitigate risk, we have employed extra people. We have done it successfully, but at our cost.

Baroness Lawrence of Clarendon: Stephen, what are your views?

Stephen Chandler: We were very much involved in the consultation on developing the proposals, so we are supportive of the balance. That said, we are cautious.

Tim made some points about the assessment of the numbers of people who are likely to be caught within the new scheme. We think that needs to be revisited. We have serious concerns that some of the numbers are an underrepresentation. Even though we think that the proportionality is right, there is a risk of the numbers being underreported, so when we start to implement the new scheme, the costs and resources—the people needed to support it—may be more than envisaged.

We have submitted a paper highlighting where we think those issues are, and some proposed alternatives. It may be helpful for the Committee to have sight of that paper, and we would be more than happy to supply it.

Chair: Do you want to summarise it? From what you are saying, the Law Commission's scheme sounds fine in theory; it is two-tier, so you focus on where there is more likelihood to be an objection to the deprivation of liberty, but bearing in mind that you do not know whether it is the tip of the iceberg and how big the iceberg is, we could pitch into an even bigger problem. Can you summarise how you as directors of social services would solve the problem?

Stephen Chandler: I am being understandably cautious, because I do not want to appear to say that every solution for a director of adult social services is money, because clearly it is not. The challenge that we face in this element of the law is that there has been very little capacity to be flexible. We have tried to help decision-makers by providing forms so that there is consistency in decision-making up and down the country. I gave an example earlier of our practitioners having to triage referrals.

Coming to the heart of your question as I hear it, a number of those people may be self-funders whose families have arranged care, and local authorities may have had nothing to do with them. Then they come on to our radar. Maybe they go to see their GP and the GP picks up something, or they may go into hospital and the hospital picks up something. We

think there are far more of those arrangements than we have been able to identify, which will result naturally in an increase in numbers.
We also referred to awareness in the care sector of capacity, and what it means in relation to supporting people who may not have capacity. Betsey started that point and I continued it. One would have expected that with the Cheshire West decision there would be an immediate increase in referrals. One would not have expected that increase to continue four years afterwards. That reflects the fact that there is still a need for awareness-raising about the system and confidence around what should be a referral. We think that had not been fully anticipated or considered. Those are just two practical examples.

Chair: What would be your solution, so that we do not plunge ever deeper?

Stephen Chandler: We think there should be an increase in the number of areas of activity and in the associated costs of meeting that activity.

Chair: Spend more on administration. Cover the same number of people but shorten the queue by having more people doing it.

Stephen Chandler: We think that more people will be caught than the impact assessment identified, so there will be more activity associated with meeting the needs of more people.

Chair: But do you think more should be caught? There are a number of ways of dealing with it. You can deal with the existing gap by shrinking the number of people and having the same system, so that there are fewer people but the system can operate; or you carry on with the number of people growing, added to by all the people who are at home, as awareness rises, and you put in more resources. Which do you think it should be?

Stephen Chandler: In fairness, I think we agree that it has to be both. Fundamentally, people's rights need to be protected, and there is not a practitioner or director in this country who does not have that at the heart of what they are trying to do. Equally, balancing resources is a critical issue for us. We think the Law Commission's work is fantastic. Trying to ensure that the activity associated with supporting capacity is managed for more people with the same resource is good, but we are still worried that a level of demand will emerge that will not be met by the available resources. One of our concerns was that the work of the Law Commission was predicated on delivering a solution within the same available financial envelope.

Chair: It is difficult because it is a known unknown, but do you have any sense of what the resource implications would be if the Law Commission scheme was implemented? What would it mean for an increase in your resources?

Stephen Chandler: I do not have the detail in front of me.

Chair: Roughly.

Stephen Chandler: I would rather not give a figure that I would have to correct. What I can say is that ADASS has pulled together a paper looking

at what it believes are the resource implications of implementation. I am more than happy to supply that to the Committee.

Baroness Lawrence of Clarendon: We are talking about people. How many of them are falling through the net while you are trying to make sure that you cover what you need to do and what the Law Commission says?

Tim Spencer-Lane: The most recent statistic in relation to DoLS is that every year about 220,000 referrals are made to a local authority. The local authority gets round to assessing just over half of those cases, so nearly half of the cases are closed, presumably because the people do not need to be deprived of their liberty any more, or they have moved, or maybe they have passed away; or the cases are added to the ever-increasing backlog. A significant number of cases go unassessed each year.

