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Welsh Government

Consultation – summary of responses

Draft Regulations for Wales: Liberty Protection Safeguards

June 2023

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

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Overview

A Welsh Government consultation was held between 17 March 2022 and 14 July 2022 on four sets of draft Regulations which will support the implementation of the new Liberty Protection Safeguards in Wales (the LPS), as introduced by the Mental Capacity (Amendment) Act 2019. The Welsh Government also consulted on supporting Impact Assessments, and a draft National Minimum Data Set for the LPS. This document provides a summary of the responses to the consultation.

Action Required

This document is for information only.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

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Additional copies

This summary of response and copies of all the consultation documentation are published in electronic form only and can be accessed on the Welsh Government's website.

Link to the consultation documentation: hyperlink

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Introduction

1. On 17 March 2022, the Welsh Government published draft Regulations for Wales to support the implementation of the Liberty Protection Safeguards (the LPS) for consultation.

2. The new safeguards are intended to provide important rights and protections for people who lack the mental capacity to agree to care, support or treatment arrangements, where these arrangements amount to a deprivation of liberty.

3. The Deprivation of Liberty Safeguards (DoLS) is the existing scheme for the assessment and authorisation of deprivations of liberty and were introduced to protect the human rights of those individuals who lack the mental capacity to consent to being deprived of their liberty.

4. Following the Supreme Court judgement in the case of Cheshire West, the UK Government introduced the Mental Capacity (Amendment) Act 2019, with the view to repealing DoLS and replacing it with the LPS.

5. Unlike DoLS (which only applies to arrangements in care homes and hospitals and to people aged 18 and above), when implemented, the LPS is intended to apply in all settings, including people's homes and to anyone aged 16 and over.

6. On 5 April 2023, the UK Government announced their intention to delay the implementation of the LPS until the next Parliament. Welsh Government has issued a Written Statement expressing their deep disappointment at this decision, given that the new safeguards are intended to deliver improved outcomes for people deprived of their liberty and their families by creating a new simplified legal framework which is compliant with Article 5 (right to liberty) and Article 8 (right to respect for private and family life) of the European Convention on Human Rights.

7. This document provides a summary of the consultation responses provided by stakeholders on the draft Regulations for Wales, supporting Impact Assessments and a draft National Minimum Data Set. We will use the consultation responses to inform next steps here in Wales and actions to continue supporting the implementation of the Mental Capacity Act 2005, ahead of any future decision on implementation by the UK Government.

Consultation

8. On 17 March 2022 the Minister for Health and Social Services published draft Regulations for Wales to support the implementation of the LPS for a 17 week period of public consultation. The purpose of the consultation was to gather views and feedback on:

    - The four sets of draft Regulations for Wales: The draft Regulations are focussed on the appointment and role of Independent Mental Capacity

Advocates (IMCAs); who can undertake assessments, make determinations and carry out pre-authorisation reviews; the role and appointment of the new Approved Mental Capacity Professional (AMCP); and monitoring and reporting on the new safeguards.

- A draft National Minimum Data Set to support monitoring and reporting on the LPS.

- A number of draft Impact Assessments – including a Regulatory Impact Assessment; a Children's Rights Impact Assessment (CRIA); an Equalities Impact Assessment; and a Welsh Language Impact Assessment;

9. A covering consultation document, together with easy read versions of the draft Regulations and supporting animations for use by stakeholders, were available on the Welsh Government website.

10. Alongside the opportunity to respond online or by email, during the consultation period, Welsh Government also held a number of stakeholder engagement sessions. This included a live information session on 5 April 2022 held via Microsoft Teams to provide an overview of the draft Regulations, as well as information about the consultation process, supporting resources and planned engagement.

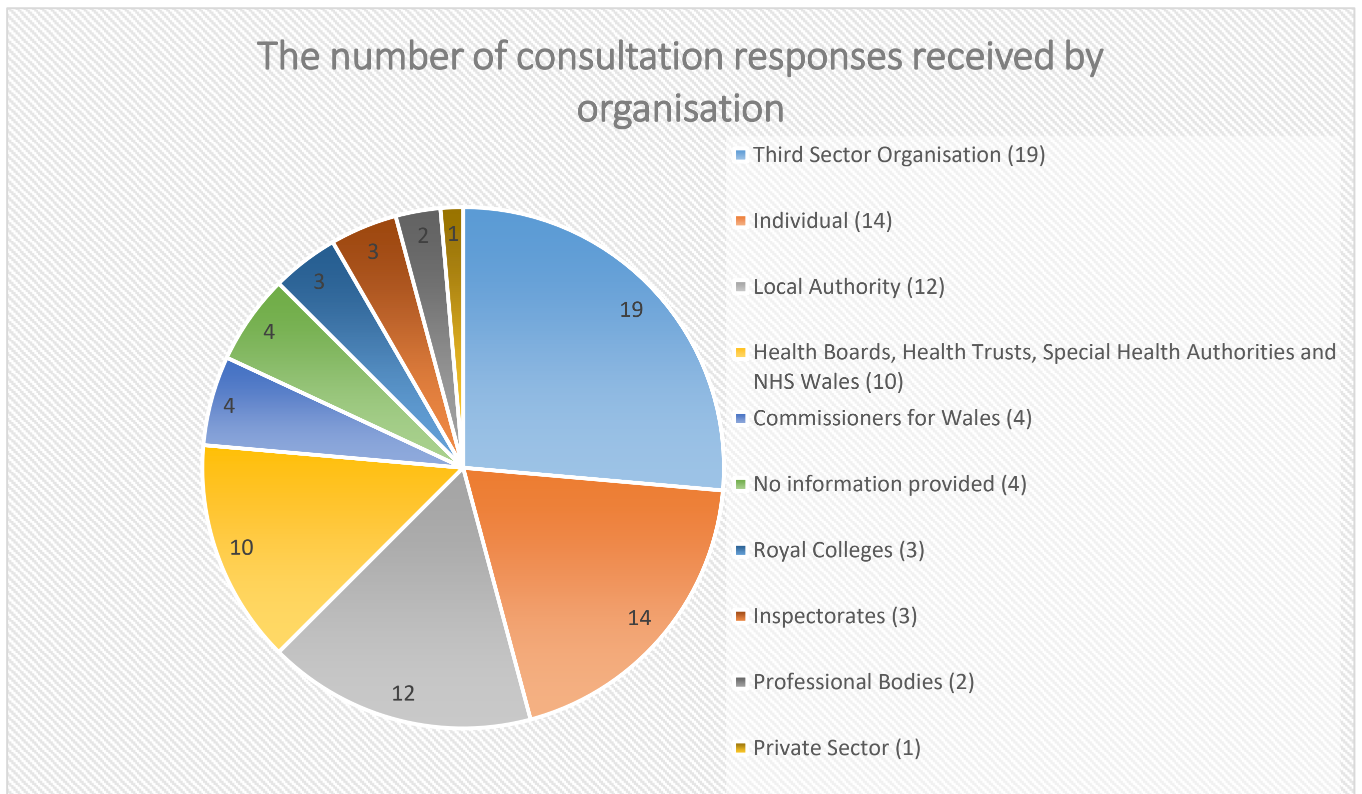
11. Specific stakeholder engagement sessions were held with the LPS Implementation Steering Group for Wales, and the LPS Steering Group Sub-Groups on Monitoring and Reporting, Transition, 16 and 17-year-olds, and Workforce and Training. Engagement sessions also took place with Allied Health Professions, as well as those with lived experience of Dementia and Learning Disability. A further eight engagement events were held where the focus was on the draft Regulations. Information about the consultation on the draft Regulations and the implementation of the LPS was also shared at other scheduled stakeholder meetings, including with the Dementia Oversight of Implementation and Impact Group (DOIIG), the Mental Health Forum, and events held by Care Inspectorate Wales (CIW) for care providers.

12. Children in Wales had also been engaging with children and young people regarding the planned implementation of the LPS.

Who responded to the consultation

13. Welsh Government received 72 written responses to the consultation and would like to thank all those who responded.

14. Those responding to the consultation represented a range of public, private and third sector bodies; health and care sectors; and individual responses. The chart below provides a breakdown of the respondents by organisation type. A small number of responses were from a consortium of local authorities and / or health boards.



Summary of responses

15. This document summarises the responses to the consultation questions. It does not aim to capture every point raised by respondents. It looks to present the key recurring themes and issues.

16. The consultation document asked 22 consultation questions. The first twelve were specific questions about the draft Regulations. There were six questions on the draft Impact Assessments, one question on the Workforce and Training Plan, one question on the proposed LPS National Minimum Data Set, and two questions asking for views on the extent to which proposals will protect the rights of individuals. Not all respondents answered each consultation question. Some responses submitted by email provided general feedback. These responses have also been considered and included under the relevant consultation question, for the purposes of this analysis.

17. For each question, we have included two charts. The first one provides information on the number of responses that strongly agree / somewhat agree / neither agree nor disagree / somewhat disagree / strongly disagree. The second one sets this out as a pie chart – showing the equivalent in percentages – so that the reader has an "at a glance view" of the extent to which there is broad agreement (illustrated in green) or disagreement (illustrated in red).

Key messages

18. There are a number of key messages that were repeated across responses in relation to more than one of the consultation questions. These included:

- The need for further clarification on how the Regulations will work in practice and concerns that the Regulations are not supporting the intended reforms, particularly around reducing bureaucracy; embedding the principles of the MCA across care, support and treatment planning; and supporting the rights of the person.
- Questions around cross-border issues and associated practicalities around implementation, workforce, and monitoring and reporting.
- Concern that the Regulatory Impact Assessment underestimates costs associated with undertaking assessments, determinations and pre-authorisation reviews; the role of the AMCP; the role of the IMCA; plans for monitoring and reporting; and plans for workforce development and training.
- Concern over the definition of a deprivation of liberty included in the draft Mental Capacity Act Code of Practice (published for consultation by the UK Government, alongside draft Regulations for England) and associated impacts on the implementation of the safeguards in Wales.
- Welsh Language: Support for the active offer and the needing to strengthen commitments regarding preferred language, and build workforce capacity.

Question 1 Do you agree that the amendments to the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007 clearly and sufficiently set out the functions of the IMCA under the LPS?

19. 57 responses answered this question (see Figure 1a). Just over three quarters of responses (79%) either strongly or somewhat agree that the amendments to the IMCA Regulations clearly and sufficiently set out the functions of the IMCA under the LPS (see Figure 1b). 14% of responses either strongly or somewhat disagree with the question. Those who responded that they agree to some extent were largely from health boards, local authorities or individuals. The majority of the responses who disagree were from third sector organisations.

20. 19 responses strongly agree and 26 somewhat agree that the amendments to the IMCA Regulations are clear and sufficient. Seven responses somewhat disagree and one response strongly disagrees. 15 responses did not provide an answer to this question.

Figure 1a

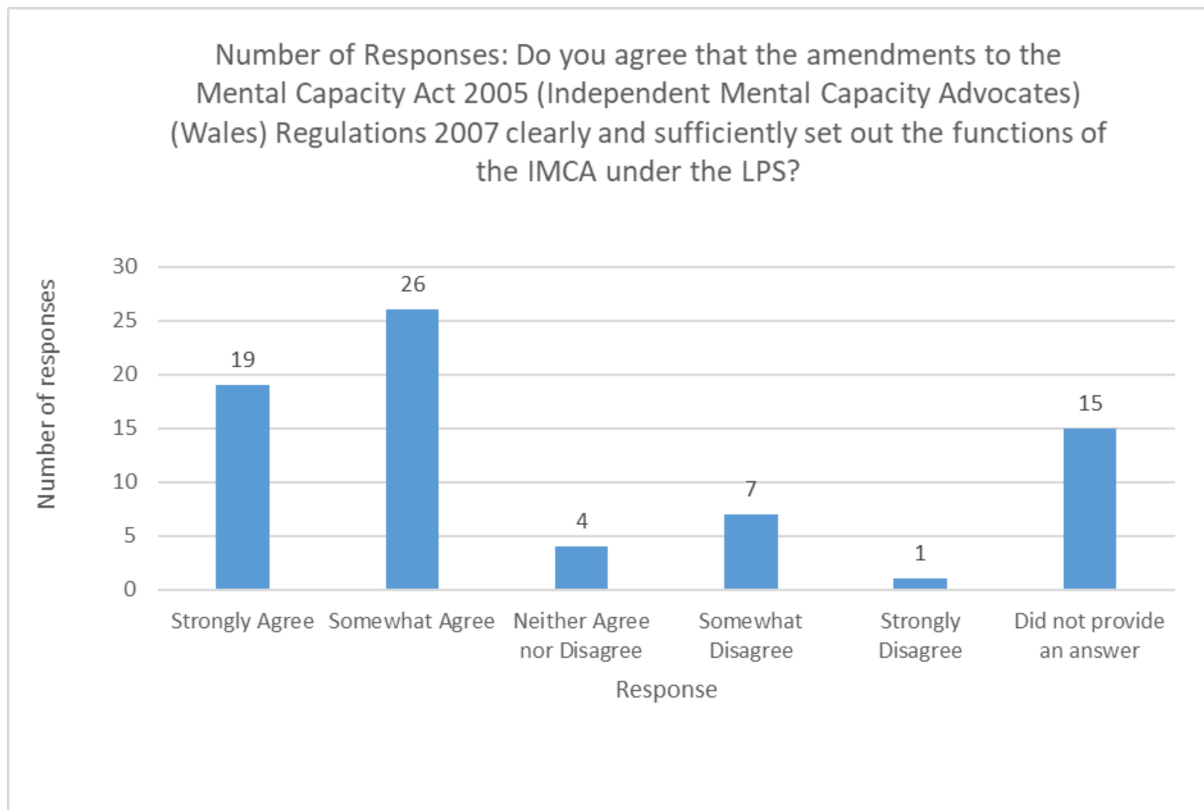
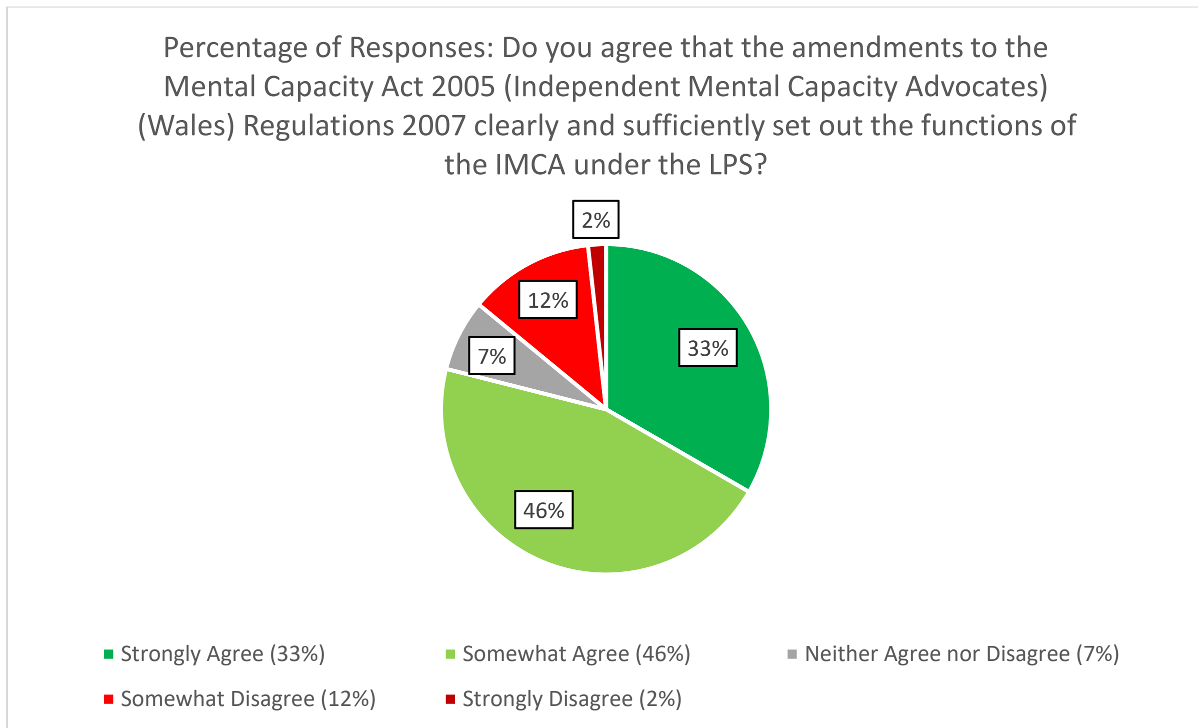


Figure 1b



21. Common themes were:

- **Support for the Regulations and how they provide clarity on the role of the IMCA (raised in more than ten responses).**

  - Functions of the IMCA are clear.

  - Having the same person acting as IMCA for different decisions seen as a positive.

  - Support for how the Appropriate Person can also be supported by an IMCA.

- **Specific comments regarding the functions of the IMCA as set out in the Regulations (raised in more than ten responses).**

  - Alternative courses of action: Responses called for clarity in relation to who would source least restrictive options – and whether this would be role of the IMCA, the Responsible Body or the Local Authority. There were also calls for clarity regarding the weight given to the proposed "less restrictive alternatives" of the IMCA by the Responsible Body.

  - Where appropriate, preparing a report for the Responsible Body: Questions raised around the degree to which the Responsible Body has to follow the findings of the report; what happens if they do not agree with its

content; and whether a report is required for different elements of the LPS process.

  - Regulation 6, insertion of the new paragraph 8 at (e) and insertion of the new paragraph 10 at (g): '*maintaining such contact with P throughout the period of the appointment as the IMCA and the responsible body consider is practicable and appropriate'*. Questions raised regarding the period for the appointment of the IMCA – and whether this is for the duration of the authorisation (which would have significant resource impacts). Concerns also raised that this provision undermines the independence of the IMCA and that the decision to no longer provide an IMCA could end up being a "financially based decision". Calls were made for the Regulations to be amended to reflect the IMCA's "independence and autonomy" in terms of maintaining contact throughout the appointment period.

  - The IMCA must support the Appropriate Person in making representation to the person carrying out the pre-authorisation review: Clarity sought regarding what is meant by "making representation" (e.g. does this mean a written report).

- **Calls made for greater clarity regarding the IMCA role and the Appropriate Person role:**

  - While the IMCA functions are clearly set out, the differentiations between the different roles under the LPS are not as clear.

  - Calls were made for the cared for person to have both an IMCA and an Appropriate Person.

  - Calls were also made for greater clarity / guidance when there is disagreement / disputes between the IMCA and the Appropriate Person. What happens for example if the IMCA does not consider that the Appropriate Person is acting in the cared for person's best interests. Related to this: Calls were made for processes and expectations in relation to specific scenarios to be set out clearly.

  - Questions were asked around whether the cared for person can have an IMCA and an Appropriate Person, and whether, if the Appropriate Person has an IMCA, they can also carry out the IMCA role for the cared for person, if they are needed.

  - Concerns raised that an IMCA will be required to support many Appropriate Persons to fulfil their role, given the knowledge and understanding they will need (with associated impacts on demand for IMCAs).

  - Calls for clarity on whether non statutory advocates can be appointed to support the Appropriate Person.

- Calls for clarity around how the IMCA will support the cared for person in relation to any application to the Court of Protection.

- **Concerns around the significant demands that will be placed on IMCAs (raised in more than 15 responses).**

  - Considerable increases in demand for IMCAs are anticipated. Questions posed around how Welsh Government are intending to respond to this.

  - IMCA services are already under significant pressures.

  - Concerns were raised that there is a significant underestimate of the number of IMCAs that will be required under the LPS. The UK impact assessment and the suggestion that an IMCA would be required in 25% of cases is potentially "grossly underestimated" (Third Sector Organisation).

  - Critical that there are sufficient IMCAs in place if the LPS is to ensure that "older people and their families are able to contribute to decision-making processes in meaningful ways" (Older People's Commissioner).

  - The high demand for IMCAs could impact on timescales for completing LPS authorisations.

- **The availability and provision of training to ensure staff capacity meets new demand was seen as critical (raised in more than 15 responses). Linked to this were concerns around the provision of future funding (also raised in more than 15 responses).**

  - Assurance sought in relation to ensuring there are sufficient trained IMCAs to manage increased demand. Transition planning is key.

  - Questions raised around how Welsh Government will guarantee sufficient funding going forward. Related to this were concerns raised regarding increases in demand and how this would be met / funded – given that there will be an increase in the need for IMCAs in light of there being no paid RPR role.

  - Questions also posed around what training will be required and who will provide it.

- **Comments that the Welsh Government needs to better explain the changes that the LPS IMCA Regulations will make to existing IMCA Regulations.**

  - Support for easy read documents that clearly set out the changes being introduced by the amending Regulations.

22. Responses also included:

- **Views on arrangements for the commissioning of IMCAs.** Calls for this to be clarified, particularly in terms of any changes to how IMCAs are currently commissioned under the DoLS.

- **Views on Welsh Language requirements and calls for the IMCA Regulations to ensure there are sufficient IMCAs available to provide advocacy in Welsh.** Concerns expressed that this is needed in order to guarantee sufficient numbers of Welsh speaking IMCAs to support the implementation of the LPS.

- **Calls for clarity regarding advocacy support for young people.** Particularly in relation to expectations where a young person may already be accessing advocacy through another route, for example – under the Social Services and Well-being (Wales) Act 2014. Working with 16 and 17 years will be new for IMCAs, there will be impacts for training.

Question 2 Do you agree that the draft Regulations on undertaking assessments, determinations and pre-authorisation reviews are clear and sufficient?

23. 57 responses answered this question (see Figure 2a). Over half of responses (60%) either strongly or somewhat agree that the draft Regulations on undertaking assessments, determinations and pre-authorisation reviews are clear and sufficient (see Figure 2b). Just over a quarter of responses (26%) either strongly or somewhat disagree. The majority of responses that agree with the question were from third sector organisations or individuals. The majority of responses that disagreed were from health boards and local authorities.

24. Eleven responses strongly agree that the Regulations on undertaking assessments are clear, and 23 responses somewhat agree. 12 responses somewhat disagree and three responses strongly disagree. 15 responses did not provide answer to this question.

