MCA and LPS Draft Code of Practice and Regulations Consultation Response

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Although this submission is from 360 Assurance and does not purport to represent the views of any other individuals or groups, it has been informed by 360 Assurance's involvement in a number of regional LPS implementation meetings (Nottinghamshire, Derbyshire, Leicestershire, South Yorkshire, East Midlands and NHSE Midlands) as well as attendance at and participation in webinars run by a number of commercial organisations. The quality and thoroughness of the conversations has been incredible and demonstrates the passion with which professionals want to ensure the rights of vulnerable individuals are safeguarded.

There are a number of typographical errors, formatting issues, links which do not work etc, in addition to some simple errors (eg references to after-care under supervision in chapter 22), throughout the draft Code. We have not included reference to these in this response as it is assumed the updated Code will be subject to a rigorous proofing process prior to finalisation.

Consultation question 1 (Consultation document page 29 / Draft Code of Practice Chapter 7)
The Code states that applications to consider deprivation of liberty cases, only, should not generally be made to the Court. To what extent do you agree or disagree with the following statement?
'Responsible Bodies should not be routinely making applications to the Court, once LPS is implemented'

- ☒ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Additional comments (can't formally submit due to word count)

Tautology – if agreed legal process in primary legislation is no longer to take to court then should not routinely make applications to court. However, need to ensure all have access to court to ensure article 5(4) rights (incorporated in the Human Rights Act 1998).

Consultation question 2 (Consultation document page 31 / Draft Code of Practice Chapter 21)
Many 16 and 17 year olds who will be subject to an LPS authorisation will have complex special educational needs or complex additional learning needs and will therefore also have an Education, Health and Care (EHC) plan, in England, or Individual Development Plan (IDP), in Wales.

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

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

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

- ☐ Very clear
- ☐ Somewhat clear
- ☐ Neither clear nor unclear
- ☒ Somewhat unclear

☐ Very unclear

Consultation question 2a
Please explain your answer if you wish (300 words)

The guidance in the draft Code explaining the interaction between the LPS for 16 and 17 year olds (where parental responsibility does not apply) and other relevant legislation is quite clear.

However, the more general interaction between the Children Act and the MCA in respect of 16 or 17 year olds who lack capacity is less clear.

Paras 21.10 - It is felt there needs to be more guidance as to when you would use the Children Act 1989 and the operation of parental responsibility as opposed to the Mental Capacity Act for 16/17-year-olds. (Also at para 6.40 states can chose between the piece of legislation). There are no clear examples identified of when each framework could be appropriate (apart from when there is no one identified with parental responsibility – para 21.18), which could lead to potential disputes.

Paras 21.11 - Where a 16/17-year-old refuses treatment, there is a question of whether you always have to go to court or whether there are any circumstances in which parents can override the young individual's decision. This could be made more explicit eg through a scenario.

Para 21.55 - To provide clarity on this point, it is felt that an example of a scenario would be helpful for LPS or other regime to authorise a DoL in a secure children's home.

Para 21.58 – This indicates foster carers may be an Appropriate Person. However, para 21.59 states that someone who receives remuneration for care or treatment cannot be the Appropriate Person. Therefore, are foster carers excluded from the role where they receive payment? It would be helpful to clarify.

Paras 21.64 and 21.71 are felt problematic as they refer to the DoL definition in chapter 12 being relied on and seek to incorporate a relative comparator as a key principle for whether a child/young person is deprived of their liberty.

Consultation question 3 (Consultation document page 34 / Draft Code of Practice Chapter 24)
Anyone, including the person, can challenge the proposed or authorised arrangements at any stage of the LPS process (including via the Court of Protection and via the Responsible Body). This is an important safeguard in the LPS process.

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

☐ Very clear
☒ Somewhat clear
☐ Neither clear nor unclear
☐ Somewhat unclear
☐ Very unclear

Consultation question 3a
Please explain your answer if you wish (up to 300 words)

Para 24.10 - Guidance is clear, but staff do not necessarily have access to mediation services, especially within the 21-day timescale.

Para 24.20 – Could the 'relevant' local authority be articulated more explicitly eg "the local authority covering where the person lives"?

Para 24.35 - It would be useful to have standard information regarding the right to make an application to the

Court of Protection under 21A rather than each Responsible Body or even each ICS producing their own.

Para 24.36 – To prevent confusion, it be more explicit that the person and their AP will qualify for legal aid eg "there is no means test *required* for legal aid for the person or their Appropriate Person *as they will be automatically eligible for legal aid*."

Para 24.40 - More guidance would be helpful around the meaning of 'regular' contact between the Appropriate Person and P.

Developing a national /regional list of solicitors would be a useful practice rather than each Responsible Body having to maintain their own.

Consultation question 4 (Consultation document page 35 / all proposed updates in Draft Code of Practice Chapters 3 – 11 and 21, - 26)
Are the principles of the MCA fully explained in the revised Code?

☒ Yes
☐ No

Consultation question 4a
If you responded No, please specify the relevant paragraph and what you think it should say (up to 250 words)

The description of the statutory principles and the quick summary guidance relating to them remains largely unchanged from the original MCA Code of Practice. We find this to be positive given that the original was clear and well written.

However, the scenarios are often very simple and do not reflect the complex real-life situations that staff have to manage, particularly around principle 3. Scenarios could be more complex and contain further detail to help people understand how to apply the principles.

It would be helpful to have more scenarios focused on applying the principles in healthcare settings, including acute and mental health hospitals. The majority of the scenarios are based on social care settings which cannot always be transferred into practice within acute and mental health hospitals.

Consultation question 5 (Consultation document page 35 / all proposed updates in Draft Code of Practice Chapters 3 – 11 and 21, - 26)
Do any of the updates to the existing guidance in the Code, as listed in Section 1 and Section 2, require further expansion or revision?

☒ Yes
☐ No

Consultation question 5a
If you responded Yes, please specify the relevant paragraph, and what you think it should say (up to 250 words))

Para 3.7 - There could be more examples of the 'relevant' information taken from case law in this section.

Para 3.11 - It is felt that there is lack of information about using a professional language interpreter etc to help communication or using someone to support with communication.

Para 4.10 – This might benefit from amendment as, if it were read without reference to para 4.93, the reader may believe that every single capacity assessment must be recorded (and the MCA applies to non-professionals as well). This also needs to be considered alongside Para 5.102 which seems to indicate that every best interests decision is recorded. Is it proportionate to record every best interests decision if there is not necessarily the requirement to record the mental capacity assessment which preceded it?

Paras 4.93 – 4.97, regarding when capacity assessments are recorded, have only be slightly amended from the extant Code. In practice, as there is inevitably much subjectivity regarding when capacity assessments should be

recorded, and in how much depth, we ask if this be expanded to guide professionals to record capacity assessments proportionately. We suggest that this section be expanded to explain that recording of capacity assessments should be more detailed if the person objects to proposed actions, and more detailed if the proposed restrictions are intense (along the same lines as listed for best interests decisions in para 5.105 and reiterated in para 6.46).

As identified in Q4 the Code would benefit from having some more complex scenarios and in relation to greater range of settings. Examples might include: unwise decisions involving drug and alcohol misuse, sexual relations (also see response to Q6), social media and internet usage (again, see also response to Q6). Some of the scenarios are unrealistic, as they seem to make the assumption that all care homes and general practitioners have a good understanding of the MCA in practice.

There are currently no scenarios or guidance around responding to or managing challenging families, which would be useful when implementing into practice (only scenario in chapter 24 is a disagreement between two relatives).

Consultation question 6 (Consultation document page 35 / all proposed updates in Draft Code of Practice Chapters 3 – 11 and 21, - 26)
Have there been any significant developments in case law or practice which the revised Code does not address but which you feel it needs to?

☒ Yes
☐ No

Consultation question 6a
If you responded Yes, please specify the relevant paragraph and what you think needs to be added (up to 250 words)

It would be helpful to provide further guidance on social media and internet usage, with specific reference to *Re A (Capacity: Social Media and Internet Use: Best Interests)* [2019] EWCOP 2 and *Re B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3.

Similarly, sexual relations is always a tricky area for practitioners and inclusion of scenario based on *A Local Authority v JB* [2021] UKSC 52 might also be helpful.

Further guidance and scenarios on difficult areas of practice such as dealing with fluctuating capacity or people who will not engage in capacity assessments or the best interest process would also be welcome.

Consultation question 7 (Consultation document page 35 / all proposed updates in Draft Code of Practice Chapters 3 – 11 and 21, - 26)
Do you have any other comments on the proposed updates to the existing Code guidance?

☐ Yes
☒ No

Consultation question 7a
If you responded Yes, please specify the paragraph which your comments relate to, and your views on this (up to 500 words)

N/A

Consultation question 8 (Consultation document page 36 / Draft Code of Practice Chapter 12)
How clear is the guidance in chapter 12 at explaining the meaning of a deprivation of liberty for practitioners?

☐ Very clear
☐ Somewhat clear
☐ Neither clear nor unclear
☐ Somewhat unclear
☒ Very unclear

Consultation question 8a
Please explain your answer if you wish (up to 300 words)

The chapter recognises the importance of case law and predominantly Cheshire West. However, it is unclear the basis for the seeming deviation from existing case law in the range of scenarios provided. Could real examples from caselaw be used instead?

