Joint consultation response on changes to the MCA Code of Practice and implementation of the LPS

July 2022

1. Introduction

1.1. This is a joint response to the government’s consultation on changes to the Mental Capacity Act (MCA) Code of Practice and implementation of the Liberty Protection Safeguards (LPS). This response has been formulated through dialogue across the advocacy sector including meetings with practising IMCAs to gather their feedback and through meetings of the Advocacy Leaders Group of over 50 organisations. This is a collective response of 32 organisations with a particular interest and expertise in the delivery of independent advocacy:

1. VoiceAbility
2. Advocacy Focus
3. Advocacy for All
4. Advocacy Services North East Wales
5. Advocacy West Wales
6. Asist
7. Blackpool Advocacy Hub, Empowerment
8. Carers Federation
9. Cloverleaf Advocacy
10. Connected Voice
11. Dorset Advocacy
12. Gaddum
13. Jacqui Jobson Consultancy
14. Kate Mercer Training
15. National Development Team for Inclusion
16. National Youth Advocacy Service
17. n-compass
18. One Advocacy
19. Onside
20. People First
21. Rethink Advocacy
22. Solihull Action through Advocacy
23. South West Advocacy Network
24. Spearman Consultancy
25. Swindon Advocacy Movement
26. The Advocacy Project
27. The Advonet Group
28. Together for Mental Wellbeing
29. Vital
30. Warrington Speak Up
31. York Advocacy Hub
32. Your Voice Counts

1.2. In parts of our response, we state where we think there would be benefit of further dialogue between the advocacy sector and with colleagues at the Department of Health and Social Care (DHSC) and the National Steering Group. We remain open to facilitate and support such dialogue. In parts of our response, we provide direct recommendations for edits to help clarify or strengthen the Code of Practice (the Code) and related documents.

2. General observations and summary points

2.1. The Code and its related regulations and other documentation are significant documents both in length and the weight they hold in determining and protecting someone’s rights when subject to the Mental Capacity Act. The Code is an opportunity to set out the guidance that will ensure the new system of Liberty Protection Safeguards is fit-for-purpose from the outset and significantly steps up how people’s rights are upheld when they are subject to such decisions and restrictions.

2.2. We echo concerns that have been shared by many across the board that there needs to be a substantial review and reconsideration of much of the content of chapter 12 with regards to the definitions and the guidance of how to apply the definition, in particular the example scenarios that are provided. We strongly recommended that there is a frank and open dialogue and a co-production approach to getting this chapter right.

2.3. Given the size of the Code, it is a reasonable assumption that most people who reference the Code for their work will do so by focusing on the specific section that relates to a query they have or will centre their attention on summary boxes and scenarios that are more easily digestible than interpreting the full Code. For this reason, it is especially important that summary boxes and example scenarios accurately reflect the law, case law, as well as the spirit of the law and appropriate best-practice and do not allow for confusion. Where we have provided a response related to these parts, we would especially welcome further dialogue due to the weight of importance we believe they will hold in practice.

2.4. Advocacy is an essential ingredient to LPS and the Mental Capacity Act’s implementation. It is envisaged that there will be a significant increase in the number of advocates in order to deliver LPS as a person-centred system that upholds people’s rights when their liberty is being restricted. We support the recognition that advocacy is being given and would welcome ongoing conversations about further details around implementation, in particular in relation to supporting and funding the recruitment and training of advocates, existing Independent Mental Capacity Advocates, RPRs as well as those new to the speciality or to advocacy. In particular, advocacy providers require targeted and specific resources, including funding, to recruit, train and manage the many thousands of newly recruited advocates and to support the transition of systems and people for the implementation of LPS.

2.5. We welcome the reference to an advocate having a long-term relationship with the person and a preference for advocates to be multi-skilled so they can support people who also access support under the Care Act and Mental Health Act. The importance and value of this to the person could be strengthened in the Code and the benefits outlined. For example, more person-centred support with better knowledge of the person’s wishes and deeper insights into how restrictions impact on the person and their life, stronger relationships with the person who is enabled to get to know and trust their advocate, and deeper understanding of how the person communicates. This also can lead to better safeguarding and understanding of fluctuating capacity, particularly when restrictions are extended or when people move locations. The interplay with the Care Act and Mental Health Act could be made clearer in places and emphasised, particularly in Chapter 10 that sets out the role of advocates.

2.6. We also welcome the recognition of the important role of advocacy and advocates in the Code. The Code currently indicates that advocates should be present for every meeting, assessment, etc. This is a considerable undertaking and may have an impact on average estimated hours reflected in the Impact Assessment. Particularly in areas where advocates may cover a large geographical area and travel time has to be taken into account when attending meetings and assessments. We welcome the reference to the ongoing role of an advocate, in particular under the LPS. We also welcome the expectation that advocates should have meaningful and regular contact with the person to ensure there are no changes to situation relevant to any authorisation and given the additional and important safeguarding role advocates play. There may be reasonable examples where an advocate's presence isn't required for high quality advocacy support. We would recommend exploring how references to attending meetings and assessments is worded to ensure that there isn't an arbitrary requirement that places an unhelpful burden upon advocates and advocacy providers. We would welcome further clarity around the definition of "regular contact" and the attendance of meetings and assessments.

2.7. In parts of the Code, there are references to the role of advocates which do not align with the principles of advocacy or the role that advocates actually play. Advocates are independent of the Responsible Bodies and care providers and are there to be on the side of the person they are supporting, to make sure they are heard, their wishes are taking into account, and their rights are upheld. Advocates do not have a role in mediation, negotiation, or conflict resolution. Advocates do not take a view or express opinion on what the person should or should not do. They do not have a role in supporting the Responsible Body achieving any particular objective or decisions they have set out for the person they are supporting. We provide further specific examples in our comments related to Chapter 10.

2.8. The role of the Appropriate Person is a serious undertaking and must be considered as such by the person carrying out the role and by the Responsible Body. In general, the Code reflects reasonably the seriousness of the role and the burden of the requirements of the role. Where there are mentions of volunteers taking up the role of Appropriate Person, even where there has been an attempt to provide clarity on when such a scenario might arise, we find that this is unclear and unhelpful and will inevitably lead to confusion and misinterpretation. References to "volunteers" carrying out the role should be removed, as when referring to volunteers in these places, the Code then explains that the rationale for their appointment as an Appropriate Person would in fact be their friendship with the person and their volunteer role is a misleading reference. Primacy must always be given to the requirement that the Appropriate Person knows the person well.

2.9. In reviewing the draft Code, we identify particular gaps which could risk people's rights and safeguarding if not resolved appropriately. This stems from the way IMCA support for the Appropriate Person is set out in the draft Code.

2.9.1. The IMCA role is set out to support the Appropriate Person only and not to support the person, as is the current context of RPR. If there is an Appropriate Person, the IMCA has no direct role in person-centred support for the person subject to a deprivation of liberty. They also have no right to meet with that person, speak with that person. This could be resolved by making sure the overriding obligation for an IMCA is to make sure person is supported, through appropriate advocacy practice, rather than only supporting the Appropriate Person in their role.