Figure 2a

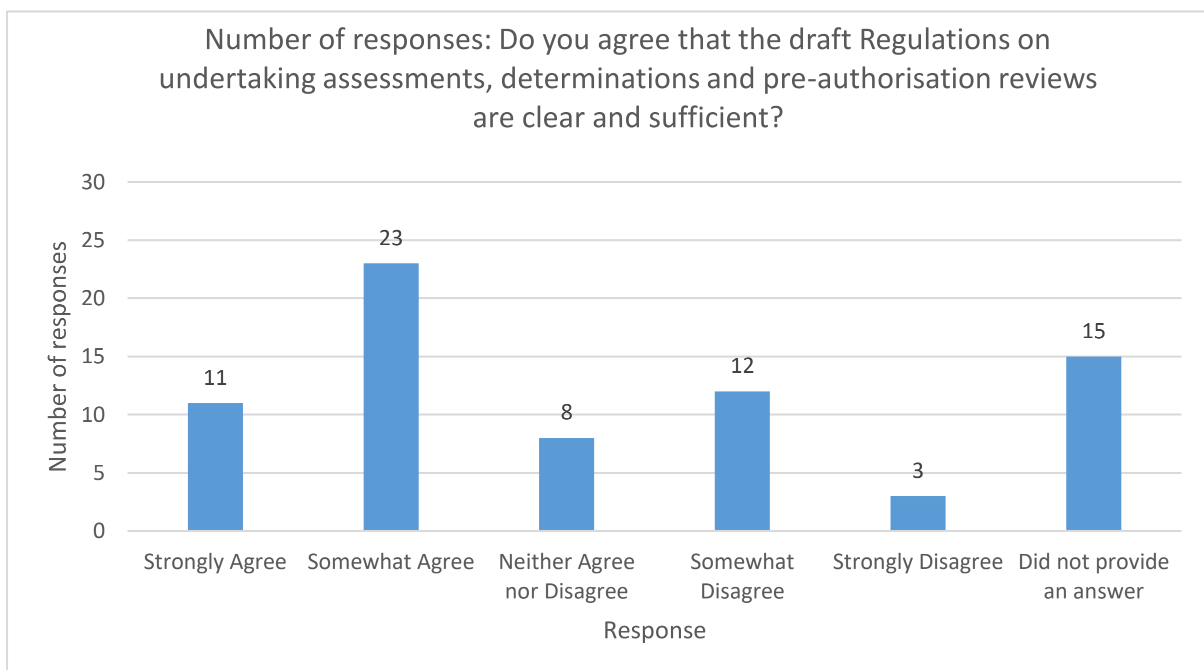
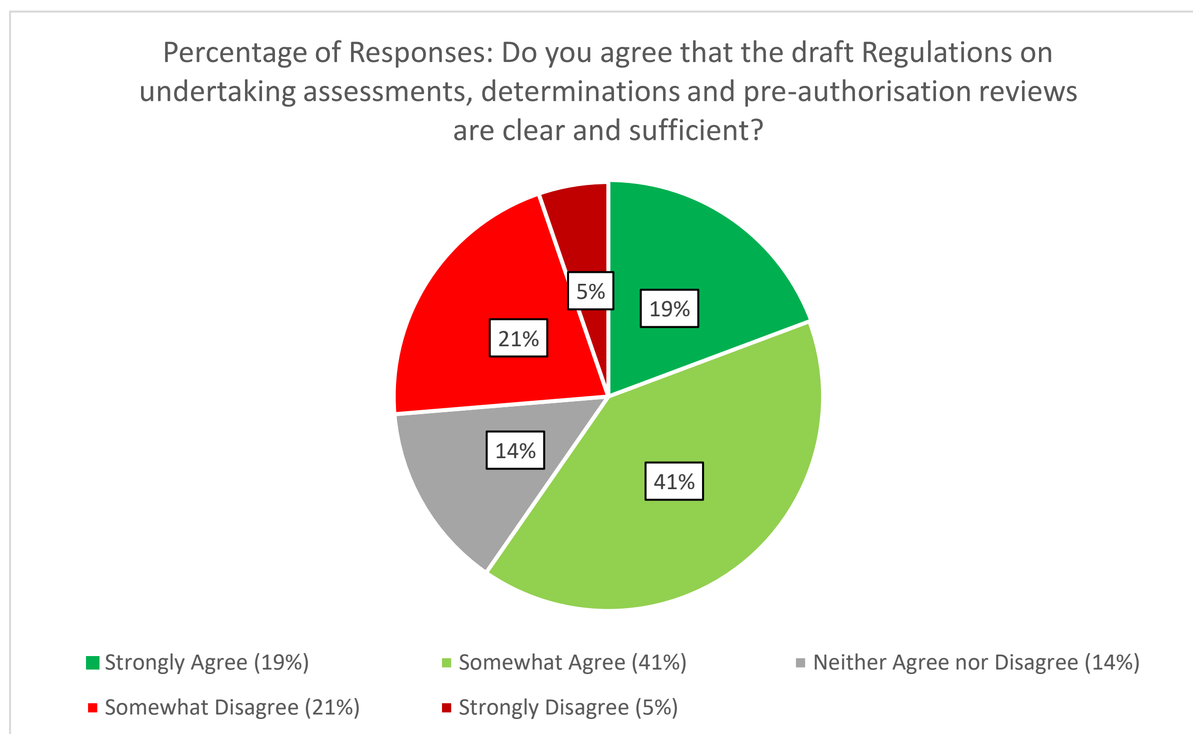


Figure 2b



25. Common themes were:

- **Mixed views on the drafting of the Regulations**

➢ Some responses noted that the Regulations were clear and sufficient.

➢ Other responses raised a number of concerns around the drafting of the Regulations setting out that they were too long and would benefit from simplification.

- **Concerns that the Regulations do not make provision directly relating to the pre-authorisation review (raised in more than ten responses).**

➢ Responses noted that the Regulations do not set out expectations as to who should carry out a pre-authorisation review and requested that this is included.

- **Views that further guidance was needed.**

➢ Further guidance requested on renewals (to support the development of internal processes); guidance on equivalent assessments and how they should be used; clarification on cross-border arrangements; the authorisation record to be used across Wales; and guidance on operational aspects of implementation.

- **Views around the requirement for a person carrying out an assessment to act independently.**

➢ Responses queried whether the requirement is that a person undertaking an assessment cannot be someone who is involved in the care of the individual, or if the requirement is that they can be involved – but must have the ability to act independently when undertaking an assessment. Responses requested that further clarity is provided on this in the Regulations.

- **Similar concerns around whether individuals within the same team are able to undertake assessments.**

➢ Responses highlighted the role of integrated teams. The wording in the Code of Practice suggests that those carrying out an assessment should not be members of the same team who work together for clinical purposes on a routine basis.

- **Concerns that the eligibility criteria would exclude some individuals who would normally undertake the kind of assessments used in the LPS.**

➢ Responses referenced a number of professionals who may undertake assessments but are not listed in the Regulations. These included physiotherapists, teachers and solicitors.

➢ Responses also highlighted cases where a medical diagnosis is given by someone other than the professions listed in the Regulations, such as a diagnosis of autism.

- **Comments around the suitability of GPs to provide medical assessments.**

➢ Responses raised a number of concerns including: the ability of GPs to provide a diagnosis unless they have a relevant speciality; the willingness of GPs to be involved in the process; and the capacity of GPs to be involved in the process. (This issue was also highlighted for Question 3.)

➢ The eligibility criteria for medical assessments should be widened to account of this. However, some responses also suggested that the criteria should be narrower to only include those with a speciality.

- **Comments relating to the timescales set out within the Code of Practice for assessments to be undertaken.**

➢ Some responses voiced concerns that the 21-day time period to undertake assessments was not realistic. Particular challenges were highlighted in community settings.

➢ Some responses set out that the timescales should be reflected in the Regulations rather than in the Code of Practice.

26. Responses also included:

- **Comments requesting further clarity in relation to financial interest.** Requests for further guidance on how the restrictions in relation to financial interest would work in practice. Further clarity was requested in relation to residential homes owned and registered by the local authority. It was also requested that the Regulations were amended to include parents in law as an individual who may be defined as a relative with a financial interest.

- **Views on the need to consider Welsh Language in eligibility requirements.** Eligibility requirements should include the ability to assess in Welsh. It was suggested that this should be included in the Regulations to ensure that skill mix is taken into account across the workforce.

- **Concerns about staffing, and the ability of the health and social care system to deliver the LPS (this was also a major theme in relation to Question 3).** Responses noted that the person undertaking the assessments would require an extensive knowledge and understanding of the Mental Capacity Act 2005 and the MCA Code of Practice, and that this was unrealistic across a wide workforce. Responses noted that if care planning and assessments continue to be undertaken by individuals not listed in the Regulations then this would lead to an increased workload as assessments would need to be repeated. It was also raised that assessors should have experience of working with children and within the children's legislation framework.

- **Comments around the need for assessors to hold relevant insurance.** Responses queried whether the employee or the employer would be responsible for funding relevant insurance. It was also stated that the medical assessment may not be covered within a GP's existing cover.

- **Cross border implications for implementation.** Professionals registered in both England and Wales will need to understand the differences between the Regulations in each country.

Question 3 Do you agree the draft Regulations enable the relevant professionals to carry out assessments and make determinations?

27. 56 responses answered this question (see Figure 3a). Over half of responses (55%) either strongly or somewhat agree that the draft Regulations enable the relevant professionals to carry out assessments and make determinations (see Figure 3b). Nearly a third (32%) of responses said they strongly or somewhat disagree. Of those who agree, the majority of responses were from third sector organisations or individuals. Most of those who disagree were from health boards, NHS organisations or local authorities.

28. 12 responses strongly agree and 19 somewhat agree that the Regulations enable the relevant professionals to carry out assessments and make determinations. 15 somewhat disagree and two strongly disagree. 16 responses did not provide an answer to this question.

Figure 3a

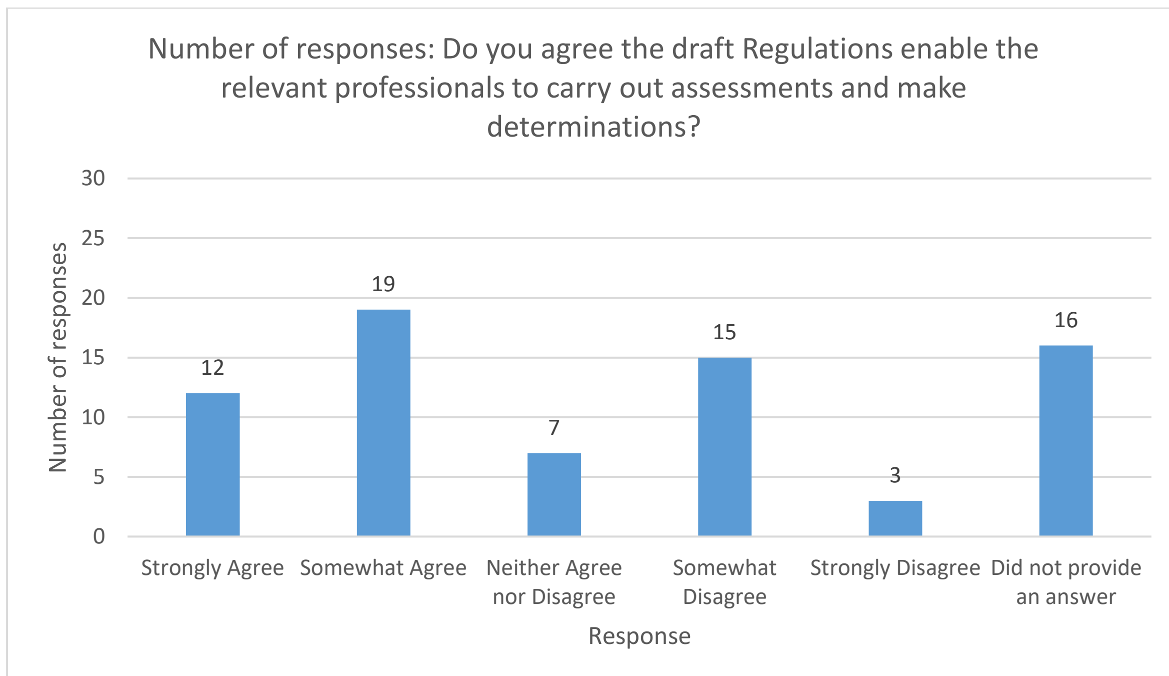
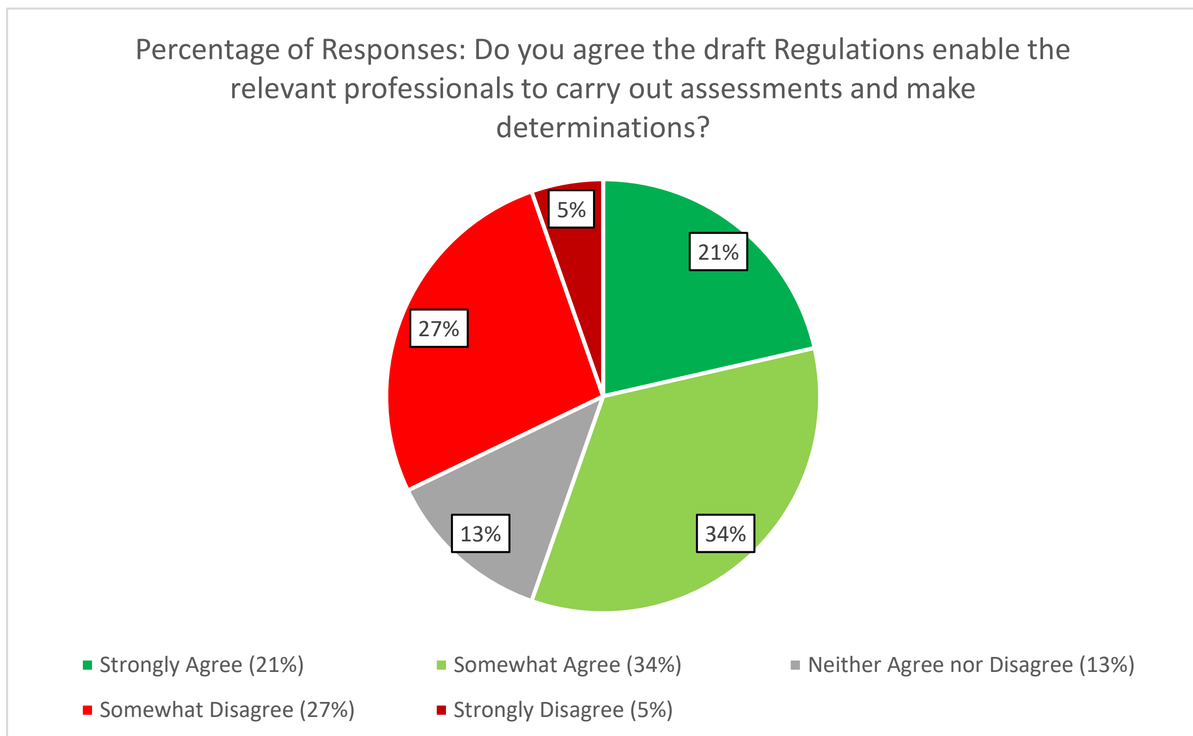


Figure 3b



29. Common themes were:

- **Concerns regarding capacity to deliver the assessments (key theme for this consultation question – highlighted in more than 15 responses).**

➢ Resources are "…absolutely critical for effective implementation and to protect the rights of people with a learning disability and others. We echo many of the concerns that have been raised about funding and availability of professionals with appropriate skills and training to carry out the roles under LPS, including assessments, advocacy and AMCPs" (Third Sector Organisation).

➢ There are currently considerable challenges regarding staff resources / capacity – which will impact on delivery of the LPS if not addressed.

"We are in agreement that the capacity assessment and the necessary & proportionate assessment requires a registered professional with the necessary skills and experience to undertake them. However, social work teams do not have sufficient staff who meet these requirements currently and in all likelihood will still not have sufficient staff to meet the requirements when LPS is implemented. We would request that Welsh Government provide further guidance and advice on how Local Authorities can meet their statutory requirements in the light of these difficulties." (Local Authority)

"Given the extreme pressures on the NHS and the double burden on GPs of Covid and systemic under-resourcing, there is no capacity to undertake significant additional work, such as assessments of capacity for the LPS…. If

the new system is going to rely on medical input, the resource implications must be fully thought through with the direct involvement of the BMA." (Professional Body).

- **Workforce training and upskilling for those undertaking assessments and determinations and pre-authorisation reviews seen as critical.**

➢ There is currently a lack of knowledge and expertise regarding DoLS and the MCA across different settings.

➢ Wider workforce issues – for example, the lack of social workers.

➢ Skills and knowledge gaps: The level of knowledge and skills required for professionals to undertake the necessary and proportionate assessments exceeds core professional skills and is more in line with specialist practitioner such as BIA (Social Care Team, Local Authority).

- **Comments on medical assessments:**

➢ Concerns around the competency of professionals carrying out the medical assessment. Medical assessments are not routine work for medical practitioners or psychologists. Calls made instead for an alternative model e.g. similar to the approval of a Section 12 Doctor.

➢ Concerns that the requirement for assessment to be carried out by a doctor or psychologist will make the implementation of the LPS very challenging (see also Question 2). In particular: "GPs will be reluctant to do this unless remuneration is considered." (Health Board)

➢ It will be difficult for social care to access medical assessments and determinations.

➢ Calls for the eligibility criteria for carrying out assessments and determinations to include all Health and Care Professions Council (HCPC) registered professionals (Health Board) and educational psychologists (Consortium – Health Board and Local Authorities), as well as "people who fall into competency group D [those undertaking pre-authorisation reviews and authorisations] in the training triangle" (Local Authority).

➢ Pre-existing diagnoses should be taken into account, and people should not be subject to lengthy re-diagnosis processes.

- **Comments on necessary and proportionate assessments:**

➢ Calls for the requirements for undertaking "necessary and proportionate" assessments to be competency-based and not qualification-based. Point also made that "non-social work qualified Care & Support Practitioners are trained and competent to undertake mental capacity assessments and make best

interests' decisions where necessary" (Consortium – Health Board and Local Authorities)

30. Responses also included:

- **Calls for further clarity on who can carry out assessments and determinations.** Responses commented that it is clear who can undertake assessments, but not who can undertake determinations.

- **Comments on cultural change:** A holistic and person-centred approach will be needed, which is co-productive and involves family and carers who understand a person's communication needs (Third Sector Organisation).

Question 4 Do you agree that the draft Regulations relating to financial interest provide the necessary safeguards for the cared-for person?

31. 54 responses answered this question (see Figure 4a). Over three quarters of responses (78%) strongly or somewhat agree that the draft Regulations relating to financial interest provide the necessary safeguards for the cared-for person (see Figure 4b). 11% either strongly or somewhat disagree with this question. The majority of the responses who agree were from health boards, health organisations or local authorities, as well as some third sector organisations or individuals. The responses that disagree were mainly from third sector organisations.

32. 22 responses strongly agree and 22 somewhat agree. Six responses either strongly or somewhat agree. 18 responses did not provide an answer to this question.

Figure 4a

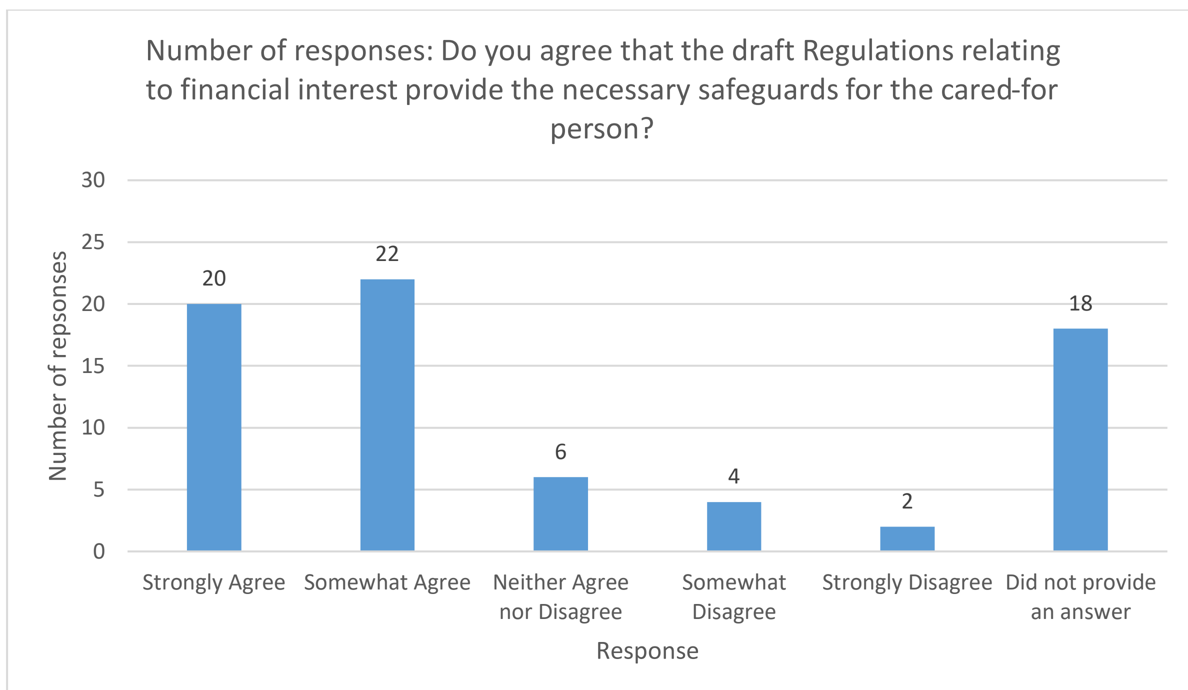
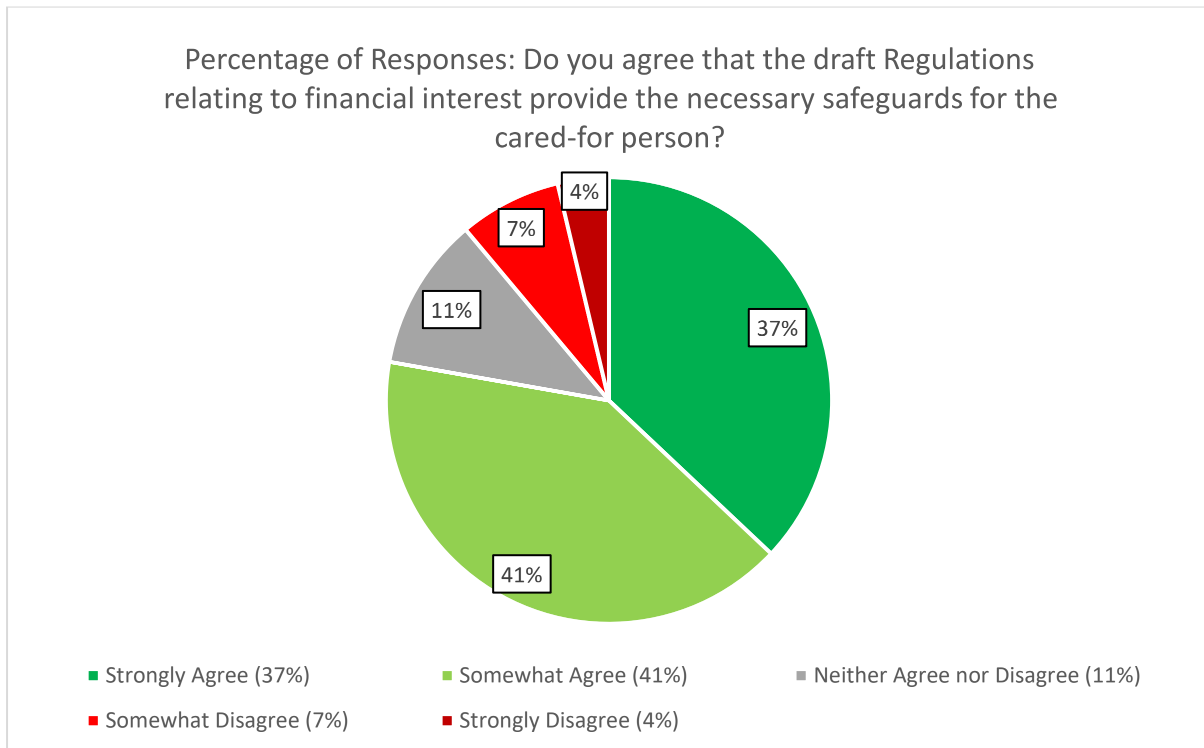


Figure 4b



33. Common themes were:

- **Broad support that the provisions included in the Regulations on carrying out assessments and determinations and the pre-authorisation review relating to financial interest provide the necessary safeguards for the cared for person.**

  - Regulation 3(5) which sets out the eligibility conditions for carrying out assessments and determinations which the Responsible Body must consider, and Regulation 3(6) which provides the definition of a "relative" and "financially interested" are comprehensive.