Part of the LPS process is to assess whether someone is or is not deprived of their liberty. Practitioners should be encouraged to err on the side of caution to ensure people have the appropriate safeguards. Guidance in the Code should perhaps focus on the 'risk that someone may be deprived of liberty' as this should be the threshold for referral into the process. It will then be for LPS assessors, reviewers and authorisers to remain up to date with changing case law.

We have significant concerns about the formulation of 'continuous supervision and control', especially the suggestion that if someone has time alone in their room that they are not under continuous supervision.

Advance consent for a DoL feels like it would create a strange anomaly of law (would it not require primary legislation?) in which you can consent to being deprived of your liberty in advance but cannot consent to receiving a particular medication in advance. Unlikely to be useable in care home situations.

R (Ferreira) v HM Senior Coroner for Inner South London and others is not mentioned or footnoted in the draft Code. The draft Code and the scenario of Ms K seems to go significantly beyond this.

Very uncomfortable with the suggestion of making a distinction of arrangements that are only to meet physical health needs. This group of people who lack capacity to consent but need intense support for physical disabilities would lose an important safeguard if we tried to limit application of LPS in this confusing and unnecessary way. Clarification of the interplay between these provisions and section 4B is needed.

A much more satisfactory arrangement would be a statutory definition that involved 'objection' or a process of authorisation (to meet the requirements of Article 5) that acknowledged the large numbers of people who are deprived of their liberty and therefore was very simple and unbureaucratic in cases where there was no objection, but required secondary oversight and monitoring where there were suggestions of objection.

The three points for consideration at 12.26 would make a good starting point for a wide but understandable definition of continuous supervision and control.

A much fuller response is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

There may be merit in having a separate document containing examples (akin to Annex B on the Northern Ireland MCA Code of Practice: https://www.health-ni.gov.uk/sites/default/files/publications/health/mca-dols-cop-november-2019.pdf) which could be updated without having to update the whole Code as case law and practice develops (as the introduction to the chapter acknowledges that "Further legal developments may occur after this guidance has been issued".)

The scenarios presented, if followed, would significantly reduce the number of people deemed to be deprived of their liberty. If the threshold for what constitutes a deprivation of liberty is raised and the scenarios provided relied upon, there will be large numbers of individuals in care homes who would not meet the threshold but do object to residing in the homes. It is in these scenarios that the secondary oversight and scrutiny of arrangements potentially has the greatest benefit and the framing of the scenarios in chapter 12 therefore may discriminate against older people in particular. The purpose behind LPS, as with DoLS, is to promote liberty and to reduce unnecessary suffering. This is most likely to be achieved when applied to people who object to their accommodation, care or treatment.

An alternative to contorting the case law is that primary legislation could be amended to create a statutory

definition of deprivation of liberty which would indeed reset the case law. This could most helpfully focus on individuals who object and exclude from any detailed oversight and scrutiny process those who are content in their gilded cages (ie include some form of subjective element which reflects feelings of imprisonment).

Para 12.20 – This seems to go against the paras above (12.15 – 12.19) in shifting to whether they can leave temporarily. Surely the same test should apply in terms of leaving permanently. The 'limiter' might naturally be the available options but often scenarios are 'theoretical' so the same should apply here ie if someone who currently lives at home turned round and said they were going to move in with someone they had made friends with at the pub last week would they be 'allowed'? The freedom to leave on a temporary basis more sensibly forms part of the continuous supervision and control if you try to draw a distinction between them.

Para 12.21 – makes a very specific point of saying (in not quite these words) that must have continuous supervision *and* continuous control. Para 12.23 then claims there is very little difference in the meaning of 'continuous' and 'constant' (with no mention of 'complete' which was used in the Cheshire West judgment). In combination these premises then form the basis for some of the scenarios, the conclusions of which seem to go against the current case law, as well as the final sentence of para 12.22

Para 12.29 introduces the factor of whether the person has time alone in their room. This could (?should) be irrelevant if, as per para 12.26 staff know where the person is (ie in their room), know what the person is doing (simply by lieu of there being very little to do in the room) and would intervene if they were at risk of harm (ie might lock the door to the room to prevent them going in if there was any suspicion they might do something risky). A much simpler test might be that if someone cannot (or would not be able to) leave a particular building/premises without staff/ a carer then it is probably safe to say that they are under continuous supervision and control (the control following from the supervision, as you shouldn't be supervising or monitoring someone unless it is because you would intervene if there was a risk). An exception could be made in situations where someone is normally enabled to leave unsupervised but for a particular reason on particular occasions is prevented eg "because the person is drowsy having received medication" (as per para 12.37). Where someone needs assistance when out (eg to push a wheelchair) then this would not need to count as supervision if they could chose who did this, when they did this, where they went, what they did etc.

Scenario Mrs B (p261) – agree that by itself this is not continuous control but disingenuous as if this is the only time each week Mrs B goes out and she is prevented from going out unsupervised at other times then her circumstances might still amount to a DoL.

Scenario Mr C (pp261-262) – If Mr C is only able to go out at pre-determined times and for these two or three times each week staff still know where he is then hard to see how the three bullets at 12.26 are not met. If it was discovered that Mr C was undertaking risky behaviour whilst out, would the staff not remove the outings or chose to accompany him, thus demonstrating that they are still in control? The same might apply to Mina (p266).

Of the types of devices listed at para 12.40, would there be any other purpose for which they could be used other than "to react and intervene if the person was at risk of harm" (as per para 12.41) that would not be sinister/raise concerns in itself?

Scenario Mrs L (p263) – Mrs L may be happy and would probably be very unlikely to want to live somewhere else but theoretically she might not be 'allowed to' live somewhere else if she said to her daughter that she wanted to move in with Bob across the street. Due to the fences and the door alarm her daughter and carers always know where she is and, given that carers come three times a day, what she is generally doing and they would (presumably) intervene (exercise control) if she was exhibiting risky behaviour.

Para 12.44 asks us to consider the fact that someone is in their own home as part of determining whether they are subject to continuous supervision and control. The cases in insufficiently made as to why these cases should be treated any differently as to the actual meaning of continuous supervision and control.

Scenario - Jennifer (p264). Staff at the home always know where Jennifer is (ie in the home) and she cannot go out unsupervised. Staff will always know roughly what Jennifer is doing (due to natural limits of options and presumably some out of bounds areas within the home) and would take steps if Jennifer was at risk. Therefore, just because she can move between communal areas and her room cannot/ should not suddenly rule her out from the LPS process. If we added to this scenario that Jennifer was constantly at the garden gate screaming to "be released from this prison" would that change the situation and bring it within scope? If so, then what is the material difference? The same could be applied to Jack (p265).

Scenario – Marsha (pp264-265). This one is interesting. If Marsha wanted to stay overnight somewhere one night would she be enabled/supported to do so? The scenario potentially over simplifies for the sake of brevity and this might not be helpful to staff who will need to understand some complex subtlety and nuance. How realistic is it that someone would be allowed out completely unsupervised for 9 hours a day if they lacked capacity to make a decision about accommodation?

Scenario – Tom (pp265-266). On the basis of the information provided it is impossible to draw a reasonable conclusion as important questions aren't answered such as whether he is allowed out unsupervised at other times (ie not to college) or whether at break times in college they are allowed off the premises or if there are certain areas they are confined to.

Scenario – Jake (p266). Again, this scenario is too simplified to provide the necessary information to help staff – Jakes does not go out often and when he does t is accompanied/supervised. His wife/carers know he is always in the house and therefore what he is doing (within the limits of the house). Control is being exercised in his wife choosing not to take him out because she does not feel capable of looking after him.

Scenario – Jason (p267). When at home, Jason's parents will know that Jason is in the house and therefore undertaking a limited range of activities. If he was found to be doing something risky control would be exercised to reduce the risk. The scenario is therefore too simplified to usefully try to draw an overall conclusion on whether Jason is at risk of being deprived of his liberty or not.

Para 12.53 - Unclear why the "test of capacity is likely to be less onerous" where the arrangements are being carried out in the person's own home. The provision of information may be more straightforward and the person may find it easier to understand the information because it is already familiar to them but the actual threshold for whether the person has capacity or not should be exactly the same (or else it undermines the test). This may simply be a terminology issue – possibly "the assessment of capacity may be more straightforward" rather than "the test of capacity will normally be less onerous". The terminology is used again in para 12.61 where it says "the decision to continue living in a home environment, while having restrictions in place such as the door being locked overnight, is less onerous than deciding to move permanently to a care home or hospital". The information required to make the decision (especially regarding consequences) is certainly less complex but 'onerous' is a strange choice of words.

The examples of advance consent for a DoL given at para 12.58 are treatment in a hospital for mental disorder and post-surgery recovery. The treatment in hospital for mental disorder may have multiple permutations so on the grounds of specificity is only likely to be applicable when someone has repeat admissions with a particular care plan routinely put in place during their admission. However, relying on advance consent for the DoL would still not provide consent to treatment (which would presumably be part of the plan in a mental health hospital) so there is no advantage to the individual as they would lose this other important safeguard.