2.9.2. There are limited safeguards and processes under the draft Code established to safeguard the person and ensure the Appropriate Person once appointed fulfils their duties as required and continue to fulfil their duties during any ongoing authorisation. Under the Code as proposed, if the Appropriate Person is not deemed to "need" IMCA support by the Responsible Body then they can choose to have support or not. Should they choose not to access IMCA support, there are limited safeguards to make sure they are properly fulfilling the role and challenging where it might be necessary to ensure someone's rights. While it's clear that it's the Responsible Body's duty to make sure the person is appropriate, additional guidance and clear expectations of how they should undertake such monitoring to fulfil that duty would be very helpful to address some of the gap we raise as a concern.

2.9.3. Currently under 39D an IMCA is required to take a case to the court to challenge where the person is objecting - even if the unpaid RPR (for example, a family member) does not want to challenge. An IMCA would do this in their role of making sure that the person is appropriately represented and safeguarded by the unpaid RPR and acting accordingly, if it is necessary and in the best interests of the person, even if against the stated wishes of the unpaid RPR. One possible solution to this might be that where someone is supported by an Appropriate Person and there is any evidence noted by the Responsible Body or anyone with a role in treating or caring for the person that they might object to a placement or decision, however mildly, (including when an assessment is referred to an AMCP for review), there is an automatic referral by the Responsible Body to the IMCA service to support the Appropriate Person and that the Appropriate Person is required to engage with the IMCA. However, this still would not resolve the issue of an Appropriate Person who refuses to challenge when if fulfilling their role appropriately they would do so. While the draft Code makes clear that anyone can take a challenge to court under LPS (7.35), an IMCA would not be aware of the issues and the need to take a case to court to safeguard rights were the IMCA not supporting the Appropriate Person.

2.10. Under the emergency provisions of Section 4B, we are concerned about its application and monitoring to ensure that it is not applied in an arbitrary manner or as a means to avoid the appropriate advocacy and LPS process. We recommend that in the monitoring of LPS, the application of 4B by Responsible Bodies is monitored and statistics are made publicly available to map trends should a particular Responsible Body appear to use it more frequently than might be expected without due cause. We also recommend there are restrictions in place around timescales for the use of 4B so that people are safeguarded appropriately.

2.11. In relation to the role of the Approved Mental Capacity Practitioner, we agree with the proposal set out in the code that this be managed by local authorities and would propose this is included as a firm recommendation in the Code. Local authorities are already well-placed to understand the wider definition of capacity outside a clinical setting. We should avoid using an overly clinical model of assessing and understanding capacity, particularly in light of fluctuating capacity or differences in capacity in relation to different decisions. Local authorities will be better able to manage that assessment process than clinical institutions such as NHS bodies.

2.12. We support the intention behind setting a short deadline for the completion of the LPS process. We also support the inclusion of the 21-day deadline. In order that proper advocacy support can be provided to the person during that period, we propose that a deadline is set by which time a Responsible Body must have referred the person for advocacy support. We suggest this deadline is 24hours. Responsible Bodies should make sure they refer a person for the support of an IMCA as soon as possible and it should be established in the implementation process that they are unable to complete the start of the LPS process without confirming that they will take these next steps and have understood their duty – systems should be designed to ensure compliance is as high as possible. We also want to avoid unintended consequences of such a target and make clear that the target itself cannot be used as a trump card by Responsible Bodies to rush through a process and decision without meaningful advocacy and inclusion of the person. In some circumstances, effective and high-quality advocacy that is properly person-centred may take longer than 21 days from the start of the LPS process, in particular if a person is being supported by an advocate for the first time and doesn't already have a relationship with them or requires additional time and support to communicate. The person should remain at the centre of the process at all times and this should be emphasises in the Code, including in relation to timescales. Additionally, we repeat our point about ensuring funding and resources are protected and funnelled to advocacy providers to be able to meet these timescales.

2.13. In the Impact Assessment, it is stated that an estimated 5% of people will have neither an Appropriate Person nor an IMCA to support them when subject to LPS. There should be only very rare and exceptional cases where it would be in the person's best interests to not have someone supporting them in an official and legally proscribed capacity. The estimate of 5% would still mean thousands of people a year do not have someone supporting and representing them when subject to LPS. This seems like a considerable number of people and we would expect this number to be much lower.

2.14. References to conditions of an LPS authorisation are welcomed and are considered helpful as they stand in the Code that is currently being used. Where conditions can be set in an authorisation, we encourage this as much as possible as they are a useful way to focus attention of the Responsible Body on changes that can be made, support that can be provided and progress towards to least restrictive option as much as possible.

2.15. In relation to Chapter 16, we also make the following observations:

2.15.1. That we support the government's decision that care home managers will not play a lead role in assessments and we thus recommend that this is made explicit in the Code for the avoidance of doubt and benefit of smooth implementation of LPS.

2.15.2. That references to affordability as a consideration for implementing the least restrictive option under a deprivation of liberty is inappropriately weighted and affordability should not be the basis of whether a condition is met or a less restrictive option is implemented.

2.15.3. The explanation of fluctuating capacity is not clear and is particularly vague in places without many qualifying examples of description to help understanding of how fluctuating capacity may be treated under LPS and how it should be identified and the action to be taken throughout the process.

3. Definition of a deprivation of liberty – Chapter 12

3.1. We have very serious concerns about the definition of a deprivation of liberty as outlined in the Code and these concerns are especially pronounced when reviewing the example scenarios which are provided. From our assessment and our discussions with hundreds of practicing advocates, the definition does not align with the Act or case law as it stands.

3.2. With regards to the definition itself:

3.2.1. For clarity, with regards to state ‘imputability’, it should be made clear that this applies to those ‘self-funding’ their health social care as much as it does to those whose health and care is state-funded.

3.2.2. In 12.1 and 12.3 the Code refers to a ‘non-negligible’ time period which is hard to quantify. Where there are attempts to explain this (12.7-11), it remains difficult to interpret and hard to see how it applies to various scenarios. Further guidance should be given with regards to how to interpret this.

3.2.3. There is a strong relativism in the Code where a deprivation in one place would not be in another. This potentially provides for highly institutional provision, for example, in 12.29 "*whether or not a person is subject to continuous supervision is something that will have to be assessed on a case by case basis. In doing so, it will be relevant to consider the setting that the person is in."* and in 12.35*"As a general rule, measures which are applicable to all residents and intended to facilitate the proper management of the premises should not be regarded as control"* could result in restrictions being viewed not to constitute a deprivation of liberty as these are considered the institutional ‘norm’, for example, in care homes, this is what happens and thus this is not a deprivation of liberty.

3.2.4. The exclusion of time alone in a person’s room being an excluding situation from a deprivation of liberty even if supervised in all other settings and not free to leave would appear contrary to most interpretations of a deprivation of liberty.

3.2.5. It appears there is an effective exclusion of a deprivation of liberty in any setting which is usual for carrying out *“medical treatment for a physical disorder”* where it states *"[d]eprivation of liberty will not occur in cases where medical treatment for a physical disorder is being provided, in any setting, which is materially the same as that provided to a person without a mental disorder."* This would read as a deprivation of liberty not applying in a hospital if someone were, for example, receiving treatment for cancer, where the ward and situation is the same for any other cancer patient whether deemed to have capacity or not. This appears a problematic gap.

3.3. With regards to the scenarios, in the vast majority of cases, they would benefit review, removal or rewrite using the questions outlined in 12.16 of the Code as a relevant tool. We find that:

3.3.1. It is unclear what action would be taken were the person to attempt to leave or change their circumstances and the scenarios are weakened by missing this detail in terms of interpreting whether a scenario is a deprivation or not.