  - Individuals with any interest or relationship where an LPS authorisation could have a material / financial impact on that relationship must be declared and protections need to be "in-built into the system to prevent abuse" (Third Sector Organisation).

"The Commissioner strongly endorses the decision that care home providers and those with other financial interests in the care of the older person, should not be in a position of making authorisation. Were these persons to undertake an active role in LPS determinations, there would be an inevitable conflict of interest; with the potential that fairness and objectivity in the best interest of the cared-for person, would then be compromised." (Older People's Commissioner)

- **Further clarity needed in relation to specific issues.**

  - Question raised regarding people with Lasting Power of Attorney (LPA) – in terms of how the LPS process works, and whether those with LPA would be eligible to undertake assessments and determinations.

  - Question raised as to whether the person's GP would be able to carry out an assessment as they have "a financial interest in the survival of the patient" (Individual).

  - Calls for further consideration to be given to the potential for conflict of interest when the NHS employs locums. Specific example given in relation to Locum OTs [Occupational Therapists] who may also work in private practice alongside NHS work and could have links to care providers, placements or suppliers of equipment / adaptations.

  - Concerns raised regarding challenges associated with securing "assessment independence" when individuals present at crisis, and particularly when the cared for person has no Appropriate Person.

  - In relation to the Code of Practice: Questions raised in relation to Chapters 15 and 16, with questions on whether the provisions mean that individuals who may be a beneficiary in the will, or someone who receives carers allowance, or is employed as a direct payments or a foster/kinship carer, would also be excluded from carrying out assessments.

34. Responses also included:

- **Comments that the Regulations do not provide the necessary safeguards for the cared for person.** Comments made in relation to the LPS process as a whole and the need for effective management.

  "I'm not confident that the necessary checks and balances are in place. There is a lot of instruction for the professional but effective management of the system is imperative to safeguard the person concerned and the professional. There have been many high profile examples of 'professionals' who have made the wrong decisions, poor assessments and poor record-keeping, to the detriment of the person at risk." (Community Health Council)

- **Views that training for AMCPs on the eligibility criteria for carrying out assessments and determinations – particularly in relation to the definition of a financial interest – will be important.** The area of financial interest and the necessary safeguards is complex – and one that requires training.

Question 5 Do you agree the draft Regulations on the role and appointment of AMCPs are clear and sufficient?

35. 53 responses answered this question (see Figure 5a). Over half of responses (58%) strongly or somewhat agree that the draft Regulations on the role and appointment of AMCPs are clear and sufficient (see Figure 5b). However, just over a quarter (28%) strongly or somewhat disagree. The majority of responses that agree were from individuals or third sector organisations, whereas responses that disagree were mainly from health boards or local authorities.

36. 12 responses strongly agree and 19 somewhat agree that the draft Regulations on the role and appointment of AMCPs are clear and sufficient. Two responses strongly disagree and 13 somewhat disagree. 19 responses did not provide an answer to this question.

Figure 5a

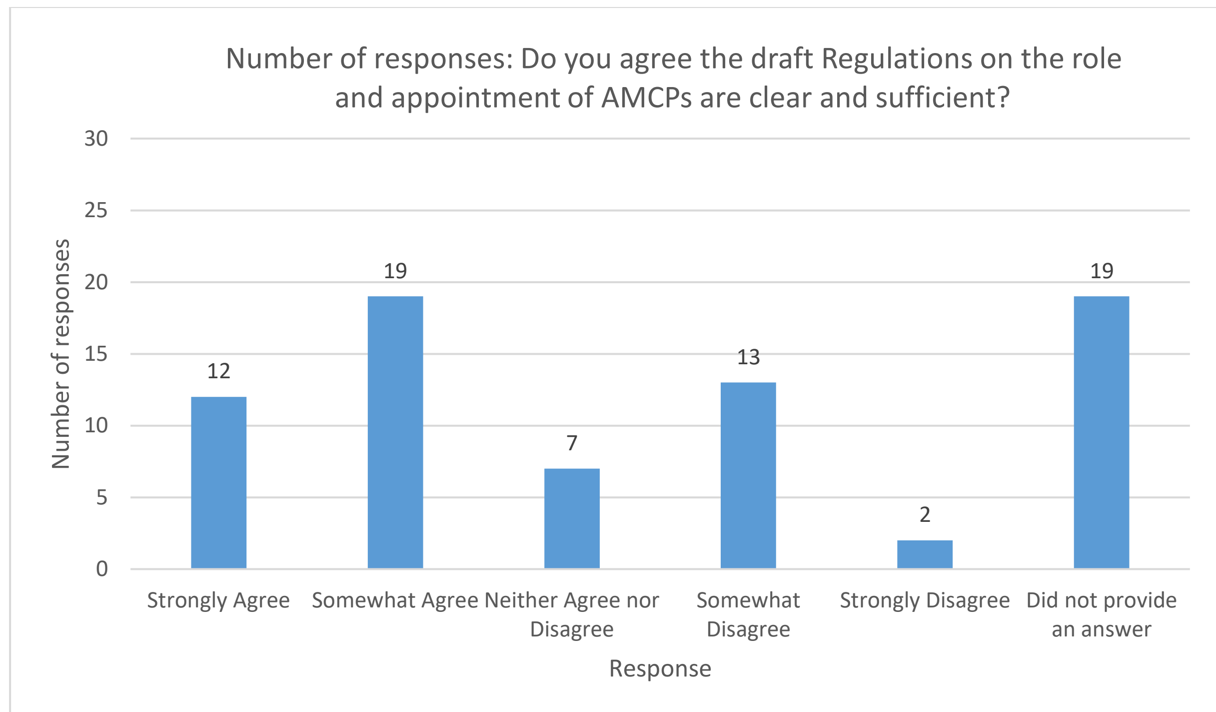
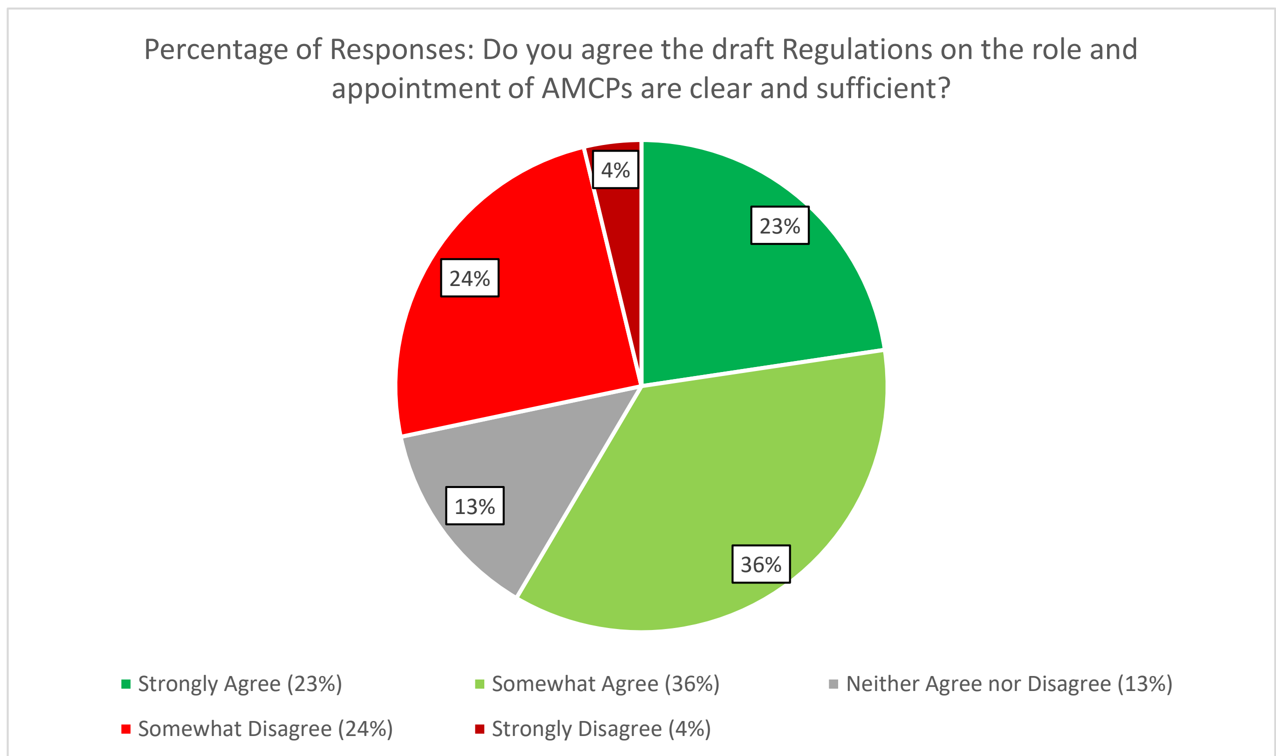


Figure 5b



37. Common themes were:

- **Regulations seen as clear and sufficient (raised in over ten responses).**
  - ➢ The three different types of training are clearly set out, and the summary of the Workforce and Training Plan was considered helpful.
- **Comments that further clarity is needed – either in the Regulations or as part of supporting guidance (raised in over ten responses).**
  - ➢ Calls for greater clarity in relation to the expectations of the role and training required, as well as questions around how the training will be embedded across the workforce (see Question 9 for a further discussion).
  - ➢ Requests made for simplified and practical guidelines, that can be easily understood and applied, for example – in terms of when the pre-authorisation would be carried out by an AMCP.
  - ➢ Comments that the Regulations do not set out the circumstances where the AMCPs must act as the pre-authoriser. Calls for further clarity around the role of the AMCP and a clear framework for when to refer to an AMCP for the per-authorisation review.
  - ➢ Calls for guidance to assist with any difference of opinion between the Responsible Body and the AMCP.

- Comments that it is not clear whether an AMCP can complete a pre-authorisation review and then give the final authorisation. Questions were also raised around whether an AMCP can complete a pre-authorisation review and then give the final authorisation for a Responsible Body that they are not employed by (see theme on independence / accountability).

- The Regulations should explicitly state that approval is indefinite subject to the AMCP completing 18 hours of training and other eligibility criteria. (Responses noted that this is different from the AMHP Regulations which allow approval for up to 5 years.)

- **Specific comments on the approval process (raised in more than ten responses).**

  - Calls for further guidance / clarity around how the AMCP is expected to evidence the quality of their work.

  - Support for consistency around what is required from an AMCP in terms of evidence to support their continuous approval, and consistency in terms of how the Responsible Bodies assess this evidence.

  - Calls for competency standards for the workforce / a competency-based approach to having ongoing approval. In particular, responses suggested a need for "greater clarity on what competence looks like in this context" and called for "a framework to ensure that there is consistency across Local Authority/Health Board/Regional Partnerships Board areas to ensure that the same standards and measures are applied to the AMCP role" (Third Sector Organisation).

  - Concerns expressed that there could be multiple Responsible Bodies involved in monitoring and checking the evidence provided by the AMCP, in relation to ongoing approval.

  - Questions raised around how local authorities will be assured that AMCPs have adequate knowledge of best practice.

- **Requests for greater clarity across the process for approving and managing the AMCPs, the relationship between health boards and local authorities, and how AMCPs will be managed (raised in more than ten responses).**

  - Calls for guidance more generally on the approval of AMCPs for local authorities, which would then ensure greater consistency in terms of role, appointment and ongoing approval.

  - Requests for further information on whether the AMCPs are expected to sit in specialist teams, or whether AMCPs are to be regarded as standalone roles, as views currently "vary significantly".

- Questions raised regarding whether the approval and monitoring of AMCPs needs to be carried out by a specialist team in order to comply with the Regulations and manage their ongoing approval.

- Concerns that without consistency in relation to the role and remuneration between health and social care, there will be a constant movement of staff between employers.

- **Requests for clearer provision in the Regulations in terms of how local authorities will make arrangements for adequate AMCP provision for health boards.**

  - The role of the local authority in arranging and approving AMCPs for health organisations needs to be specified. (This is considered further under responses provided for Question 10.)

  - Calls for strengthened assurances that local authorities will support health boards in developing their own AMCPs and ensuring adequate AMCP provision.

- **Comments relating to the position that only local authorities can arrange for the provision of AMCPs whilst both local authorities and health boards act as Responsible Bodies.**

  - Support for health boards to be able to approve and regulate the AMCPs, as well as approve training (see other consultation questions on training).

  - Concerns raised in relation to accountability where local authorities are approving AMCPs who then work across other local authorities and health boards.

- **Specific comments in relation to accountability and AMCPs.**

  - The Regulations do not make it clear how this will work in practice – for example: in terms of whether the AMCP has to be employed by the Responsible Body (e.g. health board X) if they are carrying out the pre-authorisation review for health board X.

  - Concerns were raised around the appropriateness of an AMCP approved by one local authority making decisions on behalf on health boards / other local authorities (see theme on independence).

- **Independence of AMCPs: Concerns raised around the independence of AMCPs when approved/appointed by the local authority, and when acting in respect of individuals whose Responsible Body is their own employer.**

  - Suggestions were made to seek alternative models of approval.

> "Given how much influence AMCPs have in authorisation assessments, [XXX] believes AMCPs should never be employed or appointed by the local authority acting as the Responsible Body in a case. This would represent a conflict of interest: even if a cared-for person was not objecting to the proposed arrangements. [XXX] therefore partly disagrees with the draft Regulations on the role and appointment of the AMCP, as this cannot be truly independent if their employer is acting as the Responsible Body in a case the AMCP presides over. We encourage Welsh Government to pursue other models to approve AMCPs, much like UK Government are attempting in Chapter 18 of the Code to ensure the independence of AMCPs." (Third Sector Organisation)

- **Service provision and capacity to deliver and manage AMCPs, and the need for appropriate resources (raised in more than 10 responses).**

  - Concerns were raised around the ability of the heath and care workforce to act as AMCPs when considering their capacity and current workloads.

  - Concerns around the skills, knowledge and resources required. Comments made in relation to the lack of BIAs across Wales and challenges associated with increases in demand for current DoLS assessments.

  - Responses suggested that initially, the AMCP role may be required to undertake pre-authorisation reviews for all cases (due to the level of skill knowledge and experience required) – this has also been highlighted as a key theme for consultation Question 14 and our assessment of impacts in the Regulatory Impact Assessment. Some responses also anticipated that a significantly higher number of LPS authorisations will be required and that "it is unrealistic given the number of qualified BIAs that they will be able to undertake the role of AMCP for all that need it" (Local Authority).

  - Specific concerns raised in terms of potentially unfair impacts on local authorities, regarding the approval process.

  "Will the LA be responsible for employing the AMCPs? What provisions will be in place for the financial implication of this. It is unclear why again this task (as in the situation with AMHPs) the role of the AMCP like the AMHP has fallen on the responsibility of the Local authority in ensuring there are sufficient numbers. Not clear why this is as the health Board as RB will also have to use the services of the AMCP. This will be unfairly drawing out resources from the LA as likely that vast majority (if not all) the AMCP's will be social workers." (Local Authority)

38. Responses also included:

- **Views on pre-authorisation reviews and the AMCP – and children and young people.** Calls for AMCPs being considered for all cases involving young people. As one response noted: "It is totally new for the children's sector to be doing this and people with specialist training to be carrying out pre-authorisation seems a sensible safeguard" (Third Sector Organisation).

Training for AMCPs also critical – in terms of their role as a pre-authorisation reviewer for 16 and 17 year olds (BIAs who become AMCPs will tend to have worked with adults).

- **Views on Welsh Language:** Calls for the Regulations to "include a section that requires local authorities to ensure they have a sufficient number of Welsh-speaking AMCPs to meet the requirements of Welsh speakers in their area" (Welsh Language Commissioner).

Question 6 Do you agree the draft Regulations enable the relevant professionals to carry out the role of the AMCP?

39. 54 responses answered this question (See Figure 6a). Two thirds of responses (66%) said they strongly agree or somewhat agree that the draft Regulations enable the relevant professionals to carry out the role of the AMCP (see Figure 6b). 17% of responses somewhat disagree, and the other 17% said they neither agree nor disagree. Most of the responses who agree were from individuals or third sector organisations.

40. 12 responses strongly agree and 24 somewhat agree that the draft Regulations enable the relevant professionals to carry out the role of the AMCP. None of the responses say that they strongly disagree but nine somewhat disagree. 18 responses did not provide an answer to this question.

Figure 6a

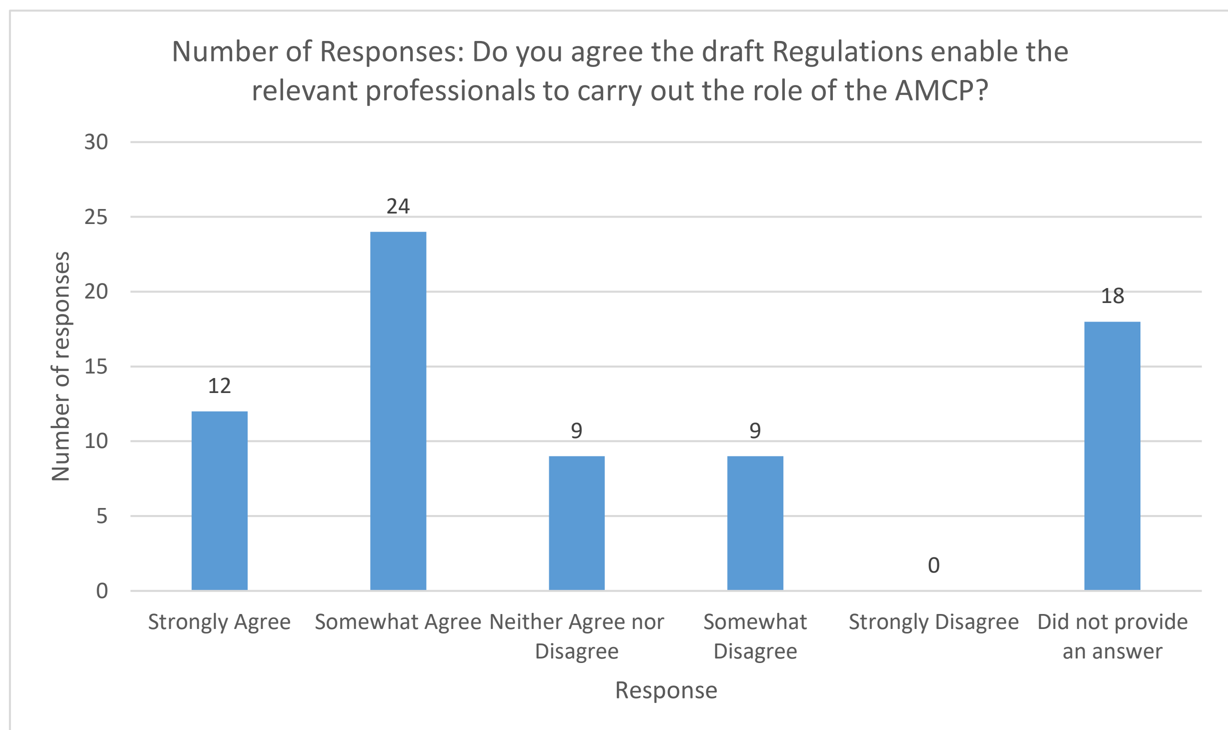
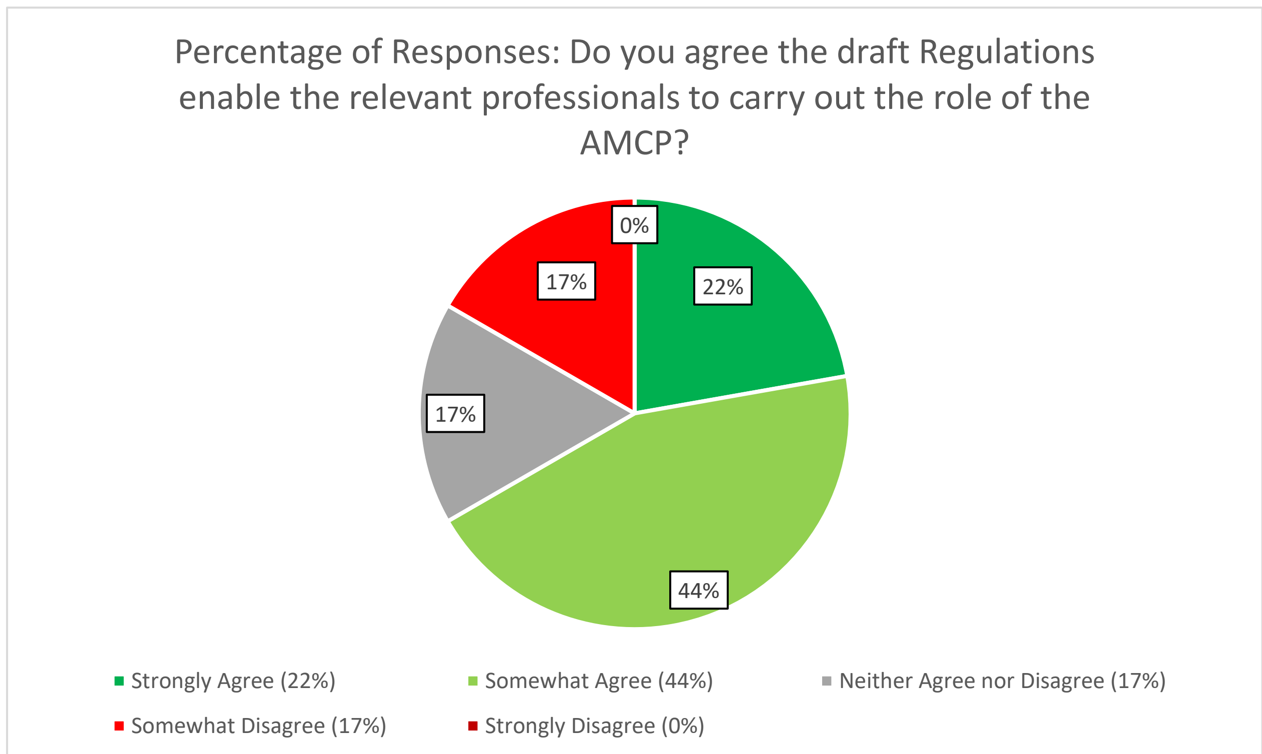


Figure 6b



41. Common themes were:

- **The draft Regulations enable the relevant professionals to carry out the role of the AMCP (raised in more than ten responses).**

  - The professions listed to carry out the role of AMCP are appropriate.

  - The Regulations clearly identify who is eligible to become an AMCP.

  - Support for the inclusion of speech and language therapists.

  "Given the impact that communication difficulties can have on perceptions of an individual's mental capacity, and the specialised knowledge that SLTs [Speech and Language Therapists] have regarding speech, language, communication, and swallowing, we are pleased to see government recognition of the important role that speech and language therapists play in assessing mental capacity." (Professional Body)

- **Calls for other professions to be named in the Regulations to be eligible to undertake the AMCP role.**

  - Specific calls made for: physiotherapists / social care professions / registered professions within health and social care / all professions registered with the Health and Care Professions Council.

