EXPLANATORY MEMORANDUM TO

THE MENTAL CAPACITY (DEPRIVATION OF LIBERTY: MONITORING AND REPORTING; AND ASSESSMENTS – AMENDMENT) REGULATIONS 2009

2009 No. 827

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This instrument makes regulations in relation to the monitoring and reporting of the operation of Schedule A1 to the Mental Capacity Act 2005 (the Mental Capacity Act Deprivation of Liberty Safeguards 'MCA DOLS'). It also amends the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 This instrument is subject to the affirmative resolution procedure as provided for in section 65(4B) of the Act.

4. Legislative Context

4.1 This instrument is part of the implementation of the MCA DOLS, which were inserted as Schedule A1 into the Mental Capacity Act 2005 by the Mental Health Act 2007.

4.2 The instrument places a duty on the Care Quality Commission (CQC), the new regulator for England, to monitor and report on the operation of the MCA DOLS. It provides the CQC with powers to visit hospitals and care homes, interview residents and inspect records. These powers of inspection are in addition to the wider powers of inspection conferred on the CQC by the Health and Social Care Act 2008.

4.3 This instrument also requires the CQC to report to the Secretary of State on the operation of Schedule A1. Under powers in the Health and Social Care Act 2008, the CQC is required to produce an annual report on its key functions. It is envisaged that the MCA DOLS will be included in this report. Therefore, the powers in this instrument enable the Secretary of State to make additional requests for information on the operation of the MCA DOLS, as appropriate.

4.4 In addition to the monitoring and reporting powers, this instrument makes changes to the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 to:

- provide that MCA DOLS assessors are eligible to carry out assessments where they have in place an adequate and appropriate policy of insurance, indemnity arrangements or a combination of both. Under the existing regulations, only those assessors who have a policy of insurance in place will be eligible to carry out assessments. It was never the Government's intention to prevent professionals with indemnity arrangements (rather than policies of insurance) from becoming assessors in this way.

- enable local authorities to recover costs where a determination made by the Secretary of State under paragraph 183 of Schedule A1 concludes that another local authority is the relevant person's local authority of ordinary residence. This is to bring the MCA DOLS in line with

other legislation[1] under which an ordinary residence determination can be sought from the Secretary of State and costs recovered from another local authority where appropriate.

The MCA DOLS

4.5 The Mental Capacity Act 2005 provides a statutory framework for people who lack the mental capacity to make their own decisions. It sets out who can take decisions, in which situations, and how they should go about doing this. It contains principles, procedures and safeguards to empower people to make as many decisions themselves as they can and to play as full a part as possible in the decision-making process when they lack the capacity to make a decision. The Act also enables people to make provision for a time in the future when they may lack the capacity to make some decisions.

4.6 The MCA DOLS, found in Schedule A1 to the 2005 Act (as inserted by Schedule 7 to the Mental Health Act 2007), provide a framework for approving the deprivation of liberty of people who lack the capacity to consent to the arrangements made for their care or treatment (in either a hospital or care home) but who need to be deprived of liberty in their own best interests, to protect them from harm. The MCA DOLS legislation contains detailed requirements about when and how deprivation of liberty may be authorised.

5. Territorial Extent and Application

5.1 This instrument extends to England only.

6. European Convention on Human Rights

6.1 The Minister of State for Care Services, Phil Hope MP has made the following statement regarding human rights:

In my view the provisions of the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) regulations 2009 are compatible with Convention rights.

7. Policy background

7.1 The MCA DOLS are a response to a European Court of Human Rights' (ECtHR) judgement in October 2004 – the case of HL v UK. The Court found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment, and who had been admitted informally to Bournewood Hospital, was unlawfully deprived of his liberty in breach of Article 5 of the European Convention on Human Rights.

7.2 Lawful deprivation of liberty is achieved by introducing a system for "authorising" deprivation of liberty based on assessments to determine whether six "qualifying requirements" are met. A "standard" authorisation should be obtained in advance of deprivation of liberty commencing but an "urgent" authorisation may be given, as a preliminary to obtaining a standard authorisation, if the need for a person to be deprived of liberty is so urgent that it is appropriate for the deprivation to begin before the standard authorisation process can be completed. Where an urgent authorisation is given, the qualifying requirements assessments must be completed within 7 days, otherwise up to 21 days is allowed for the assessment process.

7.3 Monitoring by the CQC will ensure that managing authorities are complying with the MCA DOLS.

[1] Section 32(3) of the National Assistance Act 1948 and section 8 of the Community Care (Delayed Discharges etc) Act 2003

8. Consultation outcome

8.1 The deprivation of liberty safeguards policy was the subject of a formal consultation exercise for a period of 12 weeks between March and June 2005. This consultation invited responses to outline proposals for addressing the legal shortcomings identified by the ECtHR in its 2004 judgement. The consultation document[1] identified three possible options. The deprivation of liberty safeguards have been developed from the option that received most support within the consultation responses. A report on the outcome of the consultation process was published on 29 June 2006[2]. At the same time, an announcement was made setting out the proposed deprivation of liberty safeguards policy.

8.2 There was a further formal 12 week consultation exercise between September 2007 and December 2007. This consultation sought views on the deprivation of liberty safeguards Code of Practice guidance and two sets of deprivation of liberty safeguards regulations[3], one of which was **t**he Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008. A report on the outcome of the consultation was published on 9 June 2008[4].

8.3 The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 have recently been the subject of a further short consultation. This consultation ran from 19 December 2008 to 30 January 2009. The Government response to this consultation is attached to this Explanatory Memorandum.

9. Guidance

9.1 The main source of guidance on the MCA DOLS is the Code of Practice that was laid before Parliament in draft on 13 June, and was subsequently published on 26 August 2008.

9.2 A range of further guidance is available through the deprivation of liberty safeguards webpage. In addition, a great deal of implementation preparatory work has been, and is being, done through links into local networks and attendance and presentations at seminars, conferences, etc.

