

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### MENTAL CAPACITY (AMENDMENT) BILL [*LORDS*]

*First Sitting*

*Tuesday 15 January 2019*

*(Morning)*

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#### CONTENTS

Programme motion agreed to.

Written evidence (Reporting to the House) motion agreed to.

CLAUSE 1 agreed to.

SCHEDULE 1, as amended, under consideration when the Committee adjourned till this day at Two o'clock.

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**not later than**

**Saturday 19 January 2019**

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**The Committee consisted of the following Members:***Chairs:* MARK PRITCHARD, † IAN AUSTIN

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|---|--|
| † Afolami, Bim ( <i>Hitchin and Harpenden</i> ) (Con)       | † Morton, Wendy ( <i>Aldridge-Brownhills</i> ) (Con)     |
| † Chalk, Alex ( <i>Cheltenham</i> ) (Con)                   | † Norris, Alex ( <i>Nottingham North</i> ) (Lab/Co-op)   |
| † Cunningham, Alex ( <i>Stockton North</i> ) (Lab)          | † O'Brien, Neil ( <i>Harborough</i> ) (Con)              |
| † Debbonaire, Thangam ( <i>Bristol West</i> ) (Lab)         | † Sherriff, Paula ( <i>Dewsbury</i> ) (Lab)              |
| † Dhesi, Mr Tanmanjeet Singh ( <i>Slough</i> ) (Lab)        | † Syms, Sir Robert ( <i>Poole</i> ) (Con)                |
| † Dinéage, Caroline ( <i>Minister for Care</i> )            | † Whately, Helen ( <i>Faversham and Mid Kent</i> ) (Con) |
| † Keeley, Barbara ( <i>Worsley and Eccles South</i> ) (Lab) | † Williams, Dr Paul ( <i>Stockton South</i> ) (Lab)      |
| † McCabe, Steve ( <i>Birmingham, Selly Oak</i> ) (Lab)      | Adam Mellows-Facer, <i>Committee Clerk</i>               |
| † Moore, Damien ( <i>Southport</i> ) (Con)                  | † <b>attended the Committee</b>                          |
| † Morris, James ( <i>Halesowen and Rowley Regis</i> ) (Con) |  |

## Public Bill Committee

*Tuesday 15 January 2019*

*(Morning)*

[IAN AUSTIN *in the Chair*]

### Mental Capacity (Amendment) Bill [Lords]

9.25 am

**The Chair:** Welcome, everyone, to the first meeting of the Committee. Can we start by making sure that our phones and iPads are on silent? We will first consider the programme motion on the amendment paper. We will then consider a motion to enable the reporting of written evidence for publication. I hope we can take those two things without too much debate. I call the Minister to move the programme motion, which was agreed by the Programming Sub-Committee yesterday.

**The Minister for Care (Caroline Dinéage):** It is a great pleasure to serve under your chairmanship, Mr Austin. The Bill amends the Mental Capacity Act 2005 and reforms deprivation of liberty safeguards, which, if the Committee will forgive me, I will refer to as DoLS. DoLS came into force in 2009 to provide protections for vulnerable people who require care and treatment but do not have the capacity to consent. However, due to the cumbersome and inefficient nature of the current DoLS system, many people are not receiving those vital protections. Hon. Members across the House heard on Second Reading that there is currently a shocking backlog—

**The Chair:** Order. All you need to do at this stage is move the programme motion.

*Ordered,*

That—

- (1) the Committee shall (in addition to its first meeting at 9.25 am on Tuesday 15 January) meet—
  - (a) at 2.00 pm on Tuesday 15 January;
  - (b) at 11.30 am and 2.00 pm on Thursday 17 January;
  - (c) at 9.25 am and 2.00 pm on Tuesday 22 January;
  - (d) at 11.30 am and 2.00 pm on Thursday 24 January;
- (2) the proceedings shall be taken in the following order: Clause 1; Schedule 1; Clauses 2 to 4; Schedule 2; Clause 5; new Clauses; new Schedules; remaining proceedings on the Bill;
- (3) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 5.00 pm on Thursday 24 January.—(*Caroline Dinéage.*)

**The Chair:** I now call the Minister to move the motion about written evidence. Again, you just need to move that formally.

*Resolved,*

That, subject to the discretion of the Chair, any written evidence received by the Committee shall be reported to the House for publication.—(*Caroline Dinéage.*)

**The Chair:** Copies of the written evidence received will be made available in the Committee Room.

We now begin line-by-line consideration of the Bill. The selection list for today's sitting, which is available in the room, shows how the selected amendments have been grouped for debate. Amendments grouped together are generally on the same or similar issues. Decisions on amendments take place not in the order the amendments are debated, but in the order they appear on the amendment paper. The selection and grouping list shows the order of debate; decisions on each amendment will be taken when we come to the part of the Bill the amendment affects. I will use my discretion to decide whether to allow a separate stand part debate on individual clauses and schedules following the debates on the relevant amendments.

#### Clause 1

DEPRIVATION OF LIBERTY: AUTHORISATION OF  
ARRANGEMENTS ENABLING CARE AND TREATMENT

*Question proposed,* That the clause stand part of the Bill.

**Caroline Dinéage:** As I said, due to the cumbersome and inefficient nature of the current DoLS system, many people are not receiving the vital protections they need. Members across the House heard on Second Reading that there is a backlog of 125,000 people waiting to have their safeguards considered. That is 125,000 people who are not receiving the protections they are entitled to, as well as families who do not have peace of mind and carers who do not have legal cover. Worse still, more than 48,000 of those people have been waiting more than a year for an authorisation to be considered. I hope hon. Members agree that that simply cannot be allowed to continue.

The Government tasked the Law Commission with reviewing DoLS and, after more than three years of extensive engagement, it concluded that the system needed to be replaced as a matter of pressing urgency. The Bill concentrates on the Law Commission recommendations that focus on the delivery model. In certain regards, such as making consultation on the individual's wishes and feelings an explicit feature of the Bill, we go further than the Law Commission recommended.

The Bill has passed through the other place. We worked constructively with the Lords to make important changes, including by ensuring there is no conflict of interest in the role care home managers play in the new system and by removing references to "unsound mind", which is outdated and stigmatising. We hope to continue working constructively as the Bill passes through the Commons. Indeed, I have already met hon. Members from across the House, as well as key sector stakeholders, to ensure that we listen and respond to their concerns. I know the hon. Member for Worsley and Eccles South cares as much as I do about getting this right.

Clause 1 inserts schedule AA1 into the Mental Capacity Act. This replaces DoLS with a new administrative scheme for authorising deprivation of liberty, known as liberty protection safeguards.

**Barbara Keeley (Worsley and Eccles South) (Lab):** It is a pleasure to serve under your chairmanship, Mr Austin. I look forward to the hours of important debate we

have ahead of us on the Bill. Let us hope the temperature in the room balances out somewhat over the next few hours, because we are suffering a little bit at the moment.

I want to say clearly that the Opposition are committed to improving the Bill, despite the many reservations we have about not only its contents, but the way it has been developed so far. Should the Government push ahead with the Bill, our job is to ensure that it is the best it can be. We have tabled nearly 30 amendments, which are the minimum reforms needed to ensure that the Bill is fit for purpose.

I am sure that the Government want to produce a Bill that works. No Minister or Department wants to introduce a law that creates complicated case law and necessitates further legislation in the near future. We will work with the Government over the next few weeks to improve the Bill in a spirit of co-operation. If we can do that, we might just have a serviceable Bill at the end of this process.

We will not oppose clause 1 stand part. Indeed, clause 1 is the only part of the Bill that nobody is trying to amend.

*Question put and agreed to.*

*Clause 1 accordingly ordered to stand part of the Bill.*

### Schedule 1

#### SCHEDULE TO BE INSERTED AS SCHEDULE AA1 TO THE MENTAL CAPACITY ACT 2005

**Caroline Dinanage:** I beg to move amendment 2, in schedule 1, page 5, line 19, leave out

“if a person objects to arrangements”

and insert “in certain cases”.

*This amendment is consequential on Amendment 9.*

**The Chair:** With this it will be convenient to discuss the following:

Amendment 38, in schedule 1, page 16, line 4, after “if” insert

“the cared-for person is aged 16 or 17 and in other cases if”.

*This amendment makes provision for an AMCP to be involved in all cases involving 16 and 17 year olds.*

Government amendments 8 and 9.

Amendment 37, in schedule 1, page 16, line 12, at end insert—

- “(c) the arrangements include the use of physical restraint, or
- (d) the arrangements include the use of sedating medication, or
- (e) a person interested in the cared-for person’s welfare has objected to the arrangements, or
- (f) the cared-for person owns or has the right to occupy a different property to the property in respect of which the arrangements apply, or
- (g) the cared-for person is receiving covert medication, or
- (h) the cared-for person is restricted from having contact with named persons, or
- (i) the cared-for person is being detained in a mental health establishment for the purposes of treatment of a mental disorder, or
- (j) there is a less restrictive option for the cared-for person’s care or residence available, or

- (k) the cared-for person, or a person interested in the cared-for person’s welfare, requests the review be by an Approved Mental Capacity Professional.”

*This amendment provides for access to an Approved Mental Capacity Professional in specific circumstances.*

Amendment 39, in schedule 1, page 16, line 12, at end insert—

- “(c) the arrangements provide for the cared-for person to receive care or treatment, and it is reasonable to believe that the cared-for person does not wish to receive the specific kinds of care or treatment which the arrangements provide for, or
- (d) it is reasonable to believe that the cared-for person does not wish to receive care or treatment overall.”

*This amendment broadens the criteria of objection in the Bill, so that it applies to objections to the kinds of proposed care or treatment to be given, or to an overall objection to care or treatment.*

Government amendment 10.

**Caroline Dinanage:** With your leave, Mr Austin, I will address the amendments in my name before I speak to the Opposition’s amendments. This group of amendments relates to pre-authorisation reviews, which are conducted by an approved mental capacity professional, or AMCP. The AMCP provides an additional level of scrutiny for cases that need it, such as where somebody has raised an objection. Amendment 9 requires an AMCP to conduct the pre-authorisation review should arrangements mean that the cared-for person receives care or treatment mainly in an independent hospital. It also clarifies that cases can be referred to an AMCP by the responsible body, providing that the AMCP accepts the referral. The other amendments in the group are consequential on this.

I am sure that hon. Members of different parties have been as distraught and dismayed as I have at the widespread reporting of cases of inappropriate restrictive practices, such as the prolonged use of seclusion. They will recognise that the scrutiny of cases in independent hospitals must be absolutely robust. Stakeholders are right to raise their concerns about this, as many did in the debate on the Bill in the other place. The Government have acted to address those concerns by requiring authorisations in independent hospitals to be considered by an AMCP, regardless of whether an individual objects to their arrangements. We have added a further level of security to the process. The AMCP will meet the person, complete any relevant consultations, and review assessments to decide whether the authorisation conditions are met.

Amendment 9 also clarifies that the AMCP can conduct pre-authorisation reviews in any case, not just where an individual objects. The Government’s view has always been that certain cases might benefit from scrutiny by an AMCP due purely to their complexity or nature. The amendment will apply to all cases, not just cases where the independent hospital is the responsible body. The statutory code of practice will be used to explain in detail how these powers should be exercised. For example, authorisations that relate to people with an acquired brain injury might benefit from consideration by an AMCP, as the nature of their illness means that it can often be difficult to establish whether they have capacity, and their capacity might fluctuate. AMCPs will also play a key role should particularly restrictive arrangements be proposed.

The code of practice is a statutory document that will be approved by both Houses and will form the basis of the responsible body’s decision to refer cases to an

[*Caroline Dinenege*]

AMCP, which could extend to cases in which physical restraint is used. The approved mental capacity professional will then decide whether to accept the referral, in line with the code of practice. It is important that AMCPs are focused on cases that need additional scrutiny, so that the system can be targeted and can deliver protection to all those who need it more quickly. That is why AMCPs have a role in making a judgment about whether to accept referrals. The amendments strengthen the safeguards in the Bill, and I hope the Committee will support them.

Let me turn to the amendments tabled by the Opposition. I thank hon. Members for initiating this important discussion about objections and access to AMCPs. Amendment 37 would provide for access to AMCPs in specific circumstances. The Government absolutely agree that AMCPs should review authorisations where appropriate, but the issue is that, by putting too much detail in the Bill, we can sometimes be caught out by what is left out. The Bill already requires that an AMCP completes the pre-authorisation review if it is reasonable to believe that the cared-for person does not want to reside in, or receive care or treatment at, a certain place. The objection can be raised by anyone with an interest in the cared-for person's welfare. The Bill already requires that arrangements are necessary, proportionate and the least restrictive possible. That is to be considered as part of the pre-authorisation review.

The Government amendment previously discussed requires that an AMCP reviews every authorisation from an independent hospital, even if there is not an objection. That is an example of our commitment to protecting the most vulnerable.

**Alex Cunningham** (Stockton North) (Lab): I am interested in the expression that the Minister used a moment ago—"where appropriate". There is no clear definition anywhere in this material of who will determine what "where appropriate" means, and who will be involved in the decision making. I would welcome an explanation of what the Minister means by that. I would much rather see everybody covered by this provision.

**Caroline Dinenege:** Everybody is entitled to an AMCP if they are in an independent hospital. That is on the face of the Bill in terms of decision making, case studies and how we make sure people have the training and information to implement the Bill in the way it is intended. Let us not forget that we started with a well-intended Bill with DoLS, but because of the way it was worded and subsequent decisions by judges, we have now got a one-size-fits-all Bill. That is why we have a statutory code of practice, which runs alongside the Bill. It is a legal document and will be approved by both Houses. It will be put together with stakeholders and will set out very clearly the guidelines that dictate how and when action should be taken. It will include case studies and will be compiled very closely with stakeholders, who are on the frontline and deal with individuals.

**Dr Paul Williams** (Stockton South) (Lab): I wonder whether the Minister can tell us what it is about independent hospitals that warrants an AMCP assessment, given that independent care homes do not warrant one?

**Caroline Dinenege:** I thank the hon. Gentleman for that interesting question. His medical background makes him a very valuable member of this Committee—as is everybody else, of course. There have been a lot of high-profile cases involving independent hospitals recently, and we have to pay attention of them. We are talking about a very tiny cohort of vulnerable people here—slightly less than 1%—but they are very important, given that they are extremely vulnerable. Given the nature of the concerns that have been raised about independent hospitals, we felt, and the Lords agreed, that it is important to ensure that additional protection is there from the outset, whether or not the person objects to their care.

**Steve McCabe** (Birmingham, Selly Oak) (Lab): Will the Minister give way?

**Caroline Dinenege:** I will just get to the end of my sentence.

The Government amendment already clarifies that AMCPs can review authorisations in other relevant cases—for example, if circumstances are complex or if particularly restrictive practices are used.

**Steve McCabe:** I am grateful to the Minister for giving way; I did not want to interrupt her flow. I want to clarify the answer she gave to my hon. Friend the Member for Stockton South a second ago. How many people reside in independent homes, as opposed to independent hospitals? I would have thought that the greater proportion are in independent homes, which is all the more reason why we should have concern about them.

**Caroline Dinenege:** With deprivation of liberty safeguards or liberty protection safeguards, roughly 80% are in care homes, 20% are in hospitals and—I know this will add up to over 100%, but it is there or thereabouts in each case—about 1% are in independent hospitals. We have to avoid recreating the painfully inadequate DoLS system we have at the moment. Where something is straightforward and simple, we do not want to take the power and decision making out of the hands of families, loved ones and those trusted to help people in decisions about their care.

We have put in this clause about independent hospitals because Members from both sides of both Houses have had particular concerns. I know that the hon. Member for Worsley and Eccles South shares these concerns with me. That is why we felt that the clause was particularly important.

We know that situations can be complex and incredibly far-ranging, which is why we intend to use this code of practice to capture the full scope of circumstances to which it may apply. We will set out in detail the circumstances that may trigger a review by an AMCP. I am keen to take input from all Members from across the House on this document.

Amendment 38 relates to the involvement of approved mental capacity professionals in arrangements for 16 and 17-year-olds. We understand that many 16 and 17-year-olds would benefit from the additional scrutiny of an AMCP. This is why the Government amendment clarifies that relevant cases should be referred to an AMCP.

**Alex Cunningham:** Again, the Minister uses words I am uncomfortable with—the word "relevant". Who determines what is relevant in the case of an individual young person?

**Caroline Dinanage:** In each case, these are professional social workers who have the required skills and training to make this kind of decision. We do not want to recreate the current system, which very much leaves families and loved ones excluded from the whole process. We want to make sure that their consideration is taken into account at the same time, but we also want to rely on the judgment of professionals, who are incredibly skilled and well trained and who will have the additional workforce training to ensure that they are able to carry out this function successfully.

Amendment 39 broadens the criteria for objections within liberty protection safeguards. The Bill currently provides that the referral must be made to the AMCP if there is a reasonable belief that the person objects to the arrangements to reside in or receive treatment at a specified place. The amendment would expand this to care and treatment overall. I agree that it is important to take into account a person's wishes and feelings in relation to their care and treatment. It is really important to remember that the provision of care or treatment is already governed by section 4 of the Mental Capacity Act. This amendment to the Act does not override some of the existing parts of the Bill, which are very valuable. In these situations, a best interest decision would need to be made, having regard to ascertainable wishes and feelings, as set out in the Act.

If a person objects, or has objected in the past, to the care or treatment, this must be taken into account within best interest decisions. In some cases a best interest decision must be referred to a court if the person or their family objects. Nothing in the Bill changes this. The statutory code of practice will set out how liberty protection safeguards work within the wider framework of the Mental Capacity Act.

**Barbara Keeley:** I will come to this in more detail later, but constantly referring to a code of practice we have not seen is not helping us here. We are trying to make sure that the Bill is fit for purpose.

**Caroline Dinanage:** I completely understand the hon. Lady's feelings on this. She will know, because we met and discussed this, that I am very keen that the code of practice is put together by taking on board the advice and guidance of all stakeholders and Members from across the House. This work has already started. We have a first meeting in a couple of weeks, where we will get all the stakeholders together to flesh this out.

This is a statutory document that will bear weight in a court of law. There has already been a lot of commitment in both Houses to what the code of practice will include, so we would like to provide Members during the Committee with a document that will set out exactly the sort of things that we are already committed to.

**Barbara Keeley:** Briefly, if the Minister had done what I asked her to do on Second Reading, and what 40 organisations asked her to do, and paused the Bill, she would have had time to develop the code of practice before we got to this point. We would have the Bill and the code of practice here, and we could check them. We do not have them. That is why we will have a problem.

**Caroline Dinanage:** I understand where the hon. Lady is coming from. The code of practice will be a living document. It will go alongside the Bill and have case

studies. It has to be put together in a very co-operative and collaborative way. It will have to come before both Houses to be signed off before it can be published and released, so there will be plenty of opportunity for Members to get involved in drawing it up. I have committed to providing a list of what we have already agreed will be part of it. Members will get a chance to vote on it before it is published, and it will need the approval of both Houses because it is a statutory document.

9.45 am

We expect that when a person objects to the arrangements, they will also object to the care or treatment being delivered, so we will get an AMCP referral. Considering less restrictive alternatives is a really important aspect of the wider Mental Capacity Act 2005. For example, the fifth principle of the Act requires decision making to have regard to less restrictive options. The cared-for person or their advocate can also challenge the authorisation in the Court of Protection; it is unnecessary for that to be made explicit again in this Bill.

I agree that a person should have the ability to express a wish not to receive care or treatment. However, there is provision in the wider Mental Health Capacity Act for a person to object to the care or treatment given overall. In those situations, a "best interests" decision would need to be made, taking into account wishes and feelings, as set out in the Act. Nothing in this Bill changes that, which is why I ask hon. Members to withdraw their amendments and support the Government amendments.

**The Chair:** I call Barbara Keeley.

**Barbara Keeley:** I have nothing to add.

**Alex Norris** (Nottingham North) (Lab/Co-op): It is a pleasure to serve under your chairmanship for the first time, Mr Austin. It always feels a bit risky to speak before one's Front Benchers. Let us hope that I do not re-write Labour party policy and cause it to have to be unwritten two minutes later.

This is a really serious issue, as has been said. It is exceptionally impactful for individuals and the health and social care system. The Minister rightly notes the backlog that has built up in the 10 years since the DoLS regulations were put in, that it has been five years since the critical Cheshire West judgment, and that the system is cumbersome. It is right for us to look at that.

As played out on Second Reading, we have significant concerns that this legislation is rushed. We will frequently come back to the point on the code of practice, because it feels as though we are dealing with half the information. We are putting significant arrangements into law, knowing that we will be relying on another code of practice. I am glad to hear of the legal basis for that code of practice, but would like to see it alongside the Bill. Otherwise, how do we know whether these arrangements are really suitable? We do not know what the counterpart arrangements in the code of practice would be. I certainly have fears that the process is rushed, that the arrangements are a little bare, and that we are expecting to fill them out with the code of practice, which we will not get to see during these proceedings, so there is a risk that we will not achieve what we are trying to.

[Alex Norris]

I remember the Cheshire West judgment well. When I looked it up last night, I could not believe that it happened in 2014, five years ago. I was the lead member for adult social care and health on my local authority, Nottingham City Council. I got one of those concerned calls from the director of adult social services that one gets periodically, saying, “We have a problem. Oh, goodness me!” We reacted, as I suspect every other upper-tier local authority did, by saying, “There is a legal risk, which has been tested in case law, that for this case load, we, the local authority, have not been complying with our responsibilities in law, which is very serious.”