- **Expectations of the AMCP role and anticipated demand for AMCPs: Resource impacts.**

  - Concerns raised that it will not be possible to meet the requirements of the Regulations.

  - Concerns raised around the skills, knowledge and resources / funding required to meet demand and provide adequate training and improve services.

  - As with Question 5, concerns raised about anticipated increases in LPS authorisations, and the number of AMCPs that might be needed (particularly during the first year of implementation).

  - Recruitment challenges anticipated.

  - Calls for clarity around which cases will need to be considered by AMCPs and whether the intended approach is realistic (where the AMCP would only be considering complex cases / where the cared for person is objecting).

- **Partnership working between health boards and local authorities to ensure there are sufficient AMCPs available (raised in more than ten responses).**

  - This was also a key theme raised in relation to Question 5.

  - Concerns raised that the AMCP workforce will only come from social workers.

  - Calls for the Regulations to include a greater focus on how health boards will be supported by local authorities.

  - Calls for ongoing monitoring by Welsh Government of local authorities on how they are ensuring there are sufficient numbers of AMCPs for their area.

42. Responses also included:

- **Views on cross boundary issues:** Questions raised around arrangements for AMCPs in terms of cross boundary placements.

- **Views on Welsh Language:** Specific consideration needed in relation to Welsh Language. In cases where Welsh speakers need the services of an AMCP, calls for the AMCP to be able to speak Welsh (with responses stating that it would not be appropriate to use an interpreter in such cases).

Question 7 Do you agree with the arrangements for the approval of the AMCP?

43. 54 responses answered this question (see Figure 7a). Well over half of responses (61%) either strongly or somewhat agreed with the arrangement for the approval of the AMCP (see Figure 7b). Just under a quarter of responses (24%) strongly and somewhat disagree. The majority of responses in agreement with the approval arrangements for AMCPs were from individuals or third sector organisations, whereas the majority that disagree were from local authorities.

44. 14 responses strongly agree and 19 somewhat agree with the approval arrangements for AMCPs. Eight responses said that they neither agree nor disagree, four strongly disagree and nine somewhat disagree. 18 responses did not provide an answer to this question.

Figure 7a

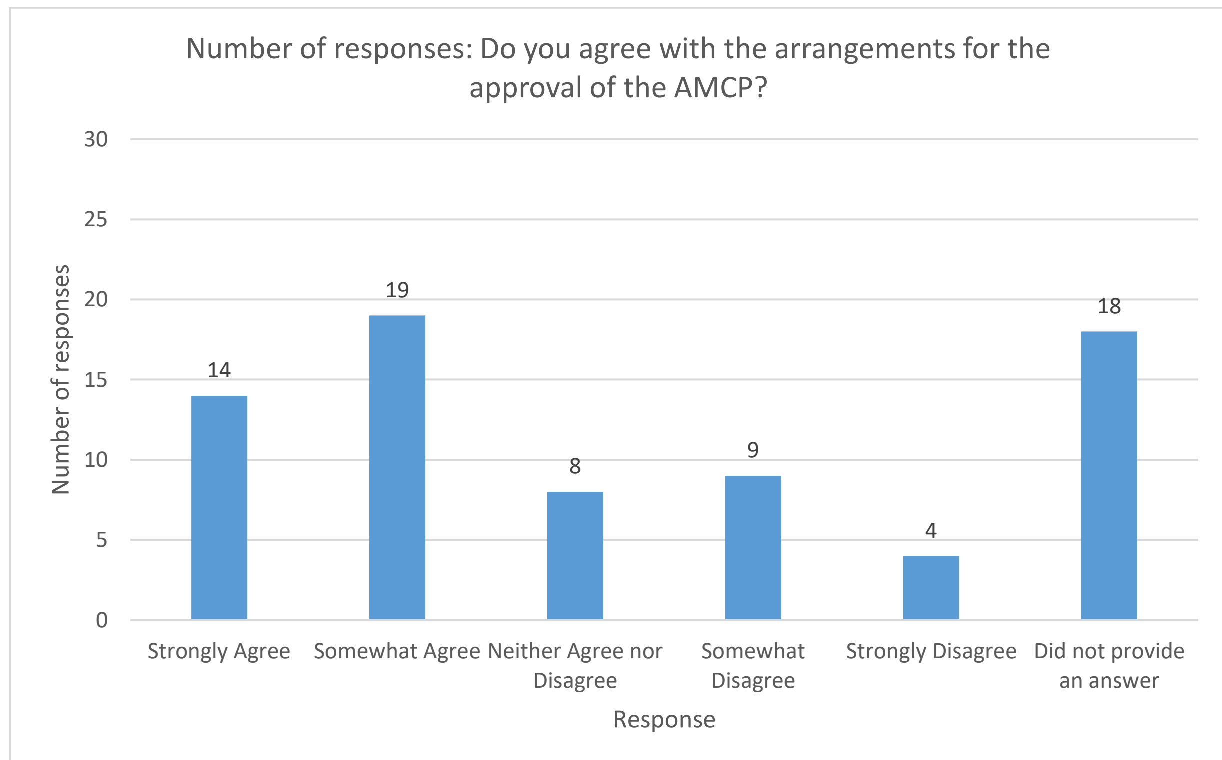
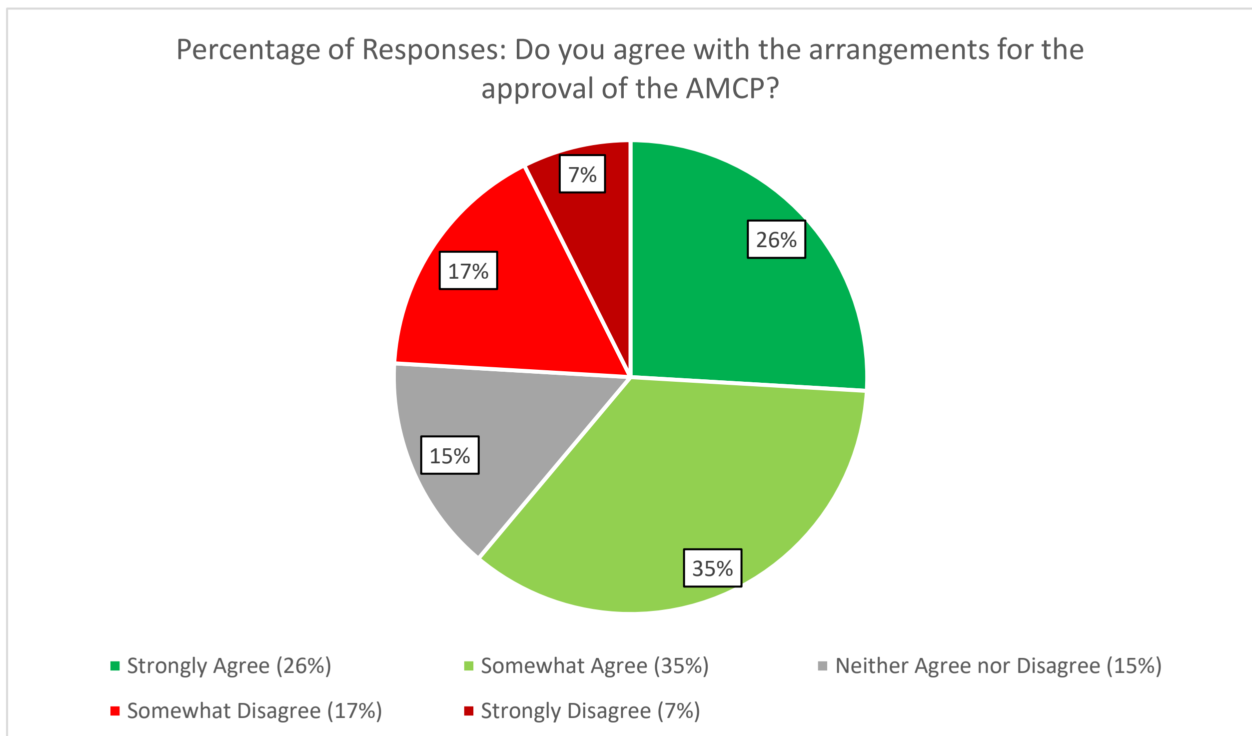


Figure 7b



45. Common themes were:

- **Approval should be given for a set period (as opposed to there being indefinite approval).**

➢ The Regulations are drafted to provide AMCPs with approval to act as an AMCP indefinitely, providing they undertake the 18 hours of further training and continue to meet with relevant eligibility criteria set out in the Regulations. Some responses disagreed with this approach – instead suggesting that it would be preferrable for AMCPs to be approved for a set period of time and then undergo a reapproval process.

- **The AMCP Regulations should mirror the AMHP Regulations more closely in relation to ongoing approval.**

➢ Some respondents felt that the requirement for an annual check was too onerous.

- **Uncertainty around the number of AMCPs needed.**

➢ There is a danger that AMCPs might be overstretched as they can be employed to work across multiple local authorities.

➢ The role of the AMCP must be trialled and reviewed.

- **Further issues raised regarding AMCPs more generally (which are also picked up in responses for the other consultation questions on AMCPs).**

- There should be central approval by Social Care Wales and a central All Wales register of AMCPs, to prevent local and regional differences.

- Consistency in how AMCPs are approved by the Local Authorities is critical. Calls made for common standards.

- Questions posed around how resourcing, job grades and roles will be aligned across health and care settings.

46. Responses also included:

- **Calls for clarity around the monitoring of individual AMCPs to support ongoing approval (data driven approach) and how AMCPs are expected to demonstrate the quality of their work on an ongoing basis**. This was also raised as a theme in responses for the other consultation questions on AMCPs. Standardised approach needed in terms of demonstrating competency. It was suggested that this could include data from monitoring and reporting systems to support objective decision making.

- **Views on exemption: [The AMCP Regulations will enable the Responsible Body to make a decision to exempt an AMCP from undertaking the further training before a set date. The AMCP will not be able to undertake the functions of an AMCP until they have completed the training.]** Calls for clarity around how exemption from the requirement to undergo further training works. Responses noted that there is no clarification on which factors can form the basis of a decision to exempt an individual from further training and requested clarity on whether an individual can continue to work as an AMCP when such an exemption has been provided.

Question 8 There are three main types of training that will be provided for AMCPs: conversion training; initial training; and further training. Do you agree with the overall approach being taken to providing training for AMCPs?

47. 54 responses answered this question (see Figure 8a). Over half of responses (57%) either strongly or somewhat agreed with the overall approach being taken to provide training for AMCPs (See Figure 8b). A quarter of responses (26%) either strongly or somewhat disagree with the approach. The majority of responses that agree with the approach came from third sector organisations, individuals or health boards. The majority of responses who disagree were from local authorities.

48. Eleven responses strongly agree with the approach to training AMCPs, and 20 responses somewhat agree. Three responses strongly disagree and 11 somewhat disagree. 18 responses did not provide an answer to this question.

Figure 8a

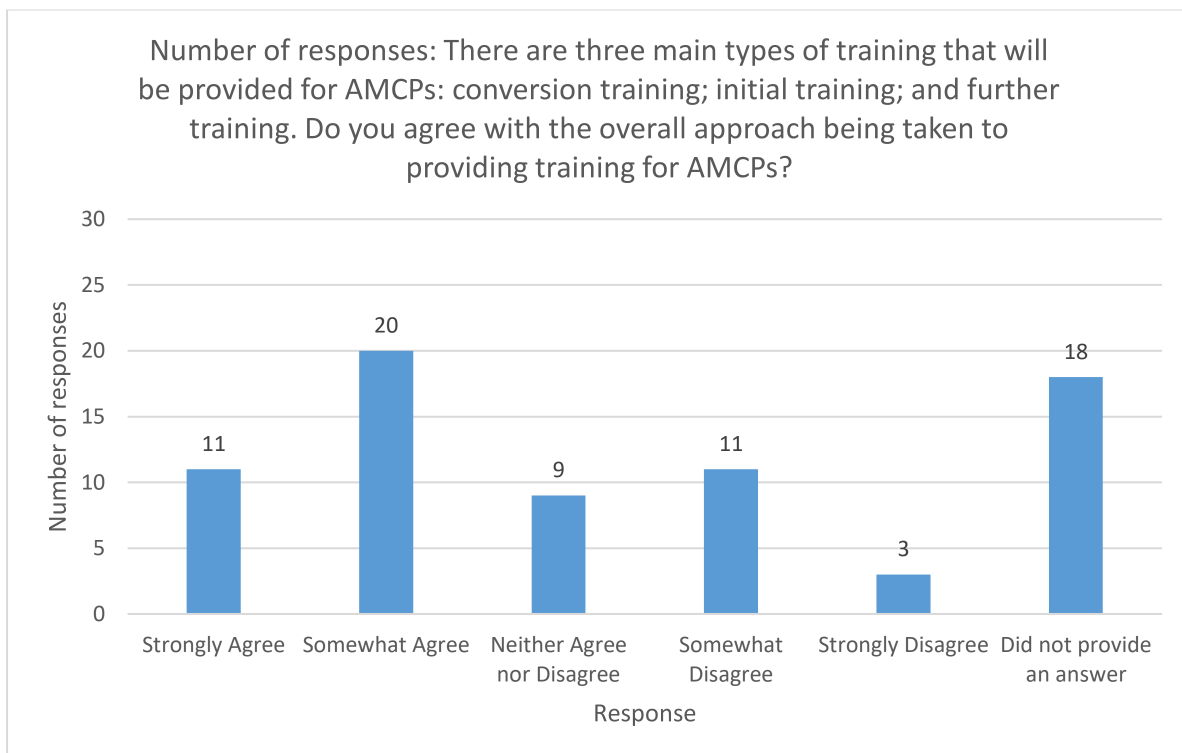
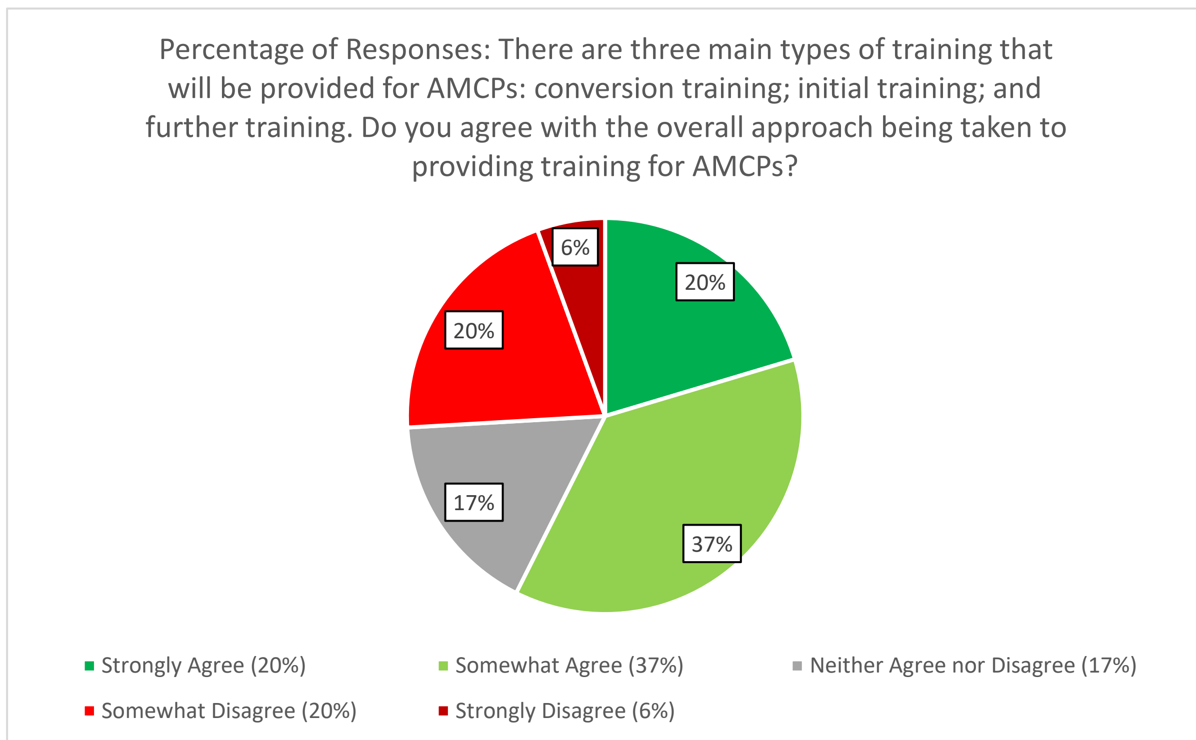


Figure 8b



49. Common themes were:

- **General support for the overall approach being taken (raised in more than ten responses).**

➢ Approach is positive and should ensure consistency and quality of those carrying out role.

➢ Agreement with the plan for conversion training for current BIAs "as long as they meet all competencies, otherwise they should go on to do new training" (Health Board).

➢ Tiered system of training seen as beneficial.

"We welcome the commitment to separate training for active BIAs and new AMCPs without a BIA background and that this training will be approved by Social Care Wales." (Third Sector Organisation)

- **Concerns raised over time and resource impacts of the proposed training (raised in more than ten responses).**

➢ Sectors are currently under immense pressure.

➢ Questions posed around what measures will be put in place to support local authorities with the costs of training AMCPs.

- ➢ Concerns raised that this appears to be "a lot of hours to complete" especially if the training is specifically focussed on the LPS. Calls for the training to be broader, and inclusive of case law. (In contrast, other responses stated that the AMCP carries out a significant role and more robust training arrangements are needed – see discussion in Question 9).

  "…if this remains the sole responsibility of the Local Authority what measures will there be in place to provide for the cost implications for this? Initial costs of training an AMHP is over £5,000 per person plus Social Workers/AMHPs providing placements and resource as practice educators. Ongoing AMHP training (for qualified and working AMHPs) currently stands at approx. £6000 per year for the Local Authority to ensure that there are sufficient AMHP specific days of training to meet the criteria set out in the regulations." (Local Authority)

- **The content and quality of training is key (more than ten responses).**

- ➢ This was a key theme for all consultation questions on training.

- ➢ There needs to be a specific focus on cultural competency, lived experience, palliative and end of life care, learning disability awareness.

- ➢ Hard to know what the quality of the training will be and what the conversion, initial and further training will entail.

- ➢ Regulations seen as "too ambiguous" and greater clarity needed on what would be included in the training.

- **Conversion training should be accredited.**

- ➢ Some responses not in agreement that any AMCP training should be non-accredited (conversion or new). Responses commented that the "nature of the work that will be undertaken and the responsibility held by the AMCP needs to be recognised" (Local Authority).

- ➢ Calls for the AMCP qualification be equivalent to the AMHP qualification.

- ➢ Calls for the Regulations to be changed to ensure that initial and conversion courses are both accredited by a higher education institute.

- ➢ Linked to this are concerns over the potential for creating what some stakeholders have called "a two tier-ed approach to approval" where one set of AMCPs are seen to be "more qualified" than another, depending on the training route (initial / conversion) they come through.

  "We strongly disagree with the proposal…that the approval for conversion training is not a course of higher education. Whilst Welsh Government state that their policy intention is that the term 'qualified' AMCP will be used rather

than ‘accredited’ AMCP (which could only be used having undertaken a course of higher education) the Workforce and Training Plan refers to accredited and non-accredited AMCP training. In consultation with BIAs the strong perception is that this creates a 2-tier system that equates to more experienced and knowledgeable staff [having]…a lower-level qualification which will not provide credits towards further qualification (for example under CPEL).” (Local Authority)

50. Responses also included:

- **Views on initial training and support for this being accredited.** Support for the approach of initial training being a course of higher education (and also with the approach that best interests assessors can undertake the conversion training). However – others raised concerns that some professions may find the training requirements too onerous and may be “put off” if it is too academic.

- **Views on Welsh Language.** Welsh Language skills need to be developed to ensure that there is a sufficient number of AMCPs who can speak Welsh.

- **Issues in relation to cross border working.** Questions posed around whether a Welsh BIA (who does not have the recognised qualification that England currently require) who converts to an AMCP will have their qualification recognised in England.

Question 9 With specific reference to further training do you agree with:

i. the proposed requirement to carry out 18 hours of further training each year?

51. 53 responses answered this question (see Figure 9a). Two thirds of responses (66%) either strongly or somewhat agreed with the proposed requirement to carry out 18 hours of further training each year (see Figure 9b). A fifth of responses (21%) somewhat disagree. The majority of responses that agree with the proposed requirement were from third sector organisations, local authorities or individuals. Those who disagree were from health boards or NHS organisations.

52. Seventeen responses strongly agreed and 18 somewhat agreed with the proposed requirement to carry out 18 hours of further training each year. None of the responses strongly disagree, but eleven somewhat disagree.19 responses did not provide an answer to this question.