3.3.2. The interpretation of freedom to leave v supervision and control are poorly balanced. The lack of a locked door does not indicate freedom to leave and this needs to be clear in the Code.

3.3.3. In relation to regular monitoring, it is unclear where the arbitrary reference to 30 minutes comes from and why this would be considered the appropriate determination.

3.3.4. The language and terminology used is not person-centred, often overlooks the social model of disability, and establishes a baseline in terms of cultural attitudes to capacity that is not as progressive as it should be for a revised Code.

3.3.5. The scenarios are too weighted towards what is considered a deprivation of liberty. Even discounting the well-established disagreement with the interpretation of the definition in the Code, these scenarios are not especially helpful in supporting people to understand how to apply LPS to their work and decisions they need to take. More scenarios that reflect deprivations of liberty would be helpful here.

3.4. We strongly recommend that Chapter 12 is reviewed substantially and many of the scenarios are changed or removed. We would welcome a co-production approach to this review, in particular including advocates, people with lived experience, and those who will be using the code of practice in their day-to-day work and will need to apply the definition and use the scenarios to make decisions about applicability of LPS.

4. Chapter 10 – Independent Mental Capacity Advocacy

4.1. As mentioned in our general observations, the summary boxes and scenarios are especially important when it comes to making sure they are clear, compliant with the law and reflect the spirit of the Mental Capacity Act. In relation to Chapter 10 of the Code, we recommend the following changes to the 'Quick Summary' box and include these in the text box below:

Quick summary

Criteria to become an IMCA

- IMCAs must have the appropriate experience, training and character, as well as other requirements as specified in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006.
- IMCA services are often provided by advocacy organisations. ~~that are~~ IMCA services must be independent from local authorities, NHS bodies and health boards.
- ~~Some IMCAs are freelance and can be approved by the local authority to act as an IMCA.~~

Understanding the role of the IMCA service in decisions about serious medical treatment or accommodation (section 37 -39 of the MCA)

- An IMCA must be instructed to provide independent advocacy and safeguards for people who lack capacity to make certain important decisions and have no-one else (other than paid staff) whom it would be appropriate to consult to determine what is in the person's best interests.
- IMCAs must be able to act independently of the person or body instructing them.

Instructing and consulting an IMCA for decisions about serious medical treatment or accommodation (section 37 - 39 of the MCA)

- IMCAs can only work with an individual once they have been instructed by the appropriate body. For accommodation decisions, this will be the local authority or NHS body responsible for the arrangements. For serious medical treatment decisions this will be the NHS body that has responsibility for the person's treatment.
- An NHS body or local authority must instruct and consult an IMCA when there is no one else for it to consult it (other than paid staff) to determine the best interests of a person who lacks capacity to make the decision, whenever:
  - o the NHS body is proposing to provide serious medical treatment, or
  - o the NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home or residential accommodation, and
    - ☐ the person will stay in hospital longer than 28 days, or
    - ☐ they will stay in the care home or residential accommodation for more than eight weeks
- An IMCA may be instructed when an NHS body or local authority is proposing to review accommodation arrangements which have been provided for more than 12 weeks.

Ensuring an IMCA's ~~views~~ representations are taken into consideration in decisions about serious medical treatment or accommodation (section 37 -39 of the MCA)

- The IMCA's role is to independently represent and support the person who lacks the relevant capacity. Their ~~views~~ representations should not be influenced by how the IMCA service is funded.
- In order to carry out their role, IMCAs have a right to see and take copies of relevant healthcare and social care records.
- Any information or reports provided by an IMCA must be taken into account when determining whether a proposed decision is in the person's best interests.

Appointing an IMCA under the LPS

- In cases where the person has no friends or family suitable to represent and support them, the Responsible Body must ~~take all reasonable steps to~~ appoint an IMCA to represent and support the person, in ~~most cases~~ all cases with rare exception.
- If someone does have family or friends suitable to represent and support them, this role is called an Appropriate Person. In ~~some~~ many cases, an IMCA will be appointed to support the Appropriate Person representing and supporting the person.

Understanding the role of the IMCA in the LPS

- The aim of the IMCA under the LPS is to represent and support an individual, or their Appropriate Person, throughout the LPS authorisation process and whilst any LPS authorisation is in force.
- The IMCA should represent the wishes and feelings of the person to the decision-maker.
- The IMCA should ~~ensure~~ take appropriate action so that the person's rights are upheld and take appropriate steps to challenge or support challenges where rights may not be being upheld.

4.2. Paragraph 10.11 states "The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 had introduced a role for IMCAs in certain adult protection cases (regulation 4). Following the introduction of the Care Act 2014, this particular regulation no longer applies." However, we find there is discrepancy between that and references to safeguarding referrals in chapter 23. This would benefit review and further clarity.

4.3. Section 10.17-10.20 appears to be referring to consultation of friends and family but this is not explicit and therefore the section is unclear. Good practice would be for an IMCA to 'consult' with friends and family as appropriate to understand the person's situation and, in particular, in the case of non-instructed advocacy, to understand what their wishes might be and preferred communication methods. Referring to whether decision-makers consult in a general way with family or friends makes it unclear what process is being referred to and whether it is actually talking about a formal and legally prescribed role and process of consultation or whether it is a more general idea of informing, consulting, coordinating with family and friends around a person's care and support.

4.4. In Section 10.22, we propose the following changes to strengthen and clarify the Code:

4.4.1. Where it references that an IMCA "may interview the person in private", this should be strengthened and changed to "should always be able meet with the person in private"

4.4.2. Where it states that an IMCA *"may examine and take copies of any health, social services or other record held by the provider which the person holding the record considers may be relevant to the IMCA's investigation"* this should be strengthened so it makes clear that the IMCA has appropriate access to records and documentation (in line with what it states in 10.28) and can carry out their role is supporting the person to exercise their rights. We propose a change to *"may examine and take copies of any health, social services or other record held by the provider which the IMCA or the person the IMCA is supporting considers may be relevant to the IMCA's investigation"*

4.4.3. Where it states *"must consult anybody else who can give information about the wishes and feelings, beliefs or values of the person who lacks the relevant capacity, as is practicable and appropriate"* there should be an additional reference to include consultation specifically with family and friends to sufficiently recognise their role in providing insight into the person's wishes and communication preferences or methods.

4.4.4. Where it states *"should satisfy themselves that a capacity assessment has been carried out and that reasons for the outcome have been clearly recorded"* we would expect that an IMCA should require a review of an assessment or challenge if a person has not been supported to have as much capacity as they may have had, had they been supported. Clarity around this requirement of an IMCA would be useful.

4.5. In 10.26, the Code refers to times when it would not be possible to appoint an IMCA. It simply refers to an example of "when the decision is urgent".

4.5.1. This section could be strengthened and clarified to make clear that these should be exceptional circumstances and there should be criteria to help make such a decision.

4.5.2. In addition to recording such decisions, there must be a process of review of these decisions on a regular basis to ensure there are not trends of particular practitioners or institutions deeming a decision urgent in order to circumvent people's rights to advocacy support.

4.5.3. It should be made clear that it is expected that the circumstances in which an IMCA should not be appointed due to the urgency of a decision are rare and prescriptive – simply referring to urgency leaves it too open to interpretation which may be problematic.