Again, we did what I suspect everybody did, which was to traffic-light the case load—to sort it into red, amber and green—to indicate which cases we thought matched most closely the circumstances of the judgment and therefore where the risk was greatest, where there was less risk, and where we thought there was probably no relation. We matched our assessment capacity against that, so that we could get on with ensuring that we were complying with the law, as we would be expected to do.

Assessment capacity is not an infinite resource. It is not a matter of putting in an extra bit of money and gaining more assessors. Assessment capacity across social care and social work in general is increasingly stretched. Local government has been an exceptionally difficult place to work for eight years, so that was a really challenging exercise.

It has been some time since I led that brief in Nottingham and was in local government, but there were certainly times when I felt that the traffic light system was no longer a way of trying to remove an initial risk; it had become the way in which local authorities would have to operate with stretched resources. They would ask, “Where are we most at risk of challenge? Where are we least at risk of challenge? That is how we will match up our resources.” That is not a satisfactory way to operate. Today and in future weeks, it behoves us to ensure that whatever arrangements we come up with go past that and ensure that we operate in the best interests of the individual. That is all we are concerned about, and why I still have concerns.

I am sure we will come back to the subject of impact assessments in future sittings. The impact assessment is very clear about what it would take to develop a series of people who could make the assessments, but there is no sense of who will resource those individuals, whether we have enough of them, how we might find them and how we will grow them for 10 years’ time.

**Steve McCabe:** Does my hon. Friend share my concern that so far, we have heard no reference to resources associated with this legislation? The Minister said at the outset that she was concerned about the backlog, but it is reasonable to argue that the backlog developed partly because of the shortage of local authority resources. It is difficult to see how capacity to grow professionals will develop if that same starvation of resources continues.

**Alex Norris:** I share that view completely. On my first day here, if my hon. Friend had stopped me and said, “You’ve just come from Nottingham, where you were the adult social care lead. What was your situation with DoLS? Why did you have a backlog? Are the regulations

too cumbersome?” I would have said that they probably were, but that that was about our assessor capacity, because there have been eight years of growing demand in social care, while the council has experienced extraordinary reductions in resources. That toxic cocktail meant that we were increasingly stretched to the point where we really struggled to keep up with our responsibilities. There is concern that, while we could write the best legislation, if we do not understand the context, we will not deliver what we are trying to.

**Alex Cunningham:** On resources, I spent yesterday evening with the lead for adult services in my local authority of Stockton-on-Tees, Councillor Jim Beall. He told me that the council has made the political choice to plough resources into the DoLS system to ensure that there is no backlog. Throughout north-east England, political decisions have been made to take resources from other areas and put them into that, to ensure there is no backlog. Might that not be good practice?

**Alex Norris:** Yes. That clearly shows Stockton’s commitment to ensuring that there are no backlogs and that it complies with its legal responsibilities. It also shows that the system there works in the best interests of the individual, rather than around council budgets. That is a political decision, as my hon. Friend says. There is a real question as to whether we establish and resource a system that makes that the norm everywhere, or whether, up and down the country, hard-pressed social care leads will make judgments and say, “Hang on a minute; I am getting a bit of pressure from colleagues at council budget time. Can we really afford to resource this properly?”. That should be a real concern to us.

I move on to amendments 37 to 39. In general, beefing up the arrangements on page 16, line 12, of the Bill seems a good idea; we know that, because the Minister seeks to do it through a Government amendment. I am concerned that if we accept only Government amendments, there is still far too much interpretation in the Bill. My hon. Friend the Member for Stockton North—I have two hon. Friends from Stockton behind me and I am not sure who is from the north and who from the south.

**Alex Cunningham:** I am north.

**Alex Norris:** I am sure *Hansard* will correct that and make me seem a lot more articulate, which is one of the real perks of this place. Already, we have heard a lot about the interpretation of what is appropriate. I worry that if we accept only what is in the Bill and Government amendments, the Bill will be very much open to interpretation in the moment by a third party who, presumably, is busy and has other responsibilities. Our amendments develop the situation further.

I heard what the Minister said about the perils of putting in a long list that risks failing to be exhaustive, but I would say, “Let’s develop that list a little.” Amendment 37 is clear about our wanting to make sure that areas with the highest risk—those that would have been the flashing reds I talked about earlier—are definitely and in all cases covered, without that being open to interpretation under the Bill. I think that is important.

Amendment 38 extends and tidies up arrangements for 16 and 17-year-olds, and brings in a new category of person—young people—for whom there is lots of risk. It is prudent to make sure that all such cases are covered. Amendment 39 broadens that trigger of objection, so that when a third-party interpretation is made in a care setting, it is a lot clearer what constitutes an objection, and what might just be the individual not enjoying their day. Again, that is wise and gives us a great deal of security. I will finish on that point. This is important legislation, but it is important that we know the full story, which means having the code of practice. If we mean something, we should state it in the Bill, and not wait for interpretation later.

**Barbara Keeley:** It was not clear to me that you wanted me to speak to my group of amendments, Mr Austin, but I understand that now. Some Committee members have not been on a Bill Committee before, and I have not been on one for about two and a half years, so you might have to bear with us. In speaking to amendment 38, I want to mention an important principle that my hon. Friend the Member for Nottingham North touched on, which was introduced in the House of Lords: the extension of the liberty protection safeguards to 16 and 17-year-olds, and their right to a pre-authorisation review by an approved mental capacity professional.

Extension of the liberty protection safeguards was added in the House of Lords. The Government ought to be congratulated for this addition, as there was a large and glaring inconsistency within the Mental Capacity Act. This was timely recognition that 16 and 17-year-olds are vulnerable to slipping through the gaps the Bill would create for them if they were not included. The Mental Capacity Act applies to people aged 16 plus, but the Bill originally excluded those below 18 from the liberty protection safeguards, leaving an important gap in the legislation.

The Law Commission conducted a detailed consultation on this and concluded that most respondents to the consultation supported the proposal to include 16 and 17-year-olds in the new scheme. In its words, most organisations

“argued this would provide consistency with the rest of the Mental Capacity Act, and that in many cases the use of the Mental Health Act and section 25 of the Children Act would be inappropriate.”

The two recommendations from the commission’s report were that

“The liberty protection safeguard should apply to people aged 16 and above”—

this would give effect to their inclusion in the commission’s draft Bill—and that

“The Government should consider reviewing mental capacity law relating to all children, with a view to statutory codification.”

As was noted during Committee in the House of Lords, extending the Bill to cover 16 and 17-year-olds will empower some of the most vulnerable young people and ensure that they can access adequate help. However, the liberty protection safeguards do not completely fill the gap regarding the deprivation of liberty of people under 18. The extension comes with some problems, but these are soluble.

Under existing legislation, deprivation of liberty must be authorised either by a court, most likely the Court of Protection, exercising powers under the Mental Capacity Act 2005—

**Mr Tanmanjeet Singh Dhesi (Slough) (Lab):** Does my hon. Friend agree that, with regard to 16 and 17-year-olds, we need to ensure there is provision for parents or guardians to object to care arrangements? If that has an impact on their child’s deprivation of liberty, that is not an acceptable situation.

**Barbara Keeley:** I agree with my hon. Friend, and we will talk specifically about that later.

The Court of Protection exercises powers under the Mental Capacity Act 2005, under section 25 of the Children Act 1989 or its inherent jurisdiction, or under the Mental Health Act 1983, should that young person require in-patient treatment. The limited protection safeguards created by this Bill introduce a new administrative process as an alternative means of authorising a young person’s deprivation of liberty, and that is why we have to be careful.

In one sense, having this alternative means of authorising a deprivation of liberty of a young person is desirable, in that it may address some problems associated with the cost of making an application to the courts under the pieces of legislation I just referenced. The liberty protection safeguards might also act as an appropriate and proportionate bulwark in cases where care arrangements are not contentious, due to the type of care that is provided, the level of restrictions imposed and the consensus on the suitability of arrangements. For instance, if the placement meets with the young person’s approval and has been made with the agreement of the young person’s parent—a point that my hon. Friend the Member for Slough raised—in relatively straightforward cases, the extension of liberty protection safeguards might act as a convenient and straightforward mechanism.

10 am

The wider effectiveness of the liberty protection safeguards, however, depends on the additional safeguards, and we remain concerned that those provisions are not sufficiently robust in the Bill. One concern is about how the liberty protection safeguards will be resourced, a point that my hon. Friend the Member for Nottingham North has discussed at some length. We will come back to the question of resourcing when we reach the new clauses, so I will only touch on it here. The liberty protection safeguard system must be sufficiently resourced, and I hope the Minister will give an indication that she will address that point.

Our second concern is the information given to families that makes them aware of their right to apply to the Court of Protection in cases in which scrutiny of the court must occur, such as when a young person’s parents object to a proposed care plan. I will speak about parents’ objections and rights in the process of depriving liberty later when I speak to amendment 30, but it is worth mentioning here. There are further measures that we could put in place, which is why we have tabled amendment 38 to offer an additional layer of safeguards to the process and to reassure stakeholders, such as the Law Society, who have rightly expressed concerns.

Amendment 38 would extend the obligation for an approved mental capacity professional to conduct a pre-authorisation review for 16 and 17-year-olds. That should be explicit in the Bill and I am hopeful that the

Government will agree to the amendment. It seems illogical to include 16 and 17-year-olds in the scope of liberty protection safeguards in the Bill but not to extend the obligation for an AMCP to conduct pre-authorisation reviews for them, and to omit to put in place the same safeguard for adults over the age of 18.

It would be useful to reiterate why pre-authorisation reviews undertaken by approved mental capacity professionals are a crucial component in implementing the liberty protection safeguards, and to reinforce the point that they should be conducted in cases that concern 16 and 17-year-olds. The Bill has moved on substantially from the proceedings in the House of Lords, which—thankfully—removed the responsibility for pre-authorisation reviews from care home managers, and so removed much of the dangerous conflict of interest enshrined in the first draft of the Bill. It is absolutely essential that the pre-authorisation review takes place and that it is undertaken by a professional.

On amendment 37, we welcome the principle of additional safeguards in relation to AMCPs. There has already been some discussion about independent hospitals and, as we will explore in further amendments, we feel that does not go far enough. Independent hospitals should under no circumstances be the responsible body.

In evidence to this Committee, we heard from Lucy Series on mental health detention—I have to say that things are being done in such a rush here, and the evidence to the Committee came in very late. Dr Series said that the liberty protection safeguards

“apply in hospital settings where the Mental Health Act also applies, and some people in the community may be subject to both the MHA and the LPS (as they currently are under the DoLS).”

The Minister referred to numbers earlier, and it is important to have the numbers in mind as we think this through in relation to independent hospitals. This is not about a small number of cases. In 2017-18, there were 4,670 DoLS applications from mental health establishments in England. Of those in which the local authority completed the required assessments—the Minister has referred to the backlog, so the assessment can only be of a proportion of the total cases—the majority were for people with dementia, and a substantial proportion were for people with learning disabilities and other mental health needs, most likely to be autism. Supervisory bodies authorised 1,660 detentions in mental health establishments in 2017-18, but in 305 cases, they found that the qualifying requirements were not actually met, which indicates that 16% of all completed applications from mental health establishments were found by assessors not to meet the DoLS qualifying requirements.

As the next paragraph of Dr Series’s evidence covers:

“Extremely complex rules govern the interface between the MCA and the MHA.”

We will return to that. She goes on:

“For a person who is deprived of their liberty in hospital for treatment for mental disorder, the DoLS cannot be used where a person is objecting (meaning that the MHA must be used instead), but where a person is not objecting then either the Mental Health Act or the DoLS can be used.

The Law Commission had proposed that the LPS should not be used for mental health detention (except for limited circumstances where the MHA cannot be used). This was partly because the MHA offers much stronger safeguards”—

that is a very important point for us in this Committee—

“including second opinions for medical treatments where the person lacks capacity, stronger rights for the ‘nearest relative’ to object to detention or discharge the patient, automatic referrals to the tribunal and free after-care to facilitate discharge. It was also because of the desire to reduce the complexity of this interface. The Bill, however, replicates this extremely complex interface and if recent proposals by the chair of the Independent Review of the MHA are adopted, even more people would be subject to the LPS than currently are under DoLS.”

That is an important shift that we need to bear in mind. The evidence continues:

“The fairness of denying people with dementia and learning difficulties the stronger safeguards of the mental health act is questionable, and should be the subject of further consultation before a mental health bill is introduced.

In the meantime”—

and that is where we are with the Bill—

“the people subject to the LPS are likely to be regarded as not objecting, meaning they are unlikely even to qualify for a review by an AMCP.”

So, an AMCP review is not going to be the entire safeguard that we need it to be, and:

“This is extremely problematic. Mental health detention is one of the most restrictive (and arguably dangerous) forms of detention under the LPS scheme. It contains some of the most complex assessments of the interface between the MCA and the MHA, which at present can only be undertaken by a professional with specialist training and qualifications under the MHA. DoLS assessors often find that the qualifying requirements are not met in mental health establishments.”

I have quoted the numbers on that—16% of people being held did not even meet the qualifying requirements. The evidence continues:

“There are very serious risks of unlawful detention and excessive restrictions in these settings. An AMCP review should be required in every case where the arrangements are to secure inpatient treatment for mental disorder.”

Amendment 37 proposes that an AMCP review be required in cases where physical restraint, sedation or covert medications are used; where it is requested by the cared-for person or their family or friends, regardless of whether that person is seen as objecting; where restrictions are placed on contact with family or friends—I will talk about cases with such restrictions later; and, as we have already heard, where there is a less restrictive option for the cared-for person’s care or residence.

Crucially, the amended clause would provide for a pre-authorisation review by the AMCP if it reasonable to believe that the cared-for person does not wish to receive care or treatment overall. The approach that we have taken in our amendment reflects the higher-risk criteria adopted by the Association of Directors of Adult Social Services. With the backlog of DoLS applications, that tool is used

“to help local authorities prioritise the DoLS applications and manage the backlog.”

so it is an approach adopted up and down the country by social services departments. The higher-risk criteria suggest that a response may be needed so as to safeguard the individuals concerned.

Those provisions have been prompted by cases such as that of Steven Neary, a young man with autism and a learning disability who was placed for a period of respite care in a small behaviour support unit by his local authority, Hillingdon. That was not an unusual

situation as it was part of the mix of measures from Hillingdon to support Steven. However, the local authority held Steven unlawfully in that unit for nearly a year and against his father's wishes.

The Minister referred to amendment 39, which would broaden out the terms of objection that would trigger an AMCP review. The Bill, as it stands, calls for an AMCP to be involved if one of two specific objections is registered. The first is that the cared-for person does not wish to reside at the place that the arrangement provides for. I want to highlight to Members a case showing the need for broader criteria of objection; X, who we have been asked to keep anonymous, was a 99-year-old woman living in a care home. Daily, she objected to the fact that she was there. In fact, she was described as walking up and down the care home, objecting to being there. Despite this, the care home had never applied for a deprivation of liberty safeguard for her. The local authority only found this out when they went into the care home to investigate a separate safeguarding matter. When a DoLS was then applied for, it was quickly identified that a return home was both desired and possible for X, with a robust care package. She returned home within the month. X's case shows the dangers of leaving the responsibility for flagging objections to the care home, and I will refer to care homes in greater depth later.

The second specific objection is where the cared-for person does not wish to receive treatment at the place that the arrangement provides for. Both of these cases are bound up with the location of the cared-for person, but they do not cover the wide range of other things to which a person could quite reasonably object. To give an example, some people subject to provisions of this Bill will be receiving medication, often in quite large amounts. It would not be unreasonable for somebody to object to the medical regimes to which they are subject. They may feel that the medication affects their quality of life, or—in some palliative care cases—that they no longer desire to keep receiving treatment at all. That does not mean that they are objecting to the place they are in, as they may be in their own home or in a care home that they like. They are simply objecting to the treatment and support they receive. In such cases, the Bill currently makes no provision at all for the involvement of an AMCP. Despite the fact that a cared-for person might be deeply unhappy with the arrangements put in place, the system will look exclusively at their opinion of the place where they are being held.

Our amendment is designed to ensure that such cases do not fall through the cracks. Any objection to proposed care and treatment should trigger an AMCP review. If the Government had paused this Bill, as I said earlier, to consider the implications of the independent review of the Mental Health Act, we would not be having to have this discussion. Sir Simon Wessely proposed that all cases in which somebody objected to any element of the proposed treatment should be covered by the Mental Health Act, not the Mental Capacity Act. Perhaps we can all send our best wishes to Sir Simon Wessely, who, I understand, has somehow fractured his shoulder. He was tweeting pictures this morning of the state of his shoulder with a split in the middle of it, and extolling the virtues of the European health insurance card and of receiving treatment in another country. Let's all wish him the best.

It is important to focus on the strongest safeguards contained in the Mental Health Act. Sir Simon Wessely has been clear that when somebody has any objection to the arrangements, we must ensure that greater safeguards are put in place. This amendment will, I hope, only be a stopgap. Once the Government have responded to Sir Simon Wessely's review, we should see further legislation that ensures that the people about whom we are talking—those who are not content with their care and support—are afforded the greatest safeguards offered by the Mental Health Act. Until that point, this amendment will ensure that all objections are captured, and that nobody is denied a review from an AMCP simply because the Bill does not cover the precise issue to which they are objecting.

I want to give one example that illustrates where these questions might come into play. An 86-year-old woman had kidney failure and had recently survived a stroke. Prior to the stroke, she had made the decision to turn down further treatment that would prolong her life in a generic sense, although she had not registered a specific advance refusal. She received care and support in her own home, where she wishes to remain. As part of this, she was placed on dialysis for several hours a day. She does not object to where she resides, or where she receives treatment. She has a very specific objection to certain elements of that treatment. She did not want to receive that treatment. In such cases, the Bill makes no provision for an independent professional to review whether the arrangements are appropriate. In order to safeguard people's liberty in such circumstances we need to have an AMCP review if there is any objection to the arrangements.

10.15 am

**Alex Cunningham:** It is a pleasure to serve under your chairmanship, Mr Austin, and not for the first time. Children and young people have always been my focus in politics. I spent many years as the lead member for them in Stockton-on-Tees Borough Council. I used to meet them in the most positive circumstances and often the most negative too. I celebrated with them, I spent time with looked-after children and young carers, I even did more school visits than I do now, and I listened to the challenges and problems they faced. I know that we have a tremendous responsibility to them all, but there cannot be any group of young people to whom we could have more responsibility than those that the Bill proposes to cover.

We are starting with one of the most important aspects of the Bill. We must, of course, take care when making decisions about how mental capacity will be assessed for all people, but never more so than when young people are involved. The Bill extends these measures to 16 and 17-year-olds, and as a result we must make very specific provision for them throughout the legislation. That starts with and is not limited to agreeing on the involvement of approved mental capacity professionals in all cases involving 16 and 17-year-olds. I know that that has already been clearly stated by others, but it cannot be emphasised enough.

A few minutes ago the Minister said that there were issues with that suggestion because of the possible involvement of others—perhaps family members or other advocates for the young person—but I cannot see how that can be the case. If a young person is being

[Alex Cunningham]

assessed properly, surely anybody involved and the whole system should be ensuring that everybody involved in the care and welfare of that young person is consulted and engaged. I hope the Minister will respond to that later.

In current law, 16 and 17-year-olds are mostly considered to be children—I know they all think they are adults, but they are still children. Although as MPs we do not have the same sort of corporate parenting responsibilities many of us had in local authorities, if anything, we have to give them even more protection—protection, if you like, from the state. Let us remember what a child is. Among other things, they are not allowed to vote. They cannot buy nicotine or alcohol products. They need parental permission to marry. If they work, the law decides that their labour is worth less than that of an 18-year-old. If it is the Government's position that 16 and 17-year-olds are not adults, we must take special measures to ensure extra safeguards for them and for their families. One is amendment 38, which makes provision for an AMCP to be involved in all cases involving 16 and 17-year-olds. I simply cannot understand why such a provision would be rejected by the Government.

I have been contacted, as I am sure everybody else has, by a number of organisations that have raised concerns. Most of them tell me that the Bill does not do enough to safeguard 16 and 17-year-olds. For example, the Law Society has been particularly vocal about ensuring that an AMCP must review the care arrangements for all 16 and 17-year-olds subject to the liberty protection safeguards. They must also have the right to an independent mental capacity advocate. Mencap tells me that its concern is that the LPS proposals were predominantly developed with the focus on people over the age of 18 and the specific needs of young people to be protected must not be passed over. Mencap believes that they could be.

Young people cannot be an afterthought in the legislation. Extensive consideration is required and I am very disappointed that there has never been a proper evidence session for the Bill, either in the Lords, where the Bill started, or here. There has not been that extensive consultation. Having said that, I know sure that all the organisations involved have been in touch with us to provide us with material. I know there have been written submissions as well. Any decisions taken about young people will affect them for the rest of their lives—in their care, their future education, their employment prospects, their day care and so many other things too, but ultimately their freedom, the freedom that most young people take for granted.

I know that we will get into information and consultation later in the Bill, but it is critical in this context. Most young people have their parents and others to speak up for them, but even those advocates can be shut out in some circumstances so we need to ensure that those young people's protections are protected in law.

Let us remember what vulnerable young people can be subjected to if and when we apply the provisions of the Bill to their lives. Some of them are spelled out in amendment 37; among them are physical restraint, sedation and covert medication, and a ban on seeing particular people. We cannot have a situation in which some people in our nation can have these things done to

them or restrictions placed on them without the strongest possible protections, of which the decision makers must always be mindful.