A specific scenario for advance consent would be helpful.

Can't imagine that advance consent could be used to provide consent to a DoL in a care home as some people living in care homes may be deprived of their liberty and some may not and this wouldn't necessarily be known in advance (at a time when the individual still had capacity). "I give consent to arrangements being put in place that amount to a deprivation of liberty in order to accommodate me in the care home" is too vague as per para 12.60

(and rightly so). End of Life care could be distinguished and therefore not need this particular provision to cover it. Post-anaesthesia care could all form part of the consent that a patient currently gives prior to surgery which already covers what the anaesthetist and the surgeon have permission to do whilst the person lacks capacity due to an anaesthesia-induced unconsciousness.

How would advance consent be communicated across providers? This has been a problem with ADRTs and there does not yet seem to be an adequate solution.

There is a seeming contradiction between para 12.62 which stipulates that the advance consent must be signed and witnessed with para 12.64 which says "consent given in advance does no necessarily have to be written".

Para 12.71 – for the avoidance of doubt, it might be appropriate to include the scenario of placements (other than care homes) and also make early reference to situations in which the NHS or Local Authority is funding or arranging a care package as 12.72-12.75 are quite legalistic.

R (Ferreira) v HM Senior Coroner for Inner South London and others is not mentioned or footnoted in the draft Code. Arden LJ stated that *"any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in Austin) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose"."* The draft Code and the scenario of Ms K seems to go significantly beyond this.

Very uncomfortable with the suggestion of making a distinction of arrangements that are only to meet physical health needs. The only applicable situations might be where someone is in a medically induced coma or otherwise unconscious (as per Scenario – Ms F (p248)). Treatment for physical health problems alone that amounts to a deprivation of liberty (which includes a lack of capacity, which in turn necessitates a mental disorder) is surely 'impossible'? Care planning of physical treatment for someone with a mental disorder must and should take account of their mental disorder (if in *any way* relevant – which it always will be if it is the basis on which they lack capacity to consent) and therefore the treatment can never be 'the same'. The question at 12.80 "would they be put in place for any other person, without mental disorder?" is disingenuous as someone without mental disorder would have mental capacity to consent or refuse and could simply discharge themselves from the arrangements (against medical advice if necessary). This group of people who lack capacity to consent but need intense support for physical disabilities would lose an important safeguard if we tried to limit application of LPS in this confusing and unnecessary way. Scenario Ms K (p248) – Ms K lacks capacity to consent but it is not clear if this is because of the dementia or as a result of the stroke. Either way this is a fundamental factor in care planning and completely impacts on her vulnerability.

Consultation question 9 (Consultation document page 37 / Draft Code of Practice Chapter 13)
The Code sets expectations about how long key LPS processes should take to complete. Specifically, it states that the LPS authorisation should be completed within 21 days and that Responsible Bodies have five days to acknowledge an external referral.

Do you think the timeframes set out in the Code are:

☐ Too long
☒ About right
☐ Too short

Consultation question 9a
Please explain your answer if you wish (300 words)

If (except in section 4B situations) authorisations should be requested in advance, then 21 days seems like too long a timeframe, as it may delay the discharge from hospital or instigation of a care package whilst awaiting the authorisation. Many packages of care and treatment that require arrangements that amount to a deprivation of liberty are not necessarily planned more than 21 days before they realistically need to commence.

However, from the perspective of completing the review and authorisation process if appropriate assessments are in place, the timeframe is probably about right – it is realistic in terms of accessing information and managing to consult with the necessary individuals if there were sufficient staff dedicated to LPS with appropriate caseloads (which is probably dependent on reducing the number of potential applications but in a clear, fair and equitable way). However, in situations where the appropriate assessments are not in place (which we believe will be a much higher proportion than the Impact Assessment estimates) the ease with which assessments can be arranged (mental health assessments in particular) will be the major determining factor in the realism of the timeframe.

Given the current delays with undertaking assessments under the DoLS regime, if the numbers of applications remain similar (as suggested in the Impact Assessment) then significantly more staff will be needed who are 'dedicated' to LPS (although these will not all need to be qualified to the same level ie there may be a reduction in the number of AMCPs (compared to BIAs) that would be needed, but this would be countered by a significant increase in the number of dedicated non-AMCP pre-authorisation reviewers). Without this increase, it would be naïve to think that the process can be completed significantly quicker than currently, which is <21 days in relatively few cases. Current urgent timeframes of 7 or 14 days are consistently not met and a significant backlog of cases has been generated.

Also need to consider the ability of the IMCAs to respond in short timeframes. This will be dependent on having adequate numbers of IMCAs both nationally but also within each Local Authority area.

It would be useful to have specific examples of the exceptional circumstances when the 21 calendar day timeframe would not be the guiding 'benchmark'.

A fuller response is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

The legal status once a referral/request for authorisation has been made and the outcome is awaited should be clarified. If the arrangements already amount to a DoL it seems like this would be unlawful unless the criteria of section 4B are met. Therefore, it would make sense for the formulation of section 4B to be wider or for care providers to be lawfully covered once they have made the referral/requested authorisation (possibly only once the three supporting assessments have been submitted).

At paras 15.73 and 19.24 it makes reference to 21 calendar days. Elsewhere (paras 13.26, 16.50, 20.20) it simply refers to 21 days. It would be helpful to refer to 21 calendar days consistently so practitioners reading particular paragraphs in isolation do not get confused as to whether it might mean working days.

Please consider including (or publishing separately) clear guidance regarding how DoLS backlogs (of people who do not object) should be prioritised during the first year (or relevant cross-over period) of LPS. In the absence of this, a national shortage of DoLS assessors would result, and £millions will be spent on non-objecting DoLS assessments (benefitting few people), when that money is urgently needed elsewhere. Several Local Authorities are again considering if they should clear their DoLS backlogs (and several independent agencies are offering their expensive services to assist with this aim). NHS Digital figures indicate that as at 31 March 2021 the backlog of cases was 119,740. Applying the costings used in the Impact Assessment for Options 0 and 1 this would equate to a cost of £180million for current Supervisory Bodies (in addition to the costs of LPS in the first year).

When LPS previously appeared imminent, in the absence of such guidance from Government, some Local Authorities invested heavily in their attempts to clear their DoLS backlogs. Market forces and the finite number of DoLS assessors led to a significant shortage of DoLS assessors elsewhere.

Consultation question 10 (Consultation document page 38 / Draft Code of Practice Chapter 13)

The Code aims to support health and social care workers to integrate the LPS process into other health and care assessments and planning, as far as possible. How clear is the guidance in chapter 13 at explaining the interface

between the LPS and other health and care assessments and planning?

☐ Very clear
☐ Somewhat clear
☐ Neither clear nor unclear
☒ Somewhat unclear
☐ Very unclear

Consultation question 10a
Please explain your answer if you wish (300 words)

Practitioners are worried about the specific requirements the assessments and determinations need to include (specifically for LPS) and how this can be incorporated into the processes and paperwork already in use.

Overall, it feels like the expectations are currently very unrealistic and it will take several years before this becomes routine (given that it is acknowledged that the MCA is not fully embedded).

Again, no health or health care setting scenarios are provided.

Para 15.51 on the role of the Appropriate Person indicates that the AP should be involved in the assessments undertaken. However, if the assessments relied on for the LPS genuinely become part and parcel of routine assessment and care planning processes then they are likely to take place prior to or simultaneously with triggering the LPS process and therefore before the AP is appointed by the Responsible Body.

Comments on each of the assessments are included in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

Mental Capacity Assessments
Whilst it is recognised that there should be a mental capacity assessment in place for everyone who is receiving care and support in arrangements that may amount to a deprivation of liberty it is also acknowledged that this is far from reality. Getting these assessments in place on a routine basis will require a considerable shift in practice and be initially very resource intensive on the health and social care workforce. The Impact Assessment figures for how many people will need a new mental capacity assessment are very unrealistic for the first couple of years, until assessments do become embedded as part of the assessment and care planning process.

Within hospital environments the suggestion might be that a mental capacity assessment should be done as part of the admission processes and therefore how much time can realistically be given to this is a major consideration.

Mental Health Assessments
Ability to access or commission mental health assessments seems to be the biggest concern for community/social care settings. There seems to be mixed messages circulating about what expectations will be. Para 19.6 of the Impact Assessment states "Many GPs are already carrying out assessments under DoLS, and recover the cost from the relevant Supervisory Body. We would expect that to be the case under the LPS as well." However, elsewhere there seems to be an expectation that the GP PMS contact could be amended to include this expectation.

Access to these assessments will generally be much easier in a hospital environment but as for the mental capacity assessment if it is expected as part of the admission process then it might not be given sufficient time or consideration.

Necessary and Proportionate Assessments
Para 13.29 states, 'When undertaking the necessary and proportionate assessment and determination, this should be combined with, for example, the person's needs assessment or NHS continuing health care assessment.' This process would be effective if most recipients of care, including self-funders, already receive timely capacity assessments, Care Act assessments and reviews. Nationally available statistics show that most local authorities across England and Wales must prioritise those with the greatest need and therefore these assessments would

not necessarily be in place

Consultation question 11 (Consultation document page 38 / Draft Code of Practice Chapter 13)
Is the guidance in chapter 13 on the authorisation, reviews and renewals processes clear?