4.5.4. It should also be made clear that the perceived urgency of a decision cannot be a default 'trump card' to be used to diminish or weaken the role of the advocate, particularly in relation to decisions which have longer-term consequences, such as accommodation decisions.

4.6. In Section 10.29, it should be reflected that best practice would be that IMCAs also consult with family and friends where appropriate to ascertain information about the person's wishes.

4.7. In 10.30, it refers to "situations where the person cannot communicate at all". These circumstances are going to be very rare and exceptional, so this sentence is unhelpful. IMCAs are specialists and are trained in non-instructed advocacy, an approach to advocacy to support people who may face barriers to communication and/or communicate non-verbally. We recommend referencing non-instructed advocacy in the Code as the approach that IMCAs should take in such circumstances. We also recommend emphasis on an IMCA taking reasonable and practicable steps to find out how the person communicates and supporting them to do so.

4.8. Paragraph 10.41 appears to set the bar high in terms of what constitutes Serious Medical Treatment and provides examples that are not especially helpful in understanding the balance and burdens that weigh up whether something is Serious Medical Treatment or not. Some useful examples to consider could be treatment for cataracts, general anaesthetic, dental treatment, taking blood, etc. There should be clarity that *any* treatment *could be* serious for *anybody* depending on the person's circumstances and how something has to be administered.

4.9. In 10.63, it states the in the case of a disagreement between the decision-maker and what the IMCA has put forward in their reporting of the person's wishes and best-interests, that *"[i]f this happens, they should try to settle the disagreement through discussion and negotiation as soon as possible."* The use of the term "negotiation" is inappropriate when explaining the IMCA's role. Their role is to support and represent the person, not negotiate or mediate a position between the person and a decision-maker or public body. If in their role, the IMCA feels that the person's best-interests and wishes are not being met, then their role is to challenge that or support the person to challenge it if they wish to do so, it is not their role to enter into a negotiation. It may be best to delete paragraphs 10.63 and 10.63 given this lack of clarity and that there are references to what an IMCA should do if there is disagreement in the following paragraphs from 10.66 which more accurately reflects the IMCA's role in such a situation.

4.10. In 10.69, there is reference to the IMCA's "views". This does not reflect the IMCA's role in supporting and representing the person. They are not providing their "views" on a matter, they are providing a report and insight into what the person they are supporting wishes to happen or making their best assessment as to what they might wish to happen if taking a non-instructed approach. We would recommend this paragraph be reworded so it does not reference an IMCA's "views".

4.11. Paragraph 10.70 is unclear in terms of what it is referring to. If suggesting that an IMCA would sit on a steering group or board that makes decisions about people's accommodation or treatment, then this would be an overreach of the role of the advocate and diminish independence. It is unclear what is suggested by this suggestion in the Code and as it is very vague, it could be open to problematic interpretation. We would recommend its removal as we do not see how it reflects and IMCA's role nor is in line with other content of the Code.

4.12. Paragraph 10.72 should be strengthened in relation to safeguarding. The following sentence should be added to the paragraph: *"If an IMCA has concerns not directly related to compliance with the MCA, for example a concern about the healthcare or social care provided to the person they are supporting, they may use complaints or safeguarding procedures as necessary. Where the concern is a safeguarding concern, they must always raise it appropriately through the necessary routes for reporting safeguarding concerns to the local authority or relevant body."*

4.13. Paragraphs 10.74-10.75 reference to the overarching role of Responsible Bodies in relation to advocates and in particular the reference to having an IMCA not being in someone's best interest are highly problematic and risk undermining LPS safeguards.

4.13.1. Paragraph 10.74 states: *"[i]t is the role of the Responsible Body to appoint an IMCA. The Responsible Body must take all reasonable steps to appoint an IMCA for the person as soon as the LPS process has been triggered"*. This could be strengthened, and the duty and requirements of the Responsible Body could be made clearer. In almost all circumstances in order for someone to be supported, the Responsible Body must appoint, not just take steps to do so. A failure to do so risks the integrity of the LPS process. We propose it is changed to: *"[i]t is the role duty of the Responsible Body to appoint an IMCA. The Responsible Body must take all reasonable steps to appoint an IMCA for the person as soon as the LPS process has been triggered and within a specified timeframe. These reasonable steps must include the proactive provision of an IMCA service that is high-quality, well-resourced and establishing internal systems that prioritise the appointment of an IMCA within the LPS process"*

4.13.2. The third bullet point in paragraph 10.74 and paragraph 10.75 are problematic with their reference to the appointment of an IMCA not being in the person's best interests. Such a circumstance is so very rare that including it in the summary bullet point gives it a level of weight that is inappropriate and could be misinterpreted.

4.13.3. The example given in 10.75 of someone being *"at the end of their life and the person and the family do not want an IMCA"* is also problematic. The family's desire for the person to have an IMCA is not relevant, unless they are taking on the role of Appropriate Person and stating that they do not require IMCA support for themselves. However, if it is deemed that the person is subject to LPS due to their assessed lack of mental capacity, then appointing an IMCA is an appropriate safeguard of the person's rights. If an IMCA is appointed and the person subsequently makes clear that they have capacity to consent to advocacy but state that they do not want to have advocacy support then they can do so, but it should not be the Responsible Body's decision about whether a person is able to access advocacy and have their rights safeguarded or not. It is inappropriate to require Responsible Bodies to make such best interest decisions and put this responsibly in such a prominent place in the code to add weight to the expectations that such decisions are anything other than extremely exceptional.

4.13.4. The Code needs to make clear that the Responsible Body (working with the commissioning body, if separate) must work proactively to secure the necessary capacity, supply and availability of IMCA at all times. This must be a proactive and ongoing duty around reliable, quality and consistent service provision and not one which merely arises at the point of referral. The Code should emphasise that Responsible Bodies and commissioning bodies must prioritise working together proactively and responsively to secure appropriate advocacy provision, making clear that the person's wellbeing, safeguarding and rights depend on this.

4.13.5. We strongly recommend the removal of any reference of Responsible Bodies being required to make any best interest decisions with regards to access to IMCA. If there remains any reference, there must be appropriate safeguards in place. 10.75 currently states that "[w]here this decision is taken it should be appropriately recorded in the person's records." This is a weak safeguard in terms of record keeping an accountability. In order to safeguard against any inappropriate use of a best-interest clause to weaken people's right to advocacy support, there must be records of when such a decision is taken that are the matter of public record in terms of statistical scrutiny and that can be assessed by relevant regulatory bodies when assessing LPS and compliance with the law and regulations.

4.14. Paragraph 10.79 refers to multi-skilled advocates in recognition that some people may already have an advocate under the Care Act or Mental Health Act or as a result of other advocacy support. There is an opportunity here to strengthen this point and make it clear that it is often beneficial to the person and so more person-centred if they can have the same advocate for LPS or MCA support as in other circumstances. This would encourage integrated commissioning of advocacy services.

4.15. Paragraphs 10.81-10.82 refer to out-of-area arrangements but do not provide clarity on the funding and commissioning of such arrangements. The duty for the instruction is clear but the funding of advocacy in such a circumstance is not made explicitly clear. This is also the case in paragraph 10.54. It needs to be clear that the Responsible Body or commissioning body (if separate) are required to ensure there is funding for out of area advocacy support, with the simplest and most straightforward arrangement possible.