We also have to take into account the knock-on effects of other elements of the deprivation of liberty safeguards, such as the annual review of the need for an authorisation and the provision of advocacy. There are increasing backlogs for those provisions as well. There is a shortfall in all areas of deprivation of liberty safeguards.

Q13 **Alex Burghart:** How would we know whether a reformed system was working well? What do you think the indicators of success would or should be?

Nicholas Paines: First, statistics showing that the applications were being dealt with in reasonable time and, secondly, an acceptable rate of successful appeals. One could look at cost measures, to see what the system was costing. Our system is designed, certainly in the standard cases as opposed to the more sensitive ones Tim has spoken about, to add what is required to ensure compliance with Article 5 but with no unnecessary costs.

If a person is to be moved into a care home and deprived of their liberty, the Care Act requires a care plan. The provisions of the Mental Capacity Act that I talked about earlier require certain processes in the decision-making. We have grafted on to that purely what we thought was necessary to ensure Article 5 compliance.

One of those things is a medical assessment that the person is, in the slightly old-fashioned language of the convention, of unsound mind warranting deprivation of their liberty for their own protection. Other things are an assessment of capacity to ensure that a decision is not being taken on their behalf when they could take their own decision, and an assessment that it is necessary and proportionate to deprive them of their liberty. That is something Article 5 requires.

In many cases, the answers to those questions are obvious. Article 5 requires, in order to protect the person, that their unsoundness of mind be certified by somebody medically qualified, and it requires necessity

and proportionality to be thought about. Our scheme requires that those things be done, but it is designed to add only what is necessary to the costs that would be incurred anyway in complying with Care Act requirements and basic Mental Capacity Act requirements.

Tim Spencer-Lane: The other crucial thing is buy-in from the health and social care sector. At the moment, DoLS are too often seen as a rubber-stamping exercise and a burden for the sector, so the key outcome of the new scheme has to be that health and social care professionals, the care home sector and the care provider sector see some tangible benefit from using safeguards.

Alex Burghart: And that individuals themselves see a tangible benefit.

Tim Spencer-Lane: Absolutely, and family members as well.

Q14 **Alex Burghart:** Contingent on that, what measures might there be to show us that the system is serving the individual with mental health problems above and beyond everything else?

Stephen Chandler: As well as the numerical examples, there are qualitative measures. There was a reference to the Care Act and the requirement to have a care plan. I would like to see within that care plan evidence on the question of how a person's independence is being supported within the limitations of their capacity. I would like to see much more detail on that.

One of the fantastic benefits of the increase in the number of cases being considered is that practitioners have become very good at evidencing how individuals' preferences, wants and wishes can be met within very restricted environments. It has forced practitioners, more than ever, to evidence why they are proposing a package of care, whether that be the care provider, the social worker or the best-interest assessor. That qualitative data will be vital. You will get that from a number of sources, hopefully from the person, although clearly there is a limitation to that, and from their family and their independent advocate. I would be looking to gather feedback from all those individuals on how, despite limitations of capacity, the person's choice and control can be maximised whatever support arrangement they are in.

Q15 **Lord Trimble:** We are dealing with the Mental Capacity Act and deprivation of liberty, but a rather curious aspect is that there is no definition in the legislation. Is that in any way connected with the result in the Cheshire West case? That led to a tenfold increase in applications, so it looks as though the court in Cheshire West hugely increased the definition, but there was no definition. Would it help if there was a definition in legislation?

Nicholas Paines: We thought about that, and we know that it is a matter the Committee is considering. When we conducted the project, some

consultees urged us to come up with a definition, and the subtext was that they wanted one that caught fewer cases than Cheshire West. We thought about it and decided that it was not practical, frankly. Whether or not one agrees with Cheshire West is a matter I would like to park; it is not something on which I want to make observations.
The fact is that Cheshire West was a decision by our Supreme Court on the scope of Article 5 of the convention. One cannot, as it were, write it out of the history books. It would remain there even if Parliament enacted a different definition. There would be huge problems, which I can go into, if there was a British statute that deprivation of liberty means only this and a Supreme Court decision interpreting Article 5 as deprivation of liberty meaning that.
For reasons of workability, we did not recommend trying to adopt a domestic definition of deprivation of liberty. The Supreme Court has given a definition—the acid test, as it has become known—which is capable of being applied, and we think it is being applied and increasingly understood. The number of cases it brings within the pool is a separate issue.