**Barbara Keeley:** On the point about control of family members, though, in a lot of places they are told that they are not allowed to visit. We will talk more about independent hospitals later, but family members are being excluded from contact. That is a terrible thing for 16 and 17-year-olds and leaves them totally isolated.

**Alex Cunningham:** My hon. Friend spells it out very clearly. I get very anxious when I see parents shut out. People come to see me when children are being taken into care—though I know that that is not necessarily directly applicable to this Bill. They are often in tears or do not understand the system; they are not being properly consulted. Anything that we can do in the Bill to give protection in this specific area is very important, so I welcome what my hon. Friend just said.

Mencap confirmed in its briefing that:

“We believe that there are some situations in which the LPS system will not be the appropriate framework to authorise interventions. For example, where young people's care arrangements include physical restraint, we believe more scrutiny would be required and should therefore be undertaken by the courts.”

Those are the protections and safeguards that we need to consider while providing care to under-18s. My local authority of Stockton-on-Tees has raised its own concerns that including 16 and 17-year-olds in the legislation is likely to contribute to increased workforce pressure in any given local authority. One area that it has particularly flagged is the possible impact on foster carers. Would this lead to a reluctance among foster carers to come forward? Has the Minister considered what happens for other people who care for children who are not with their families? The measures proposed in our amendments go a long way to providing the protections needed. They are the very least of what we should be doing to protect vulnerable young people.

Although I have spoken mainly about 16 and 17-year-olds being included in the Bill, their access to an AMCP and the development of other protections, I support the notion that access to a genuinely independent AMCP should be standard—not the exception—for every person. I do not think that the Government amendments go far enough. Why would that not be standard? Are there financial reasons? My hon. Friend the Member for Nottingham North has already started the conversation about that. Is it a case of expense or resource? Will the Government make sure that we have not only the resources in the system to deal with this, but the training and even the career development for people to move into this area?

AMCP work is not inexpensive and there is no doubt that anything in the Bill that involves local authorities, commissioning groups or health boards and their teams is bound to have a considerable financial impact on them. If it were left to me and other Opposition Members then local authorities, commissioners and health boards would have even greater responsibilities on them, and therefore even greater increased cost. We must not lose sight of that. I am sure that there will be other opportunities to talk about resources and what already works, but for now I would welcome hearing from the Minister not just about the protections that she sees as necessary to

the Bill, particularly for young people, but how she will ensure that the various bodies involved in delivering them will have the financial and staff capacity to deal with the work they need to do.

**Steve McCabe:** It is a pleasure to serve under your chairmanship, Mr Austin. I want to make a brief contribution, particularly on amendment 37.

If I may say so, the Minister was rather dismissive in her contribution. It has become evident in the past hour that the real challenge for the Bill will be to provide an affordable and worthwhile set of arrangements that guarantees that people who genuinely need care and protection get it, but that protects individuals' liberties at the same time. We do not want to end up putting the wider establishment's interests first and the individual's second.

The Minister said that she was anxious not to put too much in the Bill, because that might expose it to challenges about what had been left out. Conversely, the Government cannot put too little in the Bill and ask us to rely on a non-existent code of practice. As legislators scrutinising legislation that will have a massive impact on the liberty and human rights of some of the most vulnerable people in our society, we need to ensure that the Bill is fit for purpose; I notice that Sense, an organisation with a lot of experience of many people who will fall within the Bill's remit, takes the view that it is not. We need to be certain that we have the balance right, rather than tipping it in favour of the authorities or institutions—the people with power, effectively—against the interests of vulnerable people.

I know that the Minister's intention is to streamline the process, but if she succeeds in streamlining it by flouting the legitimate liberties of some of our most vulnerable people, it seems to me that she is exposing the system to some risk. Disability Rights UK fears that one of the Bill's dangers is that it

“takes the rights of disabled people backwards.”

**Mr Dhesi:** My hon. Friend is making very powerful points. Does he agree that there needs to be greater democratic accountability and responsibility? If a clinical commissioning group or local health board decides that a cared-for individual should be looked after in an independent hospital, it should be the responsible body. It is important that we have that accountability and responsibility in the whole process.

**Steve McCabe:** Yes, I agree.

I happily accept that every member of this Committee is committed to trying to do the right thing by very vulnerable people—there is no doubt about that. However, it is easy to rush such a Bill, particularly at a time when the Government are a bit distracted by other matters. The argument may seem simple on the surface: “Oh, we have a bit of a backlog, but let's not concentrate on how it developed—maybe it was resource-driven. Let's focus on the fact that we have a backlog and find a way of streamlining things to get that down.” When taking that approach, it is easy to gradually step away from the essential safeguards.

Sometimes these things take time. I do not want there to be unnecessary repeat authorisations. The Minister mentioned that to me recently and I accept that it is just

pointless bureaucracy, but it is possible to try too hard to limit it. One of the reasons why protections and safeguards are built in is to stop us from trampling over people. It was a long time ago now, but I should confess that in my dim and distant past I was once a social worker, and I know what happens when people are under pressure. The case load of an average social worker these days is unbelievable compared to 30 or 40 years ago, and they are under enormous pressure to get things done with insufficient resources.

10.30 am

People do not consciously set out to cut corners; they inevitably set out to get the job done. If we do not create a piece of legislation that constantly draws them back to the sort of things that should be considered in order to protect a person's interests and to ensure the right balance is struck between providing proper care and protecting that person's legitimate rights and liberties—we need to put that on the face of the Bill—we risk a situation that is weighted against the interests of the vulnerable person and in favour of the powerful authorities. However we choose to look at it, those authorities always have a different agenda, or more than one agenda, to satisfy.

**The Chair:** Does anyone want to speak now?

**Barbara Keeley:** Are you allowing summing up on this group, Mr Austin?

**The Chair:** If you want to speak, it is completely up to you.

**Barbara Keeley:** I think it is worth quickly winding up on the Opposition's three amendments. As I said earlier, it was right to extend the liberty protection safeguards to 16 and 17-year-olds, and some very helpful points on that have been made by my hon. Friends. I ask the Minister to accept that it introduces a new process to authorise a young person's deprivation of liberty. We stick to the view that the AMCP's conducting a pre-authorisation review for 16 and 17-year-olds is absolutely vital.

I ask the Minister to reflect on the points that emerged in the discussion of Opposition amendment 37. Some 4,670 DoLS applications came in from mental health establishments. Of those, 305 did not meet the qualifying requirements. Those people should not have been deprived of their liberty where they were. Given the backlog of DoLS assessments, there might be a larger number than the ones we know about. We need to reflect on the fact that mental health detention is one of the most restrictive under the liberty protection safeguards, which we should take into account. Evidence has been put to us that there is a serious risk of unlawful detention and excessive restriction. Although we want to deal with that through the new process, we do not want people to be detained unlawfully.

Our amendment means that a review will be required for 16 and 17-year-olds where physical restraint, sedation or covert medication is used. The Minister and the Secretary of State are instigating reviews on this, as are other Committees of the House: there is an ongoing review by the Joint Committee on Human Rights. There

[Barbara Keeley]

are really serious concerns and we have to be specific, but we cannot do that without a code of practice, which we have not seen.

On restrictions on contact, my hon. Friend the Member for Nottingham North and I talked about cases in which parents are banned from visiting—they are just not allowed to visit, which is totally unacceptable. There should be a review where there is a less restrictive option for the cared-for person's care or residence. We should reflect on the well-known case of Stephen Neary, which I mentioned. He was kept unlawfully for a year, which should not happen.

**James Morris** (Halesowen and Rowley Regis) (Con): The hon. Lady talked about it being unacceptable for family members to be restricted in their access to children who have been deprived of their liberty, and I have a lot of sympathy for that point. Does she accept that there are cases where that would be deemed appropriate due to the particular circumstances in which a young person has found themselves? Giving family members an automatic right to have access to a child is not a black and white issue, because it depends on the particular circumstances in which the child has been deprived of their liberty.

**Barbara Keeley:** I very much accept that point. Clearly there are difficult family circumstances and sometimes contact is not allowed. All the Opposition are saying in amendment 37 is that those cases where the family is denied access are more risky, and there should be the possibility of an AMCP review. We are not saying it should not happen—we know it does happen for a variety of reasons—but the risk of another Steven Neary case is clear once parents or other family members are banned. Once family members have their contact reduced or taken away, that becomes a high-risk case.

**Steve McCabe:** Does the hon. Member for Halesowen and Rowley Regis not make the argument for the Government to spell out more clearly the circumstances in which to consider these matters? Surely, that is exactly the sort of thing that both courts and professionals would be asked to take into account. He makes a valid point and I agree with him. His point is an argument to be more specific rather than more vague.

**Barbara Keeley:** I agree with my hon. Friend that that argument makes the case for us. In amendment 37, we suggest that the Government adopt in the Bill the process for assessing risk that social services departments up and down the country currently use on the DoLS application backlog. That is what they are doing and that is why that important amendment should be taken forward.

In response to the points made about amendment 39, it broadens out the terms of objection that would trigger an AMCP review. As I showed with examples, it is not always about the location. Just being able to raise objections about location is not enough. People often object to forms of treatment. There are some very difficult cases, such as eating disorders. There are often difficulties around the treatment.

I gave the example of an older person receiving palliative care who did not want dialysis. Medical people might find it hard, but there are cases where somebody does not want a treatment but wants the course of their disease to progress. In the cases I have mentioned, people were forced into situations that they did not want and where they did not have a basis to object. I believe that there is a case to broaden the grounds of objection to include not just location but the other points we have put forward in the amendment.

I just wanted to finalise those points and pull together what my colleagues have said. We will push our amendments to the vote at the appropriate time.

**Caroline Dinéage:** A number of valid points have been raised by hon. Members and I will cover some in more detail when we reach the relevant part of the Bill. I want to get through as many as I can now that relate to this matter.

The hon. Member for Birmingham, Selly Oak may have done it with a cheeky smile, but he said that I am flirting and dismissive in the way I address amendments to the Bill. Can I reassure him from the outset that I have not been dismissive of any of the amendments? I take the Bill incredibly seriously; I am not flirting with it. I look at every single amendment to see whether it would add to the Bill. That is why we amended the Bill so much in the House of Lords. I have committed to that.

I want to talk briefly about 16 and 17-year-olds. The hon. Member for Worsley and Eccles South is absolutely right that we have to be incredibly careful. The current system just does not work for 16 and 17-year-olds and the only recourse is the Court of Protection. We see a swathe of 16 and 17-year-olds who have no protection and no form of DoLS. That is simply not good enough.

Before making this change, we gave careful thought to how the inclusion of 16 and 17-year-olds would interact with other legislation, including the Children Act 1989. We are comfortable that it would work alongside existing legislation. We also looked at the interface with the Mental Health Act and the Mental Capacity Act. Sir Simon Wessely, who is conducting the review of the Mental Health Act, suggests that that is the way it should go.

We have given careful thought to how parents are involved when their child is subject to liberty protection safeguards. Where appropriate, they will be consulted. We have to say “where appropriate” because of the very small number of safeguarding issues that could arise. That is the problem with having absolutes in the Bill. We do not want to recreate what we have at moment—a system that tries to catch all and to be one size fits all, but that ends up helping nobody. We want a targeted system focused on resources where they are needed most. That is why we have not taken a blanket approach to AMCPs.

The hon. Member for Stockton North suggested that the problem is something to do with resourcing, but it is not—it is about focusing resources where they are most needed. In a case where a young person agrees to their care, their parents are happy with it and all professionals agree it is in their best interests, what does an AMCP add? The case would still be reviewed by someone not

involved in their care, through the pre-authorisation process. Every single application under the liberty protection safeguards will be carefully reviewed by someone not involved in their care or treatment.

**Barbara Keeley:** The Minister asks what an AMCP review adds; it adds independence at a point where family members are banned from contact, where 16 and 17-year-olds are involved. This is new legislation and a new process. In amendment 37, we suggest that there is a need for additional safeguards; the safeguards we suggest are the ones currently used by social services departments up and down the country.

**Caroline Dinanage:** With the greatest respect, I do not think the hon. Lady listened 100% to what I said. I said that in a case where the young person agrees to their care, their parents are happy with their care and all professionals agree that it is in their best interests, what does an AMCP add when there is already pre-authorisation scrutiny? It is not to do with resources but with wanting a targeted system that focuses resources where they are most needed, protecting vulnerable people in the very best way we can. We understand that there are particular concerns about the use of restrictive practices on young people with learning disabilities or autism. That is why we have tabled an amendment to clarify that responsible bodies can refer cases other than those with objections to an AMCP. In many cases, we would expect that to happen.

The code of practice keeps being referred to as something peripheral, but it is key. The hon. Member for Birmingham, Selly Oak talked about not having the ability to scrutinise it. There is not only the ability to scrutinise the code of practice; hon. Members can contribute to it. That is why it is very important that it is laid out in the way my hon. Friend the Member for Halesowen and Rowley Regis said. That is exactly the place where we lay out the case studies, individual concerns and the very complex cases that need to be definitively scooped up by this Bill. Trying to do a catch-all in the Bill would not provide sufficient protection for the people we all care so desperately about.

**Alex Cunningham:** I want to come back to resources. The Minister is right that we need to target resources where they are most needed, but the fact remains that there are insufficient resources in the system. My local authority has lost 55% of its budget since 2010. It still makes the political decision that I mentioned earlier to try to pull money from other areas to bolster the work that is needed in this area. The Government must commit to putting more resources in. It should not be left to local authorities to let other services suffer to subsidise this type of activity. The Minister needs to take that away and think seriously about resourcing.

**Caroline Dinanage:** I completely understand where the hon. Gentleman is coming from, but as he says, that is a political decision taken by local authorities up and down the country. He spoke with great knowledge about the fact that his local authority has decided to clear its backlog. Others do not have that capacity. We know that some local authorities are under a lot of pressure.

**Alex Cunningham** *rose*—

**Caroline Dinanage:** If the hon. Gentleman lets me get to the end of my point, I will give way to him. The situation is this: if every local authority across the country was to completely clear its backlog, we are looking at an additional cost of about £2 billion. So much of that is unnecessary.

The hon. Member for Nottingham North spoke about his experience of this issue, and I have personal experience too. My uncle, whom we sadly lost in September, was living with dementia and had health problems that kept causing him to end up in hospital. In his case, the lovely care home he was in gave him great care and support. According to him, it was where he was very happy, and according to us, his family, it was the best place for him. All the doctors' reports said that that was where he should be, but he kept having to go into hospital because he had fits and kept collapsing. Every time he went into hospital—probably three or four times a year—the hospital had to apply for another DoLS. That meant that, often, by the time he got back to the original care home, the DoLS from the place he went to second had not been applied. How can the hon. Member for Stockton North tell me that that is a viable use of Government and local authority resources? It is not. It is a terrible waste of money, and it does not protect the people who are most vulnerable.

10.45 am

**Alex Cunningham:** That can be corrected in the system. Some would say that £2 billion is a small price to pay to ensure that everything in our system is legal—there are tens of thousands of cases where people are being held illegally. We need to do something about resourcing and looking at that backlog. I take the point that we do not want repetition, and the legislation needs to knock out the repetition that the Minister describes, but the bottom line remains that local authorities, clinical commissioning groups and others are extremely stretched as far as resources are concerned, and we want to put even more responsibilities on some of them through this legislation, albeit maybe doing things a bit more efficiently.

**Caroline Dinanage:** I disagree. We are not putting more responsibilities on to local authorities—we are just targeting them better. The hon. Gentleman says £2 billion would be a small price to pay. That would be £2 billion wasted on a system that all the stakeholders across the board say is not fit for purpose, whatever their feelings about the Bill at the moment. The hon. Gentleman worked in his local authority, and he will know that there is desperate waste in the system. We are trying to get to the bottom of that waste here; we are trying to make sure that the money is much better spent, supporting the vulnerable.

**Barbara Keeley:** It is important that we do not tar all local authorities with the same brush. The overall situation is as the Minister presents it, but my hon. Friends are right to highlight that some local authorities—Stockton is one—have decided, in the current situation of cuts, to dedicate resources, and they have a very low backlog. In my own area of Salford, fewer than 200 applications were outstanding at the end of last year. In the London Borough of Bexley, the backlog is as low as 20 cases, and it had 1,385 applications last year. Some of our larger authorities—Salford, Bexley and Stockton—have

[Barbara Keeley]

decided to dedicate resources to this area, to effectively take resources away from other areas of their operation and to make this area a priority.

I met with DoLS leads in stakeholder meetings for the Bill, and they have a feeling that we are somehow denigrating them and running them down. A brilliant job is being done in places such as Salford and Bexley, and certainly Stockton. I do not want to send out a message from here that a resource problem that came upon this process because of the Cheshire West decision should be used to denigrate a process that can work and is working in some of our larger authorities. I hope the Minister will agree.

**Caroline Dinenage:** I agree very much with that sentiment. We know that local authorities up and down the country are doing sterling work processing applications, but we also know that there is huge geographical disparity, and there are vulnerable people who are not being looked after, with 125,000 cases in the backlog—48,000 of those for more than a year. As with the case of my uncle, many of those cases could already be moot. He had been in and out of hospital and was already back in his care home, and two DoLS applications were still sitting waiting on the backburner that would now never need to be done and were just adding to the bureaucracy, when there are other valid and vulnerable cases waiting to be addressed.

I will move on to a few other issues that were raised. The hon. Member for Worsley and Eccles South raised objections in terms of medication rather than location. There must be a best interests meeting, and sometimes a court hearing, on things such as covert treatment. That is already part of the Mental Capacity Act. We want objections to be considered as broadly as possible. They can be raised by those with an interest in welfare, a family or an independent mental capacity advocate. Streamlined systems mean that objections can be considered more quickly and can be acted on sooner.

The hon. Lady also spoke knowledgeably and passionately about the case of Steven Neary, who was held for a year despite parental objections. Under the provisions in the Bill, Steven's parents would have been able to raise an objection on his behalf. Independent AMCPs would meet Steven and his parents. They could determine that conditions are not met and could agree arrangements so that these things would not be authorised. That type of provision would need to be reconsidered if they continued to deprive him of his liberty; it would be a breach of statutory duty but also of article 5 of the European convention on human rights.

**Barbara Keeley:** The Minister is making an assertion there, but to my view, the crux of the Steven Neary case was that the social worker involved listened to the care home staff and not to Steven Neary's parents. She dismissed his parents' objections entirely. We have talked about that substantially, and it is an important aspect. His parents' objections were ignored, and it is quite clear from the court case that the social worker just listened to the care home managers. The Bill, as we will discuss later, just brings that to the fore. We will cover that later, but the Minister should not jump over that point in talking about that specific case.

**Caroline Dinenage:** I am grateful to the hon. Lady for clarifying that point, but I feel strongly that having an independent responsible body overseeing how these things are processed will make matters clearer.

**Barbara Keeley:** It is not clear what the Minister is saying there. In the specific case of Steven Neary, which independent responsible body would have done that? The local authority is the responsible body. This was a case of a care home and a young man held against his wishes and his parents' wishes. Which independent responsible body is the Minister talking about? That did not work in the Steven Neary case. The parents were ignored.

**Caroline Dinenage:** The hon. Lady makes a strong point, but that underlines the issues we have with DoLS at the moment: despite a backlog of 125,000 and a cost ticket of £2 billion, the system is not working. That is why we need to change it.

I will talk briefly about the ADASS—Association of Directors of Adult Social Services—tool. ADASS worked carefully to develop it in response to increased numbers of cases, which were overwhelming some local authorities. That included recognising issues such as clear objections that are raised and providing help with prioritising important cases, but it still leaves that 125,000 backlog, and that is unacceptable. There are various other issues about how we will resource it, but we will discuss those nearer the time.

In conclusion, AMCPs can consider any relevant case—for example, a particularly restrictive practice that is being used, or people with mental disorders. In this case, an AMCP can complete the pre-authorisation review. We will set out the detail, the case studies and clear guidance when we have the statutory code of practice. Every authorisation must be reviewed by somebody who does not deliver the day-to-day care or treatment, and the pre-authorisation reviewer must be satisfied that the authorisation is valid before approving it.

AMCPs should have the opportunity in certain cases to allow a targeted approach that will deliver a more efficient system and to allow people the better protections they need more quickly. I appreciate 100% the hon. Lady's concerns about the conflict of interest in independent hospitals. We will discuss that at greater length, but she knows I share her concerns about how individuals in those settings can best be protected.

*Amendment 2 agreed to.*

**Barbara Keeley:** I beg to move amendment 19, in schedule 1, page 8, line 17, at end insert—

“(aa) if the arrangements are for the cared-for person to be accommodated in an independent hospital for the purpose of assessment or treatment for mental disorder, and that care is commissioned by a clinical commissioning group or Local Health Board, it is the clinical commissioning group or Local Health Board, that is the responsible body;”

*This amendment would mean that, where a person is accommodated in an independent hospital for the assessment or treatment of a mental disorder, and their care is commissioned by a CCG or Local Health Board, then the responsible body will be the CCG or Local Health Board.*

**The Chair:** Can I just say that we are considering only amendment 19 at this stage, so we are all clear?

**Barbara Keeley:** That is helpful, Mr Austin.

We have already touched on independent hospitals, but there is so much more to say. Amendment 19 deals with the extremely important and troubling issue that remains in the Bill regarding the role of independent hospitals. The Opposition know, and the Minister knows all too well, the pernicious behaviour of independent hospitals when it comes to the treatment of vulnerable people with learning disabilities and autistic people detained under mental health legislation.