10. Impact Assessment

10.1 A full MCA DOLS Impact Assessment (IA) was prepared for the formal consultation process that took place between September 2007 and December 2007. This was revised to accompany the laying of the MCA DOLS Code of Practice, the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 and the Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008. A further IA was prepared for the consultation on the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 and is attached to this Explanatory Memorandum[5].

10.2 Subsequent work has not changed these assessments.

11. Regulating small business

11.1 The legislation on MCA DOLS applies to small businesses largely to the extent that many of the care homes that come within the scope of the legislation will be small business enterprises.

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[1] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4113613
[2] http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4136791
[3] The consultation papers can be accessed at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078052.
[4] http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_085353
[5] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_092048

11.2 Detailed guidance, for example the Code of Practice and a forms and record-keeping guide for hospitals and care homes, has been prepared that will minimise the impact of the requirements on small businesses. Because of the low numbers of people who are expected to need to be deprived of their liberty under the deprivation of liberty safeguards, it is not anticipated that the introduction of the safeguards will have a major impact on individual small businesses.

12. Monitoring & review

12.1 The Care Quality Commission (CQC) will have responsibility for monitoring and reporting on the operation of the deprivation of liberty safeguards. This instrument places a duty on the CQC to monitor and report on the operation of the MCA DOLS.

12.2 The Care Quality Commission is a new organisation formed by the amalgamation of the previous health and social care services inspection bodies- the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care inspection.

13. Contact

13.1 Helene Shaw at the Department of Health, Telephone: 202 7972 4958 or email: helene.shaw@dh.gsi.gov.uk, can answer any queries regarding the instrument.

Mental Capacity Act 2005
Deprivation of Liberty Safeguards

Response to Consultation

February 2009

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
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Cross Ref	MCA 2005 Deprivation of Liberty Safeguards Code of Practice
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Timing	**N/A**
Contact Details	Kate Hardy SCPI-DQ Unit 124, Wellington House 133--155 Waterloo Road London SE1 8UG
For Recipient's Use	

The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009

Response to a consultation carried out by the Department of Health. This information is also available on the Department of Health website:
http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

Contents

Introduction 2
Background 3
Responses received for each question 4
Conclusion – our response and next steps 11

Introduction

This document is the post-consultation report for the consultation paper ‘Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Consultation on the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) and (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence (Amdenment) Regulations 2009) which was published on 23 February 2009. The consultation covered one set of draft regulations for England: The Mental (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009.

This post-consultation report is published by the Department of Health. It covers:

- the background to the report;
- a summary of the responses to the report;
- a detailed response to the specific questions raised in the report; and
- the next steps following this consultation;

Further copies of this report can be obtained by contacting the **Project Management Team** at the address below:

Mental Capacity Act Deprivation of Liberty SafeguardsImplementation Programme
Room 124, Department of Health
Wellington House
133 -- 155 Waterloo Road
London SE1 8UG

Telephone: 020 7972 3963

This report is also available on the Department’s website at:
http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

Background

A formal consultation on the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) and (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence (Amendment) Regulations 2009 set out draft regulations which sought to:

- confer power on the Care Quality Commission (CQC) for the purpose of monitoring, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards
- amend regulation 3 of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations

The consultation took place between 19 December 2008 and 30 January 2009. It invited comments and views on the regulations.

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) are a response to a European Court of Human Rights' judgement in October 2004 – the case of HL v UK. The Court found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment, and who had been admitted informally to Bournewood Hospital, was unlawfully deprived of his liberty in breach of Article 5 of the European Convention on Human Rights.

The MCA DOLS remedy this breach of the ECHR and were inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007. The new provisions (found in schedule A1 to the 2005 Act) provide a framework for approving the deprivation of liberty of people who lack the capacity to consent to the arrangements made for their care or treatment (in either a hospital or care home) but who need to be deprived of liberty in their own best interests, to protect them from harm.

Twenty-nine responses were received, all of which were broadly in support of the regulations. A list of respondents is set out at Annex A. The responses were helpful and constructive. Many offered more detailed comments including requests for further clarification and suggestions about how the regulator should undertake the designated monitoring responsibilities.

The consultation paper asked a number of specific questions about the regulations. All respondents based their responses on these questions (although some included general observations about monitoring activity and the nature of insurance and indemnity). The summary of responses that follows is framed around the questions that were asked in the consultation paper.

Responses received for each question

1. Do you support the proposal that power should be conferred on the CQC for the purpose of the monitoring of, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)?

Summary of responses

All respondents who commented on this issue agreed that the responsibility for monitoring the operation of the MCA DOLS should be conferred on CQC.

Consultation responses

Respondents sought further clarification about how CQC would undertake this role and also offered suggestions about how the regulator should discharge this new responsibility.

"…we believe this [MCA DOLS monitoring] should be integrated with their wider role of inspecting care homes against registration regulations and compliance criteria."

"[We] can't comment on how effectively it will do the job until more information is provided about how it will undertake its duties."

Key concerns included:

- How will CQC integrate MCA DOLS activity into its broader role inspecting hospitals and care homes?
- The focus of the regulations is predominantly on the managing authority. Who scrutinises the supervisory body?
- What training will staff have to prepare them for their role as inspectors; as managers of a care home or hospital undergoing inspection?
- Inspectors need training in understanding particular needs of the client group so they can undertake their duties in an informed way
- "The CQC intends to pursue a strategy of risk-based targeted inspection and enforcement, and its methodology for assessing risk will be crucial to its effectiveness in monitoring and reporting on deprivation of liberty. As well as the assessment by CQC it is essential that there are rigorous procedures built into self-assessment."
- "CQC must involve key stakeholders in the development of both their inspection methodology and the information they require as part of self-assessment."

The Government's response

We welcome the majority view that CQC should be responsible for operating the monitoring of the MCA DOLS.