- ☐ Very clear
- ☐ Somewhat clear
- ☐ Neither clear nor unclear
- ☒ Somewhat unclear
- ☐ Very unclear

Consultation question 11a
Please explain your answer if you wish (300 words)

It is positive that the process can be triggered by anyone and there is 'no wrong door'. However, this does mean that the process will often be triggered without the assessments or other good evidence of the conditions being met being immediately available. As identified in Q9 this will affect the likely timeframes for the authorisation process.

If authorisations have to be in place prior to the arrangements commencing there will be situations where people have to remain in inappropriate settings (eg remain in an acute hospital) rather than be transferred to the environment in which the ongoing care and support deemed to be in their best interests can be provided. (Para 19.5 suggests that an urgent move can be completed prior to the authorisation being in place). Whilst in the inappropriate setting they may be deprived of their liberty and there does not appear to be any way for this to be deemed lawful if it does not fall within the criteria for section 4B (eg if they are in hospital awaiting discharge but the LPS authorisation needs to be in place for their care home before they can be discharged to the care home). Even if an additional request for an authorisation is submitted in respect of the present location, this either will never result in authorisation (due to discharge) or will lead to a very short authorisation. Either way this would not be an effective use of precious resource.

Further guidance or suggestions on the appropriate people within Responsible Bodies to 'authorise' on their behalf would be welcome as prior to the consultation we were seeing organisations with wildly different ideas of the necessary seniority (versus in-depth operational knowledge of the MCA/LPS) of the individuals which may result in disparity and potentially inequity for people subject to LPS.

A fuller response is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

Informal or family carers will not necessarily have the knowledge to recognise a DoL and/or know how to seek authorisation. There is a question as to whether there will be a national campaign to help the public understand the Act, its principles and the LPS process.

Draft form Template 8 (Notice to Responsible Body that an LPS authorisation may be required) looks fairly straightforward to complete for the referrer (which is welcome).

Authorisation

Who is the Responsible Body in the case of a patient in an ambulance? It may be rare, but there may be situations in which restrictions, such as restraining staps, are used for a sufficient period (given long ambulance handover times) to constitute a DoL. This would likely fall within the scope of section 4B but which Responsible Body should be notified – the hospital the ambulance is heading to/waiting at or the Local Authority as the patient is still in the community or possibly the ICB as the commissioner of the ambulance service.

Para 13.48 identifies that the same person cannot be an assessor, pre-authorisation reviewer and authoriser. It

goes further to say that the same person should not be an assessor, determiner and pre-authorisation reviewer. However, this does not cover the situation where the assessment and determination are completed by different people so that would benefit from being made explicit (this appears to be covered for AMCP cases in para 13.51 where it says "If an AMCP has carried out any of the person's assessments ***or*** determinations…they should not carry out the pre-authorisation review".

Appropriate Person – It is clearly part of the primary legislation that the Appropriate Person be identified/'appointed' as soon as possible after the LPS process has been triggered to enable them to be involved in the consultation and support the person through the process. This will require Responsible Bodies to act quickly and throughout the consultation it may become clear that an alternative individual is better placed to fulfil the role. Given that these changes may need to be made it would be very helpful if the recording of 'Appropriate Person' was not bureaucratic during the LPS process (ie it is simply captured within draft form – '*Template 8 - Notice to Responsible Body that an LPS authorisation may be* required'), with the draft form '*Template 5 – Submission for Pre-Authorisation review (PAR)'* amended to include a recommendation as to who is now considered to be the most appropriate Appropriate Person, rather than the simple Yes/No question currently included.

Para 13.24 places a duty on the RB to monitor the suitability of the AP on an ongoing basis. Further guidance on what this might look like would be welcomed.

Para 13.44 identifies that the pre-authorisation review in cases not undertaken by an AMCP can be completed by an individual who is not a health or social care professional. It is our opinion that the pre-authorisation review *should* always be undertaken by a registered professional. We do not necessarily think this should be restricted to the registered professionals who can become AMCPs, but they should be registered with the Health and Care Professions Council, the GMC, the British Psychological Society or Social Work England. It is likely to be the case that Responsible Bodies would only consider registered professionals for this role anyway, so this explicit requirement would support them in this. It would ensure that the credibility of the process was maintained and that assessors did not feel that their assessments were potentially going to be challenged by a non-professional.

Para 13.80 – pausing authorisations – a time limit would be helpful.

Reviews

Para 13.85 – an example schedule of reviews might be helpful.

Paras 18.63-18.68 and chapter 18 generally identify that an AMCP should be involved in review if the person now objects/is believed to be objecting and an AMCP was not involved in the pre-authorisation review. If an AMCP *was* involved in the original authorisation (because there was objection or something other reason for referral to an AMCP) does an AMCP need to be involved in the review and/or renewal process? – An explicit statement would be helpful.

Renewals

Para 13.104 – Instead of 'drawing near' would it be possible to identify the earliest point at which the renewal can take place eg anytime after 28 days' before the end of the authorisation period.

13.107 We suggest adding to the final sentence, '… unless the person objects' (to help ensure LPS scrutiny is focused upon people who feel imprisoned).

13.110 The suggestion that a new authorisation must be put in place for even small amendments to the record feels overly bureaucratic with little benefit. Perhaps a review, or a brief record made by a pre-authorisation reviewer or AMCP, would be sufficient.

Consultation question 12 (Consultation document page 39)

The government has decided not to implement the role of the care home manager (outlined above) in the LPS, having heard a range of concerns raised by stakeholders about this role. Do you agree that the care home manager role should **not** be implemented?

☒ Yes, I agree that it should **not** be implemented
☐ No, I disagree

Additional comments (can't formally submit due to word count)

Care homes vary so significantly that it is appropriate to not place this additional responsibility on care home managers who will be at very different stages in terms of MCA and DoL knowledge and understanding as well as implementation.

Consultation question 13 (Consultation document page 41 / Code of Practice Chapter 16)
The Code sets out that previous and equivalent assessments can be used in the LPS process if it is reasonable to do so. This will help streamline the process and reduce the potential 'assessment burden' on the person when suitable assessments already exist. Previous assessments are assessments carried out for an earlier LPS authorisation. Equivalent assessments are assessments carried out for any other purpose (for example, for a care plan).

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

How clear is the guidance in chapter 16 at explaining the use of previous and equivalent assessments for the purposes of the LPS?

☐ Very clear
☐ Somewhat clear
☐ Neither clear nor unclear
☒ Somewhat unclear
☐ Very unclear

Consultation question 13a
Please explain your answer if you wish (300 words)

Response focused on mental disorder assessments as this is what there appears to be most concern about.

Para 16.45 – States that the same professional should normally carry out both the assessment and determination for the mental disorder assessment but unclear why and seems to go against other paras (eg para 16.61) and the general notion of having the two 'stages'.

Para 16.47 – In many cases there will be appropriate and sufficient evidence that the person has a mental disorder within the record or at least on the NHS Spine. However, this will not necessarily be in a prescribed or consistent format but it would be reasonable to rely on it. To prevent unnecessary burden – this should simply be accepted and the suggestion at para 16.49 that a standard diagnosis letter signed by a registered medical practitioner should be abandoned. An alternative proposal would be that the assessor and determiner could be different individuals, with only one needing to be a registered medical practitioner. The pre-authorisation reviewer always has the option to not be satisfied at the reliance on a previous assessment and elsewhere in our response we have suggested that possible a case should go to an AMCP for pre-authorisation review where there are specific characteristics of the assessments and determinations (which could include that the assessor and determiner are different with a previous or equivalent assessment used).

There is little explicit reference to the possibility of some or all of a mental disorder assessment being undertaken by someone other than a registered medical practitioner or psychologist. There is reference at para 16.15 to a mental disorder assessment completed by a nurse – it is stated that this would not qualify as a previous assessment but it is unclear why as para 16.13 states that a "professional may ask another professional or practitioner to carry out some or all of the elements of that assessment and determination on their behalf"

without reference to a specific assessment. Therefore, a medic undertaking a mental disorder assessment could ask a nurse to complete the assessment on their behalf (whilst retaining ultimate accountability). If they can do this contemporaneously, then why would it not be appropriate for the medic to use a previous assessment completed by a nurse if they were prepared to do so (ie prepared to retain ultimate accountability)? (Para 16.16 implies that where a previous assessment is used the assessor and the determiner will be different).

Given that there is a distinction in the case of mental capacity and mental disorder assessments between the assessor and the determiner (they can be different individuals), would it be helpful to suggest that the assessor might not meet the registration requirement but the determiner must?