4.16. Paragraph 10.85 refers to the appointment of an IMCA to support an Appropriate Person. The role of the Appropriate Person is a significant undertaking and responsibility. Our assessment is there are very few people who would not benefit from having advocacy support when carrying out this role. We would recommend making clear that Appropriate Persons have the right to an IMCA throughout the Code and then specifically providing clarity in this paragraph by changing the text to: "In ~~some~~ many cases, there may be someone suitable to act as the Appropriate Person, but they ~~need~~ would often benefit from support from an IMCA to carry out that role. Where this is the case, an IMCA must also be appointed to help the Appropriate Person to represent and support the person."

4.17. Paragraph 10.89 refers to the IMCA gathering information about the person's wishes and beliefs and makes recommendations to whom they should speak to get a better understanding of the person. We propose adding in an explicit reference to family and friends as being key people from whom the IMCA should seek information and making clear that there is an expectation on the IMCA to gather information from those who know the person. We suggest the following change and additional text: "Additionally, where practicable and appropriate, the IMCA ~~may~~ should consult with those caring for the person, including in a professional capacity, and others who are likely to know the person and therefore their wishes and feelings well, including the person's family and friends."

4.18. Paragraph 10.90 refers to non-instructed advocacy but misrepresents verbal communication as the default means of communication in the wording of the first sentence. We would recommend change this paragraph to: "Some people may ~~be unable to communicate their wishes and feelings to the IMCA~~ not communicate verbally. In these situations, the IMCA should explore alternative communication methods. If the person is unable to express their wishes and feelings on an issue then the IMCA, as far as possible, should try to work out their likely wishes and feelings from speaking to and observing the person, speaking to other people, accessing records and through observation. This is often referred to as non-instructed advocacy. The person may use behavioural, or other communication methods, to make their wishes about the arrangements and feelings known.

4.19. Paragraph 10.97 refers to the IMCA's role in relation to outcomes.

4.19.1. We recommend changing the paragraph to: *"In part, the IMCA's role is to represent and support the person ~~in their relationship~~ when engaging with the Responsible Body. The IMCA should ~~seek the best outcome for the person~~ represent the person and their wishes and support them to have their rights upheld, which includes encouraging the Responsible Body to consider all options for the person's arrangements with the objective being to agree the least restrictive option."*

4.19.2. Additionally, where it states *"If an agreement cannot be reached, the IMCA may request than an AMCP considers the case. […] Upon receiving such a request from the IMCA, the Responsible Body should consider the principles set out in 18.50chapter 18 when deciding whether the case reaches the threshold for referral to the AMCP service. As with any case, the AMCP team should consider whether they think the threshold for an AMCP is met before accepting the case."* It appears to state that both the Responsible Body and the AMCP have a dual responsibility of deciding whether a case reaches a threshold, which seems unclear and impractical. If it is the Responsible Body that is being challenged, it would appear to be a conflict of interest for it to be responsible for deciding whether a case meets a threshold or not – this responsibility would be best placed solely with the AMCP.

4.20. Paragraph 10.99 sets out what the IMCA has the power to access and do to carry out their role. We recommend a review to ensure consistency with powers and duties that an IMCA has when carrying out other duties – where the power or principles are the same using the same language would be advisable (in particular in relation to 10.22).

4.20.1. Where it states *"[b]e consulted about the person's wishes and feelings about the arrangements"* this is unclear and is very limiting in terms of the advocate role. The IMCA is not in a passive role where they are consulted. Rather IMCAs are there to ensure the person they represent is fully consulted and involved in decision making and the IMCA should proactively consult with those people who know the person well what their wishes and feelings might be.

4.20.2. Where it refers to an IMCA *"[m]eet[ing] the person, including at the place (or places) where their care or treatment is taking place"* the additional clause "in private" should be added to make clear that the IMCA can meet with the person privately. This is important for both safeguarding and ensuring the person is able to express their wishes freely without undue pressure or coercion from others.

4.20.3. Where it states that the IMCA should be *"provided with a copy of the person's authorisation record"* it negates to mention the power to access other records, for example relevant health and social care records which may help to indicate the person's wishes. The power to access records and documentation should be the comparable to when carrying out other IMCA duties.

4.21. The wording in 10.99 contradicts the wording in 10.96 in relation to the duty of an IMCA to write a report. 10.99 states that *"[i]f an IMCA has written a report…"* which suggests there may be occasions under LPS when an IMCA would not write a report but these circumstances are not clear and in other parts of the Code, there is an explicit requirement for an IMCA to write a report. This should be clarified and consistency ensured.

4.22. In paragraph 10.100, it states that *"[a]fter the arrangements have been authorised, the IMCA should maintain contact with the person throughout the period of the authorisation as far as it is practicable and appropriate to do so."* The clause "practicable and appropriate" add a layer of vagueness to the Code here that might be unhelpful. If the expectation is to maintain contact the threshold of practicable and appropriate is so low that it likely bears little value in stating. What such examples are the government considering might be it is not practicable nor appropriate for an IMCA to maintain contact with the person?

4.23. In paragraph 10.104, it refers to times when an IMCA *"may, where appropriate, submit a written report to the Responsible Body"*. We would suggest that this should change to state that the IMCA "*must submit a written report*" in the circumstances listed, in line with best practice, necessary documentation and record keeping and to make sure that the Responsible Body is held accountable to respond.

4.24. Paragraph 10.107 refers to how the IMCA supports an Appropriate Person. It is inaccurate to state that the Appropriate Person is *"generally carried out by someone who knows the person well"*. The word *"generally"* should be removed from this sentence as it suggests there are times with an Appropriate Person could be someone who does not know the person well and this is not the case based on the criteria for becoming an Appropriate Person.

4.25. Paragraph 10.108 states that *"[t]he Responsible Body must publish information about when an Appropriate Person may need to be supported by an IMCA in an accessible and appropriate place. They should also publish information about what an Appropriate Person can expect from the IMCA service."* We recommend strengthening this to make sure the Responsible Body takes the appropriate steps necessary to raise awareness and understanding of the support available to Appropriate Persons. For example, a requirement to "publish information" may be met by putting up a poster in the Town Hall. Rather, the Responsible Body should take some responsibility in ensuring that information is provided to Appropriate Persons on their right to access the support of an IMCA and how they can self-refer for that support. We suggest a change of wording to: *"The Responsible Body must ensure that information about how an Appropriate Person can be supported by an IMCA is available in accessible formats and appropriate places and that the Appropriate Person is given this information alongside any information about the role. They should also ensure information is accessible and easily available about what an Appropriate Person can expect from the IMCA service."*

4.26. Paragraph 10.109 states "In some cases, the Appropriate Person may request support from an IMCA, in order to best support and represent the person" This should be changed to state that the right of the Appropriate Person to request IMCA support applies in all cases, not just some, and thus we propose a change to: *"~~In some cases,~~ The Appropriate Person may request support from an IMCA, in order to best support and represent the person"*

4.27. Paragraph 10.113 states that *"[t]he IMCA should support the Appropriate Person through any meetings they have with the person carrying out the pre-authorisation review, including supporting them to express their wishes and feelings."* In other parts of this section it refers to support the IMCA *"can provide"* or how they *"may support"*. We recommend it states that the *"IMCA may support the Appropriate Person through any meetings…"* to allow for the appropriate flexibility of support that the Appropriate Person might need.