We cannot comment on how the regulator will undertake its monitoring activities. The Health and Social Care Act sets out the legislative framework for the regulation of health and adult social care. It set out the functions of the Care Quality Commission clearly whilst giving it independence on how to deliver those functions. The high level regulatory requirements that providers of regulated services must meet will be set in secondary legislation and then regulator will have the freedom to develop the criteria by which it assesses compliance. The Commission will have the flexibility to make different provisions in different cases or different circumstances to reflect different services. This is to allow for the fact that, for example, measures to assure some issues in care homes may be very different from those required to assure the same issues in, say, acute wards.

2. Do you support the proposal to give the Care Quality Commission general powers to:

- **visit hospitals and care homes**
- **visit and interview people accommodated in hospitals and care homes**

• require the production of, and inspect, records relating to the care or treatment of people accommodated in hospitals or care homes who are, or should be, deprived of liberty under the MCA DOLS.

Summary of responses

Most respondents indicated their support for this proposal but with a number of provisos and specific recommendations for changes to the regulations and CQC activity. The one dissenting voice wanted to see enhanced powers for CQC in relation to MCA DOLS.

Consultation responses

Recommendations for specific changes to the regulations were, as follows:

"[Regulations should] include a requirement for CQC to monitor the quality, standards and extent of the contractual and reviewing arrangements of local commissioners with regard to people who are subject to the Deprivation of Liberty Safeguards."

"The CQC should be given powers to interview *both* adults who are accommodated and professionals involved in the care and treatment of adults who are or should be deprived of their liberty."

"Regulations should require the CQC to instruct a managing authority to make an urgent application to authorise the deprivation of liberty in any case where CQC is of the opinion that deprivation of liberty is occurring."

"CQC should also have the power to monitor those cases where authorisation of deprivation of liberty has not been granted because conditions have been outlined by the supervisory body in the care plan so that deprivation of liberty is avoided."

Other recommendations for regulations sought greater powers for CQC in relation to the MCA DOLS.

- As people in scope of MCA DOLS lack capacity and may not be able to self-advocate, CQC should also be enabled to interview any IMCA other advocate, family member etc. to ensure the person's views are best represented.
- CQC should have a power to respond urgently if concerns are raised that a person is deprived of liberty without authorisation and raise the issue with the supervisory body.
- CQC should have a power to immediately require the managing authority to seek authorisation for deprivation of liberty. Regulations should require CQC to instruct the managing authority to make an application for an urgent authorisation in any case where CQC is of the opinion that an unauthorised deprivation of liberty is occurring.
- Supervisory bodies should be required to notify CQC of each authorisation; numbers of authorisations requested but not granted; each case where deprivation of liberty is not granted but conditions are imposed so that deprivation of liberty can be avoided.
- CQC should have a power to inspect records for individuals where deprivation of liberty has been turned down.
- CQC should have a power to make an individual inspection of a managing authority where it has been brought to their attention that a person may have been deprived of liberty without authorisation.
- Regulations should specify information and records should be provided by managing authorities prior to inspections of numbers and nature of authorisations and if any applications for authorisation were not granted CQC then need to see that care plan is being adhered to and no deprivation of liberty is occurring.
- Could the regulations specify that an inspection should be carried out either as a routine or special themed inspection on MCA DOLS?
- Regulations should give CQC a power to visit and monitor supervisory bodies, any of the various assessors and IMCA services on the provision of MCA DOLS processes and procedures.

Respondents also raised the following issues:

- Local commissioners should have a responsibility for monitoring local standards of care and treatment and should perhaps be included in CQCs remit.
- Monitoring imposes additional burden on managing authorities. No account is taken of this in RIA costings.
- Inspectors need to have teeth and not just function as overseers of the process.
- There are additional costs associated with training for inspectors.
- The inspection team must not function as an alternative DOLS police force.
- Training should be provided for inspectors to understand the particular needs of client groups.

The Government's response

Regulation 3 (b) gives the CQC the power to visit and interview persons accommodated in hospitals and care homes which covers all the people who respondents were anxious to see included in any proposed interview conducted by the regulator. There was therefore no need to explicitly give them the power to do so. We cannot in any case provided for the CQC to decide who it was appropriate to interview because this amounts to sub-delegation and we lack a specific power in the primary regulation-making power to enable this. We feel that CQC has sufficient power and scope to interview under the terms of the Health and Social Care Act.

The other recommendations for changes to the regulation went beyond the regulation-making power in the primary legislation.

Recommendations for CQC will be passed on to the regulator for their information but, as outlined under question 1 in our response, it will be for CQC to determine how it undertakes the monitoring of the safeguards and to set its own compliance criteria for this activity.

3. Do you support the proposal that supervisory bodies and managing authorities must disclose information requested by the Care Quality Commission within twenty-eight days?

Summary of responses

Most provider/professional organisations indicated support for the 28 day time frame. Only one dissenting voice suggesting the time frame should be longer (2 months).
Organisations representing the interests of service users and some MCA Local Implementation Networks strongly suggested that the timeframe was too long.

Consultation responses

Respondents made useful recommendations and raised a number of key issues, including recommendation for a specific change to the legislation:

- It must be a shorter timescale to protect vulnerable people particularly as the regulator will be investigating deprivation of liberty.
- The timeframe for disclosure of information should mirror the timeframe for the MCA DOLS assessment process.
- The timeframe needs to be more flexible. 28 days might be too long for some; too short for others. Organisations should be able to ask for an extension in exceptional circumstances. Give CQC a power to decide the period within which it is reasonable to require the information to be provided.
- It is assumed any system of notification introduced as part of regulation requirements will be subject to separate timescale linked to their responsibilities under the Health & Social Care Act.

The Government's response

We cannot give CQC discretion to determine the time taken for the disclosure of information, as the primary legislation did not allow these regulations to do this.

We have decided to remove the requirement altogether from these regulations and allow CQC to use other powers under the Health and Social Care Act. These also provide that failure to provide information when requested may constitute an offence.