Figure 9a

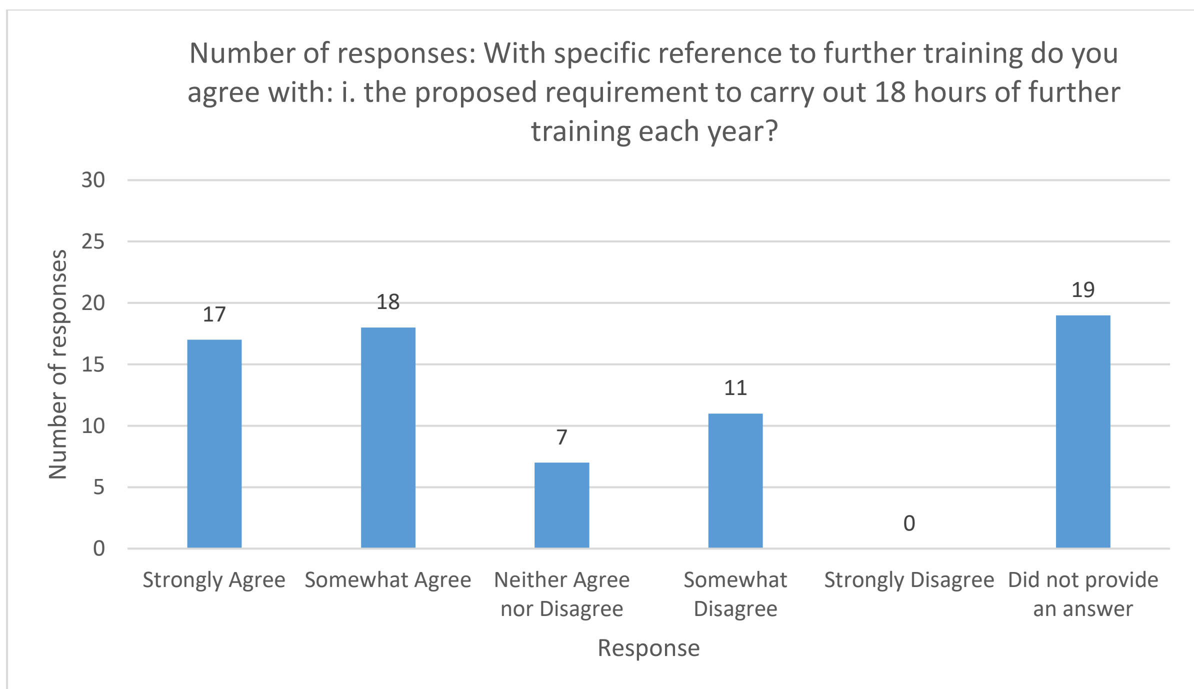
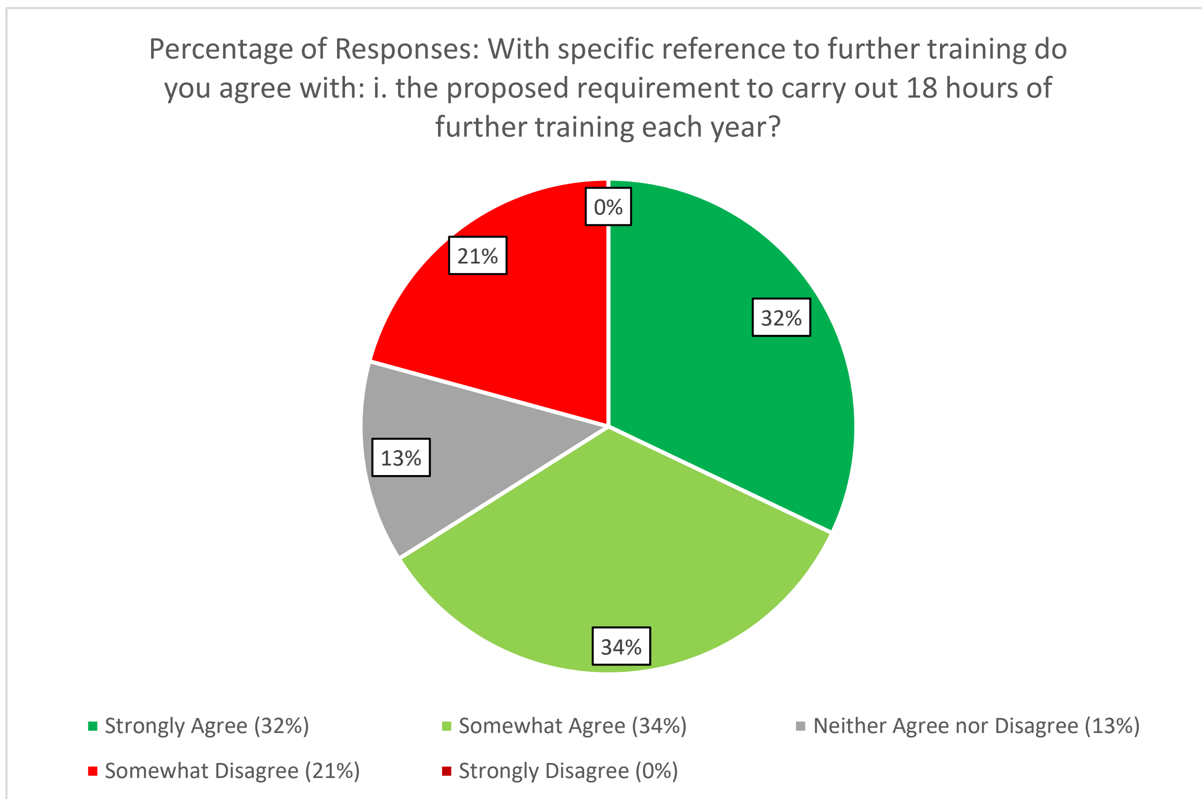


Figure 9b



53. Common themes were:

- **Mixed views on the proposal of 18 hours of further training annually for AMCPs.**

➢ Some responses stated that 18 hours was reasonable, while others stated it was too onerous. Others commented that 18 hours was not enough given the complexity of the role.

➢ There were also calls for the Regulations to mirror the AMHP Regulations more closely and "require a limited maximum approval time and then a re-approval process that will take training into account and not prescribe the amount of training expected on an annual basis, but over the course of the approval period" (Consortium Response – Health Board and Local Authorities).

➢ Some responses stated that mandated hours were unnecessary. The focus should be on demonstration of competence through reflective learning rather than set number of hours.

➢ Calls for further detail on what the 18 hours will involve (see theme below on further clarity needed).

ii. **the content of further training being non-accredited and approved by either Social Care Wales or a local authority in Wales?**

54. 51 responses answered this question (see Figure 9c). Less than half of responses (45%) strongly or somewhat agree to the content of further training being non-accredited and approved by either Social Care Wales or a local authority in Wales (see Figure 9d). Just over a third of responses (35%) either strongly or somewhat disagree. The majority of responses that are in agreement were from local authorities, whilst it was mostly health boards / NHS organisations or third sector organisations who disagree.

55. Nine responses strongly agreed and 14 somewhat agreed with further training being non-accredited and approved by either Social Care Wales lor a local authority in Wales. Five responses strongly disagreed and 13 somewhat disagreed. 21 responses did not provide an answer to this question.

Figure 9c

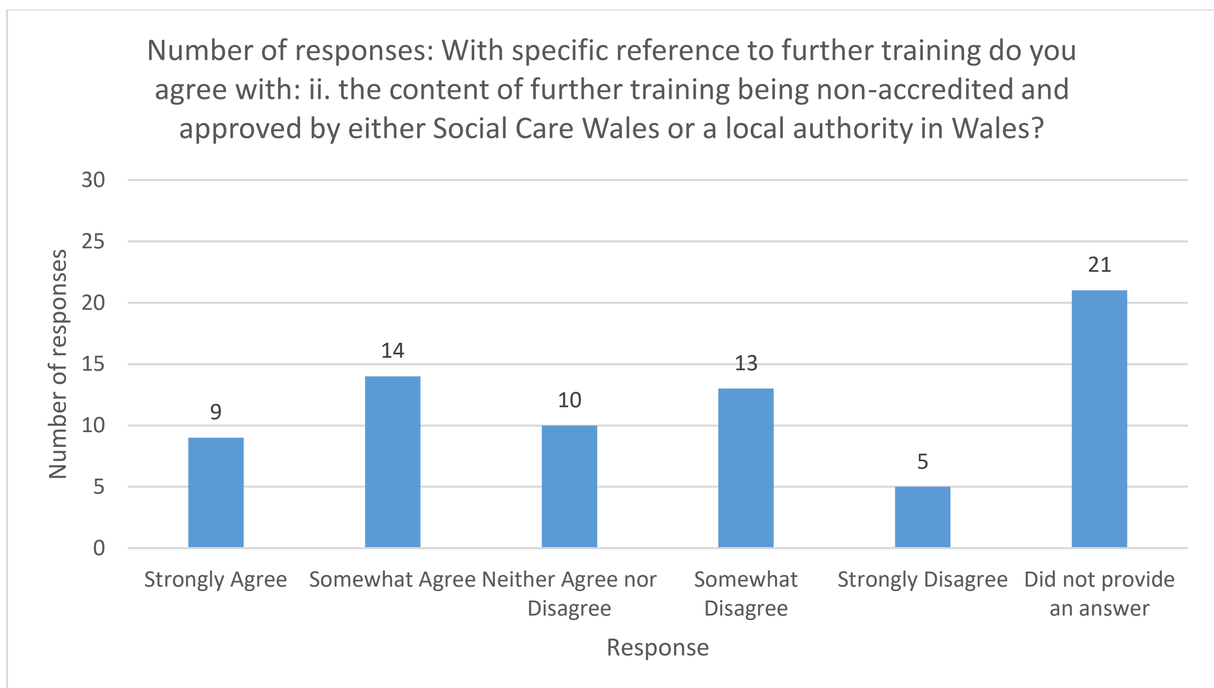
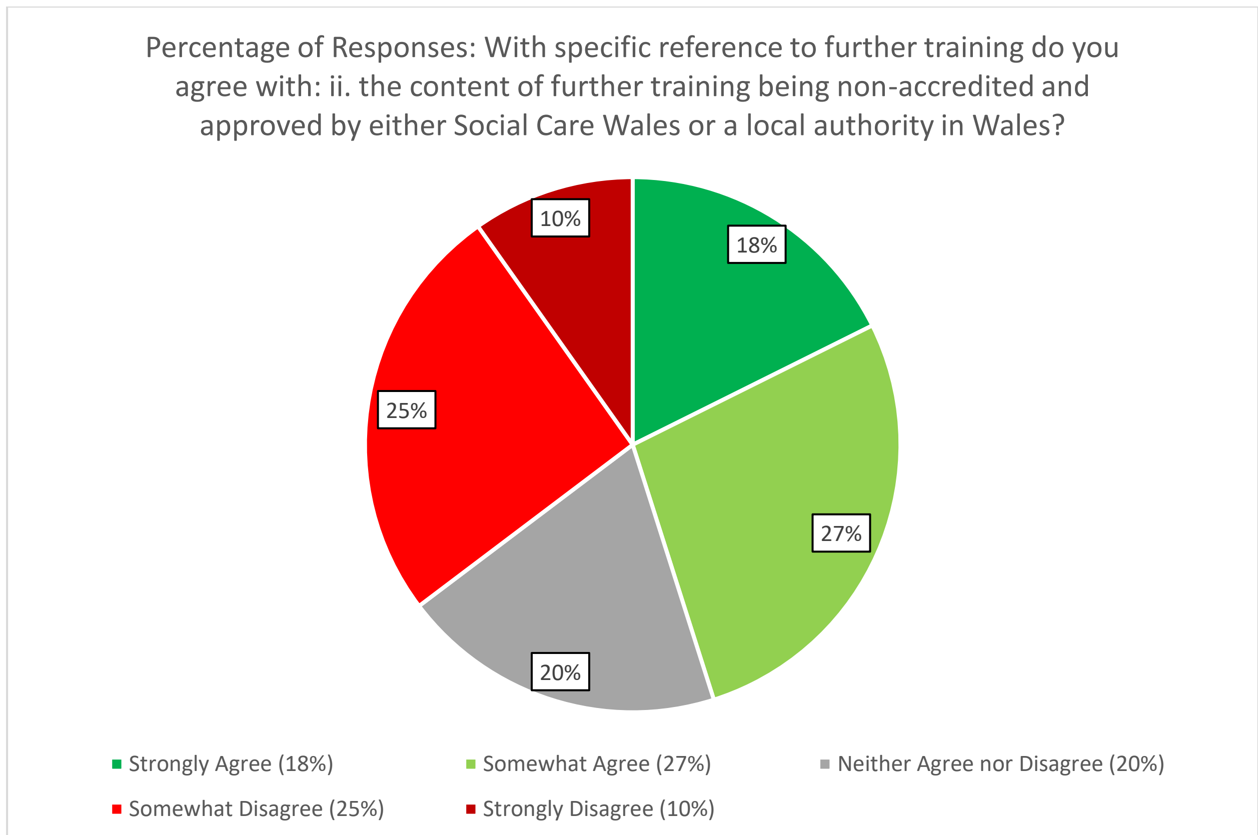


Figure 9d



56. Common themes were:

- **Mixed views on the content of further training being non-accredited and approved by either Social Care Wales or a local authority in Wales.**

➢ Support for the proposed approach amongst some responses. No accreditation needed. Instead, minimum standards and consistency in the training provided seen as sufficient. Approach seen as responsive / agile / adaptable. As one response noted: "There should be flexibility in training provision – accredited training would be limited to [HEIs] to deliver, which cannot be arranged quickly or be adapted according to emerging themes or needs." (Health Board)

➢ Strong support for health boards to also be able to approve training.

➢ Others (more than 15 responses) called for training to be approved by an independent body, while others commented that Social Care Wales should review and approve all further training developed by local authorities.

- **Specific concerns raised around local authorities being able to approve the 18 hours of further training and how this would lead to inconsistencies and no standardised approach to training provision.**

- Concerns were raised in relation to “governance and standardisation” if 22 individual local authorities are able to approve further training (Professional Body).

- **Views on the content of further training being non-accredited and approved by either Social Care Wales or a local authority in Wales: Disagreement with non-accredited training.**

- Strong support for further training to be accredited, with responses stating this would ensure standardised provision and that standards are maintained.

- Accredited training seen as particularly important given that the AMCP role has “additional responsibilities and there are requirements to maintain competence” (Individual Response). In addition: “Accreditation would support in revising job descriptions and ensuring staff have the correct skills for their role requirements” (Individual Response).

  “All Wales training approach would support consistent quality and staff moving across organisations. Training should be accredited and managed by Social Care Wales to prevent variation or dilution in quality. Alternatively could HEIW be considered as one of the organisations.” (Health Board)

- Other comments included that a proportion of the 18 hours should be accredited by a Higher Education Institute.

- **Standardised approach seen as key – regardless of whether the further training is approved by Social Care Wales or Local Authorities**

- Calls made for a set of training standards.

- Also, training needs to be recognised as valid Continuing Professional Development (CPD)**.**

- **Further clarity needed in relation to the 18 hours of training.**

- Responses commented on a lack of clarity in relation to the training itself for example: “It is unclear what would constitute '18 hours further training' will this be a specific course for renewal each year or will this be for the AMCP to make their own arrangements and identify training which they deem appropriate?” (Health Board).

- Questions posed around whether the training will need to be completed as a “block”.

- **Concerns over time and resources needed for training (more than ten responses).**

- Requests for the training requirement to be assessed over a three year period with competency observations and self directed learning.

Question 10 Do you agree the draft Regulations should enable local authorities to work together with their partners to put in place regional or national arrangements for the approval of AMCPs?

57. 55 responses answered this question (see Figure 10a). Nearly three quarters of responses (72%) strongly or somewhat agree that the draft Regulations should enable local authorities to work together with their partners to put in place regional or national arrangements for the approval of AMCPs (see Figure 10b). Nearly a quarter of responses (24%) neither agree nor disagree, and just 5% somewhat disagree. Of the responses that agree to some extent, the majority were from third sector organisations.

58. 16 responses strongly agree and 23 somewhat agree that draft Regulations should enable local authorities to work together with their partners to put in place regional or national arrangements for the approval of AMCPs. Only three responses somewhat disagree and 13 neither agree nor disagree. 17 responses did not provide answer to this question.

Figure 10a

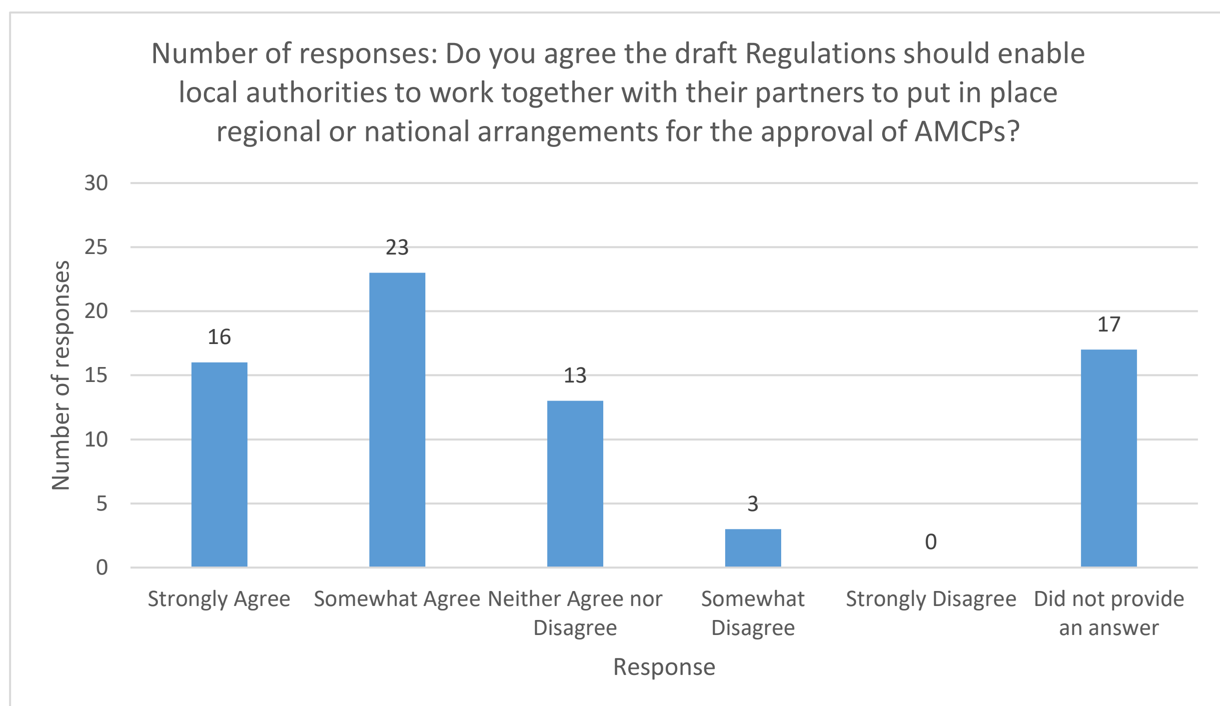
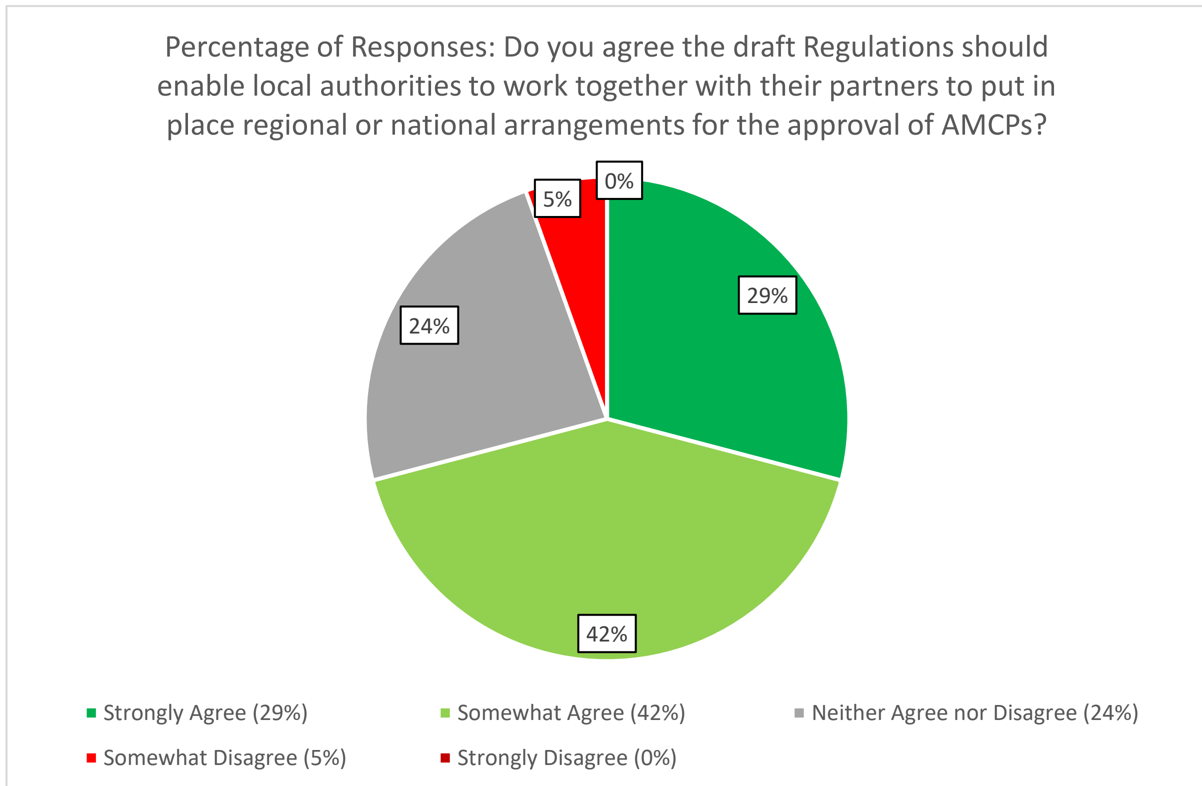


Figure 10b



59. Common themes were:

- **Support for the proposed approach (more than ten responses) and how the Regulations should enable local authorities to work with partners to put in place regional or national arrangements for the approval of AMCPs.**

➢ This allows for more flexibility as long as agreed arrangements are fully understood by all parties.

➢ Regional arrangements are essential where a health board area is covered by more than one local authority. They will enable a collaborative approach.

➢ The approach supports and enables better workforce mobility. Professionals may move across different locations and so a consistency of approach across regional and national partners would be helpful.

➢ The ability for local authorities and their partners to work together will assist those regions with a significant rural population. Also, if local authorities and health boards are pooling resources it enables AMCPs to work within health board boundaries and to ensure that independence of the AMCP can be ensured.

- A compulsory move to a regional or national resource without adequate discussion would not be helpful. Flexibility needed for where it may be possible.

- Potential to use existing Regional Partnership Board and Public Services Board arrangements and clearly set out involvement of Third Sector Organisations and other partners.

- **Calls for a regional approach to collaboration.**

- Welsh Government should endorse a regional arrangement for the approval and functioning of AMCP teams. This would create a unified approach across Wales.

- Concerns raised around arrangements in practice and suggestions made for an amalgamated team approach for delivery.

- **Calls for a stronger mandate regarding collaboration between partners and for this to be set out in the Regulations.**

- A national approach to co-operation should be prescribed in Regulations.

- Responses suggested that requiring this type of co-operation would be more helpful than simply enabling it.

- Concerns raised around arrangements in practice and suggestions made for an amalgamated team approach for delivery.

- **Calls for further information / guidance on how this would work in practice.**

- Guidance on the expectations of Welsh Government would be beneficial.

- Requests further information and discussion on national arrangements for the approval of AMCPs – for example standardised approval arrangements and requirements to provide consistency regionally or locally.

- There needs to be consistency in relation to job descriptions / grades. Calls for this to be provided at a national level.

60. Responses also included:

- **Views on resource impacts.** Concerns raised about the resource implication and ability to recruit and retain AMCPs (including those with Welsh and other languages). A regional / national approach to the approval and functioning of AMCPs could assist in Welsh Language AMCP allocation and provision. There will need to be a local or regional plan in terms of workforce planning

and training sufficient numbers of AMCPs for each area. It was also noted that AHPs should be fully involved in these discussions at an early stage to opportunities to expand the workforce are not missed.

Question 11: Do you agree that the draft Regulations on monitoring and reporting are clear and sufficient?

61. 54 responses answered this question (see Figure 11a). Two thirds of all responses (67%) either strongly agree or somewhat agree that the Regulations are clear and sufficient (see Figure 11b). There was broad agreement to this question across the responses from local authorities, heath boards, or NHS organisations, as well as individuals or third sector organisations. The majority of responses that disagree were from individuals or third sector organisations.

62. 12 responses strongly agree and 24 responses somewhat agree that the Regulations on monitoring and reporting are clear and sufficient, while four strongly disagree and five somewhat disagree. 18 responses did not provide an answer to this question.