4.28. Paragraph 10.114 states *"[i]f there is a disagreement between the person or the Appropriate Person and the Responsible Body, the IMCA can support the Appropriate Person to manage that disagreement."* Referring to the IMCA role supporting the management of a disagreement is problematic wording. The IMCA role is to support the Appropriate Person to best represent the wishes of the person and so that the person's rights are upheld. It is not to manage relationships or disagreements between parties as the IMCA role isn't one of neutral mediator. This paragraph should be reworded: *"[i]f there is a disagreement between the person or* *the Appropriate Person and the Responsible Body, the IMCA can support the Appropriate Person to understand the options to challenge the decision and what steps they could take should the person want to or be likely to want to challenge a the decision."*

4.29. 10.117 provides a definitive list of records that the IMCA can access. We recommend that this is cross referenced where the power to access records is mentioned elsewhere in the Code to ensure consistency of understanding and application of powers.

4.30. 10.120 refers to multi-skilled advocates, but through mentioning on the Care Act, it risks suggesting that only Care Act and MCA advocacy can be combined into one advocate providing support under both legislation. We suggest rewording for clarity to state; *"An Independent Advocate appointed under other legislation~~, such as the Care Act (2014),~~ can also be the IMCA for the person for the LPS if they meet the requirements outlined in paragraphs 10.70 – 10.73. In many cases, having the same advocate will benefit the person and so should be encouraged where possible."*

5. Appropriate Persons – Chapter 15

5.1. As previously mentioned, the summary boxes will be frequently used 'go-tos' by practitioners and therefore must be clear and consistent. We recommend the following changes to the Quick Summary of Chapter 15 as proposed in the text box below:

The Appropriate Person role is ~~normally~~ carried out by someone who is close to the person. When an individual is identified for the role, the relevant Responsible Body must determine if the individual is suitable for the role before appointing them. The individual should not receive remuneration for fulfilling the Appropriate Person role, and the individual must consent to being appointed to the role.

Quick summary

~~Who can be an Appropriate Person~~ How will an Appropriate Person be identified?

- It is the Responsible Body's responsibility to determine if there is someone suitable to fulfil the requirements of the Appropriate Person role. The identified individual must consent to taking on the role before they are appointed.
- The person must consent to the individual being appointed to the role of Appropriate Person. If they lack the capacity to consent, the Responsible Body should make a best interests decision~~s~~ for the person.
- If there is not an individual suitable to undertake the Appropriate Person role~~, in most cases,~~ the Responsible Body must appoint an Independent Mental Capacity Advocate (IMCA).

Who can be an Appropriate Person

The Appropriate Person must know the person well in order to be able to support them to express their views and wishes and understand how they communicate.

The Appropriate Person must understand the gravity of the role and the role's duties and responsibilities.

The Appropriate Person must be able to have regular contact with the person.

The Appropriate Person must be willing and able to challenge decisions, including through the court, should that be required to safeguard the person's rights.

What is the role of the Appropriate Person?

- The Appropriate Person will need to understand the LPS process to help ensure that the person's wishes and feelings are properly considered. The Appropriate Person has the right to access certain information to help them with this.
- The Appropriate Person provides representation and support for the person and supports them throughout the LPS process. The Appropriate Person should ~~ensure that the person is supported~~ support the person to understand the different stages of the authorisation process and the authorisation itself.

The Appropriate Person's rights.

- The Appropriate Person also has the right~~, in certain circumstances,~~ to be supported in the role by an IMCA.

5.2. In paragraph 15.2, the Code references the relationships or roles that a person might have when being an Appropriate Person. In 15.3, the Code provides more details on the reference to volunteers. However, the Code is currently worded in a way that might allow volunteers who do not have a significant or meaningful relationship with the person to be appointed as an Appropriate Person or, as a minimum, risks confusion and additional layers of test when ultimately the reference to a friendship is sufficient. If the example of a *"volunteer who provides support to the person in non-professional capacity (this can include via organisations that both do and do not provide care or treatment to the person)"* is included to cover the relatively rare occasions when a befriending volunteer may have struck up a positive and long-term friendship with someone and could take on the role, then ultimately the reason they are able to be an Appropriate Person is because they are a *"friend of the person"* not because of their volunteer role or volunteer status. The inclusion of "volunteer" in the list in any way simply risks causing confusion and the possibility that volunteers will be parachuted into an Appropriate Person role without the necessary relationship and understanding of the person, nor the skills and consistency required to provide full and ongoing support for someone in such a high risk and vulnerable situation. We recommend it is removed from the list to resolve this issue and that paragraph 15.3 is deleted.

5.3. We agree with the list outlined in paragraph 15.15 stating the considerations that the Responsible Body must take into account when appointing and Appropriate Person. We propose the addition of an additional bullet point to fully reflect the gravitas and requirements of the role: *"Would the proposed Appropriate Person be willing and able to challenge a decision, including taking the necessary legal action to challenge a decision if this was in the person's best interests and represented their wishes?"*

5.4. Paragraph 15.21 would seem to prevent a spouse being able to take on the role of Appropriate Person in circumstances where a home was jointly owned or was to be sold to cover the cost of care. This may be an unintended consequence or remain considered as a necessary protection but the Code currently reads to prevent such a scenario at present.

5.5. Paragraph 15.23 is loose guidance that could impact on the safeguarding of those who are subject to LPS in their own home and whose family members restrict their freedoms, ability to self-advocate, or ability to express their views independently. In such a circumstance, it would be highly recommended that should it be considered that a family member is able to be the Appropriate Person that they must access the support of an IMCA and the IMCA can play an additional safeguarding role to ensure that the Appropriate Person has able to fulfil the role as necessary. However, it is likely that in these circumstances, the ideal scenario for fully guaranteeing the person's wishes are understood and rights are upheld would be to appoint an IMCA so this should be considered very favourably or the Code reworded to state this.

5.6. Paragraph 15.26 can be made clearer by removing the clause "in most cases" as there are very, very rare exceptions when an IMCA shouldn't be appointed and none of these examples would be when it's been identified that the person requires support but there happens not to be an Appropriate Person available – such a circumstance has already met the threshold for support whether by an IMCA or an Appropriate Person.

5.7. The bullet list provided in paragraph 15.28 is a little confused. It mentions *"challenging"* decisions twice but doesn't mention communication, understanding the person's wishes or representing them once. In particular, the bullet that states *"How to carry out the role, such as meeting the person regularly and challenging decision makers,"* could be improved by being changed to read: *"How to carry out the role, such as communicating effectively with the person, meeting the person regularly to understand their situation and their wishes, reviewing documentation and communicating information, representing the person and acting independently of your own personal views, and challenging decisions when it is necessary to do so"*

5.8. Paragraph 15.29 is unclear in places and seems to suggest that somebody who would struggle to carry out the role of Appropriate Person should still be able to do so, if they had the support of an IMCA. It has been assumed in the Impact Assessment that an IMCA supporting and Appropriate Person will require fewer working hours because they Appropriate Person is taking on the role of understanding and representing the person. However, if the Code introduces muddy water where an Appropriate Person requires substantive support to the extent that the Responsible Body is considering whether an assessment of capacity is required, then this significantly increases the role of the IMCA. The paragraph would benefit from review in terms of intended message and outcome.