A number of scandalous cases have come to light in recent months relating to the treatment of autistic people and people with learning disabilities in assessment and treatment units. The BBC's "File on 4" programme exposed the horrific case of Bethany, who was held in an independent hospital and subjected to appalling treatment and constant seclusion. I have discussed Bethany's case at the Dispatch Box on several occasions, along with those of other vulnerable people who were virtually imprisoned in these units at enormous cost. I make no apology for touching on these cases again. Bethany's case has been tortuous. She has been taken in and out of seclusion and treated with astonishing cruelty by the independent hospital holding her.

Bethany is a 17-year-old young woman with autism and extreme anxiety, and is being kept in seclusion at St Andrew's Hospital, Northamptonshire. She is held in a cell-like room and fed through a hatch in a metal door, and even her father must kneel at it to speak to her when he visits. She has been detained and held in seclusion despite an assessment that the current hospital setting is not able to meet her needs and a recommendation that she be moved to a community residential setting with high support.

Bethany's case is one of an alarming set of cases of people being held in assessment and treatment units—ATUs—for extremely long periods. Some 60% of such people are held for more than two years, and 20% are held for more than 10 years. Around half of the 2,350 people with a learning disability and autism in ATUs are held in independent hospitals. The Government pledged to reduce the instances of people with autism and learning disabilities being held at these units by between a third and a half, but the reality is that the number of adults with autism and learning disabilities locked up in ATUs has fallen by a pitifully small number over the past three years. Shockingly, the number of children held has more than doubled.

The average cost of placements in ATUs for people with a learning disability is £3,500 per week, but it can be as high as £13,000 per week, as in the case of Bethany. The average stay in these independent hospitals is five and a half years. Independent hospitals have been shown to have a profound vested interest in detaining people for long periods. The journalist Ian Birrell exposed in *The Mail on Sunday* the obscene amounts that private companies that run independent hospitals make out of these detentions, which should not come as any great surprise, given the length of time that people are detained. He revealed that seven providers charged taxpayers up to £730,000 for each patient held in an independent mental health hospital. I was astounded to learn that one man alone is thought to have cost the taxpayer more than £10 million after being detained against his family's wishes for more than 17 years.

Among the companies running these institutions—these places have been called bedlam-like, which I believe is appropriate—are two large US healthcare companies, a

global private equity group and a Guernsey-based hedge fund, as well as two British firms. These companies pay their executives half a million pounds or more, and their profit margins are as high as 31%. One director of a British firm was paid more than £1 million over two years. One director of American company Universal Health Services, whose UK operation is run by Cygnet Health Care, earned £39.5 million in a single year.

Then there is the Priory Group, which earned £720 million from the NHS for providing independent mental health hospital services. Since 2012 it has been criticised by the coroner in relation to 17 deaths, including the deaths of five teenagers. Following a recent judgment, it potentially faces millions of pounds in fines because of its failure to protect a girl with a history of suicide attempts in one of its hospitals. In 2012, Amy, the girl in question, who was aged 14, was found dead in her room at a Priory hospital within three months of being admitted. Coroners criticised several elements of Priory's operations, including its poor communication about the risk that patients could present and its poor record keeping. In one case, staff were found to have falsified notes to show that patients had been observed more than they actually had been.

The Priory Group manifestly failed to protect the vulnerable people it was contracted by the NHS to support. I raise this because it is an example of the type of unacceptable care provided in independent hospitals that treat mental health patients. The recently publicised cases of abuse in ATUs reveal that people are being forcibly detained. Indeed, there were nearly 29,000 restraint incidents in England alone last year—an increase of 12,000 in two years. Many people are subjected, as in Bethany's case, to cruel and often prolonged seclusion.

I will cite another case, which was brought to me by a person whose godson has been held for more than three years in an independent mental health hospital and subjected to horrific treatments. Despite his family's efforts to move him into a community setting he is still detained there, and they offer him nothing like the freedom he had in local authority-run care. He has had medication forcibly administered, leaving him obese and causing his teeth to fall out. The hospital detaining him left him for months before fitting incorrectly sized dentures. The individual who contacted me has described him as having been brutalised. They would not call the institutions hospitals, because they say that patients' health never improves.

11 am

Even more chillingly, there has been a string of deaths in assessment and treatment units in recent years. A freedom of information request from Sky News late last year found that 40 people have died in ATUs between 2015 and 2018.

Companies make inordinate profits from detaining vulnerable people in miserable conditions. That is under existing mental health legislation. I make those points because they see it as in their interest to hold patients as long as possible, because of the vast sums that they receive to provide packages of what can only loosely be described as care. Despite the commitments that the Government have made, and broken, to reduce the detention of people in those facilities, the rate at which the operation of those companies is expanding is alarming.

That is because the direction of travel is towards greater institutionalisation, not greater community social care provision.

The new NHS long-term plan has diluted important pledges, made by the Government in 2016, to reduce the number of people receiving institutional care to 25 per 1 million people; the NHS now aims for a figure of no more than 30 people with a learning disability for every 1 million adults. We want to ask the Minister why the Government are going backwards through the long-term plan. It is a backward step, suggesting that they are de-escalating the reduction of that type of care as a priority.

The Opposition share the profound concerns of stakeholders, which have been expressed to me in the direct terms by charities such as Mencap, Sense and VoiceAbility, to name a few. Without the safeguards in our amendment, there is a danger that the Bill will create a further avenue for independent hospitals to keep people in detention for long periods under the Mental Capacity Act 2005, and make millions of pounds from doing so.

The issue was discussed only briefly in the House of Lords because the focus of much of peers' attention, in the short time they had the Bill, was the deeply ingrained and equally dangerous conflict of interest within care homes. Our Labour colleagues in the Lords tabled an amendment to make the CCG or mental health trust the responsible body and ensure that independent hospitals would have no such role as a responsible body. The Minister in the Lords, Lord O'Shaughnessy, rejected that, remarking that he thought the amendment could be improved by making approved mental capacity professionals responsible for pre-authorisation reviews. He said that

"independent hospitals would benefit from AMCP involvement".—  
[*Official Report, House of Lords*, 21 November 2018; Vol. 794, c. 280.]

Clearly, that is true, but it does not alter the fact that independent hospitals should not have any control over the process of making arrangements for pre-authorisations as the responsible body in the first place.

To quote my colleague Baroness Thornton, how can someone

"be liberated from the situation they are in if the deprivation of liberty power remains with the chief executive or manager of the private hospital?"—[*Official Report, House of Lords*, 21 November 2018; Vol. 794, c. 280.]

Responsibility simply should not lie in their hands.

The Minister in the Lords made a commitment that the issue would be dealt with in the House of Commons, and the Government have indeed introduced amendment 9, which we have just discussed, which stipulates that pre-authorisation reviews must be carried out by an approved mental capacity professional if the arrangement provides for the cared-for person to receive care or treatment mainly in an independent hospital. I gather that the word "mainly" is used to ensure that the pre-authorisation review is carried out if a cared-for person moves regularly between a care home and an independent hospital, but the amendment does not allay our deeply-held concerns, or those of interested stakeholders, that independent hospitals will still have a role as a responsible body for arranging pre-authorisation reviews.

Independent hospitals could be allowed to play a role in the process, selecting their own approved mental capacity professionals. That would represent a dangerous conflict of interest. Independent hospitals could develop cosy relationships with preferred AMCPs, which would undermine the independence of the assessment process. The Minister has referred to that independence, which she clearly thinks is important. We believe that the Bill must guard vigilantly against the potential for private companies to have any say in making the arrangement for the AMCPs as the responsible body.

There are cases that show the danger of giving independent hospitals a role in the process. One was supplied to me by POhWER, a charity which provides advocacy services in the form of a relevant person's paid representative—that is a little bit of a mouthful; I might start adopting an acronym for it—to people who do not have a friend or family member suitable, able or willing to act on their behalf.

A relevant person's paid representative, RPPR, is an independent advocate, which local authorities are obliged to appoint in these instances. POhWER was involved in providing a relevant person's paid representative to a cared-for person who had been in an independent hospital for almost a year, without any representation whatsoever. He had ended up there after falling in his two-bedroom flat, where he usually received a package of home care. He was understandably furious at being held in hospital for such a long time. Shortly after the case was referred to tribunal by the RPPR, the cared-for person was returned home by the court with a package of care and he was deemed to have capacity.

The reason this is so disturbing is that it was in the independent hospital's interest not to refer the case for advocacy. Why should we have any confidence that it would not act in a similarly self-interested way where assessments are concerned? That is the real fear. Given what I have laid out about the profits that independent hospitals are making, there is a real concern. That is why we have tabled our amendment, which will ensure that independent hospitals will not be the responsible body for arranging such reviews and will have no capability to select their own approved mental capacity professionals.

The Minister and Secretary of State have been full of well-meaning words about how they want to address the appalling abuse that has been meted out to Bethany and thousands of others in these independent hospitals. The Minister has repeated that this morning. I am sure she would not want to be responsible for enabling, through the Bill, the addition of yet more of these abhorrent cases. This amendment provides an opportunity for the Government to demonstrate that they are serious about stopping the pernicious behaviour of independent hospitals. I hope the amendment will secure the Government's support.

**Alex Cunningham:** The issue of conflicts of interest is very important, particularly in relation to the previous discussion about independent hospitals. It beggars belief that we can hand over to countless private organisations the responsibility to determine whether a person in their care—for whom substantial fees are being paid—should be deprived of their liberty and detained without recourse to anyone other than those within their own circle.

We have a duty to protect the public purse in this area, and not just the public purse, but the purses of those people who pay for their own care. Currently in the Bill, the responsible body for an independent hospital is the independent hospital itself. It is simply not appropriate for an independent provider to be responsible for authorising deprivations of liberty of people in its own establishment. The shadow Minister, my hon. Friend the Member for Worsley and Eccles South, has spoken about how that would be a serious conflict of interest, as have many others in the past. The feedback I have had from organisations confirms that. They see the huge financial incentive for an independent hospital to keep people in their establishments. Does any Member here believe that an independent hospital can be truly impartial when treating patients who are paying directly for their treatment, and have no conflict of interest? Can any Member tell me confidently they do not believe that any manager of a private hospital would make any consideration of the financial benefits to the hospital when assessing a patient?

My hon. Friend stressed at length the advantages of amendment 19, which would mean that when a person is accommodated in such a hospital for the assessment or treatment of a mental disorder and their care is commissioned by the CCG or local health board, the responsible body will be the CCG or local health board. What can be wrong with the public sector having a role, not only to determine whether there is a need for a liberty protection safeguard order, but to be involved in determining what is best for the individual?

If we hand this power to an independent private hospital, who will assess whether the placement is still the best way to meet that person's needs and arrange for them to be moved elsewhere, or to another establishment, or even back to their family? If an approved mental capacity professional was involved and they too were employed directly by the hospital or happened to be their preferred go-to person, they also have a financial vested interest in the outcome of such an assessment.

We have to protect the client first and foremost, and I believe that the amendment would achieve that. There is a genuine worry that self-funders may be deprived of their liberty with no proper authorisation—and if no independent person is there to check up, who will know? An assessment is not satisfactory if there are no checks and balances for the person concerned.

There is also a concern that fees may be required for certain assessments. Again, if no genuinely independent person is involved, who can judge whether such an assessment is necessary? I am sure that the vast majority of people in such establishments will act credibly and honestly, but I am concerned about the few who may not, who may see dashing for a new order as the simplest way forward, when what the person affected really needs is a full and proper assessment. If we cannot completely trust that there can be no ulterior motive when caring for self-funders and that the individual's care and wellbeing is the only consideration, we must ensure that assessment and care are totally separate.

Many organisations with an interest in the Bill have raised concerns with me. The consensus among them appears to be that the cared-for person will be at serious

risk if responsibility for authorising their deprivation of liberty is placed in the hands of the detaining private hospital, because the managers have a vested interest in a particular outcome. As Mencap notes, it would be a serious conflict of interest because there is a huge financial incentive for the independent hospital to keep people.

Our focus should be entirely on people, not profit. There needs to be an absolute separation, so the conflict of interest needs to be removed from the Bill. Organisations tell me that it is essential that the CCG, the local health board or the relevant local authority should act as the responsible body in such circumstances, and that in each case an AMCP should carry out the pre-authorisation review and, critically, retain oversight throughout the duration of the detention. Families need to be able to raise concerns with a person who is genuinely independent; I do not believe that that can happen if the independent hospital is given total responsibility.

Amendment 19 will deliver what is needed if we are genuine about our concern to protect vulnerable individuals. I ask the Committee to agree to it.

**Alex Norris:** The Minister moved part of the way towards us earlier in the debate by noting the challenges that have happened in the sector, especially those that have received public attention. It is worth our looking at the issue, because it is clear that there are perverse incentives for independent hospitals to make judgments that serve—whether consciously or subconsciously—the broader interests of the facility, but move away from the best interests of the individual. It makes abundant sense to put some sort of independence into the system and help those organisations by moving responsibility back to those who would normally have holding responsibilities for the care of individuals.

In an ideal system, a CCG or local authority would purchase a framework, as it would in general needs social care, in which the cost was related to the care that it was buying for the needs of individuals. It would be relatively fixed and understood, rather than going up and down according to individual circumstances. However, with the individuals and the care packages that we are talking about, frameworks break down instantly; the package needed for each person is so specific that there are no models to buy from and no fixed prices, so the benefit of a market falls away. In my experience in local government of commissioning analogous packages of support for people with very profound needs, often only one provider came forward, so it very much set the price.

Amendment 19 would take away the perverse incentive and ensure, as we would all wish, that care is designed around the individual and not around anything else.

*Ordered,* That the debate be now adjourned.—(Wendy Morton.)

11.14 am

*Adjourned till this day at Two o'clock.*



# PARLIAMENTARY DEBATES

HOUSE OF COMMONS  
OFFICIAL REPORT  
GENERAL COMMITTEES

## Public Bill Committee

### MENTAL CAPACITY (AMENDMENT) BILL [*LORDS*]

*Second Sitting*

*Tuesday 15 January 2019*

*(Afternoon)*

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#### CONTENTS

SCHEDULE 1, as amended, under consideration when the Committee adjourned till Thursday 17 January at half-past Eleven o'clock.  
Written evidence reported to the House.

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No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

**not later than**

**Saturday 19 January 2019**

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**The Committee consisted of the following Members:***Chairs:* MARK PRITCHARD, † IAN AUSTIN

- |   |  |
|---|--|
| † Afolami, Bim ( <i>Hitchin and Harpenden</i> ) (Con)       | † Morton, Wendy ( <i>Aldridge-Brownhills</i> ) (Con)     |
| † Chalk, Alex ( <i>Cheltenham</i> ) (Con)                   | † Norris, Alex ( <i>Nottingham North</i> ) (Lab/Co-op)   |
| † Cunningham, Alex ( <i>Stockton North</i> ) (Lab)          | † O'Brien, Neil ( <i>Harborough</i> ) (Con)              |
| † Debbonaire, Thangam ( <i>Bristol West</i> ) (Lab)         | † Sherriff, Paula ( <i>Dewsbury</i> ) (Lab)              |
| † Dhesi, Mr Tanmanjeet Singh ( <i>Slough</i> ) (Lab)        | † Syms, Sir Robert ( <i>Poole</i> ) (Con)                |
| † Dinenage, Caroline ( <i>Minister for Care</i> )           | † Whately, Helen ( <i>Faversham and Mid Kent</i> ) (Con) |
| † Keeley, Barbara ( <i>Worsley and Eccles South</i> ) (Lab) | Williams, Dr Paul ( <i>Stockton South</i> ) (Lab)        |
| † McCabe, Steve ( <i>Birmingham, Selly Oak</i> ) (Lab)      | Adam Mellows-Facer, <i>Committee Clerk</i>               |
| Moore, Damien ( <i>Southport</i> ) (Con)                    |  |
| † Morris, James ( <i>Halesowen and Rowley Regis</i> ) (Con) | † <b>attended the Committee</b>                          |

## Public Bill Committee

Tuesday 15 January 2019

(Afternoon)

[IAN AUSTIN *in the Chair*]

### Mental Capacity (Amendment) Bill [Lords]

#### Schedule 1

SCHEDULE TO BE INSERTED AS SCHEDULE AA1 TO THE  
MENTAL CAPACITY ACT 2005

*Amendment proposed (this day):* 19, in schedule 1,  
page 8, line 17, at end insert—

“(aa) if the arrangements are for the cared-for person to be accommodated in an independent hospital for the purpose of assessment or treatment for mental disorder, and that care is commissioned by a clinical commissioning group or Local Health Board, it is the clinical commissioning group or Local Health Board, that is the responsible body;”.—(*Barbara Keeley*.)

*This amendment would mean that, where a person is accommodated in an independent hospital for the assessment or treatment of a mental disorder, and their care is commissioned by a CCG or Local Health Board, then the responsible body will be the CCG or Local Health Board.*

2 pm

*Question again proposed,* That the amendment be made.

**The Chair:** Welcome back, everyone. I am sorry about the heat. Can we make sure our phones are turned off? The selection list for the sitting is available in the room. We have grouped amendments on similar issues together for debate, regardless of where they appear in the Bill. As I said this morning, decisions on amendments do not take place in the order in which they are debated, but in the order in which they appear on the amendment paper, which lists amendments according to which part of the Bill they affect.

**The Minister for Care (Caroline Dinéage):** It is a great pleasure to respond on the amendment, after our short break, in this delightfully warm and cosy room. I will start by addressing some of the issues raised by hon. Members.

The Opposition spokeswoman, the hon. Member for Worsley and Eccles South, spoke powerfully about concerns to do with independent hospitals and, more particularly, about the case of Bethany. We are absolutely clear that it is completely unacceptable to be subject to prolonged seclusion in the way that the hon. Lady mentioned. We have commissioned an independent review under the NHS serious incident review framework. That does not necessarily have to do with the Bill, but I felt it important to set that out for clarity. In addition, the Secretary of State commissioned a section 48 Care Quality Commission review of restrictive practices, including seclusion and long-term segregation, to understand the extent to which these things happen. NHS England is working very urgently to support Bethany into a community placement. Her father and Mencap have issued a pre-action protocol to challenge the current arrangements.

More broadly, with regard to the Transforming Care agenda, detentions of people with learning disabilities and/or autism in mental health hospitals are completely inappropriate and must end. We will achieve a 35% reduction in that at the earliest opportunity.

**Barbara Keeley** (Worsley and Eccles South) (Lab): Can the Minister say why the NHS long-term plan appears to go backwards on that? It is going from 25 people with a learning disability or autism in an in-patient unit per million adults to 30. That does not sound like progress; that sounds like removing a priority.

**Caroline Dinéage:** I understand why the hon. Lady says that, but looking at it in context, we committed to reducing the numbers by between 35% and 50% by the spring. There is no dilution of that commitment, but we have recognised that ensuring that community alternatives are robust is absolutely fundamental, because as she is well aware, we have seen people taken out of hospital settings and put into the community, but ending up back in hospital because community facilities were not sufficiently robust. That is why, as part of the NHS long-term plan, both autism and learning disability are highlighted as one of the four clinical priorities.

The plan commits to building in full the right support, to continuing that support, and to reducing in-patient numbers by 50% no later than 2023-24. The key is an enduring commitment—not knee-jerk reactions to an awful circumstance such as that mentioned by the hon. Lady—to address the issue for vulnerable people in the long-term. We are clear that in assessment and treatment units, the sorts of restraints we are talking about should be very much a last resort. We are committed to supporting those with learning disabilities and autism to live well in the community, and to putting an end to inappropriate detentions.

The amendment seeks to make clinical commissioning groups in England and local health boards in Wales the responsible bodies for arrangements in cases where they commission the care of people accommodated in independent hospitals. I am sure the whole Committee agrees—I know the hon. Lady does—that it is vital to provide protection to vulnerable people in independent hospitals. We have all seen how the misuse of authority in such settings can lead to the kind of tragic and unacceptable consequences that she highlighted.

The Bill demonstrates the Government’s commitment to ensuring that vulnerable people receive protection. The Government have further strengthened those protections with amendment 9, which requires an approved mental capacity professional to conduct the pre-authorisation review if the cared-for person receives care or treatment mainly in an independent hospital. By requiring authorisations in independent hospitals to be considered by an AMCP, regardless of whether there is any objection, we add a further level of security. The AMCP will meet with the person concerned, complete a consultation and review assessments to decide whether the authorisation conditions are met.

I further reassure Members that the AMCP will act independently of the responsible body. I know that the hon. Lady has concerns about that. The AMCP will be approved by a local authority, act as an independent decision maker and be accountable to their professional body. Those acting as AMCPs will be experienced

professionals who have successfully completed approved post-qualification specialist training, which will require them to demonstrate the capability to ensure and promote the person's best interests and protect their rights.

**Barbara Keeley:** The point I was making very strongly, and which I ask the Minister to consider again, is that it is easy to see a situation in which the relationship between an independent hospital and a preferred list of AMCPs could get very cosy, with the AMCPs working only in those hospitals and the work starting to become a large part of their livelihoods. The Minister cannot reassure me that that would not happen. The responsible body is entirely responsible for the whole process of selecting the AMCP and making the arrangements, and it can just plump for the same people time and again, and develop a cosy relationship. That is a real fear.