Q16 **Baroness O'Cathain:** It seems that there is no end to the growth in the number of cases. The number has gone from 20,000 up to 217,000, if I have the figures correctly. Who assesses those people? I know that people are qualified in various ways.

In a certain case that I know about, the family was involved in decisions and discussions about somebody being put into care, but it was patently obvious to me that the person who was to be put into care was clever enough to try to avoid answering the questions properly. I got the distinct impression that the assessors were not sufficiently trained to know whether or not the patient was co-operating.

I have spoken to other people about this over the years, and I am told that it is not an uncommon situation. If so, how can you overcome it? Do you think the observation is valid? Are people being put into care homes without getting the right responses from them?

Nicholas Paines: That is probably more a question for Stephen and Betsey than for the Law Commission.
Stephen Chandler: Local authorities and social workers spend most of their practice trying to avoid placing people in care homes. What we try to do is help people remain as independent as possible in their own homes for as long as possible. Fundamentally, the system is geared to a care home being very much later in a person's care journey.
To go back to the specifics, either Nicholas or Tim talked about the six different tests or assessments currently required before a decision about

deprivation of liberty can ultimately be made. My experience is not consistent with the one you described; it is the opposite. People are very carefully assessed and considered. Those who carry out best-interests assessments must have a professional background; they must have done additional accredited training in order to be deemed suitable and competent. The medical opinion that needs to sit alongside comes from a Section 12-approved doctor, as Betsey said.

There are a number of physical steps in the process to ensure that only people deemed competent can carry out the assessment. There are a number of independent assessments, so that no individual ultimately has all the authority. I have yet to meet a practitioner who is not striving to get the best for a person, even if at times it means they have to recommend that the person's liberties are limited.

Betsey Lau-Robinson: Probably in some services it is different, but the feedback we get from colleagues across London is that you are absolutely right. There is variation in the quality of best-interest assessors, and we believe the reason is that courses are not accredited as standard. One of the recommendations we were going to propose is that whoever becomes an advanced practitioner and does future assessments under the new system should have a central accredited course.

At the moment, various universities offer very variable courses. They can run from between five and 10 days. Different universities have different assessments. I am a qualified best-interest assessor. Two of my staff who did the qualification found that there was a difference in the way the course was delivered, so you are absolutely right. There have been concerns about some practitioners not being up to the required standard and quality, as you discovered.

Tim Spencer-Lane: Given that the new scheme would cover so many more people, it is crucial that the existing workforce is upskilled. Ideally, decisions about deprivation of liberty should in most cases be taken by the front-line social worker or nurse as part of their assessment under the Care Act. All social workers should be trained at university to understand what deprivation of liberty means and how to authorise it. That is vital.

Baroness O'Cathain: Are you going to recommend that?

Tim Spencer-Lane: It is intrinsic to our proposals. The vast majority of assessments would be made in a much more straightforward way. The other side is that you need the workforce to carry out skilled assessments across the board. That is the vital part.

The other aspect is that we recommend amending Section 5 of the Mental Capacity Act. Section 5 is probably one of the most crucial aspects of the Act, because it gives health and social care professionals cover for legal liability in civil and criminal affairs when they take care and treatment decisions on behalf of people who lack capacity.

In the report we say that in important decisions, such as placing a person in a care home, professionals should be required to take additional steps. They should document that they have undertaken a proper capacity

assessment, that they have looked at the person's wishes and feelings, and that they have understood what the best-interest decision is and outlined how they reached that conclusion.

Baroness O'Cathain: That would certainly meet the problems I had. They were a few years ago anyway, so I hope that things have improved.

Stephen Chandler: An interesting experience is what happens when an older person is in hospital. They may not have been known to us and then something happens; they have a fall or deteriorate and they end up in hospital. The Committee is well aware of the pressures within the NHS, particularly as regards older people. We are often trying to balance the need to reach a decision in a timely but clearly proportionate way about future care for a person, especially if the recommendation is for a residential placement. Often, our colleagues in the acute sector say, "We need this bed, and this person is medically fit to be discharged", but we have to take the time to ensure that the necessary assessments are made and the steps are taken. That is a challenge we face every day.

Baroness O'Cathain: It is very difficult.