5.9. In paragraph 15.34, there is reference to challenging the decision of the Responsible Body if the person or an individual who wished to be the Appropriate Person disagrees with the decision regarding the appointment of an Appropriate Person. It suggests that "[t]he individual or someone else may decide to challenge this decision and the Responsible Body should have appropriate channels for such challenges." Clarity regarding the expectations of what those routes to challenge such a decision might be and what processes might be employed would be useful to include or reference in the Code of Practice.

5.10. Paragraph 15.44 misrepresents the Appropriate Persons role in stating: *"In some cases, the Appropriate Person may disagree with the Responsible Body's decision. Ideally the issue will be resolved through discussion and negotiation among the relevant parties. If the Appropriate Person is unhappy with the Responsible Body's decision, ultimately this may need to be resolved by a court."* This wording suggests that the Appropriate Person is representing their own views, opinions and wishes. It should be reworded: *"In some cases, the Appropriate Person may disagree on behalf of the person that the Responsible Body's decision is the least restrictive option and takes appropriate into account the person's wishes. Ideally the issue will be resolved through discussion ~~and negotiation~~ among the relevant parties, including the person and/or the full consideration of their views and wishes. If, acting on behalf and as a representative of the person, the Appropriate Person still considers that the Responsible Body's decision does not uphold the person's rights, ultimately this may need to be resolved by a court."*

5.11. Paragraph 15.50 refers to frequent contact without any suggestion of what that might mean. It would be helpful to give specific guidelines to Appropriate Persons about the expectation of the frequency and regularity of contact. Further, in this paragraph the last sentence which reads "[t]he Appropriate Person should ensure that they are in regular contact with the person and, if possible and appropriate, meet them face-to-face" should be strengthened to make clear that the preference and expectation is that contact is, most certainly on the majority of occasions, face-to-face. Face-to-face, in-person contact should not be caveated by it being "possible and appropriate". The Appropriate Person is undertaking a legally prescribed role which means they must be able to see and assess the situation the person is in – that cannot be done properly through only remote contact.

5.12. Paragraph 15.52 should be reviewed to make it more person-centred with the onus being on the professionals and Responsible Bodies involved being able to communicate more effectively rather than setting the responsibility for communication with the person and their perceived 'inability' to communicate being established as the reason for any difficulty. A proposed edit could be: *"If ~~the person is unable to communicate their~~ Responsible Body is unable to understand the person's wishes and feelings, the Appropriate Person should ensure, as far as possible, that the Responsible Body is aware of them. For example, if ~~the reason the person cannot communicate their wishes and feelings is because~~ a professional carrying out an~~d~~ assessment and determination is unable to understand the person's communication methods, the Appropriate Person could support the person in the meeting to put their views across."*

5.13. Paragraph 15.56 refers to the "reasonableness" of a request to review the authorisation. However, no criteria or cross referencing of what that criteria of what is "reasonable" is shared. How will the reasonableness of a request be defined? We also note that references to the review process to this level of detail in relation to "reasonableness" are lacking in Chapter 10 about the IMCA role. Ensuring consistency about the powers both roles hold, the processes to follow and the routes to challenges is recommended to avoid confusion or a risk of a 'two-tier' approach,

5.14. Paragraph 15.57 refers to the Appropriate Person taking a challenge to the Court of Protection but does not set out the duty they have in their role to take a challenge forward if certain thresholds are met, for example where they know someone would continue to object to the decision of the Responsible Body or where they have established that there might be a less restrictive option that the Responsible Body has rejected. Setting out some criteria and examples of when an Appropriate Person may take forward a legal challenge would be a helpful addition to the Code.

5.15. In 15.59, the Code makes reference to the regularity of reviews and puts the duty of ensuring reviews take place on the Appropriate Person which given that the duty bearer of the Mental Capacity Act is the Responsible Body, this seems a misrepresentation or an overreach. We propose a change to: *"Once reviews are scheduled, the Appropriate Person should both ~~ensure~~ take all necessary and reasonable steps so that they take place as planned and therefore challenge the Responsible Body if they do not take place, and ~~where appropriate,~~ represent and support the person during the review."*

5.16. Paragraph 15.64 misrepresents the right an Appropriate Person has to an IMCA. We propose a change to: "The Appropriate Person has the right~~, in certain circumstances,~~ to be supported in the role by an IMCA."

5.17. In order to make sure Appropriate Persons get the support of an IMCA should they wish to, we would recommend that self-referral routes are also promoted. As the Responsible Body will commission IMCA services, this would be an easy way to ensure that Appropriate Persons can the right support for carrying out the role. We propose a change of wording to: "If the Appropriate Person would like to be supported by an IMCA, ~~they can make a request to~~ the Responsible Body should ~~appoint one~~ ensure there is an appropriate IMCA service and that the Appropriate Person knows how to access it, including through self-referral routes. The Responsible Body has a duty ~~to take reasonable steps~~ to appoint or facilitate the appointment of an IMCA for an Appropriate Person if they have capacity to consent to being supported by an IMCA and they make a request. An IMCA may be appointed to support the Appropriate Person for a short period(s) or may be appointed for the full period of the assessment process and any subsequent period of authorisation."

5.18. Paragraph 15.67 makes little sense but we recommend that the essence of the paragraph is kept in order to resolve confusion in the interpretation of the Act. It refers to an Appropriate Person being unable to consent to having support from an IMCA and suggests that it "would be rare that an Appropriate Person would be suitable to carry out this role if they were unable to consent to being supported by an IMCA". Examples of where this might be the case and this individual could be an Appropriate Person would be helpful here. It appears to be a paragraph that causes confusion over clarity and risks suggesting that people who ultimately wouldn't be able to fulfil the role could be Appropriate Persons. This is why examples would be helpful here.

6. Supporting people to make decisions – Chapter 3

6.1. The "Quick Summary box" simplifies or misrepresents some elements of the Appropriate Person and IMCA role and the Responsible Body's duties. We propose the following change:

"Supporting the person
• Can anyone else help or support the person to make the decision?
• Has an IMCA or Appropriate Person been identified and appointed?
How is the person kept at the centre of the LPS process?

• There are a number of decisions that need to be taken during the LPS process, including; on the person's care or treatment, on the arrangements surrounding the care or treatment, on whether they ~~wish~~ consent (if they are able to consent) to be supported by an Appropriate Person or IMCA.
• The person should always be supported to make those decisions as far as possible. Even if the person lacks the capacity to make one decision, they may still be able to make another.
What information does the person and their Appropriate Person or IMCA have the right to?
• The Responsible Body has a duty to publish certain information, and to ensure that the person and their Appropriate Person (where relevant) understands the information. All information must be accessible.
• The Responsible Body must also ensure that the person and their Appropriate Person understands certain information.
•The Appropriate Person and IMCA also have powers to access certain records and information to support the person to make their own decisions (see Chapter 10 and 15 for more information about this)"

6.2. The list set out in paragraph 3.9 is reasonable. Given the importance of a person being able to make their own independent decisions, it would be useful to add an additional bullet point that makes clear the person helping must not express their own judgement or opinion on what the person should or should not decide. We propose: *"Set aside your own personal judgement about what is the 'right' decision and avoid expressing opinions on the validity of the options available to the person so that the person can make their own independent decision"*

6.3. Paragraph 3.10 sets out some of the communication considerations in order to ensure communication is accessible for the person. It is also of note that this requires time and resources and should be supported and factored in to services, in particularly when commissioning IMCA services.