A fuller response covering mental capacity and N&P assessments is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

Mental Capacity Assessments

Mental capacity assessments must obviously be for the same decision and there needs to be no indication that capacity may have changed in the period since the proposed previous assessment was undertaken eg due to a change in condition. Therefore agree with para 16.39 that in the majority of cases a new assessment and determination will be required. However, a time limit on use of older mental capacity assessments where they can be used as previous assessments would be helpful (para 16.40). The fact that they must be for the same decision seems to tell against it being possible to have 'equivalent' assessments and a clear example of when this may be the case is not provided but would be helpful if it is genuinely acceptable (the list of factors to consider at para 16.40 would be the same if it was only considering previous assessments).

Para 16.25 - Request for more guidance as to example situations where more than one assessment would be needed where deprivation of liberty is occurring in more than one setting.

Para 16.30 - Fluctuating capacity and the need to carry out more than one assessment may delay processes to be completed within 21 days.

Necessary & Proportionate Assessment

N&P will not have been carried out for any other purpose (other than LPS authorisation) and therefore *equivalent* N&P assessments cannot exist.

It is not explicitly stated that *previous* N&P assessments can be relied upon but para 16.19 implies this and 16.60 seems to confirm this, so it might be worth making explicit. At para 16.60 in the final sentence would it be more explicit to say "*the* previous necessary and proportionate assessment" rather than "a previous necessary and proportionate assessment" as you would only ever rely on the most recent one relevant to the arrangements in question.

Assessments undertaken by non-registered/non-eligible professionals

There is ongoing confusion regarding assessments completed by non-registered individuals eg support workers. The Code seems to make clear in several places that a non-registered individual can complete some or all of the assessments but the legal responsibility lies with the registered professional overseeing it. This does not seem to be directly supported in the Regulations.

Para 16.13 (and para 13.29) allows 'some or all' of the assessment and determination to be completed by an unqualified worker, whilst stating that the overseeing qualified worker remains 'legally accountable'. In local authorities that employ many unqualified workers, this statement could make qualified social workers professionally vulnerable, especially if the Code does not require the qualified worker to meet the person. The

language used elsewhere (eg para 16.24 & para 16.28) does not consistently support the idea that non-registered workers might actually be involved in the assessments.

Para 16.65 seems to contradict para 16.13 (which specifically refers to the N&P assessment) by stating, "If the individual carrying out the care or health assessment or review does not meet the requirements, then someone who is able to carry out the necessary and proportionate assessment should, where possible and appropriate, carry out both assessments."

Amongst groups we sit on there has been considerable concern about the increased capacity potentially needed among the registered workforce if they have to be more directly involved in the assessments or overseeing the assessments done 'in their name'.

Other aspects of chapter 16 relating to assessments

Para 16.9 – It may often be difficult to achieve the required independence of the assessors from each other eg in a hospital environment that most appropriate medic and healthcare professionals to complete the three assessments will often be substantive members of the specific ward team.

Paras 16.29-16.33 – might it be helpful to make reference to the possibility of advance consent here?

Para 16.66 – the list of things for the necessary and proportionate assessor to consider could helpfully include whether the care/treatment that the arrangements are to facilitate are in the best interests of the person, as articulated at para 16.73.

Somewhere in paras 16.67-16.80 would it be helpful to make reference to advance decisions to refuse treatment, advance statements and advance consent?

Consultation question 14 (Consultation document page 43 / Draft Code of Practice Chapter 18)
To ensure the independence of AMCPs, the Code provides a suggested model for a central AMCP team. Do you have any suggestions for how the model, as set out in chapter 18 of the Code, could be improved?

☒ Yes
☐ No

Consultation question 14a
If you selected Yes, please provide suggestions for how this model could be improved (300 words)

Organisations appear to be struggling with how this model might work so more detailed and practical guidance (possibly separate to the Code) would be helpful.

There are concerns about centralising this service around things such as who will be responsible for indemnity, how will the AMCPs be supported when there are disputes, who will be responsible for funding ongoing training etc? These concerns would be resolved if the central team was located within a Responsible Body and the members of the team were employees of the Responsible Body. Other responsible Bodies might then be concerned that they would not receive the same 'service' as the Responsible Body hosting the team and therefore good contracts/SLAs would need to be put in place.

Overall though, a central team has a lot to commend it in terms of efficiency (particularly whilst numbers of applications stabilise) and the support the team are able to provide each other. We would suggest this goes further and the central team also includes the non-AMCP pre-authorisation reviewers and administrative staff, across the widest possible geography which realistically and feasibly will probably be ICS-wide).

Para 18.11 – Unclear why a central duty system and OOH AMCPs are required. In emergencies section 4B can be used. In other cases the suggested timeframe is 21 days and therefore there would be no need for OOH cover like there is with AMHPs where the individual may be a significant risk to themselves or others. (It is anticipated that AMHPs will have a solid understanding of the MCA and LPS, just as many are currently BIAs).

A fuller response is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

18.2 – All AMCPs being approved by the Local Authority will place them in a similar situation to AMHPs. This does not currently prevent AMHPs being employed by organisations other than their approving Local Authority. However, to distinguish, AMHPs work on a rota basis and when not on the AMHP rota may be in quite different roles. Depending on how a central AMCP team is structured (and due to the uncertainty around likely numbers of applications), it may be the AMCPs work substantively in an AMCP role if employed within a central team or at least substantively within an MCA/LPS role

The model suggested seems to be based on AMCPs still being employed by multiple agencies (potentially in quite different and wide-ranging roles) and then on a rota basis being an AMCP for the day (eg para 18.70 talks about an AMCP's "main professional role"). This cannot work in the same way as it does for AMHPs as AMCP pre-authorisation reviews are unlikely to be done and dusted within a 12/24 hour period, due to the need to consult and potentially request new assessments/determinations etc. Given the suggested timeframe has been set at 21 days, an AMCP might need to be 'on the rota' at least 4 or 5 times in each 21 day period to ensure cases are progressed and everything completed. It might work much better to have a central team with substantively employed AMCPs, along with other pre-authorisation reviewers and administrators working across all the Responsible Bodies in a particular geography (be that Place-based or ICS-wide).

One of the situations in which an AMCP must carry out the pre-authorisation review is where "the Responsible Body refers the case to a AMCP and the AMCP accepts the referral". If the Responsible Body has its own directly employed AMCPs and 'refers' directly to one of them individually (or because there is only one) then the Responsible Body will have gone against para 18.14 which says that they should not decide which AMCP is allocated. In this situation it would be difficult (conflict of interests) for the AMCP to refuse the referral (if other criteria aren't met). If the Responsible Body has its own directly employed AMCPs and refers to the 'team' does this classify as 'referral to an AMCP' or will this simply be referral into the LPS process for the team to then determine if an AMCP is needed? Where the Responsible Body does not have its own directly employed AMCPs it seems to go against other paras within the chapter if it referred directly to an AMCP – it should surely refer to the Local Authority responsible for managing (or whoever manages the appropriate central team), with an indication that although there is no duty for an AMCP to undertake the pre-authorisation review it believes it the case would benefit from such.

Para 18.3 – will there be parity between Local Authorities in terms of their willingness/reluctance to agree to AMCPs acting for other Responsible Bodies? Will there be a cap on the charges Local Authorities might make to other Local Authorities for use of AMCPs?

Further information would also be helpful on the way to deal with out of area placements.

Para 18.14 – Given that the AMCP team is most likely to sit within a Responsible Body, it is difficult to say that the Responsible Body should not decide which AMCP is allocated. Potentially could change to "Anyone who may give final authorisation on behalf of the Responsible Body should not decide which AMCP is allocated".

Consultation question 15 (Consultation document page 44 / Draft Code of Practice Chapter 19)
If the required conditions are met, as explained in chapter 19 of the Code, then the decision maker has the legal basis to take steps which deprive a person of their liberty in exceptional circumstances to provide life-sustaining treatment or a vital act. Section 4B is not a 'continuous' power, and only applies to those specific steps.

The Code sets out that the decision maker should inform the Responsible Body when section 4B is relied upon for the first time. It also provides guidance on when it may be appropriate for the decision maker to inform the

Responsible Body about subsequent instances of the power being relied upon. For example, if the decision maker relies on the power a significant number of times within a short period.

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

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

☒ I **disagree** with the Code

Consultation question 15a

Please explain your answer if you wish (300 words)

Fundamentally disagree with the formulation of section 4B as the method for covering urgent DoL scenarios.

It would be more straightforward to state that, in line with case law, cases involving the administration of life-sustaining treatment fall outside the scope of Article 5(1) and therefore the LPS process need not apply (and therefore no need for section 4B).

However, section 4B goes beyond life-sustaining treatment. But even when considering the extended application of section 4B to also include vital acts there still remains a significant gap in the provision for depriving someone of their liberty whilst awaiting an LPS or court authorisation. NHS Digital figures identify that in 2020/21, 54% of DoLS applications included an Urgent Authorisation. Whilst this proportion could be slightly reduced through increased staff knowledge and understanding (and therefore earlier application for authorisation), the vast majority of this ratio is because situations arise quickly, without 21 days' notice. What will happen in all of the cases where the situation amounting to a DoL has quickly arisen and is ongoing? A request for authorisation can be submitted, but is the care provider unlawfully depriving the person of their liberty whilst they await authorisation? If the suggestion is that in these cases an urgent court order is requested then the work of the court will significantly increase. Section 4B would need expanding further to cover all of these possible situations to prevent applications to court. If Section 4B is not continuous but the current arrangements for the person to receive care and treatment do continuously amount to a DoL, then what is their legal status while an authorisation is awaited?