Q17 **Baroness Hamwee:** There are huge challenges. I admire all of you who are tackling this. I do not have the paper with me, but if I have remembered it correctly, the Government's response to the Law Commission proposals was to say in one paragraph, "it is urgent that we get on with this", and in the next, "when parliamentary business allows". The question for us is whether the Government should get on with implementing the liberty protection safeguards as a matter of urgency, whatever the imperfections, or whether they should be delayed to allow for further work, particularly to harmonise the reforms with the outcomes of the Mental Health Act review.

Nicholas Paines: Our report recommended that the DoLS be replaced by our scheme as a matter of urgency, so that is what I say. I would say that, would I not? You have heard from Stephen and Betsey about the difficulties of the present system. It was a bad system originally and it is creaking under the strain of the current case load. It is more than creaking; it is more or less collapsing.

We have come up with a simpler solution. There have been difficulties about the interface, as they call it, between Mental Capacity Act deprivation of liberty and Mental Health Act detention. We have come up with a simpler interface. It may be that the Government's review of the Mental Health Act will get rid of some of the difficulties of the interface. If they do, that will be a further advance, but we see no obstacle to introducing our measures as soon as possible and taking an awful lot of the pressure off this intolerable situation, particularly for Stephen and

Betsey and the people about whom the decisions are made and their families.

Baroness Hamwee: I do not want to put words into your mouth, but would I be right in understanding that you are saying that, if we get on with the scheme, there is scope for tweaking it to accommodate anything that happens with regard to the Mental Health Act? It is not a question of its fundamentally undermining what might happen with the Mental Health Act. Is that the sort of balance you would give it?

Nicholas Paines: I think that is right. If the Mental Health Act review adjusted the scope of the Mental Health Act in some way, one might need to look again at the boundary we have drawn between the MCA and the current Mental Health Act, but that could easily be done, and we do not see it as a good reason for delaying implementation of our recommendations.

Baroness Hamwee: Presumably, anything that is done with regard to the Mental Health Act could be dealt with alongside consideration of further changes in that area of deprivation of liberty.

Nicholas Paines: That must be right, because the changes would be complementary.

Baroness Hamwee: You could do it all in one statute.

Nicholas Paines: That is right. We have produced a Bill that is oven ready; it could be introduced tomorrow. I do not know how long it would take for a Bill to be drafted as a result of the Mental Health Act review. It would probably take longer, but if our Bill were enacted now, and the Mental Health Act review required further adjustment of the boundary between the two Acts, it could be done in that Bill.

Baroness Hamwee: That is a single exercise.

Nicholas Paines: Yes.

Baroness Hamwee: You are nodding, Tim. Does anyone else want to comment?

Stephen Chandler: Every time I talk to Mental Capacity Act leads, they describe feeling despondent at times, not because of the workload but because they are concerned about people who have not had due diligence going through the system. For us, there is a clear priority to fix a system that, as I said at the beginning, people generally accept is not working. My anxiety, which I have to come back to, is about ensuring that there are adequate resources, so that the replacement has a chance of delivering exactly what we want it to deliver.

Chair: Does that mean that you are not in favour of urgently implementing the Law Commission's report, because you think that without the resources it would not solve the problem?

Stephen Chandler: No. We support early implementation of the Law Commission's recommendations, but we are understandably anxious about that unknown group of people and the associated costs and demand.

Betsey Lau-Robinson: I agree with Stephen. We must not forget that there is a human being in the middle of all this. All the challenges we have talked about this afternoon involve human beings. The present system is not ideal. We need to make changes, and I fully support an urgent change in line with what the Law Commission has recommended.

I echo what Stephen said. We need to learn lessons from how Mental Capacity Act deprivation of liberty was implemented. There were not enough resources and not enough preparations were made, so years later we are still grappling with the huge challenge of understanding and awareness.

In order for the system to work and be effective and efficient, we need to put resources in place. A code of practice is very important. We talked about the qualifications and skills of best-interest assessors. All of that must be clarified in a code of practice and in registration, working with all the royal colleges, the GMC and health education institutions to ensure that everybody works together to get it right this time.

Chair: Thank you very much indeed. You have been very clear about the scale of the problems and your desire to see urgent action, and on consideration of the resources required for that. You all agree, do you not? What you are saying to us is that it is not wasted money, but an important safeguard for human rights, and therefore it needs to be done. Thank you very much for taking the time to give evidence to us.