6.4. The language and framing used in 3.11 and in this section could be improved and made more person-centred, including reflecting the social model of supporting people. The section is currently worded as the person having a "problem", rather than recognising the barriers that are in place to make communication more difficult for them. We suggest the section is retitled: "***Adapting communication approaches so people understand***" and that the section is rewritten in places to put the responsibility for effective communication at the door of the practitioner or professional rather than the person.

6.5. Paragraph 3.17 misrepresents the duty to ensure someone is supported by either an Appropriate Person or an IMCA. We propose it is changed to: *"If there are no significant trusted people, or no-one willing to provide support who could be the Appropriate Person, then ~~it may be appropriate to consider~~ an advocate must be appointed."*

6.6. Where it states in paragraph 3.22 that the *"[person can make] a request to be represented and supported by an IMCA (Independent Mental Capacity Advocate) and [apply] to the Court of Protection"* this is unclear and suggest that the onus is on the person to request an IMCA for themselves rather than the duty being on the Responsible Body to appoint and IMCA. This should be reworded: *"There are also a* *number of decisions to be made by the person themselves during the LPS process, such as ~~making a request~~ whether they consent (if they are able to consent) to be represented and supported by an IMCA (Independent Mental Capacity Advocate) or Appropriate Person and applying or consenting (if they are able to consent) to an application to the Court of Protection."*

6.7. Paragraph 3.23 should make it clear that in best practice such support should mean support from an IMCA or Appropriate Person that is appropriately commissioned by the Responsible Body.

6.8. In paragraph 3.24 when stating that "a 'best interest' decision may be needed" this should be explained and the circumstances under which this "may be needed" be defined and appropriate guidance provided.

6.9. The list in paragraph 3.26 includes the question "will the person be able to see friends and family?" This is misleading and problematic as it suggests it could be legal to establish an arrangement where someone would be prevented from seeing their friends and family in violation of their article 8 rights. The question should be reframed more positively to: *"How will the person be supported to be able to see friends and family?"*

6.10. In paragraph 3.29, the Code states *"The person may request the support of an IMCA, if they have the capacity to do so."* This should be clarified and qualified with the addition of *"but it is not a requirement that they request an IMCA and the Responsible Body's duty remains unchanged in their duty to appoint an IMCA or an Appropriate Person"* The Responsible Body should not be in a position to gatekeep or qualify access to an IMCA or an Appropriate Person so the default should be the appointment of an IMCA and then the IMCA can support the person to understand and consent or withhold consent should they have capacity to do so.

6.11. Paragraph 3.30 includes: "If an Appropriate Person should not be appointed, the Responsible Body will need to consider if the legal criteria for the appointment of an IMCA applies." This is misleading in terms of the Responsible Body's duty and the support that the person needs. If a person is subject to LPS but does not consent to the proposed Appropriate Person, an IMCA should be appointed by the Responsible Body and the IMCA can support the person to understand their role and discuss with them whether they consent, in the case of their having capacity to consent.

6.12. In paragraph 3.33 where it refers to the duty of the Responsible Body to facilitate communication, this should be strengthened and a more positive duty specified. We propose: *"If the person or their Appropriate Person or IMCA has a specific communication need, the Responsible Body should ~~consider providing~~ provide assistance and respond to all reasonable requests for adaptations to communication methods, access to additional materials or resources, or the use of interpreters."*

7. Authorising LPS – Chapter 13

7.1. Parts of Chapter 13 could be strengthened, made more person-centred, and clarified or made more accurate. With regards to the “Quick Summary” box, we recommend the following change:

“Once the Liberty Protection Safeguards have been triggered the Responsible Body must~~; Once the LPS have been triggered the Responsible Body should~~:

o consider whether ~~the case is suitable for~~ the LPS applies to this case
o establish if it is the correct Responsible Body, but with a no-wrong door principle at first instance
o ~~consider~~ identify representation and support for the person by an Appropriate Person or IMCA
o commission the medical, capacity, and necessary and proportionate assessments and determinations
o carry out the consultation to establish the person’s wishes and feelings.”

7.2. Paragraph 13.6 states that *“[s]ome people may not have a statutory health or care plan, and instead may be receiving care either from family and friends or through privately arranged care. Where this is the case, Responsible Body staff should work with the carers to ensure that the person’s arrangements going forward are lawful and respect any particular considerations regarding how the carer delivers care to their friend or family member, as far as is practicable and appropriate.”* In such a scenario, how is it expected that the local authority is going to be made aware of people who are receiving care at home, if there’s no involvement by them with a health or care plan? To what extent is it expected that the Responsible Body will safeguard that person’s rights with the spirit of LPS in mind, even if their health or care is not under the responsibility of a state body. Additionally, in light of the incoming ‘social care spending cap’, there will be considerably more people who have private and family care arrangements who go through the Care Act process so that the spending cap can be applicable. If it comes to light that it appears these people are under arrangements which amount to LPS, it would be reasonable to assume they would then become subject to the LPS but this is not reflected in the Code.

7.3. Paragraph 13.7 states that *“[a]s far as practicable, the person should be supported to make their own decisions about the arrangements for their care or treatment.”* This is not a person-centred approach, as practicality of people’s ability to make their own decisions shouldn’t be a consideration in their being supported to make decisions themselves. If there are ways that a person should be supported, the Responsible Body should ensure that all steps are taken to support that person to make their own decisions, including making sure they have the support of an IMCA when necessary. We propose the deletion of the clause *“[a]s far as practicable”.*

7.4. Paragraph 13.8 refers to restrictions being “very’ restrictive” as a trigger for LPS without any criteria or reference to what would be very restricted versus simply restrictive and how that might be interpreted. We propose that the word “very” is removed because of the additional threshold it suggests. We also note that staff who may be responsible for triggering LPS procedures need very robust training to ensure their understanding of the law and how to apply it.

7.5. In paragraph 13.9, where it refers to “some circumstances, it will be possible for the Responsible Body to rely on an earlier assessment and determination or an assessment carried out for a different purpose,” this needs to be clearly qualified under particular circumstances only, for example the person is in a coma and has been for a period of time and their situation is unchanged. Given the weight given to making clear that capacity is fluctuating, use of previous assessments should be exceptional and in very narrowly prescribed cases. This may benefit from re-wording for additional clarity.

7.6. Paragraph 13.11 is confusing and should be rewritten. It refers to people being known to the Responsible Body but with no understanding of how they would be aware of the person’s situation given the arrangements are privately made and the person is not being given statutory support. It also is vague about the accountability and at what point the LPS might apply to these private arrangements and how the Responsible Body should go about “encouraging” and “informing” people.

7.7. At 13.24, there is a reference to the requirement *“consider representation and support for the person”*. The requirement around the appointment of an IMCA or Appropriate Person is more than a consideration and should in fact be framed as a positive action where someone must be ensured support from either of these roles.

7.8. In paragraph 13.57, the reference to an AMCP meeting someone in-person *“if practical and appropriate to do so*” is a problematically low-bar. Clarity on when would it not be appropriate or practical for someone assessing someone’s capacity to make a particular decision would be helpful to avoid a too open interpretation.

8. Submission and contact information

8.1. This joint response is submitted by VoiceAbility on behalf of the co-signing organisations listed on page 1.

8.2. For any follow up regarding this response, please email public.affairs@voiceability.org.