Figure 11a

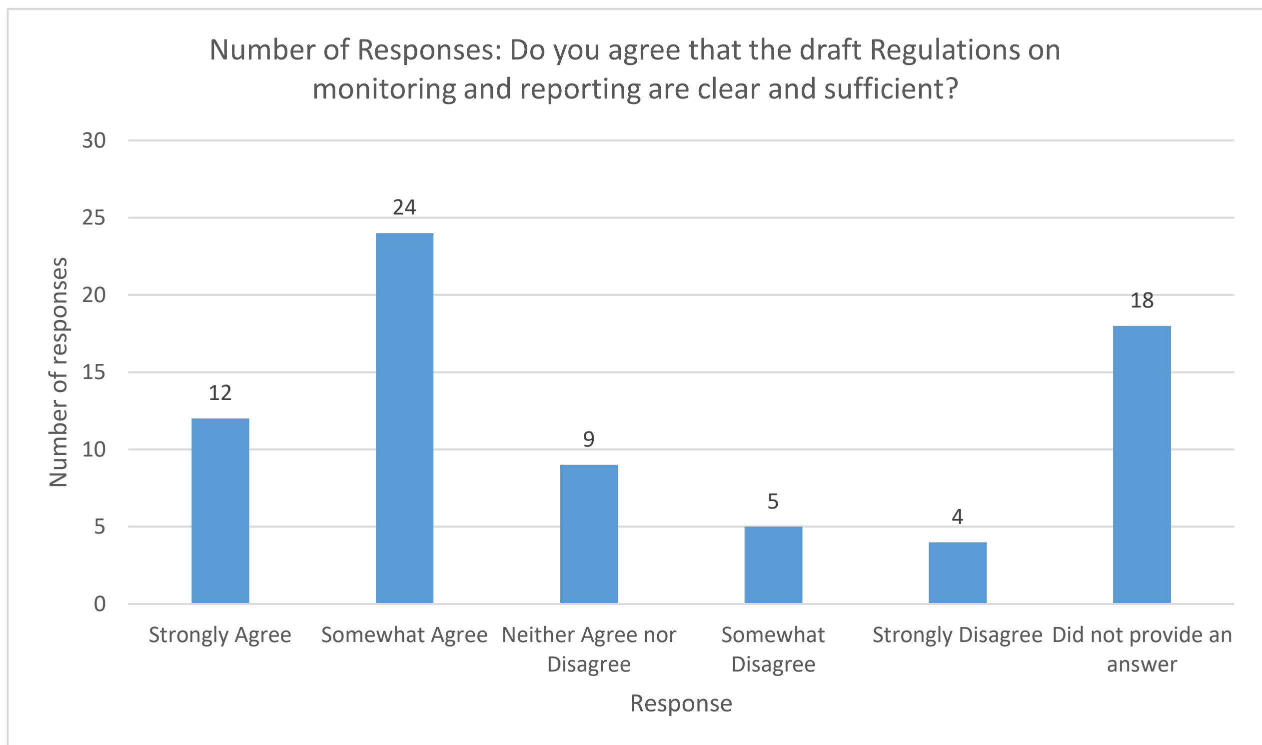
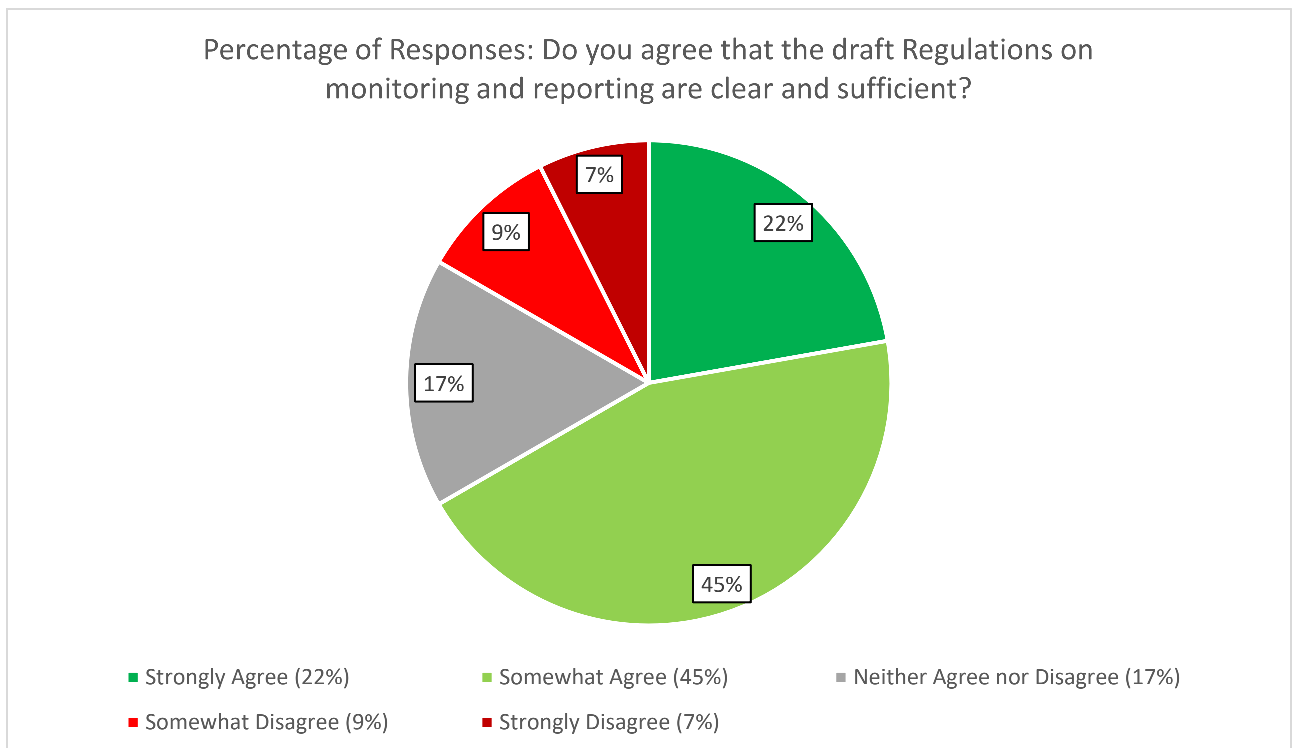


Figure 11b



63. Common themes were:

- **Overall support for the named Monitoring Bodies.**

  - There was overall agreement that CIW, HIW and Estyn should be the Monitoring Bodies in Wales and there was also support for quarterly reporting by the Responsible Bodies. Respondents agreed that monitoring and reporting on the LPS will be a safeguard in and of itself.

- **Calls for further clarification of specific issues (raised in more than ten responses)**.

  - A number of responses stated that the Regulations for Wales do not currently specify the frequency of the proposed notifications / reporting on the National Minimum Data Set. There were also calls for clarity around when the Responsible Bodies need to notify / provide information to the Monitoring Bodies. (To note: this is set out in the draft Monitoring and Reporting Strategy.)

  - Concerns were expressed that duplication may occur as there are already duties for providers to notify CIW and HIW under the Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA).

  - Clarity needed on which Responsible Body will report to the Monitoring Body when the cared for person is living in their own home.

- Clarity needed on the definition of when the LPS process is triggered.

- Concerns were raised that there is no provision in the draft Regulations covering monitoring and reporting on Section 4B (deprivation of liberty and authorisation of steps necessary for life-sustaining treatment or vital act).

- Some felt that the Regulations could be more robust: particularly in terms of how the work of professionals involved with the LPS will be "managed and checked" with calls made for more information to be shared on this.

- **Views on implementation.**

  - Concerns were raised that monitoring and reporting will only take place where someone has identified a potential deprivation of liberty and the need for this to be authorised.

- **Calls for further work to improve the data items referenced in the Regulations**.

  - Some respondents stated that the Regulations should include data items that are designed to improve the operation of the LPS and associated outcomes.

  - There were also calls for data items to monitor whether scheduled reviews happen and whether requests for reviews are accepted and the timeframe between requesting a review and getting one.

64. Responses also included:

- **Views that it is difficult to say if the Regulations are sufficient**. Responses said that time was needed to implement the change, as well as transparency in relation to proposed monitoring and reporting.

- **Comments that the monitoring and reporting measures being proposed are too onerous, with stakeholders commenting on the additional burden they will place on health boards and local authorities**. Concerns were raised that the processes underpinning the Regulations could mean reverting back to a "DoLS type referral and coordination process" to ensure data are captured. Concerns were also raised over the frequency of proposed quarterly reporting (set out in the draft Monitoring and Reporting Strategy). This is in contrast to other stakeholders who supported the proposed approach.

- **Views regarding vulnerable adults and young people**. Concerns were raised around how young people will be protected and supported to ensure they do not feel obliged to consent to meeting with the Monitoring Bodies. Responses stated that there needs to be a specific focus on children and young people as part of monitoring and reporting.

- **Comments that further detail is needed in the Regulations on the role of the Responsible Body in relation to monitoring and reporting.** The Regulations do not include enough of an emphasis on the role of the Responsible Bodies in relation to ongoing monitoring and reporting.

- **Specific issues in relation to data collection and reporting, and data sharing**. There was support for a “live” reporting mechanism to support ongoing monitoring and reporting. However, questions were posed around data sharing between Responsible Bodies and the Monitoring Bodies.

- **Views on meeting with the cared for person and taking a best interests decision**. Concerns were expressed regarding the proposal that a Monitoring Body could be involved with a best interests decision on whether Monitoring Bodies should meet with the care for person. Respondents felt that this creates a conflict of interest due to the lack of independence.

- **Comments that Regulations need to be strengthened in terms of provision for monitoring and reporting on Welsh Language and the extent to which the LPS is supporting Welsh speakers**. Concerns were raised that the current monitoring of DoLS by CIW and HIW does not adequately consider the availability of Welsh language services. As part of plans for monitoring and reporting on the LPS, calls were made for a thematic review of the extent to which the operation of Schedule AA1 “is taking place successfully for Welsh speakers”.

Question 12 Do you agree the consent based approach we are proposing to monitoring and reporting reflects people's rights and provides adequate safeguards?

65. 53 responses answered this question (see Figure 12a). Over three quarters of responses (82%) either somewhat or strongly agree that the consent-based approach we are proposing reflect people's rights and provide adequate safeguards (see Figure 12b). The majority of those who agree were from third sector organisations, health boards or NHS organisations, or individuals. Those who disagree were from either third sector organisations or local authorities.

66. 20 responses said that they strongly agree and 24 somewhat agree that the consent-based approach reflects people's rights and provide adequate safeguards. Four responses either somewhat or strongly disagree. 19 responses did not provide an answer to this question.

Figure 12a

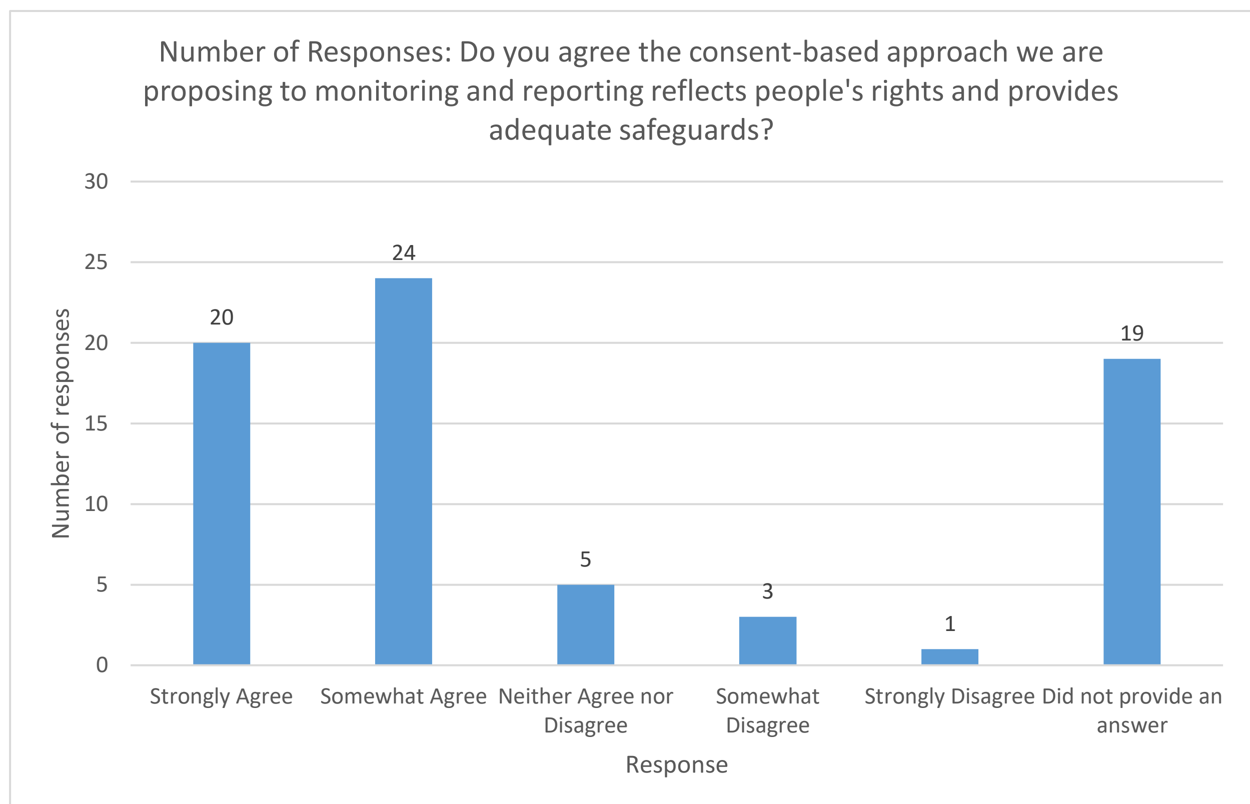
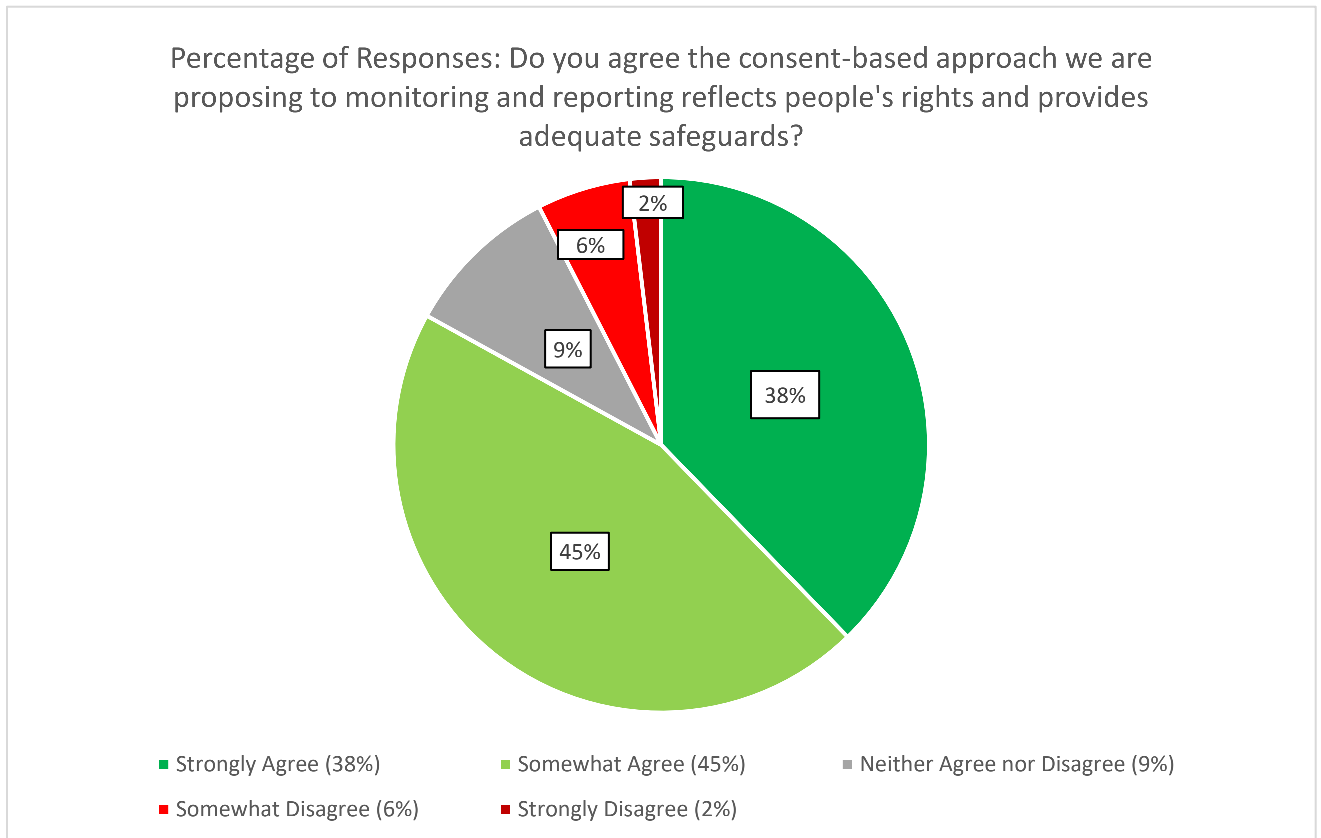


Figure 12b



67. Common themes were:

- **Support for the approach: Seeking consent from the cared for person is appropriate and vital (raised in more than ten responses).**

  - Arrangements appropriately balance Article 5 and Article 8 of the Human Rights Act 1998 and European Convention on Human Rights.

  - Seeking consent is not something new – and should always be at the forefront of all practice.

  - Without consent, there should always be a best interest decision.

  - A consent-based approach supports human rights.

- **Lack of support for the approach, particularly in relation to the use of a best interests decision (raised in more than ten responses).**

  - Unrealistic to take forward a consent-based approach. Questions posed around how a best interests decision can be made to agree/allow an unknown person enter the private property of a person who is suffering

from an impairment/disturbance of the mind or brain to discuss their care / support for monitoring purposes.

- Proposals impinge on an individual's private life (Article 8) and do not protect the person's rights.

- If a person lacks capacity to consent to having a Monitoring Body enter their home to meet with them, then this should not be determined by a best interests decision.

- **Calls for greater clarity (raised in more than ten responses).**

  - Questions posed around what happens if the cared for person does not consent to allow the Monitoring Body to visit.

  - Uncertainty on how inspectors will be able to justify entering domestic dwellings where they only regulate the regulated providers.

  - Support for the consent-based approach – however, the process should not differ from current arrangements where a person receiving services in their home would require a visit from inspectors.

  - Insufficient detail in the draft Code of Practice or consultation document as to how the Monitoring Body would document and record consent prior to any best interests meeting.

- **Questions posed around how the consent-based approach would work in practice (raised in more than ten responses).**

  - Unclear who would be responsible for determining capacity to give consent and deciding on someone's best interests if they lack capacity to consent.

  - Balancing Article 5 and Article 8 rights in domestic settings – the threshold for consent feels lower than the threshold for consent in care settings.

  - Careful consideration and reflection needed once in practice: real life scenarios should be reviewed in order to ascertain how workable and proportionate these are, with feedback from the cared for person and their families taken into account.

  - Who will make contact with families when a regulator wishes to visit if they are subject to an LPS? Need to consider the impacts of this on families if they are not known to them. Sensitive engagement needed – particularly in terms of engaging with families where they may not realise the care and support in place amounts to a deprivation of liberty.

  - The best interest assessment needs to be proportionate and not overly cumbersome.

- Concerns that the voice of the person will not be heard.

- Power of Attorney role – and whether this will allow relatives or friends who hold that role to consent to a visit from the Monitoring Bodies.

- Questions were also posed around who would provide consent under certain situations. For example – where people share tenancies.

- Also, calls for clarity around “deputyships not giving consent” (Health Board / Consortium / Local Authority).

68. Responses included:

- **Comments that the role of the IMCA in supporting the rights of the person will be critical**. If a cared-for person does not have capacity to consent to a Monitoring Body seeking permission prior to their visitation, then an IMCA must be contacted to reflect that person’s rights and provide adequate safeguards.

- **Concerns regarding the involvement of the Monitoring Body in the Best Interests decision to visit the person if they were unable to consent.** Concerns were expressed that this would mean there was no independence. Others stated that the Monitoring Body should take the lead in making the best Interests decision.

Question 13: Do you agree the Regulations protect the rights of the person and service users?

69. 55 responses answered this question (see Figure 13a). Just over three quarters of all responses (78%) either strongly agree or somewhat agree that the Regulations protect the rights of the person and service users (see Figure 13b). There was overall agreement across all sectors including local authorities, health boards or NHS organisations, third sector organisations or individuals. Five of the nine responses that somewhat disagree or strongly disagree were from local authorities or health boards.

70. 15 responses strongly agree and 27 responses somewhat agree that the Regulations protect the rights of the person, while three strongly disagree and six somewhat disagree. 17 respondents did not provide an answer to the question.

Figure 13a

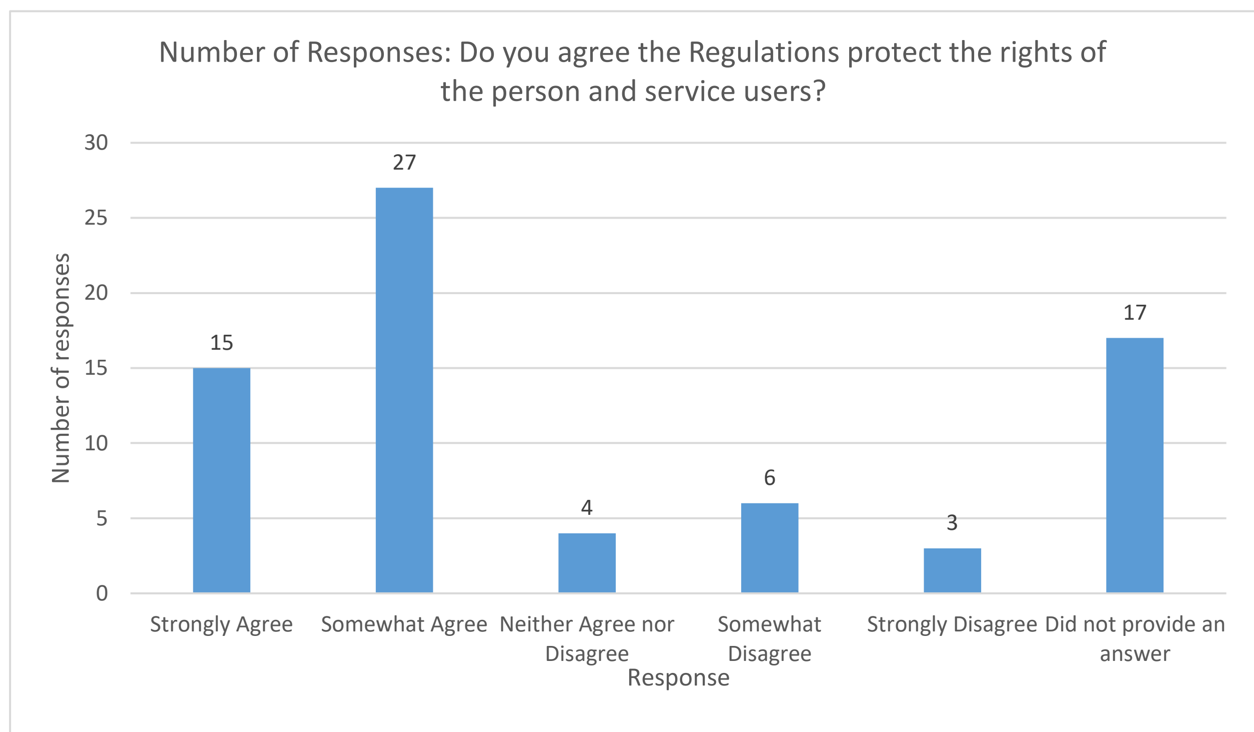
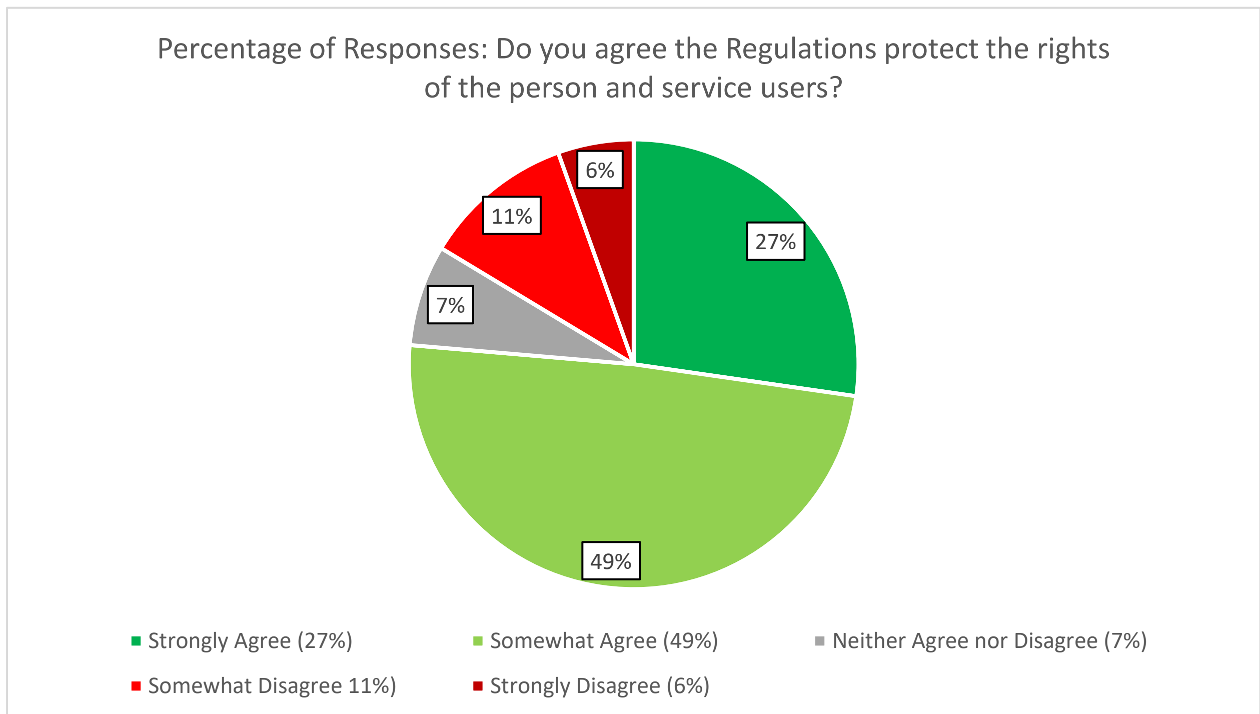


Figure 13b



71. Common themes were:

- **Support for the Regulations and how they protect the rights of the cared for person**.