**Caroline Dinéage:** The hon. Lady has legitimate concerns. Making the responsible body the independent hospital was a recommendation in the Law Commission report. Amendment 19 changes the responsible body in cases where a CCG or a local health board is responsible for commissioning the care of people for the assessment or treatment of a mental disorder.

**Steve McCabe** (Birmingham, Selly Oak) (Lab): I was reflecting on the comment made by my hon. Friend the Member for Worsley and Eccles South about the risk of the relationship being too close, cosy or convenient. Has the Minister considered giving the CQC a wider brief to investigate what happens between the various parties over a range of authorisation decisions in any given period? If a relationship that could be regarded as unhealthy was developing, that would presumably be an easy way of highlighting that.

**Caroline Dinéage:** I thank the hon. Gentleman for his suggestion; we will definitely take it into consideration. I fully understand where the concerns about independent hospitals acting as a responsible body come from. We must be careful not to stigmatise all independent hospitals. Every time we have such debates, we hear horror stories, but then I always get emails from parents who feel that their children's lives have been saved by such hospitals. We must make preparations to care for those who are most vulnerable and at risk.

**Alex Cunningham** (Stockton North) (Lab): Following up on what my hon. Friend the Member for Birmingham, Selly Oak, said, does the Minister agree that if she took up the idea of the CQC having such a role, we would need something in the Bill to ensure that if it identified a cosy or questionable relationship, someone could do something about that? In CQC reports now, homes are identified as totally inadequate, but no one can do anything about it, because the CQC will take a decision only at the very, very last minute, by which time it is matter of closure.

**Caroline Dinéage:** The hon. Gentleman makes a good point; we have to look at that interaction. The AMCP will be a professional social worker, will be accountable to a professional body, and will have the high level of skills and training to enable them to carry out their job with great professional integrity. However, the reasonable concerns that have been raised by hon. Members need to be taken into consideration, and I

find the suggestion that they make in this amendment very interesting; I have a good deal of sympathy for it, and am certainly willing to reflect further on the amendment. The problem is that its exact wording does not work. We need to ensure that any changes work for the whole system. We also know that there are examples of NHS England commissioning the care from an independent hospital; it is not just CCGs. With that in mind, I commit to considering this amendment further. I hope that answer enables hon. Members to withdraw it.

**Barbara Keeley:** Our concern is that the Bill enshrines a fundamental conflict of interest by allowing independent hospitals to be the responsible body for deprivation of liberty in their own hospitals. That is what is wrong: they have that power in their own hospitals. They are not independent of the people who are in those hospitals, and the important thing is that, as I have described, these are organisations with a vested interest in putting people in their hospitals. There was not much debate about this issue in the House of Lords, because the Lords concentrated on the role of care home managers, but the point was made that the vested interests of independent hospitals are different from those of NHS hospitals.

NHS hospitals are not perfect. We have had awful issues in them; Connor Sparrowhawk's death happened in an NHS hospital, as did other deaths. As the Minister will know, when somebody is admitted to an NHS hospital, the pressure on the system is to get them discharged. That is not the case here. The Minister knows from the case of Bethany, which I cited, and from other cases that the vested interest of independent hospitals is to keep people there. Maybe we should be looking at fee levels separately, because that is part of that vested interest, but there is a vested interest, and I would not be content to allow the situation that this Bill permits. Independent hospitals have a very substantial vested interest; the Minister heard the figures that I gave. Those are serious amounts of money, and a serious waste—it is not even a good use of money in the NHS.

Independent hospitals often receive hundreds of millions of pounds in public funding every year. They are not all bad, I am sure, but programmes such as the BBC's "File on 4" and journalists such as Ian Birrell have repeatedly revealed cases in which they are bad and things are going wrong, the most recent being the Priory group and the death of young Amy. That hospital was making £720 million out of the NHS every year. These hospitals receive public funding, and they are not up to the job that they are doing. I ask the Minister for Care to accept that these independent hospitals are, in too many cases—we do not know what proportion—deeply flawed. The company I just mentioned had been criticised by the coroner 20 times since 2012—Southern Health had a lot to answer for—so we are not talking about not one or two deaths.

As I mentioned, 40 people died in assessment and treatment units between 2015 and 2018. There are numerous cases involving the bodies that the Bill designates as responsible for organising this whole process, and that is what is wrong. The Government amendment, which will involve AMCPs in these cases, is not sufficient. It is clear to me that the power of deprivation of liberty should never lie in the hands of the organisations I have talked about, which are making such profits and have such vested interests.

[Barbara Keeley]

The Minister is clear that she wants to address the appalling abuse that is sometimes meted out in independent hospitals, and I believe she is sincere about that. However, without this amendment, there is a danger that the Bill will enable more of that type of case, because it is clear to all parties that more cases will be dealt with under this new process than under the Mental Health Act 1983—and the Act has more safeguards.

In my view, the wrong signal is being sent at this time of heightened concerns about these hospitals. If the Minister is concerned about this issue, she should be prepared to accept the amendment. We will press it to a Division; it is important that we do so. If there is anything we can do to improve the amendment before Report, we will do it, but we are going to press it to a vote today.

*Question put*, That the amendment be made.

*The Committee divided*: Ayes 7, Noes 8.

#### Division No. 1]

#### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	

#### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Morris, James	Whately, Helen

*Question accordingly negatived.*

2.15 pm

**Caroline Dinenage:** I beg to move amendment 3, in schedule 1, page 8, line 19, leave out from “mainly” to “that” in line 21 and insert

“through—

(i) the provision of NHS continuing healthcare under arrangements made by a clinical commissioning group, or

(ii) in Wales, the provision of an equivalent to NHS continuing healthcare under arrangements made by a Local Health Board,”.

*“NHS continuing healthcare” is defined, for England, by paragraph 8 of new Schedule AA1. This amendment provides that in the case of arrangements carried out through the equivalent of NHS continuing healthcare, in Wales, the responsible body is the Local Health Board making the arrangements.*

This is just a technical amendment that will help to ensure that the new liberty protection safeguard system, which I am sure we all agree is a really important part of this process, works well in Wales. There is no statutory definition of “NHS continuing healthcare” that applies to Wales. The amendment clarifies that, while in England the CCG will be the responsible body when care arrangements are mainly done through continuing healthcare, in Wales, local health boards will act as responsible bodies, if the arrangements are mainly carried out through the provision of an equivalent to NHS continuing healthcare, as defined in English legislation.

In the new system, the responsible body will have the important role of arranging pre-authorisation review, in which a person independent of delivering the day-to-day

care or treatment will review the arrangements before authorising them. This is a vital safeguard in a system that will ensure that arrangements receive proper scrutiny.

I put on record my thanks to colleagues in the Welsh Government who have worked with us to ensure that the drafting of this amendment will allow the system to work in Wales as the Law Commission recommended and as the Government intend. I ask the Committee to support the amendment.

**Barbara Keeley:** We welcome this amendment, which gives clarity on arrangements in Wales, so that there is uniformity with England through the equivalent to continuing healthcare arrangements.

*Amendment 3 agreed to.*

**Steve McCabe:** I beg to move amendment 47, in schedule 1, page 11, line 17, at end insert—

“(d) the arrangements are in the cared for person’s best interest,

(e) less restrictive options have been considered,

(f) appropriate weight has been given to the cared for person’s feelings and wishes as best as these can be determined.”

*This amendment is designed to pursue the issue of a person being deprived of their liberty as a last resort and only if it is in their best interest and a reasonable effort made to determine their wishes and feelings.*

In suggesting these additions to the clause, I will return to the matters I raised this morning, because it seems to me that it is crucial that we in this Committee are as confident as any Committee ever can be that the arrangements will prove to be for the benefit of and in the best interests of the vulnerable person, and not for the convenience of the agency or the authorising body. It seems to me that, as the pressures grow on various professionals, the temptation is to interpret legislation for the convenience of the agency, as opposed to the interests of the individual. Consequently, it would be helpful and send an absolutely clear signal about the Government’s intentions if the Minister were to include in the clause a statement that the authorisation must be in the person’s best interests. That would make it crystal clear that there could not be any room for doubt or any other agenda or issue to intrude.

I recognise that paragraph 12(c) of new schedule AA1 to the Mental Capacity Act 2005 says that the arrangements must be “proportionate”, and I guess that the Minister will tell me that my fears will, therefore, not be realised, but I was thinking about that during the break and wondered whether “proportionate” could be interpreted as “suitable” rather than “necessarily in the best interests of the person”. It is quite possible in a hospital or a local authority setting to make proportionate arrangements that are suitable.

I am sure every member of the Committee deals with housing cases in local authorities every day of the week, where the local authority says that it has been proportionate in its decision about allocating a property, particularly given the constraints on the properties it has. It will certainly be a proportionate decision, but whether it is necessarily in the best interests of the person is open to debate. I simply say to the Minister that I am not wholly convinced that the two terms are exactly the same. Likewise, I do not know that, in a situation where proportionate meant suitable, it would necessarily indicate that all other less restrictive options have been properly

considered, examined and then excluded. I am thinking of an elderly person who suffers a degree of confusion, or a brain-injury victim. If there is a lack of home care or day care in the area in which they reside, there may be a temptation to go for another option regarded as proportionate based on those considerations, rather than on what is in the best interests of the person, and to rule out more coercive options.

In such a situation, it might be perfectly possible for that elderly person or brain-injury victim to be properly and well cared for with the support of a dear relative, if that relative had access to realistic respite care to give them a break from time to time, and if the cared-for person had their care supported by reasonable access to home care and day care services. If that were the case, it would be wrong to restrict that person's liberty not because less restrictive options had been considered and ruled out, but because the available care options in the area were inadequate and nothing had been done to try to address that.

That would be a classic example of a decision being made to suit the immediate economic interests of the agency or the environment in which the person happened to reside. It would not be about what was wholly in the best interests of that person. It would certainly not be because appropriate consideration had been given to less restrictive options. It would be proportionate, because in that situation proportionate was interpreted to mean convenient or suitable, rather than anything else. That is why I raise this matter.

**Alex Cunningham:** I am interested in my hon. Friend's argument. It shows why, regardless of which part of the organisation or process we are dealing with, it is essential that there is an independent person involved in the process, whether that is to deal with a private hospital or a care home. There must be an independent person who can be an advocate and supporter for the person in care, rather than it being left to a care home or independent hospital to decide what is best for them.

**Steve McCabe:** I agree and I think that will be a recurring theme. As I tried to indicate this morning, the divide is between a person's precious liberty and the need to prove good care and protection for an individual. The whole reason we are here discussing this Bill and the Minister wants to change existing legislation is that it is thought not to be adequate and to provide appropriate independent overview and scrutiny. I certainly agree with that.

**James Morris** (Halesowen and Rowley Regis) (Con): I have a lot of sympathy for the points the hon. Gentleman makes. One of the underlying principles of the independent review of the Mental Health Act 1983 that was published just before Christmas was that we need to move towards a more care-led Act. That is reflected in some of the deliberations in this Committee.

**Steve McCabe:** I absolutely agree. From time to time we encounter horrendous examples of terrible practices by people who should never work in certain settings—things that are utterly inappropriate—but by and large, the people who work in care and helping professions do it as a vocation. They genuinely care about the people they are trying to look after, and they have nothing but the best intentions. That is my experience. None the less,

there is a tendency for the individual to be lost in the management of any kind of care system. The bigger the system or the more pressed the resources in it, the more it moves to a procedure-driven model and the less the focus is on the individual. That is the kind of point that the hon. Gentleman raises, and I agree—that is exactly how it seems to me.

Let me move on to the last part of my amendment that the Minister might consider including in the Bill. I am utterly realistic; I have served on one or two Bill Committees in the past, so I know it is very unlikely that the Minister will leap to her feet and say, "That's it—that's brilliant! I'm having those." That that is not on the cards is a severe disappointment to me, but I wonder if, rather than concern herself too much with the technical nature of my suggested additions to the clause, the Minister will reflect on the point I am trying to make about how to ensure that best interest is the first thing that people think about in this process, with less restrictive options and going the extra mile to try to find them, rather than going for restrictive options because they are convenient?

Finally, Sense argued in its briefing on the Bill that the cared-for person—this is the very point the hon. Member for Halesowen and Rowley Regis made—should be at the centre of the Bill, and every effort should be made to establish their feelings and wishes. My fear is that when the measures move from this nice green Government Bill and deliberations in this Committee to the operational stage of legislation, there is a real danger that they will become more about what we do to people, rather than what we do with and for the person concerned.

2.30 pm

I am raising this because I hope the Government will reflect that although it is absolutely right to try to streamline this process—it is never a bad idea to try to save money if it is being unnecessarily expended—we live in a world where the processes of organisations sometimes overtake the interests of individuals. The way we frame our legislation can make that easier or harder. There is an opportunity in the Bill and, I think, widespread support for that across the Committee, as we have heard today and in some things we have seen from a number of the organisations. There is an opportunity to make crystal clear that this is a modernising measure that in no circumstances will allow the person not to be at the centre, or the agency's needs to act against the interests of the person. It is a modernisation in which we will do everything possible to ensure that, where we are restricting a person's liberty, we do it because we genuinely explored everything else and worked out it is the best option, and not just the easiest mechanism to tick the box and close the file. Before Report, will the Minister consider whether there is a better way to emphasise those principal interests in the Bill?

**Barbara Keeley:** I thank my hon. Friend for introducing his amendment. Through the progress of the Bill, we are discussing the circumstances where it is appropriate to deprive someone of their liberty. That should never be done lightly. Nobody should be deprived of their liberty unless it is in their best interests. That point is really worth making and it should go without saying, but the Bill does not give an assurance that this will always be the case.

[Barbara Keeley]

I acknowledge that other areas of the Mental Capacity Act 2005 discuss this interest, but it is such a vital point that it bears being made again. We cannot leave practitioners in any doubt that best interest must be foremost in their mind when they are making decisions. Best interest, of course, should not be entirely decided by practitioners. Even where people lack capacity, we must do everything we can to take their wishes into account. Again, I hope this is an obvious point, but it is not in the Bill.

Part of the difficulty of having such a short Bill is that many words should be included to make the concept clear and they are not there. I am sure the Government do not wish to see people deprived of their liberty when it is not in their best interest. I am absolutely sure about that. I look forward to hearing from the Minister how the Government will ensure that that is the case.

The amendment also makes clear that deprivation of liberty should only be allowed if there are no less restrictive alternatives—that is a key point. Nobody should be deprived of their liberty because it is easier, cheaper or requires less paperwork, or, indeed, because it is more expensive and makes a profit for firms. If there is a way to keep somebody safe that does not deprive them of their liberty, we should always seek to pursue that.

I have touched on the fact that thousands of people with autism and learning difficulties are currently held in assessment and treatment units. A number of people in mental health hospitals, independent hospitals and others are being held under the Mental Capacity Act. I gave the numbers of applications that are made under the deprivation of liberty safeguards earlier. We know that they are kept in isolation and denied freedom. I have no doubt that in some cases they were exhibiting challenging behaviour, and that became the path of least resistance. That is why it is very dangerous. If the amendment were accepted, hospitals and care homes would have to consider whether there were less restrictive ways to keep someone safe. Those other less restrictive ways may not be the easiest to organise, but that is not a good reason to deprive somebody of their liberty.

As the Minister knows, these topics were all raised in the House of Lords. She may say that everything will be laid out in the code of practice, but we do not have that in front of us and, as I made clear earlier, it will not carry the same weight as statute. The Bill is relatively short and it can bear additions; indeed, it is so brief that it needs them. Putting these provisions in the Bill would make intentions clear to practitioners. The deprivation of liberty should be a last resort and, of course, should never happen if it runs against a person's best interest. The intention of the amendment by my hon. Friend the Member for Birmingham, Selly Oak is noble and I hope the Government will take it on board.

**Caroline Dinage:** I thank the hon. Member for Birmingham, Selly Oak for highlighting the issue, about which I always listen to what he has to say. Of course, he is quite brilliant in his own special way, and he has taken a lot of time to engage with me and to do his homework on the subject, which is close to his heart. I am grateful for that.

I share the hon. Gentleman's sentiment. As the hon. Member for Worsley and Eccles South said, we are talking about depriving somebody of their liberty, which

is our most fundamental human right, so we cannot do it quickly, based on cost, or based on the current system, which Simon Wessely described as a “perfunctory and box-ticking” exercise. It has to be done with people's best interests, and their wishes and feelings, at heart. Excellent care and the interests of the cared-for person have to be at the heart of everything we do.

In responding to the points the hon. Gentleman made in moving the amendment, it is worth reminding hon. Members that the Bill will not replace the current Mental Capacity Act 2005, but amend it. Best interest decision making remains fundamental to the existing Act, within which the liberty protection safeguards will sit. Before a liberty protection safeguards authorisation is considered, it will need to be decided that the arrangements are in a person's best interests. That is included in section 4 of the 2005 Act. It must then be demonstrated that arrangements to enable that care and treatment are necessary and proportionate.

I understand the hon. Gentleman's concern about the words “necessary” and “proportionate”, but the word “proportionate” was chosen because it has a specific meaning in human rights case law. It means that assessors must consider less restrictive options, and cannot base their decisions purely on cost or any other box-ticking exercise. The word “necessary” is used in conjunction with the word “proportionate” in the Bill, which means that the arrangements must benefit the person.

That part of the liberty protection safeguards takes place at the second stage test. I agree with hon. Members that it is fundamental for people deciding whether to authorise a deprivation of liberty to consider whether less restrictive options are available. A necessary and proportionate assessment would also include the consideration of less restrictive practices. Considering less restrictive alternatives is already an important aspect of the wider 2005 Act. In fact, the fifth principle of that Act specifies that decision makers have to have regard to less restrictive options. Nothing in the Bill changes that. Indeed, we will ensure that that is a core part of the consideration of what is necessary and proportionate.

On the matter of wishes and feelings, which the hon. Gentleman talked about so powerfully, it should be noted that they are already part of the first stage of best-interest decision-making under section 4 of the 2005 Act. I can confirm that the Bill does not change that. Wishes and feelings will form a key element of the necessary and proportionate test. During the Bill's passage in the other place, we tabled an amendment that makes it explicit that regard must be given to a person's wishes and feelings in relation to arrangements. We tabled a second amendment that explicitly requires the cared-for person to be consulted under the consultation duty. Those amendments were made purely because we agree that the person's wishes and feelings should be at the heart of the liberty protection safeguards process.

I hope that that provides some clarification and reassurance for the hon. Gentleman. I am certainly not in the business of keeping the Bill as small and tight as possible just for the sake of it; if there are amendments that I feel will materially add to the Bill, I am more than happy to take them on. In this case, I hope that the hon. Gentleman will withdraw the amendment.

**Steve McCabe:** I was not planning to press it, so I beg to ask leave to withdraw the amendment.

*Amendment, by leave, withdrawn.*

**Caroline Dinagen:** I beg to move amendment 4, in schedule 1, page 11, line 19, leave out from beginning to end of line 7 on page 12 and insert—

“13 (1) As soon as practicable after authorising arrangements, the responsible body must ensure that a copy of the authorisation record is given to—

- (a) the cared-for person,
- (b) any independent mental capacity advocate appointed under paragraph 39 to represent and support the cared-for person,
- (c) any person within paragraph 39(5) in respect of the cared-for person (the “appropriate person”), and
- (d) any independent mental capacity advocate appointed under paragraph 40 to support the appropriate person.

(2) As soon as practicable after authorising arrangements, the responsible body must take such steps as are practicable to ensure that the cared-for person and any other person listed in sub-paragraph (1) understands—

- (a) the effect of the authorisation,
- (b) the right to make an application to the court to exercise its jurisdiction under section 21ZA,
- (c) the programme of regular reviews specified by the responsible body in accordance with paragraph 35(2),
- (d) the right to request a review under paragraph 35(3)(b),
- (e) the circumstances in which a referral will be made to an Approved Mental Capacity Professional under paragraph 35(4),
- (f) the circumstances in which an independent mental capacity advocate should be appointed under paragraph 39, and
- (g) the effect of there being an appropriate person in relation to the cared-for person.”

*This amendment substitutes a new paragraph 13 of the new Schedule AAI to require that, as soon as practicable after arrangements are authorised, the responsible body must provide to the cared-for person and any other person listed in paragraph 13(1) a copy of the authorisation record and take steps to ensure that those people understand the matters described in paragraph 13(2).*

This amendment relates to the responsible body’s duty to provide information to the person receiving protections, an appropriate person, or an independent mental capacity advocate. When depriving someone of their liberty, it is crucial that they are provided with all the information necessary for them to exercise their rights. Arrangements under liberty protection safeguards will not simply be something that is done to a person, but a process they are part of—I hope that I have already explained that quite plainly in answers to previous amendments.

The duty to provide information derives from article 5 of the European convention on human rights, which is brought into effect in UK legislation through the Human Rights Act 1998. The Law Commission did not outline this duty in its draft Bill. However, views expressed in the other place have made it clear that this Bill should reflect the right to information explicitly on its face. This amendment has therefore been tabled to provide clarity on exactly what is required.

The amendment requires the responsible body to provide a copy of the authorisation record to the person under protection, as well as any appropriate person or independent mental capacity advocate, or IMCA, as soon as practicable after the authorisation is granted. It also specifies that the responsible body must, as soon as practicable after authorisation, ensure among other matters that the person understands the effect of the authorisation and their right to challenge it in a Court of Protection.

The amendment replaces the amendment inserted in the other place on this matter, which was unfortunately not workable within the existing Mental Capacity Act.