In addition, even where care arrangements are planned in advance, whilst prospective applications are encouraged and considered the expectation, whether arrangements amount to a DoL and whether the arrangements are being implemented in the least restrictive way is probably only really possible to assess once those arrangements are enacted, so it might be more sensible to only request assessments/authorisations once someone is living in the proposed arrangements. There are circumstances where arrangements are already in place but someone will move from being outside scope of LPS to within scope of LPS where pre-emptive applications would be very appropriate (eg a child in a residential setting will approaching their 16th birthday) but this is no way the majority.

A fuller response containing specific reaction to individual paragraphs is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

As mentioned in the response to Q8, *R (Ferreira)* is not mentioned or footnoted anywhere in the draft Code. This judgment included the following: *"The Strasbourg Court in Austin has specifically excepted from Article 5(1) the category of interference described as "commonly occurring restrictions on movement". In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category."* This would cover some of the cases section 4B indicates are within the scope of Article 5(1) and hence need a legal process.

Para 19.1 suggests, in part, that sedative medication may be needed to prevent a person from leaving hospital. The MCA requires hospitals to demonstrate significantly less restrictive strategies than sedation to prevent people from leaving (such and distraction techniques and locked doors).

Para 19.11 suggests that, 'delivering care and support' is a vital act akin to a medical emergency which really stretches the definition.

Para 19.15 indicates that 4B could be used if there is potential for harm to another person, to prevent the person from returning home from respite. This appears contrary to the MCA and case law, which only permits restrictions if the person, and not others, are at risk. We suggest that example could be rewritten so it is more in line with the MCA. That example could then assert the person's Article 8 rights to live with family if possible and recognise opportunities for workers to assess ways to minimise those risks at home, for example, to train family members in the appropriate use of restraint.

Para 19.31 requires that decision makers only inform Responsible Bodies on the first occasion 4B is used. This would allow potential for misuse since no further scrutiny would be required and the powers of 4B are wide ranging. It also would prevent the Responsible Body from prioritising the case appropriately. On the other hand, if the Responsible Body was notified on every occasion, combined with overly cautious carers/ individuals who may interpret 4B quite broadly, it could mean that the Responsible Body receives unmanageable levels of updates to process. Perhaps the Code could be clearer of the threshold and/ or severity of when subsequent use should be referred to the RB.

We suggest Responsible Bodies should be notified of all the times section 4B is relied upon. However, this would not need to be at the time of each use eg could be by means of a weekly update. This would provide monitoring of its use, help identify priority cases, identify possible safeguarding concerns, ensure proportionality and Responsible Bodies could expediate LPS authorisations if appropriate as per 19.24-19.26.

Says it is not a continuous power but how long can it actually last – not clear. We suggest a strict time limit of 72 hours should be imposed upon the use of 4B (making it comparable to the holding power in the MHA).

It is unrealistic to think that care home and hospital ward staff will consider that they need to use 4B (and will consider it time well spent to fill in a form) every time the person tries to leave, or restraint is needed to provide a vital act. Therefore, how will these powers genuinely be recorded and audited?

Consultation question 16 (Consultation document page 46 / Draft Code of Practice Chapter 20 / Monitoring and Reporting Regulations)
To what extent will chapter 20 and the Monitoring and Reporting regulations help ensure the monitoring bodies deliver effective oversight of the LPS? See Section 4 *(Consultation document)* for more information on the Monitoring and Reporting regulations.

- ☐ Fully effective oversight of the LPS
- ☒ Somewhat effective oversight of the LPS
- ☐ Neither effective nor ineffective oversight of the LPS
- ☐ Somewhat ineffective oversight of the LPS
- ☐ Fully ineffective oversight of the LPS

Consultation question 16a
Please explain your answer if you wish (300 words)

As currently, it will still be difficult for inspectors to identify the true number of cases where LPS is not being used but should be.

Is it possible to clarify who the monitoring body will be in cases where a 16 or 17 year old is accommodated in a setting registered with the CQC or am 18 or 19 year old is accommodated in a setting registered with Ofsted?

Paras 20.18 and 20.19 simply refer to 'regularly notify'. It might be helpful to stipulate that this is expected 6-monthly (as per Regulation 11(1)) through a central portal managed by NHS Digital (NHSE). This notification will be a new function for the NHS Responsible Bodies.

How will the people subject to LPS authorisations and their Appropriate Persons be informed about the

information sharing that will take place?

The current annual DoLS report is limited in its scope and does not necessarily have an impact on practice. Will this be the same for LPS?

Consultation question 17 (Consultation document page 48 / AMCP Regulations)
The purpose of the AMCP regulations is to ensure that there are an adequate number of trained AMCPs with the required skills and knowledge to carry out this role. Will the AMCP regulations achieve this?

☐ Yes
☒ No

Consultation question 17a
Please explain your answer if you wish (300 words)

The Regulations cannot help with understanding or estimating the likely demand for LPS and the lead-in time. Until the final Code of Practice and Regulations are published (and/or a new statutory definition of what constitutes a DoL in effected) it is very difficult to estimate the likely number of LPS authorisation requests and therefore the number of AMCPs (or other workers) that will be required. The Impact Assessment projected numbers of applications is based on current DoLS figures whereas Chapter 12 of the draft Code of Practice (and in particular the scenarios) could potentially reduce the scope significantly.

The number of BIAs wishing to convert and the number of new individuals wishing to train as AMCPs will be influenced by the process requirements and Code of Practice (given that there is no financial incentive generally). It may also be significantly affected by whether this is a full-time role or on a 'rota' basis. A substantive BIA currently can have several cases in progress but this enables them to be dealt with in a timely was as information becomes available. Where individuals are only a BIA one day a week (or whatever the arrangement is) cases can become very protracted.

CoP chapter 18 (para 18.20) require that in each year of approval "the AMCP has been carrying out their functions to an appropriate standard". Will there be further guidance to support Local Authorities in applying this provision equitably? It may be useful to have some further guidance so as all local authorities are working towards the same standards.

18 hours training at higher education level is a large amount of further training for staff to undertake each year and will come with significant costs. Further guidance is needed as to what will constitute training and who will be responsible for provision and funding of the training.

AMCP Regulation 11(3) requires that BIAs have practised for one year prior to conversion training. Is there a specific number of assessments they should have completed? Different Local Authorities may interpret this differently and BIAs will therefore be subject to unequal requirements.

Consultation question 18 (Consultation document page 48 / Draft Code of Practice Chapter 16 / Assessments, Determinations and Pre-Authorisation Reviews Regulations)
The Code and the LPS regulations outline which professionals can carry out each of the three assessments and determinations under the LPS. It also outlines the requirements these professionals have to meet. The professionals who can complete a capacity or necessary and proportionate assessment and determination are:

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

Medical assessments and determinations may only be carried out by a registered medical practitioner (including

GPs and psychiatrists) or a registered psychologist who meets the conditions of these regulations.

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

☐ Yes
☒ No

Consultation question 18a
Please explain your answer if you wish (300 words)

All of the professional groups listed are appropriate (as long as the specific individuals have the appropriate level of training, guidance and support available), but further registered professions could be added.

The requirements on registered professionals 'overseeing' and remaining legally accountable for non-registered professions undertaking or supporting assessments would be less problematic if the requirements for particular registration applied only to the determination element (or applied to one out of the two – either assessment or determination – see para below).

The availability, willingness and remuneration expectations of medics (eg GPs) is of major concern. These fears could be allayed if the mental disorder assessment was less onerous and simply required a relevant diagnosis to have been added to the NHS Spine (or alternative) by a medic (most likely the GP), with the mental disorder determination being completed by the individual pulling that information from the Spine (who could be an alternative registered professional). The requirement could therefore be that either the assessor or determiner need to be a medic/psychologist but not necessarily both.

Alternatively, an AMCP could be required to undertake the pre-authorisation review where some or all of either the mental capacity assessment or the mental disorder assessment have been undertaken by an unregistered member of staff (or a member of staff not in the listed professional groups).

We believe that the pre-authorisation review should always be undertaken by someone from a registered 'clinical' profession. It may therefore be appropriate to use the same list of professional groups to identify who can be a (non-AMCP) pre-authorisation reviewer as the current (or amended) list of who can undertake mental capacity or necessary and proportionate assessments/determinations.

A fuller response is available in the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Additional comments (can't formally submit due to word count)

There are a significant number of registered, qualified healthcare professionals who are excluded from this list eg Physiotherapists, Dieticians, Pharmacists, Radiographers etc. It is unclear why certain professional groups are included and others excluded. This goes against the principle of mainstreaming assessments and ensuring the burden of assessments is reduced as much as possible. MCA and LPS focuses on empowerment, rights and safeguards. The assessments of the patient which are necessary do not require specific clinical knowledge (ie of particular conditions) or manual skills or expertise.