4. Do you support the proposal that the Care Quality Commission should provide an annual report to the Secretary of State for Health as soon as possible after the end of each financial year? Do you have views on what this report should contain in respect of the monitoring of Schedule A1?

Summary of responses
All respondents said yes to the provision of an annual report, with most suggesting this should be part of a broader CQC annual report.

Consultation responses
Some respondents advocated that MCA DOLS (because of the nature of subject) should have its own separate report. Some respondents said that the model of the Mental Health Act Commission's annual report might provide a good template. There was a suggestion that an interim report should be provided after 6 months to provide valuable information on the first year of implementation.

Detail proposals for what the report should contain were also advanced to include qualitative and quantitative data with many feeling that, as a minimum, the report should contain:

- An analysis of numerical data relating to the operation of MCA DOLS (including numbers of applications, authorisations and characteristics of the MCA DOLS "population")
- The methodology used to monitor MCA DOLS during the period covered
- The activity that has taken place to monitor MCA DOLS during that period
- The findings of CQC, including both compliance with MCA and the Code of Practice and the experience of people who have been deprived of their liberty
- Other relevant development (eg. developing case law)

The Government's response

We welcome the broad agreement in respect of the publication of an annual report but have decided that we should not have a separate requirement in these regulations but rather rely on the requirement in the Health and Social Care Act 2008 for the CQC to provide an annual report. This report will cover MCA DOLS. Most respondents set out their proposals for the content of the report and these useful recommendations will be passed to CQC for information to inform the development of plans for the annual reporting of the MCA DOLS. It will, of course, be for CQC to determine the scope, content and form of the report. We have included an additional requirement for CQC to report to the Secretary of State as and when he may require, which will allow the Secrtary of State to obtain information between annual reports if necessary.

5. Do you support the detail of the amendment to regulation 3 of the Mental Capacity Act (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 to include both insurance and indemnity cover for assessors?

Summary of responses

Some respondents declined to comment but among those responding there was broad support for the proposed amendment with one exception. The respondent asserts that doctors and patients should not be allowed to rely on discretionary indemnity for clinical negligence claims.

Consultation responses

Most respondents welcomed the proposals but further clarification was sought on the following issues:

- Will the proposed amendment allow for practitoners to be assessors if they are employed by LAs covered by a local authority scheme?
- Do the amendments allow assessors to carry out assessments for authorities by which they are not employed?

- Who provides cover for best interests assessors (BIAs) working across boundaries?
- What about an indemnity for registered managers?
- Does the proposal go far enough to cover all professionals who may act as BIAs who do not work for LA/PCT e.g. staff employed by a MH Trust or an Actute Trust?

The Government's response

The amendment to the Mental Capacity Act (Deprivation of Liberty: Standard Authorisations,Assessments and Ordinary Residence) Regulations does not water down the requirements for assessors in any way. It provides that MCA DOLS assessors are eligible to carry out assessments where they have in place an adequate and appropriate policy of insurance, indemnity arrangements or a combination of both. Under the existing regulations, only those assessors who have a policy of insurance in place will be eligible to carry out assessments. It was never our intention to prevent professionals with indemnity arrangements (rather than policies of insurance) from becoming assessors in this way.

Comments on the Impact Assessment

Summary or responses

Respondents observed that the IA shifts the cost impact of inspection to CQC. CQC will bear internal costs but provider organisations need to know how much resource to deploy in order to support a visit of inspection. Supervisory bodies will incur management costs. CQC are asked to provide illustrative cost examples prior to 1 April.

Consultation responses

Key issues raised:

- The costs of monitoring should be borne by Government.
- If extra time needed by CQC to complete inspections extra funding should be provided.
- Legal aid for all cases should be on a non-means tested basis. Indeed anyone who the state authorises to be deprived of their liberty should not have to pay for their care home.

The Government response

It is unlikely that monitoring MCA DOLS activity in supervisory bodies and managing authorities will be a separate activity for CQC. This activity will be integrated into its broader remit as health and social care regulator.

General Comments

The Regulations focus exclusively on the role of the managing authority. Will CQC also examine how well supervisory bodies are implementing their role in respect of MCA DOLS including meeting assessment deadlines and working with care homes.

Regulations give CQC the power to monitor people subject to them but not to investigate whether people are unlawfully deprived of liberty and for whom no authorisation has been sought. Regulations should state that CQC should monitor where deprivation of liberty is occurring by no authorisation has been sought.

No opportunity to comment on how CQC will discharge its duties.

CQC should have a defined remit that covers communication with carers and relatives. They should be informed of visits and given an opportunity to meet with CQC.

Next Steps

The Regulations will be published and CQC will adopt formal responsibility for all its duties, including MCA DOLS monitoring, from 1 April 2009. CQC replaces the Healthcare Commission, CSCI and the Mental Health Act Commission.

CQC has been operating in shadow form since October 2008 and has been working closely with DH in relation to developing the MCA DOLS monitoring duties.

CQC has advised that it intends to undertake MCA DOLS monitoring following a number of key principles;

- That the focus of CQC's monitoring needs to be on the experience of people with limited capacity - when deprivation of their liberty is being considered or authorised - and on their quality of life;
- That the monitoring role needs to be distinct from CQC's wider role as a regulator of health and adult social care provision and from the role of councils and PCTs who have a local duty to "regulate" the authorisation of deprivation of liberties by providers;
- That the way that CQC monitors therefore needs to be proportionate and not duplicate what happens under other duties;
- That wherever possible, the practical implementation of CQC's monitoring duties should dovetail with its other duties of inspection and assessment – so that the burden of the tasks is minimised on those regulated and assessed and is carried out cost effectively for the regulator;
- That CQC should rely on the DH defined data returns from councils and PCTs to provide statistical context for its monitoring role and should avoid making additional demands for data wherever possible.

CQC is now finalising its monitoring proposals following the recent ending of consultation on the relevant regulations and DH's response to this consultation. It intends to talk urgently with key stakeholders about these proposals before they are concluded.