    - The Regulations will ensure the Mental Capacity Act and the Human Rights Act are more embedded into core practice which will support the rights of citizens.

    - The Regulations "go a long way to protect the rights of the person" (Third Sector Organisation) but caveats also raised.

    - Investment is needed to embed the principles of the Mental Capacity Act into care, support and treatment planning. Training, support and resources to support implementation are all crucial.

- **Concern that the Regulations do not support the rights of the cared for person.**

    - Rights to advocacy are weaker under the LPS than what was originally proposed by the Law Commission – which in turn has an impact on people's rights.

    - Suggested amendment to the IMCA Regulations to ensure that IMCAs are consulted if the cared for person is unable to consent to meet with the Monitoring Body.

- LPS assessments seen as invasive: impacts for families and the cared for person.

- Calls for a more robust approach to how decisions and assessments are ratified, and for greater clarity in relation to accountability measures if something goes wrong.

- Concern expressed that the workforce may decide not to undertake training which would then undermine how the Regulations are supposed to support the rights of the person (this links to calls for mandated training).

- People living with dementia without a support network will struggle to find the correct support and will struggle to navigate the LPS system.

- **Concerns regarding the Code of Practice and how this is does not protect the rights of the cared for person.**

    - Specific concerns raised in relation to the definition of a deprivation, set out in Chapter 12 of the Code of Practice.

    - The rights of the person and service users can only be protected when there is a clear definition of what is classed as a deprivation of liberty. Respondents “not convinced we have achieved that within the proposed legislation”.

    - The Acid Test appears to be altered which questions if the safeguards will be at a level required or as Cheshire West intended.

    - The new interpretation of the Acid Test takes many vulnerable people who lack capacity out of the reach of Article 5, yet still allows for intensely restrictive care with no right to appeal or independent scrutiny.

    - Concerns raised that some people will not come under LPS (whereas they would come under DoLS). This means they will not be offered the same right to appeal and have their case heard in court.

    - Concerns raised in relation to people who may not meet the “threshold” which would result in a deprivation of liberty being authorised. Greater clarity needed on this as there may still be restrictive practice taking place.

    - Regulations do not support and protect the rights of the individual as the Code of Practice states that a formal diagnosis is not needed for the mental capacity assessment.

    - The Code of Practice needs to include scenarios indicating how best interests and necessity/proportionate assessments under the LPS framework embrace aspects of positive risk-taking. The risks averted by depriving a person of liberty often creates risks to Article 8 rights (in particular – the cared for person’s choice about where they want to live). Calls for this to be made explicit in the Code of Practice in order that the

risks involved in an unwanted move to a secure setting are made explicit and appropriately weighed in the balance.

72. Responses also included:

- **Views on legislative frameworks:** The safeguards of the Mental Capacity Act 2005 do not protect people as much as other legislative frameworks such as the Mental Health Act 1983.

- **Concerns that the Regulations on undertaking assessments and determinations do not support the principles of the Mental Capacity Act.** Those who know the person best and are involved in their care, support and treatment are prevented from completing the assessments (e.g. Code of Practice states those undertaking the assessments should not be part of the same team that provide the care for the person). Some responses stated that the medical assessment model seems to replicate the role of a Section 12 doctor rather than keeping it to people who know the patient best and are caring for them.

- **Comments regarding the Welsh Government Framework for Reducing Restrictive Practice and using this in conjunction with the new LPS process**. This will ensure that any restrictions on people's liberties are kept to a minimum and are the least restrictive methods possible.

- **Concerns that the Regulations do not adequately protect the rights of the person in relation to the Welsh Language**. Regulations are not robust enough in identifying and providing for the need for services through the medium of Welsh.

- **Views that more is needed to support the cared for person and their families to help prepare for change.** The cared for person should always be at the centre of the process. Concerns were raised that the process itself might cause distress and fear amongst families. Responses stated that more effective and accessible communication is key to ensuring people know what to expect from the process and their rights.

- **Concerns raised in relation to protecting the rights of young people.** Questions posed around how the LPS will uphold the rights of young people who use secure services and how the LPS aligns with other legislative frameworks. Concerns raised that the LPS will offer fewer protections for these young people. The role of the workforce is critical in supporting the rights of children and young people. The LPS workforce needs to be able to understand and meet the needs of 16 and 17 year-olds as this cohort was not previously covered by DoLS legislation. The LPS workforce will need to have an understanding of children's human rights under the United Nations Convention on the Rights of the Child as well as rights under the Human Rights Act and consideration of the United Nations Convention on the Rights of Persons with Disabilities.

Question 14 Do you agree with our assessment of the financial costs and benefits / impacts of the LPS Regulations set out in the draft Regulatory Impact Assessment (RA)?

73. 47 responses answered this question (see Figure 14a). Just under a third of responses (32%) say they somewhat or strongly agree with our assessment of the financial costs and benefits of the LPS Regulations set out in the RIA (see Figure 14b). However, just under half of all responses (45%) somewhat or strongly disagree with our assessment of impacts. The majority of those who agree were from third sector organisations or individuals, whilst those who disagree were mostly from health boards or local authorities.

74. Six responses strongly agree and nine somewhat agree, eight responses somewhat disagree, and 13 strongly disagree, whilst 11 responses said that they neither agree nor disagree. 25 responses did not provide an answer to this question.

Figure 14a

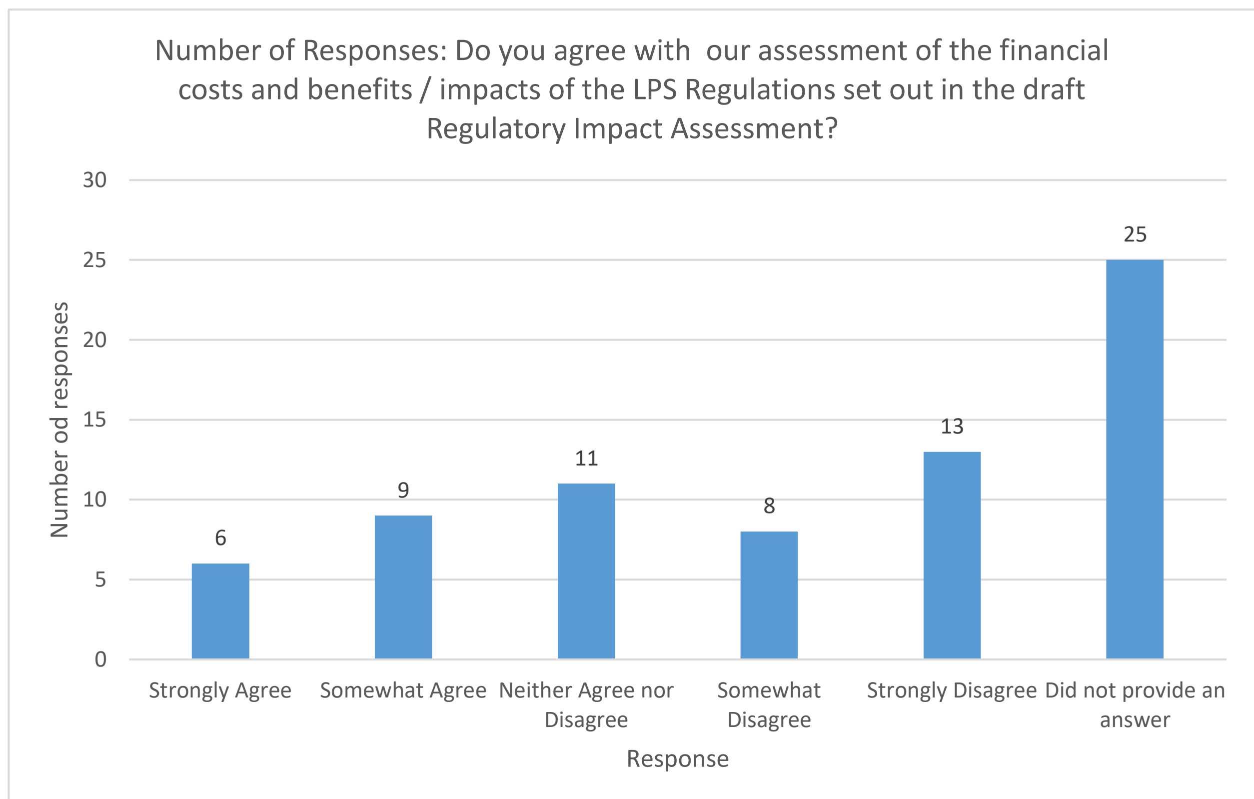
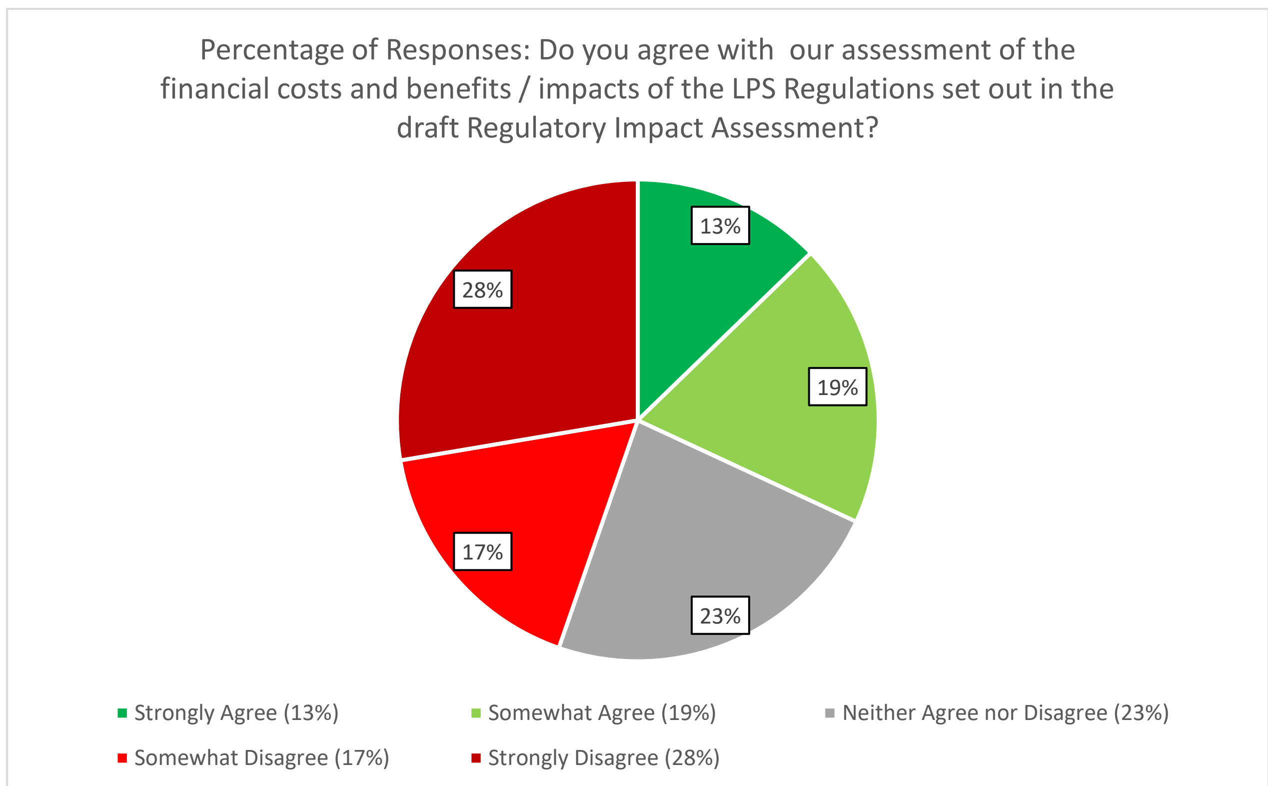


Figure 14b



75. Common themes were:

- **Disagreement with the Welsh Government's assessment of costs in Wales (raised in more than 15 responses).**

  - Funding proposals for the LPS set out in the RIA were seen as unrealistic and inadequate.

  - There has been an underestimation of costs and impacts on workforce. A high turnover of staff across the LPS workforce could directly impact on implementation costs.

  - Concerns expressed that the LPS proposals will result in a similar situation to 2015/16 – where "Local Authorities will be unable to manage the demand for an unknown quantity of authorisation requests and where we lack the necessary resources and systems to be able to respond in a timely way to LPS requests" (Local Authority).

  - LPS proposals will not reduce the amount of work that needs to be carried out.

- **Comments made in relation to the use of repeat assessments / equivalent assessments (raised in more than ten responses).**

- Mental Capacity Assessments: disagreement with estimates that a new capacity assessment will be required in 40% of cases. This assumption also contradicts the principles of the MCA and mental capacity assessments needing to be decision and time specific.

- Medical Assessments: The resourcing and availability of professionals to complete the medical assessment has been underestimated. Concerns raised regarding the assumption that 80% of people will already have a diagnosis. Responses stated there would be significantly more than 20% requiring a new medical assessment. Responses highlighted that these assessments “are not part of the usual routine work of medical practitioners or psychologists”. Also: Disagreement with the £121 estimate for a medical assessment. GPs are unlikely to undertake the assessments given current caseloads, with responses also highlighting that a Section 12 doctor will be needed to complete the assessment, who charge £180 minimum. No recognition of impacts on costs for undertaking assessments where GPs are not involved.

- Necessary and Proportionate Assessments: Disagreement regarding the amount of time that will be needed to undertake these assessments and therefore the RIA underestimates associated costs.

- **Suggestions that the RIA underestimates costs needed for advocacy (raised in more than 15 responses).**

  - This is a key theme from Question 1 of the consultation and the extent to which the IMCA Regulations are clear and sufficient. Responses consider that there has been a significant underestimate of the number of people (cared for person and the Appropriate Person) who will need an IMCA.

  - Calls were also made for all Appropriate Persons to have an IMCA – which would then further impact estimated implementation costs.

- **Issues highlighted in relation to resourcing generally and workforce capacity (raised in more than 15 responses).**

  - RIA needs to reflect the need for additional resources around Welsh Language and building capacity regarding Welsh Language workforce.

- **Significant training and upskilling required across the health and social care workforce (raised in more than ten responses).**

  - The financial costs and benefits / impacts of the implementation of the LPS Regulations in Wales are underestimated “given the scope of the regulations, increase in age, inclusion of all settings and the need to train the majority of the workforce” (Local Authority).

  - Training for certain professionals not specified in the RIA. For example: Some professionals are missing from the assessments of anticipated training costs (e.g. Speech and Language Therapists, Occupational

Therapists and Practitioner Psychologists).

- **The role of the AMCP is likely to be more significant than stated in the RIA. Anticipated costs of AMCPs are therefore likely to be higher.**

  - Disagreement with the assumption that most authorisations “should be straightforward" and that an AMCP would be needed for a “small number of cases” with some responses highlighting that a third of their DoLS referrals in 21/22 related to “objecting or complex patients who would meet the AMCP criteria”. More referrals to AMCPs also anticipated during the initial period of the implementation of the LPS.

  - Disagreement with the anticipated cost of an AMCP being involved in a case (£131). Some responses estimated it would be over £400, based on the need for three working days (21 hours) needed for each AMCP case.

- **Disagreement with anticipated costs for the conversion training for the AMCP role.**

  - Conversion training: costs have been underestimated. The role of the BIA seen as substantially different to the role of the AMCP. 12 hours training for the conversion course for BIAs seen as “grossly insufficient” and will instead require “an estimate of 54 hours training to ensure the learning outcomes required can be achieved” (Local Authority).

- **Comments that the development of supporting information and resources is critical and that this needs to be better reflected in the RIA.**

  - Specific calls made for supporting information and materials for the public, the cared for person, their families – to explain the changes.

- **Comments that it is difficult to compare / anticipate costs.**

  - Specific concerns raised in relation to the definition of a deprivation of liberty. Impossible to provide a realistic estimate of the number of LPS authorisations that will be needed at this point in time.

  - Financial costs of introducing the LPS Regulations in Wales “are difficult to judge given the ongoing pressures on services and the workforce due to Covid” (Health Board).

  - The way in which the RIA is set out and how the estimates are calculated for the implementation of DoLS and the LPS makes it difficult to assess anticipated costs.

76. Responses also included:

- **Issues / areas where further costings were required.** Specific concerns raised in relation to the transition year from DoLS to the LPS.

Question 15. Do you agree with the data items included in the draft LPS National Minimum Data Set for Wales?

77. 50 responses answered this question (see Figure 15a). Just under two thirds of responses (64%) either somewhat agree or strongly agree with the data items included in the draft LPS National Minimum Data Set for Wales (see Figure 15b). Nearly a quarter of responses (24%) said that they neither agree nor disagree with the data items and 12% somewhat disagree. The majority of those who agree with this question are from health boards or NHS organisations, whilst those who disagree are mostly from third sector organisations.

78. 15 responses said they strongly agree and 17 somewhat agree with the data items included in the NMDS for Wales. 12 responses neither agree nor disagree, and six somewhat disagree. 22 responses did not provide an answer to this question.

Figure 15a

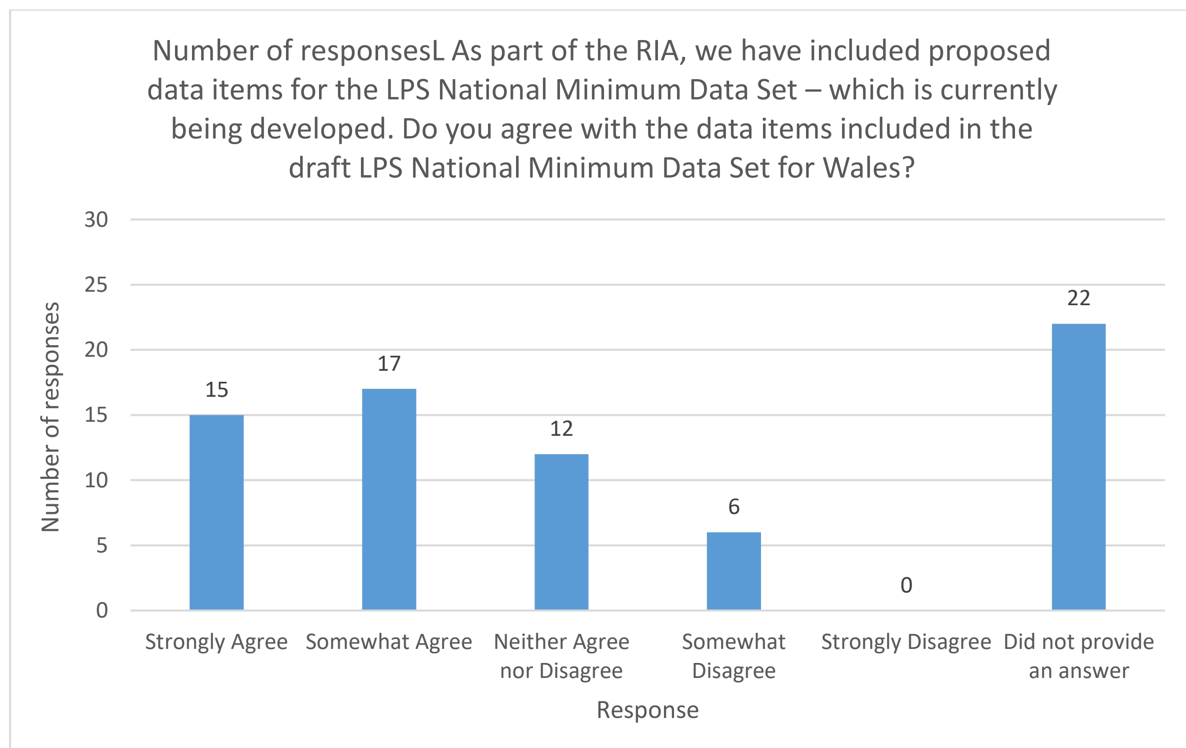
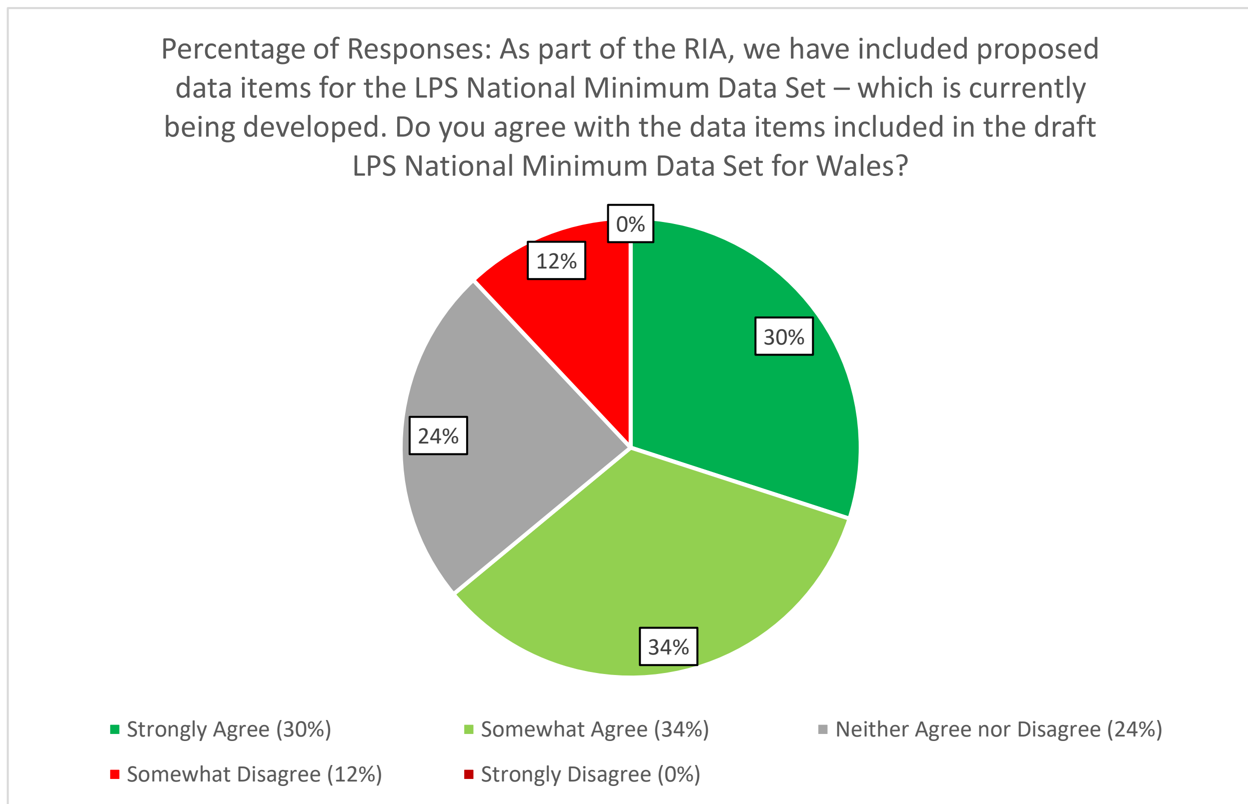


Figure 15b



79. Common themes were:

- **Overall support for the proposed data items (raised in more than ten responses).**
    - ➢ The proposed data items appear clear, comprehensive and achievable.
    - ➢ Proposed data items are similar to what is being collected currently for DoLS.
    - ➢ Support for taking a consistent approach to monitoring and reporting, and associated data items
- **Support for national systems to be able to report on the LPS.**
    - ➢ Support for the LPS data items to be included in the Welsh Community Care Information System (WCCIS), although there was also recognition that not all local authorities and health boards use this system.
    - ➢ There needs to be sufficient time to trial the system prior to implementation to make any amendments locally or share at national level.
- **Concerns expressed over impacts on local authorities and health boards and reverting back to "DoLS-type referrals" to ensure data are**

captured.