Given the exclusion of situations where treatment is solely for physical health conditions (if it is maintained), the majority of requests for authorisation are likely to come from the community. Therefore, social workers will continue to be the predominant group undertaking the mental capacity and necessary and proportionate assessments.

As identified in responses to earlier questions, at several points in the Code it suggests the potential for unregistered workers (or workers not in the listed professional groups) to undertake some or all of the assessments but be 'overseen' by the appropriate registered professional. If the requirements for particular registration applied only to the determination element (or applied to one out of the two – either assessment or

determination), the registered professional could identify that a colleague had completed the assessment and instead of having to take direct legal accountability for it could declare that they have no reason to doubt the appropriateness of the assessment and can reasonably place reliance on it in making a determination. This would significantly help with reducing the burden and mainstreaming assessments as part of other assessment and care planning processes.

Para 16.10 – in relation to the criminal records check - it should be made clear if this is expected to be refreshed at a particular frequency. Many health and social care employers complete a check at initial recruitment but do not then routinely renew or refresh this check during the individual's period of employment.

Para 16.11 – Why are these seemingly additional requirements in Wales not also going to be applicable in England?

The Impact Assessment suggests that the AMCP may redo assessments in 5% of cases. This, however, appears to be prohibited by para 13.51.

Consultation question 19 (Consultation document page 50 / IMCA Regulations)
Do the IMCA regulations allow for IMCAs to carry out their full functions effectively under the LPS?

☒ Yes
☐ No

Consultation question 19a
Please explain your answer if you wish (300 words)

Although the Regulations allow for IMCAs to carry out their functions, there are concerns that there will be insufficient IMCAs, which will cause delay to the process.

Although the Impact assessment is based on 25% of cases requiring an IMCA to support the person and 30% of cases requiring an IMCA to support the AP the reading of chapter 10 might suggest this will be much higher.

The seemingly hard to satisfy criteria for acting as an Appropriate Person (see answer to Q20) potentially over-encourage the use of IMCAs where an informal carer would do a satisfactory job and in many cases would be more suitable.

The National Workforce and Training Strategy (p19) states that all Responsible Bodies will be responsible for funding IMCAs, whereas there is no suggestion anywhere else that Local Authorities will be *entitled* to claw back money from NHS Bodies (although in many areas these joint arrangements are already in place). Para 10.2 of the draft Code explicitly states "Local Authorities are responsible for commissioning and funding the IMCA service for the local area". It might be more sensible to split the costs on a proportionate basis (which would be facilitated by having ICS-wide LPS teams and arrangements anyway) between Responsible Bodies as this would discourage potentially wasteful use of the service.

Chapter 10 of the CoP consistently refers to 'relevant capacity'. Unsure why this differing terminology and what it adds. This phrase is used a total of 56 times (twice in chapter 3 of the draft Code – both in newly added paras (3.22 and 3.30), throughout chapter 10, three times in chapter 12, four times in chapter 13, twice in chapter 14, twice in chapter 15, three times in chapter 16, once in chapter 18, once in chapter 19, three times in chapter 20, three times in chapter 21 (all newly added paras), 10 times in chapter 22 (all newly added), once in chapter 24 (newly added)). This is in comparison to over 1,800 instances where 'capacity' is used without the qualifier of 'relevant'. Is it intended to mean something different where it is used?

Chapter 10 is incredibly repetitive and could easily be streamlined.

Consultation question 20 (Consultation document page 51 / Draft Code of Practice)
The Code will be an important resource that will used by many different groups of people to understand the LPS process. For example:

- It will be especially important that chapter 3 (How should people be helped to make their own decisions?), chapter 15 (What is the role of the Appropriate Person?), and chapter 17 (What is the LPS consultation?) of the Code are understood by the **person and their family and friends to ensure they remain at the centre of the decision-making process.**
- Chapter 3 (How should people be helped to make their own decisions?), chapter 10 (What is the Independent Medical Capacity Advocate service?), chapter 13 (What is the overall LPS process?), chapter 16 (What are the assessments and determinations for the LPS?), chapter 17 (What is the LPS consultation?), and chapter 18 (What is the role of the Approved Mental Capacity Professional?) will be of particular importance to **practitioners and people involved in the person's care**.
- **16 and 17 year olds, and their parents and carers**, will need to understand the guidance in chapter 13 (What is the overall LPS process?) and chapter 21 (How does the Act apply to children and young people?).
- **Responsible bodies, including local authorities, NHS trusts and clinical commissioning groups**, will need to understand the principles of the MCA outlined in chapter 2 (What are the statutory principles and how should they be applied?), as the principles of the MCA are integrated throughout the LPS. They will also need to, in particular, understand the guidance in chapter 7 (What is the role of the Court of Protection?), chapter 10 (What is the Independent Medical Capacity Advocate service?), chapter 13 (What is the overall LPS process?), chapter 14 (What is the role of the Responsible Body?), chapter 16 (What are the assessments and determinations for the LPS?), and chapter 24 (What are the best ways to settle disagreements and disputes about issues covered in the Act?).

From your perspective, how clear is the LPS guidance in the Code and is there anything that you feel is missing (up to 1,000 words)? Please reference specific groups of people and chapters in your response. (Do not include information in your response that could be used to identify you, such as names).

Overall it is quite clear, even where it is objectionable.

Chapter 14

It would be helpful if an explicit statement was added explaining that, if ordinary residence is disputed, the RB that first received the referral should complete the LPS assessments until ordinary residence has been resolved. Currently this principle is hidden within para 63 of Annex H of the Care Act guidance and knowledge of its existence is not widespread.

Please also add guidance regarding LPS duties for people who live within England and Wales but are funded (and ordinarily resident) elsewhere. This has been an area of recurrent confusion under DoLS, and a frequent topic of conversation between DoLS Teams. Most Local Authorities host at least one person from either Scotland and or the Channel Islands.

Chapter 15

Para 15.6 – The final sentence does not really make sense and may add confusion. As it appears superfluous could it be removed?

Para 15.15 –

- *Does the individual have satisfactory skills relevant for carrying out the role?* These need to not be overly extensive
- *Has the person got any relevant experience to perform the role, such as carryingout a similar formal or informal advocacy role under the Mental Capacity Act 2005, Care Act 2014 or the Social Services and Well-being (Wales) Act 2014.* This appears overly onerous and would exclude a large number of suitable family members or carers. If the answer to this question is 'No' presumably could still appoint but this is not made explicit anywhere which could lead to misinterpretation.

Similarly, para 15.18 suggests exclusion where "a family member who lives at a distance and who only has occasional contact with the person, a spouse who also finds it difficult to understand the local authority processes, or a friend who expresses strong opinions of their own (about what a person's care needs are) prior to finding out those of the person concerned". In the case of the spouse an MCA could be supported to help them understand

the Local Authority processes as well as a duty of the Local Authority (or other Responsible Body) to explain clearly (part of information requirement). Reference to 'expresses strong opinions' may appear to support Responsible Bodies wishing to exclude from the role vociferous/challenging individuals. The emphasis should be on whether they will appropriately represent the wishes, feelings, values, beliefs and culture of the person through the process.

Para 15.22 – This suggests that if the Appropriate Person agrees with the arrangements to place someone in a setting that is not their usual home that the RB should exercise caution. This makes no sense as many relatives will agree with a care home or respite placement and this should not exclude them. Is the actual intention of this sentence to refer to situations where the person is being placed in a setting that is not their usual home and significant restraint is used that the potential AP agrees with that caution should be exercised? If so, a rewording is required.

Para 15.23 – the phrasing suggests that the default position would be that the family member who is the main carer would NOT be the most suitable AP if the arrangements take place mainly in the person's home. Surely the default position should be that they are considered.

Para 15.24 – again this may be interpreted as a high bar and therefore exclude many suitable individuals. An AP will maintain the right to the support of an IMCA and will receive non-means tested legal aid to bring a s21ZA challenge so this should be a low bar not made out to be a high one.

Para 15.39 – The informality of the transfer process could lead to many requests for a change of AP, using a lot of time and with the potential to be misused. Possibly once an authorisation has commenced (see previous comments at Q11 re appointment during the initial authorisation process) the change should only be triggered by the AP themselves if *they* have identified someone more suitable and are therefore no longer willing or by the Responsible Body if there are concerns about the AP not acting in best interests or not appropriately representing the person.

Para 15.49 – The onus for explaining to the individual the process should not solely fall on the AP. The assessors (particularly the N&P assessor) should explain what is happening and what the process if. Information should be directly provided by the RB and support should be available on an ongoing basis (whether by IMCA or the RB directly) for the AP. Paras such as this one may discourage potential APs from consenting to the role if they feel overwhelmed with the responsibility when reading the Code.

Para 15.59 – It should not be on the shoulders of the AP to ensure that LPS authorisation reviews are included in the authorisation record or that they take place as scheduled in the authorisation record. It should certainly be their right to challenge if they do not think this has happened appropriately but the onus should be on the RB.

Para 15.77 – This suggests several handover meetings which may seem unnecessarily onerous.