It is likely, depending on the sector and whether the agency is a managing authority (care homes and hospitals) or supervisory body (councils and PCTs), that the dates for implementing some aspects of the monitoring will be phased in during the year and will also be subject to ongoing review with stakeholders.
As a minimum, CQC will be publishing detailed guidance for its staff and for care services on the implications of the Mental Capacity Act and the DoLs safeguards.

CQC's Board will sign off the monitoring proposals in mid March for publication by 1 April 2009.

Annex A - List of Respondents

1. David Bond, Strategic Development Officer, Lancashire Adult and Community Services Directorate

2. Claire Mallet, Mental Health Network, NHS Confederation
3. Claire Churchill, Policy Administrator, Royal College of Psychiatrists
4. Anna Passingham, Senior Policy and Communications Officer, Counsel and Care
5. Ann Mackay, Director of Policy, ECCA
6. Ed Collins, Project Manager - Mental Capacity Act Deprivation of Liberty Safeguards, Adult and Community Services
   Durham County Council
7. Mental Health and Disability Committee, The Law Society
8. Pat Stewart on behalf of North East LIN
9. Pennine Care NHS Foundation Trust
10. Patrick Sullivan, Director of Nursing, Lancashire Care NHS Foundation Trust
11. Lorraine Currie, Mental Capacity Act Implementation Officer, Disability Resource Centre, Shropshire Council
12. Alexina Weston, Head of Professional Practice (Nursing), Colchester Hospital University NHS Foundation Trust
13. Dave Shields, LIN lead for the LA from Leeds Adult Social Care/ Peter Scanlon,lead Programme Manager for MCADoLS in Leeds NHS
14. Pat Clow, Mental Capacity Act Project Manager, Newham PCT
15. Heather Blow, Head of Deprivation of Liberty Safeguards, NHS Lincolnshire
16. Sue MacMillan, Mental Health Act Commission
17. Paul Greening, Mental Capacity Act Manager, Dorset PCT
18. Jenny Goodall and Richard Webb, Co-chairs, ADASS Mental Health Drugs and Alcohol Policy Network, Association of Directors of Adult Social Services
19. Alison Waller, Director of Children, Family and Adult Services, East Riding of Yorkshire Council
20. Robert Keys, Mental Health Law Manager, North East London NHS Foundation Trust
21. Jane Harriman, Deputy Director of Standards and Engagement, Sheffield PCT
22. Dennis Little, MCA & DOLS Coordinator, Southend on Sea Borough Council, on behalf of Southend Local Implementation Network for DOLS
23. Allan James, Chair of Cambridgeshire MCA Implementation Group
24. David Congdon, Head of Campaigns and Policy, Mencap
25. Emmet Perry, Senior Manager – Adult Safeguards, Essex County Council on behalf of the Essex Local Implementation Network
26. Age Concern and Help the Aged (joint response)
27. Mary Lou Nesbitt, Head of Governmental and External Relations, The Medical Defence Union
28. Ciara Brannigan, External Relations Manager, Medical Protection Society (MPS)
29. Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing

Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments - Amendment) Regulations 2009	
Stage: Implementation	**Version: 1**	**Date: 24 February 2009**

Related Publications: Mental Capacity Act 2005 (Schedule A1), the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, Mental Capacity Act 2005 Code of Practice, Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice

Available to view or download at:

http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

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What is the problem under consideration? Why is government intervention necessary?

The Mental Health Act 2007 inserted a new schedule (Schedule A1) into the Mental Capacity Act 2005 which contains the Deprivation of Liberty Safeguards (MCA DOLS). The MCA DOLS provide a framework for authorising the deprivation of liberty of people who lack the capacity to consent to the arrangements made for their care or treatment (in either a hospital or care home) but who need to be deprived of liberty in their own best interests, to protect them from harm. Schedule A1 of the 2005 Act provides for regulations to be made in respect of the monitoring of the operation of Schedule A1.

What are the policy objectives and the intended effects?

The policy objective is to ensure that the operation of the MCA DOLS is adequately monitored by an independent body with suitable powers to carry out this monitoring role effectively. This is to help ensure that the liberty of vulnerable people in hospitals and care homes is protected.

What policy options have been considered? Please justify any preferred option.

Option 1: Do nothing

Option 2: Confer the function of monitoring and reporting on the operation of the MCA DOLS on the Care Quality Commission. This is the preferred option – see evidence base.

Option 3: Set up a new body with the sole function of monitoring the MCA DOLS

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

The operation of the MCA DOLS will be formally reviewed by the Department of Health after the monitoring arrangements have been in place for two years.

Ministerial Sign-off For Final Proposal/Implementation Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

Phil Hope .....Date: ***26th February 2009***

Summary: Analysis & Evidence

Policy Option: 2	Description: Confer the function of monitoring and reporting on the operation of Schedule A1 on the Care Quality Commission

COSTS

ANNUAL COSTS	
One-off (Transition)	**Yrs**
	1
Average Annual Cost (excluding one-off)	
£200,000 to £500,000	

Description and scale of **key monetised costs** by 'main affected groups'

The costs to the CQC and to hospitals and care homes cannot be estimated at this stage, as they will depend on the manner of monitoring and reporting which will be for the CQC to determine. The range £200k to £500k per year is illustrative.

Total Cost (PV)	**£**

Other **key non-monetised costs** by 'main affected groups'

BENEFITS

ANNUAL BENEFITS	
One-off	**Yrs**
£	
Average Annual Benefit (excluding one-off)	
£	

Description and scale of **key monetised benefits** by 'main affected groups'

It is not possible to monetise the benefits, which take the form of improved protection for vulnerable people.

Total Benefit (PV)	**£**

Other **key non-monetised benefits** by 'main affected groups'

Vulnerable people in hospitals and care homes will benefit from the new safeguards, including the monitoring arrangements, through better protection of their liberty.