The Lords amendment set out a range of information that should be shared with the person, but it did not provide clarity on where this information should be shared, which could lead to practical difficulties for practitioners and create exactly the sort of legal loopholes we are trying to avoid.

The Government amendment clarifies exactly what information needs to be provided and to whom, as well as specifying a clear point at which information should be shared. It will impose a legal duty on responsible bodies, so it must be clear where these duties arise. Information can, of course, be shared prior to this point, and in most cases we would expect and encourage this. We will set out more details of this in the code of practice and hopefully make that as explicit as possible.

The amendment is explicit about the point at which the information about the authorisation must be shared, and I hope the Committee will support it.

**Barbara Keeley:** Opposition Members cannot support Government amendment 4. The evidence provided to this Committee by Lucy Series suggests:

“Article 5(2) ECHR requires information to be provided to the person—or others capable of representing them—about the legal and factual basis for the deprivation of liberty and rights of appeal, in a language that they understand, so that they can exercise rights of appeal.

Both the DoLS and the MHA”—  
the Mental Health Act—

“set out in statute who is responsible for providing this information to the person and any others representing or supporting them. It places explicit duties on the detaining authorities to take all practicable steps to help them to understand it. Surprisingly, this Bill did not contain rights to information when first read in the House of Lords; section 13 on ‘rights to information’ was inserted into the Bill after...a vote in the Lords.”

The Government’s new amendment would restore the fundamental imbalance in proposals that were removed by the House of Lords in the current paragraph 13 in regards to rights of information. Paragraph 13 established that the individual would receive information about their rights in a meaningful way in advance of the authorisation. That was a critical addition. Being giving information before authorisation of a deprivation of liberty is a fundamental human right.

Where a person would not be able to understand the information, it must be given to others capable of representing their interests. That is also a crucial condition, for several reasons, which were explained in the debate in the House of Lords. First, receiving information is critical because, in many cases, having information given to cared-for people and their families at the outset can clear up misunderstandings that can unsettle the cared-for person. Most people will not know what the liberty protection safeguards are, let alone have a good understanding of how they work. Knowing what the liberty protection safeguards are, the reasons for a cared-for person’s detention, and what recourse they have to change the situation in which they find themselves are critical parts of the entitlement to appeal. Knowing that the cared-for person can review this decision reduces anxiety, even if they do not wish to exercise that right of challenge at that point.

2.45 pm

The means of providing that information are just as important as the principle of the condition to provide it. For instance, providing only written information

would not always be appropriate. Some people may need easy-read information in plain English. Others may need to speak to someone about the reasons for their detention and to be able to ask questions about it. Some families or cared-for people might need a translator or to use sign language such as Makaton to understand the circumstances of their detention.

To demonstrate how important this right to information can be, I want to talk about the case of R, who lived in a care home but was unhappy with the arrangements and wanted to live elsewhere. They felt the arrangements there were too restrictive. They received support from an advocate to discuss and review their options when it came to appealing their case. Once R had had their rights explained, they initially felt that they would rather appeal to the local authority, as they did not want to bother the court. With the support of an advocate, R appealed to the local authority, but this was refused as the assessment in this case had been too recent.

R was, unsurprisingly, unhappy with this outcome and wanted to know what further steps they could take to get their care package amended. The paid advocate then informed R of their right to take the case to the Court of Protection at this stage. The outcome of the court case was that the local authority reviewed the authorisations and, as a result of that review, moved R to a less restrictive placement.

Despite R initially being unhappy with their placement, it was only when they were given the information on their rights that they came to challenge the decision. In R's case, this came after the authorisation had been granted. Had R been fully informed of their rights prior to the authorisation process, they would almost certainly have been in an inappropriate setting for less time. That is the difference that telling them about their rights made.

Government amendment 4 to paragraph 13 would simply serve to take away the duty to give information to cared-for people in advance of the authorisation process. Giving them the information after the fact is simply not acceptable. Furthermore, what the Government propose is narrower than paragraph 13 in several ways. It would not explain to the cared-for person the process they are about to undergo. For somebody with dementia, who may cope badly with strangers interrupting their daily routine, that is particularly important. Without information provided in advance of the process, they will have no idea what is happening when people they do not know are asking them questions.

The Government's amendment does not explain to the cared-for person that they have a right to an advocate. This seems counter-intuitive when the Government are also expecting people to request an advocate. How can somebody request an advocate if they do not know they have a right to do so?

The Government's amendment would make it harder to refer a case to court. As it stands, the responsible body must refer the case when the cared-for person wants to take it to court. There is no such provision in the Government's amendment. We cannot allow a situation where a cared-for person requests a court review but is given no support to make this happen.

The Government amendment would limit the information given to the authorisation record, which is a technical document detailing the decisions made. The authorisation record does not have to explain the process

undertaken, and there is no obligation for it to say why certain decisions have been made. It is not that we object to the information the Government say should be provided; our objection is to them removing provisions that are already in the Bill. If this amendment passes, we will be replacing a strong safeguard with a far weaker one.

The existing arrangements under paragraph 13 have wide third sector support, including from Mencap, Mind, Rethink Mental Illness, the Alzheimer's Society, Disability Rights UK, Inclusion London, Liberty, VoiceAbility, the National Autistic Society, Sense and a host of others. I am at a loss to know why the Government want to remove them.

As the evidence mentions, paragraph 13(5) of the Bill, as it was brought forward from the House of Lords, places a duty on responsible bodies to "ensure that cases are referred to court when the cared-for person's right to a court review is engaged."

However, this provision would be removed by the Government's amendment.

I gather the Minister has been assuring stakeholders—indeed, she made some reassurances to me—that provisions not added to the Bill will be added to the code of practice. An important point about the code of practice—we seem to keep coming back to this code of practice—was made in the House of Lords by Baroness Barker, and it ought to be repeated here. Statutory codes do not exist without a statute, and the majority of laws do not have a code of practice. Codes are there for when non-legal people are using the law directly. No one expects non-legal people to read or necessarily understand a statute, so a code is provided. Such a code follows what is in statute and sets it out in lay terms and at some length.

**Steve McCabe:** I assume that the Minister has given quite a bit of thought to this matter already. Does my hon. Friend think that this is one area where it would be extremely helpful for the Committee to be able at least to see what is in the draft code of practice covering this area before the end of our proceedings? If the Minister and her officials have been giving quite a lot of attention to this, there may be some reassurance in the draft code of practice. If there is not—if it is yet to be drafted—it would be close to a dereliction of duty for us to say that that is acceptable on such a crucial point, namely that the person does not even get the opportunity to raise issues about what is being done to them until after it has been done.

**Barbara Keeley:** I very much agree with my hon. Friend. I understand the Minister's difficulty with the code of practice. She has told us that it would have to be laid before both Houses, but the difficulty here is that the Government are trying to remove from the Bill provisions that strengthen safeguards, and are thus making those safeguards weaker. As I said earlier, I do not understand why this is happening at all; I do not understand why we would be expected to accept it or to think it was a good idea.

A code follows what is in statute, and sets it out in lay terms and at length, but it would not exist if the obligation in law was not clearly set out. I do not want the Minister to change obligations for information, yet that is what she appears to be doing. I want to make it clear that, for Labour Members, the right to information before authorisation must be on the face of the Bill.

It cannot be something added to the code of practice—even if we could see it now, and the trouble is we cannot—because it would not be a right.

There is existing case law about the Mental Capacity Act code of practice. In 2018, in the case of NHS trust v. Y, the Supreme Court said:

“Whatever the weight given to the Code by section 42 of the MCA 2005, it does not create an obligation as a matter of law to apply to court in every case.”

I think that says it all, really.

Paragraph 13 is the right approach in the case of this Bill. Furthermore, a number of Labour amendments, including amendments 17, 40 and 41, which we will come to later, would strengthen the duty on the responsible body to promote appeals.

**Alex Cunningham:** Again, it is a pleasure to serve under your chairmanship, Mr Austin. This Government amendment—this move to remove paragraph 13 from the Bill—leaves me and others seeking much more information on what exactly is intended. I did not really hear from the Minister what I needed to know. It was a very short introduction to the debate, given the fact that this was long debated in the other place. The Lords brought forward the amendment to the Bill, which is now part of the Bill, with good cause. I am concerned that it has been dismissed quite quickly.

My hon. Friend the Member for Birmingham, Selly Oak talked about the code of practice. It is critical that we have the reassurance that if we are going to have to depend on the code of practice, we know what it will say. Therefore, I ask the Minister whether she will, rather than just depending on dumping this stuff into a code of practice, make a commitment today to come back during our conversations over the next few days or on Report and spell out specifically how we can be assured that the items and protections in the Lords amendment, which is now part of the Bill, will be covered? How will she guarantee that what the Lords achieved with that amendment will be fulfilled on Report?

**Steve McCabe:** I am not sure whether I have understood this correctly. As my hon. Friend the Member for Worsley and Eccles South outlined her concerns, I tried to understand how someone could ever be confident that their wishes and feelings had been fully taken into consideration if they did not get the information explaining what was happening to them until after it had happened. How is that possible?

**Alex Cunningham:** It is totally impossible. If someone does not have the information, how can they make an informed decision? Likewise, people who advocate for someone, whether parents, relatives or whatever, cannot do that if they do not have that information. If there is no information, it cannot be acted on.

I made my career out of journalism, public relations and communications.

**The Chair:** An honourable trade.

**Alex Cunningham:** Some people say that all I need now is to be a lawyer and an accountant, and then I will have done all of the bottom four professions when it comes to public confidence and respect. However, I enjoyed my time as a journalist, my time in the gas industry and even my time running my own business. I have always believed that more information is better

than less, because people can then take what they want from it. They can understand what they want and they can challenge it.

However, the information also has to be timely and easily understood. In moving the amendment, the Government actually want people to have less information, and for it to be less timely. The Minister is shaking her head. Maybe even if there is the same amount of information, it will not come at the right time, and people will not be able to use it to understand, to decide a way a forward and to advocate for the person in care. In the light of what I just said, which the Minister refuted by shaking her head, what measures will the Government actually take to ensure that the information provided to the person being cared for and to appropriate persons is actually understandable, and in clear and simple language?

Many organisations and individuals submitted evidence to us that the consultation process for the Bill had been complicated and excluded people with learning difficulties. The very fact that we did not have an evidence session probably bears that out. Are there any guarantees that those with learning difficulties will actually be able to understand the copy of the authorisation record and other materials and what they mean?

A person with a specific speech and language problem may be able to make some decisions if information is presented to them in a way that they understand. Has the Minister made any assessment of the use of speech and language therapists to communicate the authorisation records and subsequent information relevant to a person's deprivation of liberty?

We have seen evidence from family members of those being cared for, and I have been contacted by constituents on this. They have told me that they are finding out about the authorisation of deprivation after the record has been issued, and that they are concerned that the cared-for person would not have been effectively communicated with. Does the Minister agree that speech and language therapists should be involved prior to the authorisation, to fully understand the circumstances?

**Caroline Dinenege** *indicated assent.*

**Alex Cunningham:** The Minister is nodding her head, which is very good news. She has given me that reassurance, so perhaps I do not need to continue with this particular line of questioning.

We should be very careful that a communication issue is not missed prior to an authorisation being recorded. Just because somebody cannot communicate in the same way that we can does not mean that they cannot communicate.

**Steve McCabe:** I do not want to disrupt my hon. Friend's flow. It is very good to see the Minister nodding her head, but is that the same as an assurance that there will be an obligation? It would be easy to suggest that a person is not very communicative, but that would not be quite the same as acknowledging that the person has some speech and language difficulty. A hard-pressed individual making a rapid assessment might not arrive at that conclusion unless it was absolutely clear that they were obliged to check out that area.

**Alex Cunningham:** That is most certainly the case. The Minister will forgive me if I mention resources again. If people are hard-pressed, we should perhaps

[Alex Cunningham]

have more resources in the system to deal with that. My hon. Friend is perfectly correct, and I take some comfort from the Minister's nodding. I do not so much like the bits where she shakes her head, but I like it when she nods. I think that that may indicate that she will be able to address the issue I raised at the beginning of this short speech and come back to us, either here in Committee or on Report, to spell out exactly how the protections will be covered elsewhere if they are removed.

3 pm

Have the Government considered what information is shared with the cared-for person and the appropriate persons before the arrangements are authorised? Surely, there must be ample opportunity for objection.

**Caroline Dinenge** *indicated assent.*

**Alex Cunningham:** Again, the Minister nods her head, but that opportunity must be long before a final decision on the deprivation of liberty. We must take every possible precaution to ensure that those with an interest in the wellbeing and care of the cared-for person are informed at every possible stage—before the point at which the Minister proposes that should happen. She must be clear that timely information must be given, and she must accept that to remove paragraph 13 of schedule 1 would weaken the rights of the vulnerable person, their family and any advocate. We need reassurances on those matters now, or on Report.

**Caroline Dinenge:** I completely agree that information sharing is vital in the system, and that it should be done at the earliest possible point. Liberty protection safeguards are not something that should simply happen to an individual, but something they need to be involved in from the outset. The Bill specifies that information must be shared after an authorisation is granted, purely because that is a legally cogent point. It includes having a watertight trigger point for information sharing from a legal perspective, but it does not prevent information from being provided beforehand.

Unlike the amendment tabled in the other place to existing paragraph 13, this amendment provides a clear trigger point to specify when information about the authorisation must be provided. We are clear that that point is absolutely the latest point at which information should be shared. In the vast majority of circumstances, that should be done much earlier, or at the very beginning of the process. The amendment does not prevent that from happening. The code of practice will provide detail regarding when it is appropriate to do that, and I have already made a commitment to the Committee to set out what will appear in the code of practice—

**Barbara Keeley:** The Minister cites legal points, but I read out earlier that article 5 of the European convention on human rights requires that a person be given information about the legal and factual basis for their deprivation of liberty so that they can exercise their right of appeal. Telling them after the authorisation process does not meet that requirement. I cited a case in which only on understanding their right to appeal was the person able to exercise that right, which brought about a less restrictive care situation. Apart from mentioning the code of

practice again, the Minister has not explained why the focus has shifted from before an authorisation to afterwards. That cannot be right.

**Caroline Dinenge:** I hope that what I will say gives the hon. Lady more clarity. Amendment 4 follows the current approach in the deprivation of liberty safeguards system—the DoLS system—which requires information to be provided as soon as practicable after authorisation is granted. We agree that from a legal perspective, that is a clear point at which we will always be able to carry out that duty. Amendment 4 removes the requirement to provide information about the process, which was in existing paragraph 13. This is a matter of drafting, but the paragraph did not list the significant parts of the process about which a person must be informed.

The Bill ensures that the person has the right to representation and support from either an advocate or an AMCP. If there is no appropriate person and the person does not have capacity, there is an effective presumption that an independent mental capacity advocate—an IMCA—will be appointed. Responsible bodies will ensure that the person has representation and support. The Government amendment includes steps to ensure that the cared-for person and the IMCA understand the authorisation and the right both to review and to access court.

**Steve McCabe:** Can the Minister share exactly what the draft code of practice says on the matter?

**Caroline Dinenge:** No, I do not have that to hand, but I have explicitly said that we will set out what the draft code of practice will include. I hope that that will give the hon. Gentleman more reassurance.

**Alex Cunningham:** When will that happen?

**Caroline Dinenge:** We will do that during Committee. The hon. Member for Stockton North spoke about the involvement of expertise, particularly in assessing those with speech and language difficulties. That is something that I am really interested in. It was also raised on Second Reading by the hon. Member for Swansea West (Geraint Davies), whom I met yesterday to discuss the matter. I am aware that sometimes a speech and language difficulty can be misinterpreted as somebody lacking mental capacity.

Speech and language therapists already play an important role. We are putting an individual's voice at the heart of the process, meaning that speech and language therapists will play an even greater role. We agree that their skills are essential and that all relevant health care professionals will recognise the role of speech and language professionals. That will be part of the training for this new role.

**Barbara Keeley:** There will be confusion about this, because the Minister is going back over what she has already said. Can she explain to me and my hon. Friends why the Government amendment would remove the following important steps:

“Prior to the authorisation process, the cared-for person must be fully informed of their rights... The responsible body must take such steps as are practicable to ensure that the cared-for person and any appropriate person... representing and supporting them understand the possible outcome of the assessments, the reasons why the cared-for person may be deprived of their liberty and their rights—”?

I do not understand why the Minister thinks it is a good idea to table an amendment that starts:

“As soon as practicable after authorising arrangements, the responsible body must ensure that a copy of the authorisation record is given”.

We will lose the vital early stage of explaining to the person or their advocate what is going to happen, and explaining the person’s rights. Existing paragraph 13 has widespread support. I have explained to the Minister that I think the Government have done badly in talking to stakeholders. To remove a provision that has widespread support—I have quoted some of the organisations that support it—is really rather shocking. For the Government to remove the requirement to provide explanations and fully inform a cared-for person of their rights seems to me to be a contravention of human rights and a serious matter. The Minister has not explained why the Government are doing this.

**Caroline Dinenge:** Let me explain why in two short sentences. In delivering a better and more effective system, we must ensure it is legally cogent. That includes having a watertight trigger point for information sharing.

**Barbara Keeley:** I do not understand that point.

**Caroline Dinenge:** I am very happy to discuss the matter further with hon. Members, but the issue is that there is not a watertight trigger point. When we say that information must be delivered at the earliest opportunity, it is very difficult to codify and define that in law.

**Steve McCabe:** I do not want to get bogged down in legal technicalities, but why is it necessary for the legal trigger point to be after the authorisation has been made? Why could it not be at the start of the authorisation process? That could also be a defined legal trigger point, surely.

**Caroline Dinenge:** I am happy to commit to going away and looking at the matter again. I understand that it worries hon. Members; if I am honest, it worries me, too. As I understand it, the reason is that the starting point is different, depending on the individual circumstances.

That is the problem we have had with the current Bill, from beginning to end. We are looking to create a Bill that satisfies the needs of somebody like my elderly uncle who was living with dementia, as well as the needs of a 16 or 17-year-old who was born with a learning disability. We want the same Bill to cover the needs of a 30-year-old who has been involved in a road traffic accident and has an acquired brain injury.

It is very difficult to ensure that we cover the legal bases and offer the protection needed by every one of those individuals, with their own personal support requirements. That is why we have to pay close attention to what is legally cogent, and why it is important to ensure that the Bill contains a watertight trigger point.

**Barbara Keeley:** I read out the evidence given by Lucy Series to this Committee. I am not a lawyer. We are talking about legal cogency, and I think that that is a difficulty, but the European convention on human rights requires information to be provided to the person or the people representing them about the legal and factual basis for the deprivation of liberty and about their rights of appeal in a language that they understand so that they can exercise rights of appeal. Where is that in Government amendment 4? It does not appear to me to

be anywhere. The amendment starts with “after authorising arrangements”. The Minister talks about cogent points, but she has not given me any cogent information about why she is shifting the point at which people are entitled to information to after the authorising of arrangements. That is not right. I have read out the evidence and advice given to the Committee by a very qualified lawyer, which is that the European convention on human rights insists that the information has to be given at the start, not halfway through the process.

**Caroline Dinenge:** I will only say in response that amendment 4 follows the approach taken in the current DoLS system.

*Question put, That the amendment be made.*

*The Committee divided: Ayes 8, Noes 7.*

#### Division No. 2]

#### AYES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O’Brien, Neil
Dinenge, Caroline	Syms, Sir Robert
Morris, James	Whately, Helen

#### NOES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	

*Question accordingly agreed to.*

*Amendment 4 agreed to.*

**Barbara Keeley:** I beg to move amendment 20, in schedule 1, page 12, line 12, leave out paragraph 14(b).

*This amendment makes provision for the responsible body to take on all functions relating to authorisation of deprivation of liberty in cases relating to care homes.*

**The Chair:** With this it will be convenient to discuss the following:

Amendment 21, in schedule 1, page 12, line 41, leave out paragraph 16 and 17.

*This amendment is consequential on Amendment 20.*

Amendment 22, in schedule 1, page 14, line 27, leave out from “means” to end of subparagraph (8)(b) and insert “the responsible body”.

*This amendment is consequential on Amendment 20.*

Amendment 23, in schedule 1, page 14, line 41, leave out sub-paragraphs (3)(a) and (3)(b) and insert “to the responsible body”.

*This amendment is consequential on Amendment 20.*

Amendment 24, in schedule 1, page 15, line 14, leave out from “out” to end of subparagraph (1)(b) and insert “by the responsible body”.

*This amendment is consequential on Amendment 20.*

Amendment 25, in schedule 1, page 15, line 39, leave out “or 16(d)”.

*This amendment is consequential on Amendment 20.*

Amendment 26, in schedule 1, page 17, line 14, leave out “or 17(2)(b)(iii)”.

*This amendment is consequential on Amendment 20.*

Amendment 27, in schedule 1, page 18, line 31, leave out paragraph 30(b).

[The Chair]

*This amendment makes provision for the responsible body to take on all functions relating to renewal of deprivation of liberty in cases relating to care homes.*

Amendment 28, in schedule 1, page 19, line 5, leave out paragraphs 32 and 33.

*This amendment is consequential on Amendment 27.*

Amendment 29, in schedule 1, page 19, line 36, leave out from “body” to end of sub-paragraph (1).