Further concerns or queries are included in responses to other questions, including our fuller responses (which go beyond the word limit) which are contained within the document we used to build our consultation response, available at: https://www.360assurance.co.uk/services/clinical-quality/lps/

Consultation question 21 (Consultation document page 52 / Draft Code of Practice)
The consultation team would be grateful for suggestions and drafts of new scenarios on the following topics, based on your own experience of best practice. In particular, for:

- Chapter 2 – application of the MCA principles by emergency services.
- Chapter 3 – best practices for keeping the person at the centre of the LPS decision- making process.
- Chapters 4 and 5 – assessing capacity and/or best interests decisions in the context of culturally sensitive decision-making.
- Chapter 7 – when a court makes a decision around a person's online contact or use of social media.

- Chapter 8 – gift-giving under a Lasting Powers of Attorney on behalf of a donor who lacks the relevant capacity, demonstrating the more complicated considerations of taking into account the donor's circumstances, their wishes and whether the gift is considered appropriate under the MCA.
- All guidance relevant to the LPS.

Is there any part of the Code where an existing scenario requires updating or a new scenario or best practice example is required to help illustrate the policy?

☒ Yes
☐ No

Consultation question 21a
If you responded Yes, please include here (up to 1,000 words)

Throughout the Code where case studies are given, these should (where appropriate) be related to case law and use the actual cases which underpin the outcome from the Court. In Chapter 12 there is a gap between what the case law says and what is set down in the scenarios provided - which appear to redefine what is a deprivation of liberty (but whilst claiming to represent the current case law). A lack of open discussion about this interpretation carries a huge risk of confusion from day one of LPS and Responsible Bodies will 'err on the side of caution'.

Throughout the Code, there need to be more scenarios re complex situations where people are putting themselves at risk and in relation to patients in hospital (including in a mental health setting but there are concerns about the persons physical health). A scenario about someone who will not engage with anyone would useful.

In order to better understand the new role of ICBs as Responsible Bodies for individuals funded through CHC subject to LPS, at least one scenario where the person is in hospital awaiting discharge to a care home (in arrangements that are likely to constitute a DoL) and this is likely to be funded through CHC would be useful.

As per the answer at Q8, there may be merit in having a separate document containing examples (akin to Annex B of the Northern Ireland MCA Code of Practice).

13.101 Perhaps replace 'hospice' with 'care home' in this example, to minimise inappropriate intrusions when people are in nearing end-of-life and LPS is unlikely to benefit the person (it may have originally meant to say hospital given the reference to 'ward').

Consultation question 22 (Consultation document page 54 / Impact Assessment):
The Impact Assessment constitutes the government's assessment of the costs and benefits of the LPS, including the Code and regulations, as proposed for consultation.

Do you agree with the estimated impact of the LPS, as set out in the Assessment?

☐ Strongly agree
☐ Somewhat agree
☐ Neither agree nor disagree
☐ Somewhat disagree
☒ Strongly disagree

Consultation question 22a
Please explain your answer and provide feedback on the Impact Assessment for the LPS, including on its assumptions, coverage and conclusions, if you wish. (300 words)

360 Assurance has produced a one page summary of the main figures from the impact assessment.

The costs in the impact assessment are based on a total of 278,646 applications for LPS authorisations. This number is completely dependent on the definition of a DoL, the scope of Ferreira, the applicability of section 4B and the potential for advance consent. These are some of the areas that have been most discussed and debated throughout the consultation period and therefore it is hard to make an assessment of the accuracy of the overall

number of applications.

It is assumed that 80% of cases will already have a mental disorder assessment. It is felt that this is unrealistic and additional cost will be incurred in staff time obtaining the assessments and medical professionals' time and cost.

The estimate of the number of new capacity assessment 40% is felt to be low.

The % of Necessary and Proportionate assessments at the lower cost of £32 is very unrealistic as it is likely to be routinely seen as a stand-alone assessment.

The Impact Assessment suggests that the AMCP may redo assessments in 5% of cases. This, however, appears to be prohibited by para 13.51 of the draft Code.

The assumption (p.16 of the Workforce and Training Strategy) that an AMCP report can be produced in 5.4 hours appears overly optimistic if this includes a visit, travel, consultation with several individuals, the scrutiny of records and the writing of a legally robust report. The Impact Assessment does not include this figure but gives a total AMCP pre-authorisation review cost of £358 (as opposed to £227 for a non-AMCP case).

The number of DoL in community settings is felt to be underestimated (on the basis of current Cheshire West interpretation).

In option 2 (LPS) there do not appear to be any self-funded legal costs built in as there are for options 1 and 2. Challenges will predominantly be s21ZA cases and that will attract non means tested legal aid (but only for the person or their AP and not other family members). But there will likely still be a number of challenges in which self-funded legal costs are incurred (where other family members bring a s21ZA challenge or the challenge is something other than s21ZA). This would increase the recurrent costs for Option 2 (LPS).

Consultation question 23 (Consultation document page 56 / National workforce and training strategy)
The Workforce Strategy aims to support local, regional and national employers with their preparation for implementing the LPS in England. It offers advice on the workforce planning that will need to take place and the learning, development and training that is being made available ahead of implementation. Will the Workforce and Training Strategy help your organisation prepare for the implementation of the LPS?

☒ Yes
☐ No

Consultation question 23a
Please explain your answer if you wish (300 words)

Workforce planning is dependent on numbers of staff required and the draft Code of Practice has thrown initial scoping exercises up in the air with the differing interpretation of what might constitute a DoL and the numerous exclusions (advance consent, physical health only)

It is also difficult to undertake workforce planning until organisations know whether or not they will be adopting a shared service and what services will be provided for centrally and which will be needed to be model provided by the Responsible body in order to meet our own LPS authorisation duties. This is something that we have been encouraging organisations to discuss and agree at an ICS level.

For Local Authorities, a significant challenge is the national shortage of social workers that will likely result in October 2023, when the care funding cap is implemented. As LPS will bring further additional pressures upon an overstretched workforce, a gap of at least 12, preferably 24 months, will be essential before LPS is implemented to allow this training to take place.

Consistency will be encouraged, and much time saved, if exemplar materials are produced as required by para. 14 of the Act. Likewise, exemplar LPS assessments will be needed, showing the standard and depth of scrutiny required. In the absence of these, AMCPs, as former BIAs, will expect and produce lengthy and time-consuming

reports, as currently. The Court of Protection, CQC and Ofsted are likely to then see, value and perpetually expect such detailed reports.

Training levels A+B intended to include APs. How this works with ensuring the AP is identified at the very start of the LPS process may be challenging. Possibly a video that APs can be directed to which provide appropriate info?

Consultation question 24 (Consultation document page 57 / Training Framework)
The Training Framework describes the core skills and knowledge relevant to the LPS workforce and presents learning outcomes for each workforce competency group across five subject areas. Does the Training Framework cover the right learning outcomes?

☐ Yes
☒ No

Consultation question 24a
Please explain your answer if you wish (300 words)

The learning outcomes are detailed and demonstrate a clear progression in terms of learning and knowledge required by various groups who will need to work with LPS in different roles. The timescale for delivering the training is key to the success of LPS implementation.

However, is the extensive list of learning outcomes appropriate for levels A + B given it includes carers and Appropriate Persons (possibly overly ambitious).

The overall number of learning outcomes might suggest that the number of hours' training indicated by the Impact Assessment for different tiers is significantly underestimated. Given the importance of this area of practice and competence this is perhaps appropriate, but the pressure on organisations who will have to release professionals for this training will be immense.

Would be helpful if national e-learning could be produced that specifically stipulated which tier it covered the competencies for.

Consultation Question 25 (Consultation document page 59 / LPS NMDS):
Responsible Bodies will need to notify the CQC and Ofsted of LPS referrals and authorisations in their area in order to enable them to monitor and report on the scheme. NHSD will need this data to publish Official Statistics for the LPS. The LPS National Minimum Data Set will provide a standardised data set to ensure consistent and quality submission of this data.

The Data Set has been developed via extensive stakeholder engagement and should capture data required to monitor and oversee the operation of the LPS at a national level and does not preclude local systems capturing additional data for local use.
Are there further data items needed in the National Minimum Data Set to provide effective oversight of the LPS?

☒ Yes
☐ No

Consultation question 25a
Please explain your answer if you wish (300 words)

The National Minimum data set should be compatible with the information CQC, and Ofsted will require via the notification process an example of this, CQC currently require date of admission but not on DoLS Form 1

Data item 11 - Disability needs to be consistent with CQC requirements there is currently a mismatch on what is collected on DOLS form 1 to what CQC require on Notification 18

Data item 28 needs to include – person not able to express a view

The biggest problem with the data is going to be ensuring that it is accessible across Responsible Bodies to truly

allow authorisations to be portable and to prevent duplicate or unnecessary applications. A shared secure 'database' would be beneficial, even if this simply collated minimal information, such as NHS number, authorisation dates and Responsible Body so that contact could be made with relevant Responsible Bodies to see if the current authorisation covers proposed arrangements and/or if there may be previous or equivalent assessments that can be used.

The requirement to send information to the CQC and Ofsted requires further detail, in terms of how this information will be used, and should the Responsible Body be informing the relevant person of this requirement, as the point of contact if they have concerns.