Key Assumptions/Sensitivities/Risks **See Evidence Base**

Price Base Year	Time Period Years	**Net Benefit Range** (NPV)	**NET BENEFIT** (NPV Best estimate)
		£ n/a	**£ n/a**

What is the geographic coverage of the policy/option?				England	
On what date will the policy be implemented?				April 2009	
Which organisation(s) will enforce the policy?				CQC	
What is the total annual cost of enforcement for these organisations?				n/a	
Does enforcement comply with Hampton principles?				Yes	
Will implementation go beyond minimum EU requirements?				No	
What is the value of the proposed offsetting measure per year?				£ 0	
What is the value of changes in greenhouse gas emissions?				£ 0	
Will the proposal have a significant impact on competition?				No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large	
Are any of these organisations exempt?	No	No	n/a	n/a	

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ n/a Decrease of £ n/a **Net Impact** **£** n/a

Key:	**Annual costs and benefits: Constant Prices**	**(Net) Present Value**

Option 1: Do nothing.

This is not a viable option. During the Parliamentary passage of the Mental Health Act 2007, assurances were given that robust monitoring arrangements would be put in place to monitor the MCA DOLS. Ministers said that particular attention would be paid to:

- Equality information on the client group with an MCA DOLS authorisation (to include disability, gender, ethnicity)
- Numbers of people with an authorisation
- Duration of authorisations
- Numbers of applications made for authorisations (which will provide intelligence on the number of applications made but not obtained)

Option 3: set up a new body with the sole function of monitoring the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS).

This evidence base concentrates on option 2, which is the preferred option. There is no obvious reason why a new body with the sole function of monitoring the MCA DOLS would be able to achieve greater benefits for vulnerable people in exercising its monitoring function than the CQC. The costs, however, are likely to be higher. This is mainly because a body other than the CQC would not have the scope to reap economies by incorporating monitoring of the MCA DOLS within wider inspections of hospitals and care homes.

Option 2 - Confer the function of monitoring and reporting on the operation of Schedule A1 on the Care Quality Commission (CQC).

Background

The Mental Health Act 2007, which received Royal Assent on 19 July 2007, amended the Mental Capacity Act 2005 in order to introduce the MCA DOLS into that Act. The MCA DOLS are a response to the European Court of Human Rights (ECtHR) judgment in October 2004 in the case of H.L. v UK (commonly referred to as the Bournewood judgment). This case concerned a man, lacking the capacity to consent to arrangements being made for his care and treatment, who was admitted to hospital into a care regime that the ECtHR considered deprived him of his liberty without appropriate safeguards against arbitrary detention being in place.

Most of the MCA DOLS provisions are contained in Schedule A1 to the Mental Capacity 2007. These include regulation-making powers in relation to the monitoring of Schedule A1. Specifically, the Act provides that regulations may:

- confer on one or more prescribed bodies the function of the monitoring of, and reporting on, the operation of the MCA DOLS in Schedule A1 to the Mental Capacity Act 2005

- Give a prescribed body (for the purpose of monitoring Schedule A1) authority to:

  - visit hospitals and care homes; interview people accommodated in hospitals and care homes; and inspect, or require the production of, records relating to the care or treatment of those people who are deprived of, or at risk of being deprived of, liberty.
  - require supervisory bodies[1] and managing authorities[2] to disclose any relevant information that a prescribed body requests.

[1] A supervisory body is responsible for authorising the deprivation of liberty. Where a person is deprived of liberty in a hospital, the supervisory is the relevant PCT. Where a person in deprived of liberty in a care home, the supervisory body is the relevant local authority.

[2] A managing authority is responsible for making an application for a deprivation of liberty authorisation. In the case of an NHS hospital, the managing authority is the NHS body responsible for the running of the hospital in which the person is to be deprived of liberty. In the case of a care home or independent hospital, the managing authority is the person registered under part 2 of the Care Standards Act 2000.

The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 (the 'monitoring regulations') confer on the CQC the function of monitoring and reporting on Schedule A1.

The Government recently consulted on the monitoring regulations and sought answers to the following questions:

1. Do you support the proposal that power should be conferred on the Care Quality Commission for the purpose of the monitoring of, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)?

2. Do you support the proposal to give the Care Quality Commission general powers to-

   (a) visit hospitals and care homes;

   (b) visit and interview people accommodated in hospitals and care homes; and

   (c) require the production of, and inspect, records relating to the care or treatment of people accommodated in hospitals or care homes who are, or should be, deprived of liberty under the MCA DOLS?

3. Do you support the proposal that supervisory bodies and managing authorities must disclose information requested by the Care Quality Commission within twenty eight days?

4. Do you support the proposal that the Care Quality Commission should provide an annual report to the Secretary of State for Health as soon as possible after the end of each financial year? Do you have views on what this report should contain in respect of the monitoring of Schedule A1?

Following the consultation, the regulation relating to the disclosure of information was removed from the monitoring regulations. This is to allow the CQC to determine what constitutes a reasonable timescale in which to request information, under their powers in the Health and Social Care Act 2008. These powers set out that failure to provide information when requested may constitute and offence.

The monitoring regulations also make two amendments to the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008. The first amendment, to regulation 3, is to ensure that MCA DOLS assessors are eligible to carry out assessments where they have in place an adequate and appropriate policy of insurance, indemnity arrangements or a combination of both. The second amendment, to regulation 19, is to enable one local authority to recover expenditure from another local authority, where, following a determination of ordinary residence, the identity of the supervisory body changes.

Coverage of this Impact Assessment

This Impact Assessment has been prepared to accompany the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009. The regulations and Impact Assessment extend to England only. Welsh Ministers will be issuing separate regulations in relation to monitoring the operation of the MCA DOLS in Wales.

A full Impact Assessment was prepared for the consultation on the draft Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and two sets of draft regulations, which took place between September and December 2007. Following the consultation, that Impact Assessment was updated and published on the DH website alongside the final Code and regulations. The Impact Assessment examined the overall costs of the implementation of the MCA DOLS in England and Wales.