*This amendment is consequential on Amendment 27.*

**Barbara Keeley:** The purpose of this group of amendments is to remove the remaining conflict of interest in respect of care home managers. When this Bill was first presented to the House of Lords—many people will have read all the *Hansard* reports from that House—there were enormous concerns about the role of care home managers, because they would be judge and jury for deprivation of liberty applications within their own care homes. For organisations with a clear financial interest in keeping their residents in care homes, that represented a very clear conflict of interest, so I am grateful to Members of the House of Lords for their strident opposition—there is no other way of describing it—to such a system and I am glad that the Bill is improved somewhat. No longer will the care home manager automatically be the responsible body in all cases relating to their care home. No longer will they automatically be the person responsible for renewing authorisations in their own care home. No longer will it be the care home manager who decides whether a cared-for person should get an advocate. It is worth saying that those are welcome developments.

However, that does not mean that there is no longer a conflict of interest in the Bill. It will have been noticed that I referred to the fact that care home managers no longer “automatically” have certain powers. That does not mean that they never have them. The Bill now creates a system whereby local authorities can choose whether to trust care home managers to carry out their own authorisation process. Many things in relation to care involve a postcode lottery. This risks further entrenching the postcode lottery that we can already see in our social care system. Some local authorities will conscientiously retain this role themselves. We heard this morning about some good local authorities, which handled the DoLS process well: my local authority, Stockton local authority and others. However, that will not always be the case, because some authorities are struggling so much with resources.

Other local authorities, because they do not have the staff and resources or because they simply do not want to take on the work, will delegate the whole process to care home managers. They could do that, because there is no guidance in the Bill about when it is appropriate to give care home managers that responsibility. Our amendment proposes a clear answer to that question: it is never appropriate. On a matter as important as somebody’s liberty, it cannot be right that decisions are taken by the manager of an organisation that has a financial stake in the granting of the authorisation.

3.15 pm

All cases outside a healthcare setting fall under the remit of a local authority. Our amendment would ensure that local authorities carry out the duties themselves, rather than delegating them to a care home manager.

We have to be careful not to seem to be denigrating people involved in the sector, and I am sure that the overwhelming majority of care home managers want to do the right thing for the people in their care homes, but that does not mean that they should ever be given the power to deprive someone of their liberty without proper checks.

The Minister may mention that a number of checks are built into the system, which is right, but that does not mean that the conflict of interest is any less clear. Independent reviewers are not infallible and should not be the only safeguard against improper deprivations of liberty.

I refer again to the recent court case of *Y v. Barking and Dagenham*, which is the case of a young man who was placed in an inappropriate care home. Initially, his parents were satisfied with the placement, but over time, the quality of his care deteriorated and his health got worse. As constituency MPs who are interested and involved in such matters, other hon. Members will have seen in Care Quality Commission reports examples of care in homes degrading and deteriorating to the point of “requires improvement” or “inadequate”, as I have discussed in many debates.

A turning point in the case was when a teacher at the young man’s school reported that they had seen a member of his care staff violently push him into a wall. That appeared to be assault, but the care home later described it as a legitimate restraint technique. In two years, he was restrained 199 times. He suffered significant harm in the time that he was in the care home and his behaviour worsened. The key thing with learning disabled or autistic people is that their behaviour can degrade to a point where it becomes difficult to put them in a community setting, and that made it harder for him to move to living independently in the community.

The case of *Y* was revealed by an independent social worker, but the local authority dismissed the concerns of *Y*’s parents and instead took the word of the professionals working in the care home. That mistake is sometimes made when family members disagree with professionals—we will all have seen cases in our casework where people disagree with social workers.

As a result, *Y*’s case did not receive the scrutiny that it should have had. When the case went to court, the local authority accepted that it had been too quick to accept the care home’s reassurances and dismiss the parents’ concerns. *Y* eventually got out of the placement after his court-appointed guardian visited and raised concerns, but it took the intervention of somebody completely outside the system for that action to be taken.

That case is an example of why we do not want care homes to have only one independent check before deprivation of liberty is authorised. With the best will in the world, mistakes will be made by independent reviewers. A local authority will sometimes take the word of the care home when it should not.

**Mr Tanmanjeet Singh Dhesi (Slough) (Lab):** To ignore the conflict of interest would be an absolute dereliction of our duty as parliamentarians. Does my hon. Friend agree that pre-authorisation reviews should be carried out only by individuals who are not in any way connected with that independent hospital, the day-to-day care provision for that individual or the treatment of that cared-for person?

**Barbara Keeley:** I agree with my hon. Friend, who makes a good point.

In essence, the case outlines the situation that the Government propose in the Bill. The care home provided reassurances to the local authority that the situation was appropriate and necessary, which lengthened the time that the young man spent in that inappropriate setting. The local authority accepted those reassurances, including when the case was reviewed. The end result was that somebody—this young man—was held inappropriately for two years.

To protect against that, we want all cases to be initially authorised by an independent body, which would organise the assessments and consultations itself. Because it would do that, the care home would not be able to provide initial assurances that may turn out to be incorrect. That would provide another layer of protection against people being wrongly deprived of their liberty.

We have been told that paragraph 20(1)(a) of schedule 1, which would allow care home managers to carry out the consultation with the cared-for person and others, is of concern. I have heard of cases where care homes decide to cut off contact between a cared-for person and their family, often on highly dubious grounds. As the hon. Member for Halesowen and Rowley Regis said this morning, in some cases that may be because the family are not helping the situation. However, in other cases—I am afraid to say that this applies to most of the examples that I have encountered—it is purely because the family object to something that is being done.

Fear of something like that happening can make it hard for someone to stand up to the people providing the care, whether they are the cared-for person or somebody close to them. The risk of having contact cut off, or the risk of reprisals when there is nobody there to object, can make people compliant even when they do not want to be.

I ask hon. Members to picture this situation: neither the cared-for person nor their family are confident enough to stand up to the care provider and object to the support that is being developed, and then that very same care provider asks them if they have any objection to a deprivation of liberty being granted. How many cases can Members imagine in which nobody says anything, not because they do not want to but because they are scared of the consequences?

One such case would be too many, but I suspect that there will be many more. I will raise two cases now in which such a situation could have been an issue. In one case, a resident—Mr A—had removed his hearing aid and his daughter had had to shout to make herself understood. She was then accused of bullying him and of other misdemeanours, and she was banned from the care home. She had been a regular visitor and had helped with many personal caring tasks. She was subsequently informed that the matter had been referred to safeguarding and that a DoLS referral had been made. The investigation made it clear that the restrictions had been imposed because she had asked a number of questions about the deterioration in the home's standards of care, which the care home manager was finding difficult to answer.

In another case a daughter, Ms B, was concerned about her father, Mr B. Against all attempts to prevent it from happening, Mr B had been placed in a care

home. Ms B felt that that was against both his wishes and his best interests, which is the important point that was just made. However, both the care home manager and her stepmother were content with the placement. Mr B's behaviour quickly became increasingly aggressive and he made repeated attempts to leave the home, including by climbing out of a window. His daughter's visits were then blamed for his behaviour. As a result, the care home manager prevented him from meeting friends outside the home and Ms B was asked not to visit the home.

In both those cases, relatives with a valid interest in a cared-for person's welfare were restricted—on spurious grounds—from having contact with them. In both cases, the main “fault” of the relative was to express concerns about the care that was being delivered. If expressing negative views about a person's care can get a relative banned from seeing them, of course people will be reticent about making their feelings known when they are consulted by the care home manager.

**Mr Dhesi:** My hon. Friend is making a very powerful point. Hopefully the Minister will acknowledge that if family members are excluded from the care process, alarm bells should ring throughout the entire process, because so often for vulnerable individuals their family members are the only people who visit them. That is why we need to ensure that family members have a connection with them in the future.

**Barbara Keeley:** By moving this responsibility in the Bill to local authorities, which currently have this responsibility, we can ensure that people are more confident about expressing their feelings. The consultation process should act as a crucial safeguard to prevent people from being deprived of their liberty against their wishes. Without our amendments, I am afraid that all too often the Bill will not achieve its purpose.

I turn now to the burden of work that the Bill will place on care home managers, because that is an important aspect. I hope that I have made it clear that I do not think that it can ever be appropriate for a care home manager to have a role in this process, but more than that there is no evidence that care home managers want this role or could carry it out. There is currently a vacancy rate of 11% for registered care home managers—11% of care homes do not even have a manager. That is higher than for any other role in the care sector. Care home managers are overworked in many cases, having to manage care homes that are operating on increasingly narrow margins. They are not experts in mental capacity nor trained to carry out assessments. In short, the role that they may be given is not one that they are prepared for or want.

Given that they are overstretched, we can expect them to make mistakes on occasion—that is understandable. When people are placed in high-pressure environments and expected to do more than they reasonably can or want to do, something has to give. We should not be in a situation where that something is the proper process for the authorisation of the deprivation of somebody's liberty. It would not be acceptable if the result of the Government's underfunding of social care was that people had their liberty taken away based on a tick-box exercise by a care home manager who lacks the time and skills to do any more.

[Barbara Keeley]

I understand that the Government estimate that it will cost just £20 to train a care home manager to carry out this role. I think it was said at a recent meeting of the all-party parliamentary group on social work that it takes years to train a social worker to get to the point of carrying out assessments. Twenty pounds represents perhaps half a day of training. The idea that after a few hours a care home manager will be able to go out and manage liberty protection safeguards is not plausible. These complex issues should be carried out by people who have experience and expertise.

As we heard earlier, local authorities already have teams dedicated to deprivation of liberty safeguards, so it seems a wasted opportunity not to use that resource. Ultimately, it would not even save money.

**Steve McCabe:** As I listen to my hon. Friend, I wonder if people are a little confused between process and practice and, as a consequence, are doing a disservice to the local authority or whoever the appropriate responsible body is and to the care home manager. Surely, it is the job of a good care home manager to provide and oversee the care and to give regular reports and information that explain how the cared-for person is responding to the care regime that they are receiving—what seems to help them and what may hinder them. That is extremely useful, because the alternative to that is that the person is being warehoused and there is no way of knowing what happens over a period of time. The process is to assimilate that information and think about it in the context of what is in the person's best interests and where we should go next. By suggesting that the same person should do the same thing—and it is just the same thing—have we not ended up doing a disservice to both groups of people?

**Barbara Keeley:** I think my hon. Friend is right; that is the case. Ultimately, the point is that it would not even save money. Despite what the Government's out-of-date impact assessment may say, care home managers will not be able to carry out this role for free. Time spent carrying out these authorisations is time spent not doing other work. Care home managers are not currently sitting around doing nothing all day, so there will be cost implications. When care homes are struggling to remain solvent anyway, these small differences cannot simply be absorbed.

The Bill comes at a time when social care is under enormous pressure. Years of underfunding mean that care homes are hard pressed to keep their heads above water. The brutal reality is that without more funding for local authorities, they will not be able to increase what they are paying to care homes, and that means that some care homes will have to carry out these assessments without any extra resourcing. That will mean that less time is spent delivering hands-on care and more time is spent dealing with this process. This is where the proposed reforms to the Bill would have a real implication for the delivery of social care as a whole. We need to see reform across the board if this is not to become another cost that we expect care homes to bear, pushing more of them into dire financial straits.

It would not be the first time the Government have done that. When they brought in the living wage, they made no effort to support local authorities so that they

could pay providers more. When the Government updated their guidance on sleep-in pay, they made no guarantees to providers that they would support them to pay off their liabilities. The care sector cannot afford to continue to pay for Government decisions without being appropriately supported to do so.

3.30 pm

Because of the crisis in the funding of social care, the costs of carrying out deprivation of liberty assessments will be passed on to the local authority or—importantly for self-funders—to the cared-for person themselves. There is no mention in any of the documentation around the Bill of that point. Given that there is a cost involved in giving this role to the care home manager, it could be that the costs will eventually just be paid for by the self-funder or the local authority. I know that the Government say—we had Health questions in the interval today—that reform of social care funding is coming, but even if the Government's Green Paper were published next week or the week after, reform would still be years away. This measure will cost care providers now.

I have heard from care providers that are concerned that the extra work that this measure could place on their care homes might even force some care homes out of the market. People who lack capacity may start to be too much work for some homes. It is already difficult to get places in care homes for people with advanced dementia. A care home in Tameside closed for financial reasons recently and one of the people there with dementia had to be placed in the city of Durham—nowhere near Greater Manchester—and their family had to deal with that. There are already care deserts in parts of the country—places where people with certain levels of dementia cannot get a care home place.

The Government should be upfront about this. The purpose of the Bill should not be to save money nor to shift the cost outside local government, despite the consequences that that would have. We cannot just move costs around and assume that it will not be a problem. The plans in the Bill would create an indirect cost, while removing crucial safeguards for some cared-for people. That seems to be the worst of all worlds.

**Alex Cunningham:** My hon. Friend talks about shifting the cost around. I know that we will get to it later in the Bill, but there is the issue of charges being made to the person living in a care home or elsewhere. They could end up shouldering this burden, rather than anybody else—it should be the state.

**Barbara Keeley:** I cannot see anything other than that self-funders would end up paying it. Self-funders might not just end up paying it for themselves; they might be paying it for everybody else who is in the care home, which is actually what they do—there is a certain transfer.

I want to make myself perfectly clear. Care home managers should not be involved in the authorisation of deprivations of liberty or the consultations around that. It is unlikely that they would be able to do it and, as far as I can ascertain, they do not want to do it. Given that, the best route is surely to move responsibility back to local authorities, which have considerable expertise in this area.

We also propose to remove care home managers from the process of renewing an authorisation through amendments 27 to 29. If anything, that is more critical. At authorisation stage there are some safeguards in place, but to renew an authorisation, all that a care home manager would have to do is carry out a consultation and then certify that they feel the authorisation conditions continue to be met.

I have covered our concerns about the consultation process, so will not go over them again. I cannot see how it can be appropriate, however, for an authorisation to be renewed without anyone outside the care home being involved. The Bill proposes that renewals could last for three years—longer than the initial authorisation—and we have our separate concerns about that. At the renewal stage, however, there is no independent review. There is no medical assessment by a person not connected to the care home. There is no independent consideration of whether the arrangements are suitable.

I understand the Government's argument, which was made in the House of Lords, that they do not want the renewal process to be stressful for the cared-for person where there is little prospect of anything changing, but that is not an excuse to remove vital safeguards. The most vital of those is that the decision is made by somebody with no vested interest in maintaining the arrangements. Only by doing that can we begin to make sure that the streamlined renewal process does not result in people being wrongfully deprived of their liberty.

Before I make my concluding comments on these amendments, I want to give Members another example of how things can go wrong in care homes. I recently heard from someone who was admitted to a care home after a spell in hospital. She was admitted to hospital after knocking herself out in a fall in her garden and being rescued by ambulance. A social worker had arranged her admission to the care home, which the person thought would be for a few weeks.

The care home was privately run and was

“full of elderly men and women from varied backgrounds. There were writers and businessmen and women, carpenters and vicars but they were all suffering from various degrees of dementia. I met only one resident who wanted to be there and she had been there for about 15 years and had chosen to go there after her husband had died. Most of the people there were women. Most of them were put there by their children and their houses had been sold to pay for their care or, if not, their children or their local council paid the enormous bills.

The home was a miserable place, the food was worse than school dinners and there were no events or outings organised at all. Each day had a routine of getting up, breakfast, sitting in chairs silently looking at the ceiling or knitting scarves, toilets, lunch, sitting, early tea and all in bed by 9 pm. There was no stimulation or crafts to do.”

The woman soon realised that it was difficult for her to get out, because she was given IQ tests and declared to have Korsakoff syndrome. This can happen, I understand, after a head injury. She said:

“The home wasn't interested in the residents' wellbeing or recovery. It suited them to have sedated residents sitting doing nothing all day. Their interest was making money. They owned a number of homes in the area. The guests were allowed visitors in the afternoon, but many didn't have visits at all. I continued to spend all of my days by myself, but read and researched lots of things, and insisted every day that I wanted to see someone about being released. I was told that they could release me if someone came to pick me up and took responsibility for me in their home.”

She started to do exercises designed to improve memory and got in touch with the local council. Someone from social services visited and arranged for a specialist doctor to conduct an IQ test, on which she got very high results. The social worker wrote to the home and to her, and used the deprivation of liberty regulations to secure her release.

The woman left this miserable care home some six months after being admitted there to live in a new house, which she had bought. She contacted me because she was grateful for the safeguards that enabled her to leave that place, which she saw as

“merely a depository for elderly unwanted family members.”

She told me that

“these commercial business homes are terrible institutions created to make money.”

We are asking that people like this person, if they are going to be deprived of their liberty, always have their rights guaranteed by an independent public body, rather than the organisation responsible for providing their care.

What is contained within the Bill is not a solution to a problem. There is near unanimity among stakeholders that it would be better if this role were never carried out by a care home manager. Our amendments would mean that care home managers are not given another task that they have neither the time nor skills to carry out. They would ensure that cared-for people and their families feel confident in speaking out when they disagree with the arrangements. They would ensure that people authorising deprivation of liberty are the people best qualified to do so: the well-trained professionals currently employed by local authorities for this very purpose.

More importantly, our amendments would remove one of the conflicts of interest that the Bill seems to seek to enshrine. They would ensure that nobody is deprived of their liberty in a care home on the say-so of the manager of that same care home, which is making profit from that deprivation of liberty. This is a matter of principle. Private companies should not be given responsibility for denying people their basic rights. It is right and proper that this responsibility should always lie with a public authority that is subject to democratic control. Amendments 20 to 29 achieve that and I hope that the Government will accept them.

**Alex Norris** (Nottingham North) (Lab/Co-op): Thank you, Chair: I know you have put in a double shift as Chair today. I think that might help us get to the root of why this room is so warm. We are trying to echo the micro-climate in Dudley, which I believe is quite tropical at this time of year. It is a pleasure to follow my hon. Friend the Member for Worsley and Eccles South.

This set of amendments follows on from amendment 19. When we were discussing amendment 19, the Minister said that she would take under active consideration the issue around independent hospitals; I am very glad about that. I hope that perhaps she will take these amendments in the same spirit, as they extend the same principle.

At the beginning, prompted by my hon. Friend the Member for Birmingham, Selly Oak, the Minister said she felt that independent hospitals would be a particular focus, because the revelations that we have seen on television showed that there is risk there. I suspect that the same risks are built into the care home sector, too, because the preconditions are similar—for example, a

[Alex Norris]

financial vested interest, a lack of outside scrutiny and an unhealthy power balance between those who run such schemes and those who are resident there.

The vast majority of the time, the leadership in such facilities is excellent and is geared towards supporting the individual. However, where that is not the case, those preconditions build up that risk. As I say, what we have talked about in relation to independent hospitals also applies here. We need to address a fundamental question. We have said that we believe that the DoLS system does not work, that the backlog is not tolerable, and that we ought to move to more effective arrangements. That view is very broadly shared, but I do not think that anyone would wish, in reaching a system that is more sustainable for the public purse and better for the individual, to downgrade the assessors from qualified social workers with specific qualifications in the area to others—in this case, care home managers. That is not a good way of saving money or getting things done more quickly, and the best way to make that clear is by finishing the process that began in the Lords, as my hon. Friend the Member for Worsley and Eccles South noted, and completely removing the relevant references from the Bill.

There are a couple of reasons why that is necessary. First, finances in care homes are marginal. We might sometimes blanch at the cost, but we know that they can go to the wall quite quickly. As a result, there are subconscious commercial pressures that could colour a judgment, shifting it away from the best interests of the individual and towards the best interests of the care home in general. That, of course, is not what we seek to do.

It cuts both ways. We have spoken about independent hospitals having a perverse incentive either to hold on to an individual when it is not appropriate or to provide a much more comprehensive service than is necessary, but it can cut the other way, too. I am not aware of the picture across the country, but in Nottingham the most complex care packages in a residential setting are hotly sought after and we do not have a mass market for them; the market for more general needs care in my city is quite mature and sustainable, but that is not the case for higher-end care. A different perverse incentive could therefore arise for a care home if there are individuals for whom starting the assessment process or conducting periodic reviews is more trouble than it is worth. Whatever path we take in the rest of the Bill, the issue will continue to be tested in case law, and I do not know of many care homes that would gladly take on the responsibility of being on the other side of it.

As well as perverse incentives either to keep people or to ensure that they do not stay, there is a second point, as my hon. Friend the Member for Worsley and Eccles South said: are care homes really the right responsible body? I did not know—I am disappointed that I missed it in my research—about the £20 training for care home managers in a really important subject. Of course that is not sufficient; I cannot imagine that it could cover anything beyond filling out a form in a legally compliant way. It instantly pushes us towards a tick-box approach, which nobody wants—an approach that is about clearing the necessary barriers to legal compliance, rather than working around the individual's needs and being person-centred.

As my hon. Friend said, there is a double risk. Some local authorities will identify the risk straightaway; others will not. Those that are feeling particularly hard-pressed will say, “It is our legal responsibility to ensure that somebody does this, but it does not have to be us.” With public sector cuts as they are, there is a series of perverse cost incentives throughout the health and social care system that result in individuals being pushed from one organisation to another; this will be one such incentive. Other local authorities—we have heard some good examples—will say, “Hang on a minute: this is far too important for that,” but portfolio holders and directors of adult social services are under incredible pressure.

**Steve McCabe:** Is this another situation in which we are in the dark because of the missing code of practice? It may be the case that if the Government have thought about that there will be examples in the code of practice saying how it should operate, what the minimum expectations are to avoid a tick-box approach, what good practice is and what people should aspire to achieve. If we had sight of that—if we had some indication that it was on the Government's agenda—it might be easier for us trying to scrutinise the Bill, and it would offer some reassurance to the wider public that the fears that have been expressed will not prove well-founded.