All documents are available at the following web address:

http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm.

Costs

The consultation on the monitoring regulations focused on whether the CQC should be given responsibility for monitoring, and reporting on, the operation of the MCA DOLS contained within Schedule A1 to the Mental Capacity Act 2005, and what powers it should be given to enable it to perform its responsibilities. The detail of how the monitoring process should operate in practice was not covered by the consultation and nor is it covered in these regulations as this is a matter for the CQC. This Impact Assessment does not therefore attempt to provide detailed costs to either the CQC, or to supervisory bodies or managing authorities, of the operation of the monitoring and reporting process. However, it does attempt to set out some illustrative estimates on costs to the CQC and managing authorities.

The duty on the Care Quality Commission to monitor, and reporting on, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)?

The Health and Social Care Act 2008 created a single health and social care inspectorate for England – the CQC - and dissolved the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. The new CQC, which is taking over the monitoring and inspection functions of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection from 1 April 2009, is the logical choice. There is no obvious reason why a new body with the sole function of monitoring the MCA DOLS would be able to achieve greater benefits for vulnerable people in exercising its monitoring function than the CQC. The costs, however, are likely to be higher. This is mainly because a body other than the CQC would not have the scope to reap economies by incorporating monitoring of the MCA DOLS within wider inspections of hospitals and care homes.

Setting up another new monitoring and inspection body to take on responsibility for the MCA DOLS would be out of keeping with Government policy.

The general powers to enable the Care Quality Commission to-

(a) visit hospitals and care homes;

(b) visit and interview persons accommodated in hospitals and care homes;

(c) require the production of, and inspect, records relating to the care and treatment of people accommodated in hospitals or care homes who are, or should be, deprived of liberty under the MCA DOLS?

It is not currently possible to set out in detail the costs to the CQC of carrying out inspections of hospitals or care homes for the purpose of monitoring Schedule A1. Similarly, it is not possible to set out the costs to hospitals and care homes of making arrangements to receive inspection visits by the CQC. This is because there are too many unknown factors, for example:

- the frequency of monitoring visits, and the amount of time devoted to the MCA DOLS on each visit (the regulations specify that the MCA DOLS inspection visits should usually form part of a wider CQC inspection visit rather than being an MCA DOLS specific visit).
- Who will undertake the visiting function and the number of people an inspection visiting team will consist of
- the arrangements the CQC might make to monitor how PCTs and local authorities perform their MCA DOLS functions.

However, estimates of the cost of MCA DOLS monitoring for the CQC and the number of managing authorities affected, and associated costs, are set out below. These estimates are provisional and are intended to provide a general indication of costs. The CQC is at an early stage in developing its operational policy on monitoring the MCA DOLS and therefore all estimated costs are intended for illustrative purposes only.

CQC

It is assumed that MCA DOLS monitoring will be undertaken as part of routine visits to hospitals and care homes by CQC staff. It is estimated that approximately 750 to 1,250 inspection visits per year will include MCA DOLS monitoring with each visit involving 0.4 to 0.6 days of MCA DOLS monitoring per visit. It is further estimated that the direct staff costs to the CQC for each visit will be around £350. On-costs are estimated to be low – approximately £50 per day - as no additional administrative support or travel costs need to be considered as the MCA DOLS monitoring will form part of routine inspection visits. Therefore the total CQC costs are estimated to be in the range £120,000 to £300,000 per year (central estimate around £200,000 per year)

Managing authorities

It is estimated that each MCA DOLS monitoring session will involve 0.4 to 0.6 days work for a hospital or care home manager on an average salary of £40,000 per year, which would cost around £260 per MCA DOLS visit. Therefore, the total provider costs are estimated to be in the range £75,000 to £200,000 per year (central estimate around £130,000 per year).

These costs would be incurred by the independent sector in respect of independent sector hospitals and care homes but may be passed on in higher fees to commissioners.

The requirement for the Care Quality Commission to provide a report to the Secretary of State for Health as he may from time to time request.

The cost of preparing a report, including the cost of staff time, is unlikely to exceed £10,000.

One-off costs to the CQC and managing authorities

There will be initial one-off costs associated with training and awareness raising of CQC inspectors in relation to the MCA DOLS. It is anticipated that inspectors will need to attend 0.5 days of training in order to carry out the function of monitoring and reporting on Schedule A1 to the Mental Capacity Act 2005.

There may be a requirement for managing authority managers to receive training on preparing for inspection visits. It is expected that any costs associated with training and awareness raising of the monitoring of the MCA DOLS will be met from the £40.34m allocated to health and social care services in 2009/10 for the purpose of implementing the Mental Capacity Act 2005.

Benefits

The Bournewood judgement highlighted the need for a legislative solution to prevent unlawful deprivation of liberty occurring. Following a public consultation between March and June 2005, it was decided that the introduction of the MCA DOLS into the Mental Capacity Act 2005 was the most appropriate way in which to respond to the Bournewood judgment.

The main benefits of the MCA DOLS as a whole are that they provide protection for a very vulnerable group of people and bring the legislation for England and Wales into compliance with the ECHR. The safeguards are most appropriately placed in the Mental Capacity Act 2005 since the Bournewood judgment raised what were primarily mental capacity rather than mental health issues. This means that the principles of the Mental Capacity Act 2005, for example the requirement to act in the best interests of a person who lacks capacity, will apply in the context of the MCA DOLS.

The main benefit of the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 is that they provide a means for allowing an independent body to ensure that managing authorities and supervisory bodies are complying with the MCA DOLS. Robust monitoring arrangements will ensure that the MCA DOLS are operating appropriately and give them a greater degree of credibility. This will protect vulnerable people and reduce the risk of further infringements of the ECHR.

Risks

It is difficult to estimate with confidence the number of inspection visits that will need to take place to ensure the MCA DOLS are being complied with by managing authorities. Similarly, it is also difficult to estimate the length of such visits and how many inspectors will need to be involved per visit. This IA sets out some provisional estimates in relation to the number of inspection visits likely to take place and the duration of these visits. However, there is a risk that more visits, or longer visits, will be required. There is also a risk that the costs incurred by hospitals and care homes in preparing for, taking part in, and following up visits will be more substantial than envisaged. The Government will keep this matter under review.

The full impact assessment prepared in respect of the MCA DOLS Code of Practice (referred to above) sets out the risks associated with implementing the MCA DOLS as a whole.

Competition Assessment

The monitoring regulations are not expected to have a significant effect on competition. The resource implications of the introduction of the deprivation of liberty safeguards monitoring arrangements are expected to impact largely on the CQC and to a lesser extent on care homes, the NHS and local authorities.

Small Firms Impact Test

Many small, independent, care homes operate in the social care market. All care homes registered under the Care Standards Act 2000 will be subject to inspection by the CQC. Under the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009, the inspection of compliance with Schedule A1 of the Mental Capacity Act 2005 will usually take place during routine care home inspections by the CQC. Therefore, the introduction of monitoring arrangements under the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 is unlikely to lead to any significant increase in the regulatory burden faced by small businesses operating in the market for adult social care services.

Legal Aid Impact Assessment

It is not anticipated that the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 will have an adverse impact on legal aid. Oversight of the MCA DOLS by the CQC will ensure they are being used appropriately and fairly. This should reduce the need for people to seek redress through the courts.

Age Impact Assessment

The MCA DOLS apply only to people aged 18 and over.

The MCA DOLS will be applied in the same way to people aged 18 and over who meet the criteria for deprivation of liberty, regardless of their actual age. Oversight of the operation of the MCA DOLS by the CQC will ensure that the safeguards are not applied in a discriminatory manner to any particular age group. However, a major cause of lack of capacity is dementia, which is more prevalent in older age groups. For this reason, it is likely that the nature of the criteria (i.e. a person lacking capacity to consent to the arrangements made for their care or treatment and needing to be deprived of liberty to protect them from harm, in their best interests) is more likely to embrace elderly people, particularly those with dementia. This is considered to be a positive aspect of the MCA DOLS in that it is giving this group of disadvantaged people protections that have previously been lacking.

Health Impact Assessment

The introduction of the MCA DOLS as a whole, including arrangements for monitoring the MCA DOLS, is expected to make a positive contribution to health improvement. A very vulnerable group of people will receive protection that they are currently lacking, and it will place a new focus on their human rights and the lawfulness of the arrangements made for their care. We believe this will introduce a pressure to encourage excellent planning of care regimes, taking account of the whole needs of each individual. We

expect this benefit to extend beyond people who are actually deprived of liberty in that hospitals and care homes will look for ways, where safety considerations permit, of increasing the freedoms and autonomy of people in their care such that they do not cross the deprivation of liberty threshold.

Race Equality Impact Assessment

Monitoring arrangements under the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 are not expected to impact in any different way on different racial or ethnic groups. However, the Code of Practice draws attention to the need to take care to ensure that the provisions are not operated in a manner that discriminates against particular racial or ethnic groups. The CQC will be expected to have regard to this Code.

It is intended that information will be collected about the ethnicity of people coming within the scope of the MCA DOLS. In their local populations, PCTs and local authorities will be expected to monitor whether there are any indications that the safeguards are being applied differently in relation to different racial or ethnic groups.

Disability Equality Impact Assessment

The MCA DOLS legislation as a whole will have a positive impact on disability equality. It provides important safeguards for people who lack capacity to consent to the arrangements made for their care or treatment and who need to be deprived of their liberty to protect them from harm, in their own best interests.

The people concerned will be largely those with significant learning disabilities, or older people suffering from dementia or some similar disability, but will also include other causes such as neurological conditions (for example, if someone has a brain injury).

Any action taken under the MCA DOLS must be in line with the principles of the Mental Capacity Act 2005:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Gender Equality Impact Assessment

The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 do not discriminate between men and women. A principle on which the MCA DOLS is based is that everybody should be treated as an individual, and their care regimes determined by reference to their specific needs. In some cases, those needs may relate to gender.

It is anticipated that a large proportion of those who will become subject to the MCA DOLS will be older people with dementia. This may well mean that more women than men become subject to the MCA DOLS because women tend to live longer than men do and, at higher ages (75+), the prevalence of dementia in women tends to be higher than in men. But the MCA DOLS themselves will operate in an identical way regardless of gender.

Human Rights

The purpose of the MCA DOLS is to bring the law for England and Wales into line with the ECHR with regard to the circumstances in which a person who lacks capacity to consent to the arrangements made for their care and treatment, and who is not detained under the Mental Health Act 1983, may be deprived of their liberty within the meaning of Article 5 of the ECHR.

The MCA DOLS have been introduced in specific response to the October 2004 ECtHR judgment in the case of H.L. v the United Kingdom. This judgment found that:-

- the manner in which H.L. was deprived of liberty was not in accordance with "a procedure prescribed by law" and was, therefore, in breach of Article 5(1) of the ECHR, and

- there had been a contravention of Article 5(4) of the ECHR because H.L. was not able to apply to a court quickly to see if the deprivation of liberty was lawful.

The MCA DOLS value human rights and give protection to a very vulnerable group of people. They make clear that a person's human rights cannot be infringed simply because they are profoundly disabled, or very old, and lack the capacity to consent to arrangements made for their care and treatment.

The Government believe that the MCA DOLS bring the legislation into compliance with the ECHR.

Rural Proofing

There is no reason to believe that there will be proportionately more or less people subject to the MCA DOLS in rural areas than there are elsewhere, and thus no reason to suppose that the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments – Amendment) Regulations 2009 will impact on rural areas any differently to the way in which they impact on other areas.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No