3.45 pm

**Alex Norris:** I thank my hon. Friend for that intervention. I am perfectly willing to concede that I might be being a bit too sensitive or nervous about this if a blue riband code of practice is going to be laid next to the Bill that plays out all the concerns and things that we are seeking to avoid, and that therefore really protects people and ensures that decisions in the moment will be the right ones. However, the problem is that we simply do not have that, so we are left to conceive of it, which is very difficult. We trust Ministers and civil servants to pursue the goals that they are talking about, and to pursue the best for individuals, but it is still very hard. We cannot fully discharge our responsibility if we have not seen that piece of the puzzle, so that is frustrating.

It is about knocking this bit of legislation into something that gets us to the final goal. I do not think that anybody has advocated a DoLS system that is streamlined and more financially possible simply by pushing the assessments away from someone who is exceptionally skilled and trained in the area to somebody who is not. I do not think that is desirable for the individuals who will be assessed or fair on those who will do the assessing. I hope that Ministers are minded to take that on board.

**Alex Cunningham:** During today's debate I have already raised concerns about independent hospitals, and about care home managers and their potential role in depriving people in their care of their freedom. I know that my hon. Friend the Member for Worsley and Eccles South has addressed that comprehensively, but I hope that I can still add some value to the debate.

Even if there was some way in which the Government could justify the role of care home managers as outlined in the Bill, there is still a huge number of reasons why the sector would struggle to deliver what Ministers want it to. My hon. Friend has talked about the fact that finances in care homes are very much on the margin—they could be bust one day and make a bit of profit the next.

However, some care homes do not even have care home managers. In hundreds of others across the country, the level of competence of managers in running care homes is alarmingly poor. We have some of them in my constituency. We have some great managers, and we have some excellent care homes, but we also have some that fall into the “inadequate” or “requires improvement” categories on inspection. It is not good enough for us to consider handing over this level of responsibility to people who might not be competent, or might not even be there in order to carry out the work.

On the CQC website, 2,550 care homes are listed as requiring improvement, with a further 223 deemed “inadequate”. Some of them are very large homes, but let us say that each one has an average of just 25 people in their care. That would mean that some 70,000 elderly people in care are being failed by the system. Leadership in those homes is one of the reasons they are being failed, and CQC reports bear that out time and again.

I know that that is symptomatic of a broken adult care system that has been neglected by the Government. I am sure that the Minister wants to wring my neck when I start talking about resources again, but it is about inadequate resources. Even after allowing councils to hike council tax to boost the social care budget, there is still insufficient money in the system. Profit-taking companies are often failing to provide adequate care, citing as the reason that they cannot afford to do so.

The system is in danger of failing further, as care homes close and the number of people requiring residential support increases. How on earth can the Government justify placing this most important duty on care home managers, asking them to play a central role in depriving the people in their care of their freedom? Given that the system is broken, that thousands of care homes are not anywhere near the required standard, and that in many cases there is no one competent—or no one at all—in the home, who will fill the gaps and deal with deprivation of liberty issues there? There may be other reasons why someone needs to do the work planned for the care home managers. If there is no care home manager, who are the Government expecting to carry out these assessments? Those managers do not want this duty, so what happens if a care home manager says, “I am simply not prepared to do this work; I do not want this responsibility”? Again, who will pick up that work? Will it fall on the local authority, the local GP commissioning group, or the health board?

**Steve McCabe:** Is not the reality that if the scenario my hon. Friend has depicted comes to pass, we will have a different backlog? We will have gone through this whole exercise and, rather than having fixed this system, we will have transposed one problem for a different one with exactly the same impact.

**Alex Cunningham:** Indeed that is the case. There are probably thousands of people in the system at this time who are illegally detained, or whose freedom has been denied them; we can do without additional problems of the sort that my hon. Friend describes. I talked about the fall-back position: if there is nobody in the care home who can do this work, and it does fall back on the local authorities or some other organisation, they are already dealing with very strained budgets and an overload of work, so how do we fill that gap? Again, I ask the Minister how she will ensure that these organisations

have the resources that they need, even if the duplication that she was describing earlier in the day is sorted out and the systems run far more effectively. I am aware that if our amendment is successful and these duties do not sit with care home managers, the bill for work by these other organisations will be all the greater. Again, how on earth will that be funded?

Of course, the system can work. I cite the case of the north-east of England, where the DoLS system probably works better than in other parts of the country—albeit that local authorities have chosen to take the political decision I talked about earlier. However, that is letting other services down because they feel that they must protect the interests of people whose liberty is at risk. I will return to my point about the north-east a little bit later, as I want to go back to the topic of care home managers. Does not the Minister agree that most of them should be working to improve or maintain their CQC ratings and all that comes with that, rather than carrying out those assessments of individuals in their care?

I intervened on the shadow Minister to talk about charges. Some care homes may even charge a self-funder an administration fee for the assessments. Who says that is fair, right, or proper—Members can use whatever word they like? Who on earth governs that, and who is protecting the person who is having to shell out the cash? What is to stop a care home manager from unnecessarily charging fees for “administration purposes”? Who is there to say otherwise? I said this morning that we need to protect the public purse and the purses of those who live in these establishments; this is another example of that. One of the pieces of written evidence we have received comes from a collective of organisations, including the Registered Nursing Home Association and Care England. It says:

“There is no reason for singling out care home managers for extra responsibility, over their colleagues in other care settings, except for to transfer significant costs from struggling local authorities to struggling care homes. The effect will inevitably be that some providers who continue in the sector...pass on the costs to the affected residents.”

My hon. Friend the Member for Nottingham North discussed that.

So there we are: care home associations do not want the responsibility of assessments; the persons involved will not want the care home to have that responsibility; and we Labour Members, who probably matter less than them, do not want care homes to have responsibility for assessments, so why are the Government continuing to push this? Any opportunity a care home manager has to improve their organisation’s financial outlook is bound to be considered. That is all the more reason why it should not be their job to carry out assessments for a person when they have a vested interest—and a financial interest, at that. The Alzheimer’s Society also has a concern; it argues that we urgently need clarification of the role of care home managers, and how to protect the independence of the person being cared for. That is currently dealt with by best-interests assessors. My council of Stockton-on-Tees has raised concerns with me about the fact that the decision as to the necessity of assessment still appears to rest with care homes.

I thank Angela Connor and Natalie Shaw from the Stockton DoLS team for taking the time to talk to me about their work and how it will be affected by the Bill. They provided me with some follow-up notes, for which I am very grateful, because in one hour they built my

[Alex Cunningham]

understanding more than all the reading that I had tried to do. Like others, they posed many questions. Where is the quality assurance? Who is going to check that what they are doing is both correct and within the law? Despite the obvious conflict of interest, local authorities rely on assessments made by a care home manager, including allowing care home managers to carry out a consultation to determine a cared-for person's wishes.

Between 2013 and 2018, there was a 5,000% increase in the number of applications under the Mental Capacity Act that my local authority received. Stockton-on-Tees Borough Council created the DoLS team in 2014 to manage the applications. As I said earlier, we are quite lucky in the north-east because there has been a regional arrangement in place that means that mental health assessors are paid a fixed fee of £175 for three assessments—buy two, get one free—and best-interests assessors are paid £175, again for three assessments.

As I mentioned earlier, the number of completions of DoLS in the north-east was higher than in the rest of the regions, and applications are taking a shorter time to process. Dedicated DoLS teams have been established across the region. Independent assessors are used, and that raises awareness with managing authorities. Yet the Alzheimer's Society tells me that the Bill would remove the post of best-interests assessor; part of their responsibility will shift to care home managers, who I think are ill equipped to perform the role. The DoLS team in Stockton tell me that they believe that the Government's proposals will lead to a diluted assessment.

I agree with what the Minister said this morning about ending the duplication of assessments, cutting out waste and targeting limited resources where they are most needed, but that must not be done by diluting the assessment process. I am interested to hear what the Minister has to say to address the concerns of so many stakeholders in this area.

The Government's proposals, under which care home managers, who are held responsible for providing care, are also responsible for assessment, are not in the best interests of the person affected. I do not believe that the Government intended to create this clear conflict of interest. If care managers are not to be removed from the process entirely, I hope the Minister will outline in detail exactly how this serious situation is to be avoided. We may have to rely on information provided later. A code of practice is all very well, but we need the detail now. If we do not have the assurances we require, how on earth can we support the Bill?

**Caroline Dinagen:** I thank hon. Members for raising important issues today. We have heard what amendments 20 to 29 would do. It is worth setting out that care homes already have an important role in the DoLS system. They are responsible for identifying where a person lacks capacity, and for working out where restrictions might be needed as part of care. They are responsible for making an application to a local authority. Because of the current backlog, they are responsible for chasing that deprivation of liberty safeguard, which gives them the legal protection that they need when they are keeping somebody in their care.

It is important that care home managers continue to play a central role in the liberty protection safeguard system, but we completely recognise that it would be a

conflict of interest to have care home managers completing assessments. I am not sure whether the hon. Member for Stockton North was a bit confused, or whether I misinterpreted what he said, but there is no plan for care home managers to do the assessments; they are just gathering the information required. We amended the Bill in the other place to reflect that.

4 pm

If we remove the care home manager from the process entirely, we remove a professional with expert training who is closely involved and responsible for the individual's care plan through their responsibility under the Care Act. We would be taking them out of the process, completely unnecessarily, to duplicate a system that we already know is not working and is broken.

**Barbara Keeley:** I have picked up that it was generally thought that Ministers, and possibly the Bill team, have a rather honeyed view of the relationship between local authorities and care home managers, and of how much care home managers get involved in care planning. She has just illustrated that point.

These are the points that the Minister seems to be ignoring and needs to answer. First, 11% of care homes have no manager; there is an 11% vacancy rate. Secondly, one in 20 care homes requires improvement or is inadequate. She has talked about care home managers being involved in care planning, but that does not happen in the 11% of care homes where there is nobody there to do it, or in inadequate homes. In the care home that collapsed recently in Tameside, the staff effectively took over almost everything. There are many care homes—thousands, according to my hon. Friend the Member for Stockton North—possibly dealing with 70,000 people, that are not in an acceptable situation. There appears to be no recognition in the Bill, or in anything around it, that that is the case with our care sector.

**Caroline Dinagen:** I understand the hon. Lady's concerns, but she is not 100% correct. Where there are concerns about the care home, it is possible for the local authority, which would normally be the responsible body, to carry out these functions. Care home managers should be able to arrange assessments and identify and provide valid assessments previously completed by the responsible body. Let me say why. This goes to the crux of why care homes and the system face this overwhelming bureaucracy today.

Let us take a straightforward case, such as that of my uncle, whom I spoke about earlier. He was in a care home—he is sadly no longer with us—and he was very happy. We were very happy with him being there. There was a clear medical assessment of his condition and his state on the care home's books. Why couldn't the care home manager gather that? If there was no care home manager, or if the local authority—the responsible body—had any concerns about that person, their role, or their ability to fulfil that function, they could do it themselves, as they currently do.

**Steve McCabe:** The Minister told the Committee earlier that she did not want to put too much detail in the Bill in case that in itself became a restrictive problem. If good care home managers are already involved in and informing the process as part of good practice, why does that need to be specified in the Bill? She is telling

us that this happens anyway. Presumably, this could be cited in her code of practice as an example of good practice. The role of the care home manager that she describes is one of informing the responsible person, and using their knowledge and experience, gained through engagement and regular contact with the individual, to help inform the process. Presumably, that is just existing good practice, and it could be included in the code of practice. She may want to follow her own example of not cluttering her Bill by being too specific. This is an opportunity to take something out to help her achieve what she wants to.

**Caroline Dinagen:** I am grateful to the hon. Gentleman for that kind offer, but we intend to build on the role that care homes already play. Care home managers already daily identify that a person may lack capacity and need restrictions, take part in constructing a care plan, and liaise with mental health professionals. We are committed to supporting them further in doing that, ahead of implementation. We want to make sure that training for the workforce is delivered, and want the development-type model that I have spoken about.

I spoke a lot today about reducing the backlog. That will help enormously in reducing the burden that falls on care homes. They will not have to keep chasing applications that are in local authorities' backlog in order to get protections regarding the legal right to hold somebody in their care. The care home manager is often in a strong position to identify whether a person objects to the arrangements. Having a role in the consultation allows them to do this.

**Alex Cunningham:** We can all acknowledge that there is a role for care home managers in the system, but I see them as a small cog in the engine, rather than the driver of the machine. Does the Minister understand the issues around the lack of competence in many homes? How will she spell out somewhere in the legislation who picks up the pieces? She replied to my hon. Friend the shadow Minister on this, but she has not been clear on who does the work that she is expecting the care home manager to do if the care home manager does not exist or is not competent.

**Caroline Dinagen:** I am more than happy to do that, and I will deal with that shortly. The amendments would remove the role from the care home manager entirely, and would separate the liberty protection safeguards from the wider care planning that is already being done. It risks recreating the existing failing system, in which DoLS are too often considered a separate, overly bureaucratic, one-size-fits-all, box-ticking exercise.

We have to be careful. The hon. Member for Worsley and Eccles South rightly spoke about not castigating local authorities. She also mentioned that we must not demonise care providers. I agree. Of our care providers up and down the country, 83% are rated good or outstanding. They provide an incredible level of professional integrity and care, as well as daily vocational commitment, sometimes in difficult circumstances.

**Barbara Keeley:** I want to pick up what the Minister for Care says about DoLS being a box-ticking process. I have given at least two examples of people being freed from a totally inappropriate care setting because of a well-run DoLS process. The DoLS process runs well in my local authority, in Stockton and in other large

authorities. Let us not denigrate that. With regard to care homes, 83% are better than satisfactory, but 17% are not, and 11% have vacancies. Unless we are talking about a figure in the high 90s, we cannot have confidence. We have properly trained DoLS assessors. She is calling that a box-ticking exercise, and says that half a day's training for a care home manager—when almost one in five of them are not doing an adequate job—is somehow going to be better. It is not. It will be disastrous in some cases.

**Caroline Dinagen:** I would just say to the hon. Lady that I am quoting Sir Simon Wessely. In his view, this is too often a bureaucratic tick-box exercise and does not put the individual, their wishes, feelings and best interests at the heart of what we are all trying to achieve. I would also reinforce what I said to her before: the responsible body can decide to carry out these functions where there are concerns about the quality of the care provider. That might be because there are inexperienced staff at the helm, or no care home manager, or even particularly strong social worker involvement. When it is appropriate, the responsible body can carry out the functions. The Bill already makes provision for the involvement of social workers and allows for that where appropriate. We also need to ensure that self-funders, who have had very little involvement from a responsible body, receive protections. Removing all forms of role for care home managers could easily risk such people falling through the cracks.

The hon. Member for Worsley and Eccles South raised a couple of issues that I want to address. We absolutely agree that families should be able to object, and the Bill is very clear that those with an interest in the welfare of cared-for persons can flag objections on the person's behalf. An AMCP can review the case. That can be done directly with the responsible body, bypassing a care home, which solves the problem where people have the experience that the hon. Lady spoke of, where they do not have a good relationship with the care home. If they do not have confidence or are worried about raising concerns, the AMCP can be triggered.

The Bill already makes provision for the involvement of social workers. It already allows that, where appropriate, the responsible body can take on the functions from the care home if there are any concerns. My biggest concern is, in a nutshell, that these amendments, if passed, would risk fundamentally weakening the protections available to people. On that basis, I ask hon. Members to think seriously about the amendments, which are effectively recreating a system that we have all recognised is not fit for purpose, and I ask the hon. Member for Worsley and Eccles South to withdraw her amendment.

**Barbara Keeley:** We have had a very useful debate. It has been really helpful to hear the useful contributions from my hon. Friends, although I have to say it is very quiet on the Minister's side. It is a pity that we are not hearing more from that side, as I am sure there are people here with useful experience as constituency MPs.

Although progress was made on this issue in the House of Lords, there is still potential for a conflict of interest to arise in relation to the role of care home managers. I do not resile from what I said: the provisions in the Bill risk further entrenching a postcode lottery in our social care services. We already have a postcode lottery and it could be much worse.

[Barbara Keeley]

We believe that this is a serious situation, where local authorities diligently retain some of their role, while others are delegated to care home managers. On the point that the Minister covered at the end of her speech, it is particularly unacceptable for care homes to retain a role in carrying out the consultation. I gave case study examples where cared-for people and their families become wary of expressing objections to the people delivering care for fear of reprisals. It is true that in care homes, with GPs and in NHS hospitals people do not always say what they feel about the treatment they receive because they are so worried about reprisals, and that is very much the case with ongoing care situations. I gave several examples where family members were stopped from seeing a cared-for person after objections were raised. We have to take that seriously.

As we heard, as well as it being inappropriate that care home managers retain a role in carrying out the consultation, it is not clear to me at all from meeting organisations such as Care England, the network representing care home managers, that they want or are willing to take on the role. As we mentioned, they are currently under significant strain. That is a real factor. Having an 11% vacancy rate for registered care home managers is another real factor. Adding another role to them, without proper resourcing, will inevitably lead to services suffering.

In our discussions on the Bill, we need to have a proper debate about resources, because there was no time to discuss it in the Lords. There has been no real discussion on it yet, and it is absolutely crucial. There is a cost, as I covered in my speech, and we cannot just shunt the role on to care home managers who do not even want it.

Some care home providers are concerned that local authorities will delegate the role without providing training or additional resources to care home managers. I talked about the backlog of pay claims for sleep-in rates, which is a problem. Care England and the care home networks feel very strongly that a shunting-across is going on that will lead to financial difficulties for them. It will lead to care homes either leaving the market or no longer taking on clients who require deprivation of liberty

authorisations. As I outlined, those could be cases of people involving dementia or brain injury. They will not take those cases if they think there is going to be a lot of admin linked to the processes.

4.15 pm

The issue of renewals is, if anything, even more important. The only safeguard at renewal stage is a consultation. I have talked about why it is not appropriate for care home managers to carry that out. Without our amendments, care home managers may be able to renew authorisations for up to three years based on their own opinion and a consultation in which people are afraid to express their objections.

I think that, in trying to deal with the backlog, which we all want to be addressed, the Minister is potentially moving the backlog from local authorities to care homes and setting up a new bureaucracy, which will involve a debate and perhaps legal cases between the two. I will press these amendments to a vote.

*Question put.* That the amendment be made.

*The Committee divided:* Ayes 7, Noes 8.

### Division No. 3]

#### AYES

Cunningham, Alex	McCabe, Steve
Debonnaire, Thangam	Norris, Alex
Dhesi, Mr Tanmanjeet Singh	Sherriff, Paula
Keeley, Barbara	

#### NOES

Afolami, Bim	Morton, Wendy
Chalk, Alex	O'Brien, Neil
Dinenage, Caroline	Syms, Sir Robert
Morris, James	Whately, Helen

*Question accordingly negated.*

*Ordered.* That further consideration be now adjourned.—(Wendy Morton.)

4.16 pm

*Adjourned till Thursday 17 January at half-past Eleven o'clock.*

**Written evidence reported to the House**

MCAB01 Andrew Lee, Director, People First  
 MCAB02 National DoLS Leads Group  
 MCAB03 Eloise Jones, Best Interest Assessor/Senior Social Worker MCA/DoLS  
 MCAB04 Roger Hargreaves  
 MCAB05 Dr O Sorinmade, MRC Psych., MSc., LLM, Consultant Older Adult Psychiatrist  
 MCAB06 Royal College of Speech and Language Therapists  
 MCAB07 Andrew MacTaggart, Best Interests Assessor  
 MCAB08 Mike Stone  
 MCAB09 Steven Richards  
 MCAB10 Dr Samantha Hamer  
 MCAB11 Carol Wilkinson  
 MCAB12 Kay Matthews  
 MCAB13 Sarah Paxton  
 MCAB14 Dr Anil Christopher Chopdar  
 MCAB15 David Parker  
 MCAB16 Andy Nash  
 MCAB17 Colin Newland  
 MCAB18 Rethink Mental Illness  
 MCAB19 Derek Boothby  
 MCAB20 Sue Adams, DoLS Practice Manager/AMHP/BIA  
 MCAB21 Citizens Advice Sheffield  
 MCAB22 Dr Camilla Parker, Just Equality

MCAB23 Royal Mencap Society

MCAB24 Association for Real Change (ARC), Care England, the National Care Association (NCA), the National Care Forum (NCF), the Registered Nursing Home Association (RNHA), and the Voluntary Organisations Disability Group (VODG)

MCAB25 Vincent Duffy

MCAB26 Nick Woodhead

MCAB27 Albert House Nursing Home

MCAB28 Dr Haider Malik, Consultant Psychiatrist

MCAB29 Bill O'Grady, Social Worker

MCAB30 Stephen Ward, Lead for MHA and MCA Isle of Wight Council and Isle of Wight NHS Trust

MCAB31 Tracey Hennis, qualified Social Worker and Best Interest Assessor

MCAB32 Dr Lucy Series, a Wellcome Research Fellow and Lecturer in Law at the School of Law and Politics, at Cardiff University

MCAB33 Sara-Jayne Williams, Mental Capacity Act Coordinator for Bedford Borough Council

MCAB34 Graham Hennis, a qualified Social Worker and a Best Interests Assessor

MCAB35 Roger Laidlaw, Social Worker and Deprivation of Liberty Safeguards Coordinator

MCAB36 Sian Phillips

MCAB37 Lucy Bright

MCAB38 Kings College Hospital NHS Foundation Trust, Adult Safeguarding Service

MCAB39 Learning Disability England