- Data collection likely to be challenging due to incompatible IT systems and insufficient resources to support reporting on the NMDS.

- **Concern over the data items being focussed on the LPS process, rather than on the outcomes for the person.**

  - Calls made for outcome-based data to be collected at the end of an authorisation period – as part of an annual research project.

  - Questions posed regarding the relevance and value of some of the data items.

- **Specific points being raised in relation to individual data items.**

  - Calls for an agreed definition of when the LPS is “triggered”.

  - Welsh Language: Changes suggested to the data item on Welsh Language so that the NMDS is not just collecting information on whether the person received a service in Welsh / preferred language. Also need to collect data on whether they were offered the service in Welsh / their preferred language. Calls were made for data to be collected on the number of assessments completed in Welsh / preferred language.

  - Support for the data items on protected characteristics. Some concerns raised regarding the relevance of the data item on sexual orientation and challenges associated with data collection. Question posed around whether collection of data will be compulsory.

  - Specific comments made in relation to the data items on the location of the LPS: with calls for greater clarity around data definitions.

  - Data item needed on variations to support ongoing monitoring and reporting.

  - Data needed on Section 4B[1] of the Mental Capacity Act 2005 and deprivation of liberty and authorisation of steps necessary for life-sustaining treatment or vital acts (see also Question 11).

80. Responses also included:

- **Views on information sharing between the Responsible Bodies and the Monitoring Bodies.** Questions posed around the implications of GDPR for

[1] Section 4B of the Mental Capacity Act 2005, as amended by the Mental Capacity (Amendment) Act 2019 gives authority to take steps to deprive a person of their liberty in three circumstances: (1) where a decision relevant to whether there is authority to deprive the person of liberty is being sought from a court; (2) where a Responsible Body is determining whether to authorise arrangements under Schedule AA1 of the Mental Capacity Act 2005; or (3) in an emergency.

data sharing.

Question 16 Do you agree with our assessment of the impacts of the LPS Regulations on children's rights set out in the Children's Rights Impact Assessment (CRIA)?

81. 47 responses answered this question (see Figure 16a). Just under three quarters of those who responded to this specific question (72%) either somewhat or strongly agree with our assessment of the impacts on children's rights set out in the CRIA (see Figure 16b). The majority of those who agree were from health boards or individuals, as well as local authorities, third sector organisations or professional bodies.

82. 18 strongly agreed and 16 somewhat agreed, whilst eleven said that they neither agree nor disagree and two people somewhat disagree with our assessment of impacts on children's rights. 25 responses did not provide an answer to this question.

Figure 16a

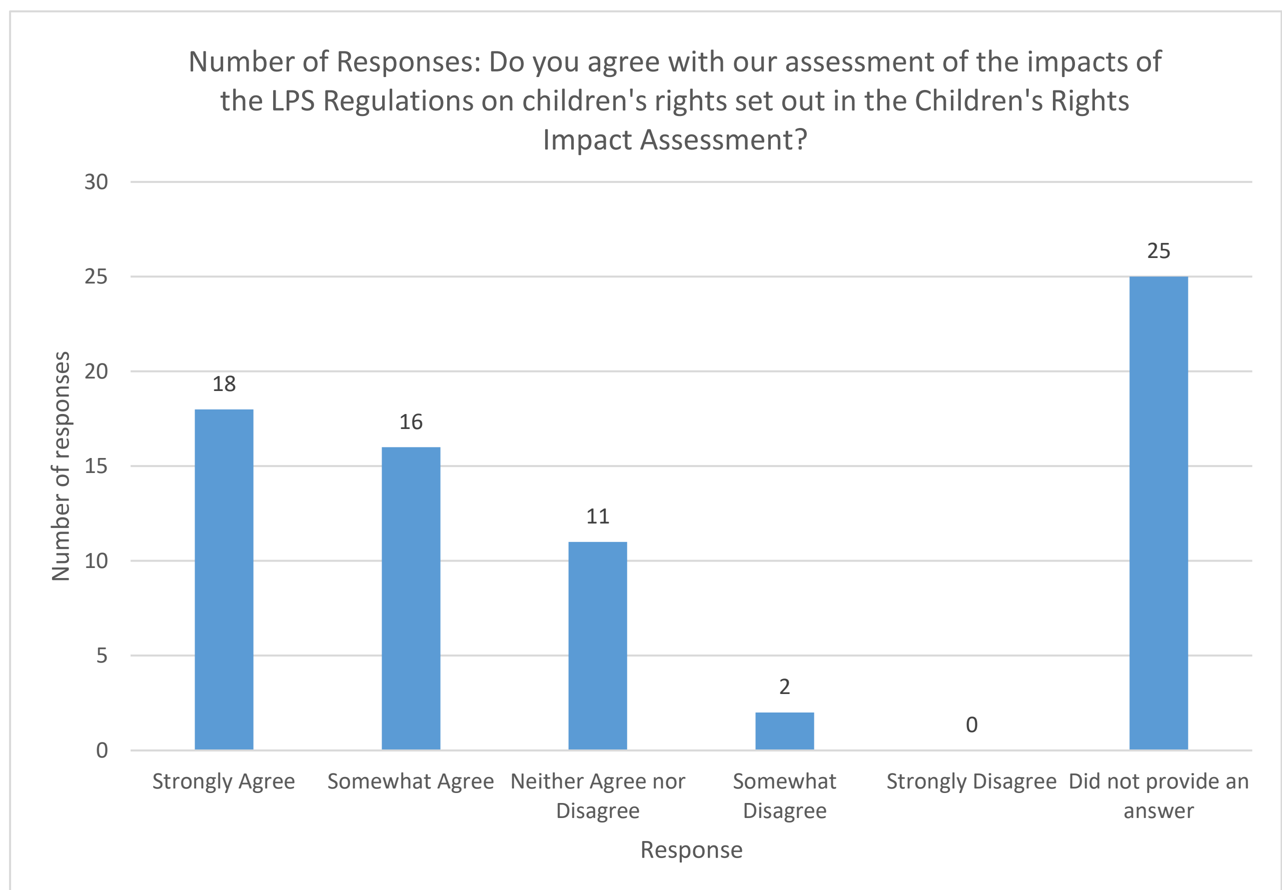
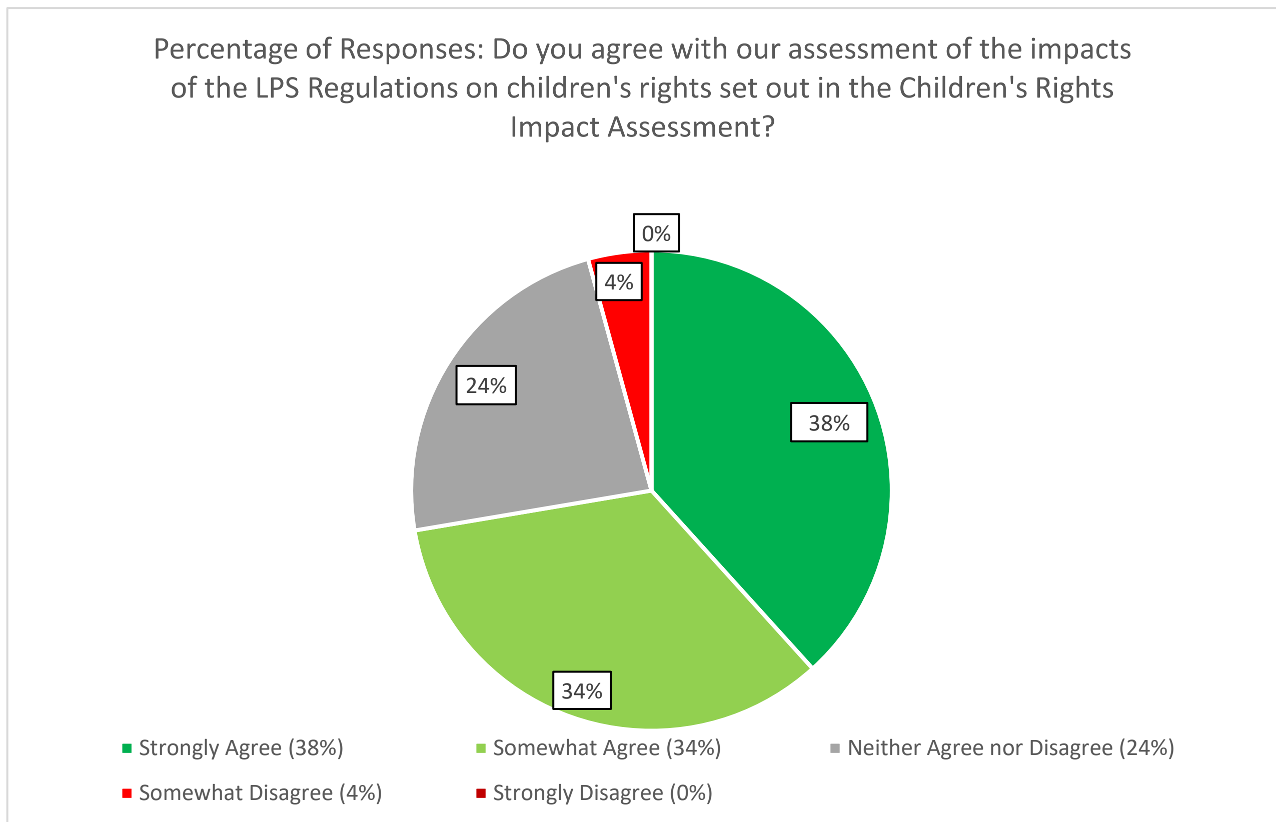


Figure 16b



83. Common themes were:

- **Broad agreement with the assessment of impacts set out in the CRIA (raised in more than ten responses).**

➢ CRIA considered comprehensive. Support for the way in which the CRIA considers all articles of the UNCRC.

➢ Agreement that the LPS will support young people to have more say in the decisions which affect them.

- **Suggested areas where the CRIA could be strengthened**.

➢ The CRIA should include an explanation of the UNCRC and its relevance earlier in the document.

➢ The CRIA could make direct reference to Articles of the UNCRC throughout the document (for example – when discussing the IMCA and AMCP roles, these could directly link to article 12 and article 13).

➢ The CRIA needs to include impacts on young people in a caring role.

84. Other responses included:

- **Concerns that the LPS will not protect the rights of children and young people.** Young people have fewer safeguards under the LPS compared to Section 25 under the Children Act 1989 and Section 119 of the Social Services and Well-being (Wales) Act 2014.

- **Comments on how the CRIA needs to reflect the importance of transitional arrangements for young people one they turn 18.** Practitioners and others need to be able to prepare the young person and those around them for any changes as their 16th birthday approaches.

- **Calls for guidance in relation to what will happen if the parents/carers opinions differ from "the professionals".** Responses stated there is very little reference to parental rights – when in most cases they will be the responsible adult for their child / young person. Therefore, clarity is needed regarding their role in best interest decisions.

- **Concerns in relation to IMCAs – and whether there is sufficient capacity to provide support for the LPS.** Similar issue raised in relation to Question 1 of the consultation.

- **Support for materials that explain the LPS to the young person and their families.** The LPS will be new for 16 and 17 year olds. The LPS could be challenging for some families. Supporting materials are therefore critical. Difficulties may also arise around assessments of young people performed by staff who do not have a personal relationship with the child or palliative care experience.

- **Views on additional training being needed for AMCPs and IMCAs (who may have more of a background in working with adults) and how this should be reflected in the CRIA.** Questions posed around whether there is an expectation that those working with and assessing those who are under 18 will have some specialist knowledge of specific issues affecting those who are not 18 yet. There is an anticipated knowledge gap in the existing BIAs (who then become AMCPs) as the current cohort have exclusively supported those who are 18 and above. Some specific concerns were also raised about the quality of advocacy for disabled children.

- **Specific comments regarding the individual articles of the UNCRC.** For example: Article 37 (no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment) should be acknowledged as one of the most relevant UNCRC Articles for the LPS Regulation's impact.

Question 17 Do you agree with our assessment of the impacts of the LPS Regulations on those with protected characteristics?

85. 50 of the responses answered this question (see Figure 17a). Over three quarters of responses (78%) said that they either somewhat or strongly agree with our assessment of the impact of the LPS Regulations on those with protected characteristics (see Figure 17bb). The majority of responses who agree were from health boards or NHS organisations, or local authorities.

86. 16 responses strongly agree and 23 somewhat agree with our assessments of the impacts of the LPS Regulations on those with protected characteristics. However, two people strongly disagree. 22 of the responses did not provide an answer to this question.

Figure 17a

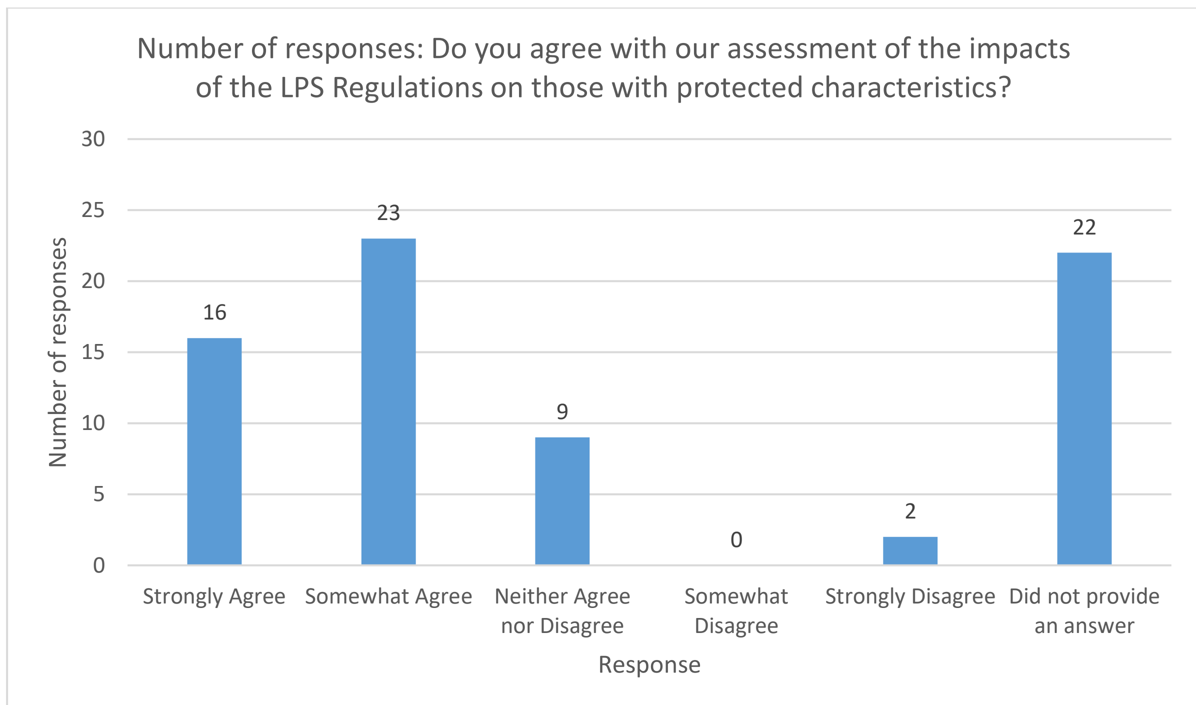
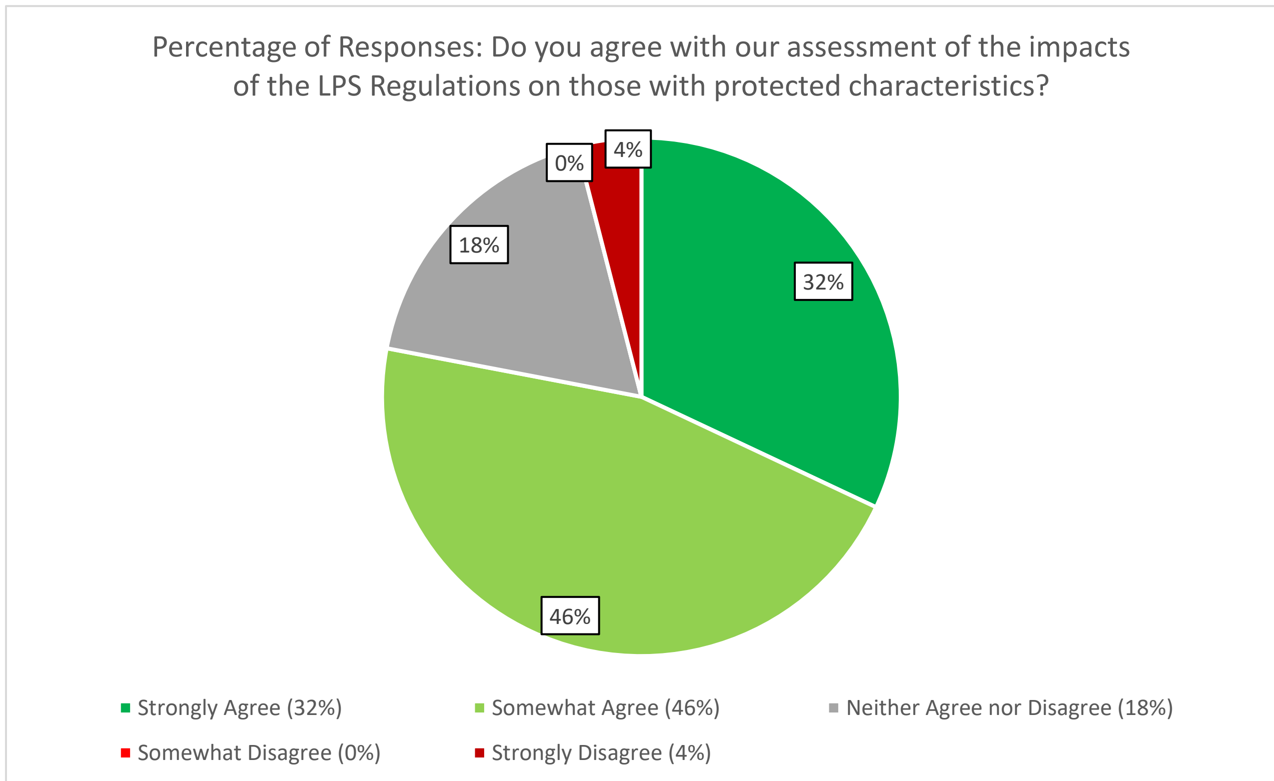


Figure 17b



87. Common themes were:

- **Support for the Welsh Government's assessment of impact on those with protected characteristics.**

➢ The Equalities Impact Assessment seen as comprehensive.

- **Further analysis of impacts is required.**

➢ Only race and age were considered in relation to mitigation impacts. This needs to be considered across all protected characteristics.

➢ The Equalities Impact Assessment focuses on issues relating to mental illness which the LPS is not necessarily about.

➢ There needs to be a consideration of the European Court of Human Rights and Human Rights Act case law.

88. Responses also included:

- **Specific comments on religion:** Further consideration needs to be given to the potential impacts of the legislation, particularly in relation to cultural views on mental capacity. There are potential opportunities to increase the uptake of mental health services within communities**.**

- **Specific comments on Welsh Language:** The Workforce and Training Plan needs to include a specific focus on Welsh Language to ensure the intentions of the LPS are realised amongst those who speak Welsh.

- **Specific comments on ethnicity:** Professionals need to be able to recognise the needs of different ethnic groups and their previous experiences and respond accordingly.

- **Views on how information included in the Equalities Impact Assessment could be better presented.** The Impact Assessment is very detailed. The table highlighting those with protected characteristics can be difficult to follow, given the volume of information included.

- **Views on training:** Everyone should understand the needs of different age groups and those with protected characteristics. A "one size fits all" approach to training will not be appropriate.

- **Calls for an analysis of impacts in relation to the pre-authorisation review.** The Impact Assessment includes a specific focus on the role of the AMCP in mitigating risks. However, the majority of cared for people will not have the pre-authorisation review carried out by an AMCP. The role of the pre-authorisation review is critical in ensuring those with protected characteristics are treated equally and yet there is very little information or guidance relating to it in the Impact Assessment.

Question 18. Do you agree that the LPS Workforce and Training Plan will promote and embed person centred planning?

89. 53 responses answered this question (see Figure 18a). Just under two thirds of responses (64%) either somewhat agree or strongly agree that the LPS Workforce and Training Plan will promote and embed person-centred planning (see Figure 18b). Almost a quarter (23%) said they neither agree nor disagree and 13% somewhat or strongly disagree. The majority of those who agree with the question were from third sector organisations or local authorities, whereas those who disagree were from third sector or NHS organisations.

90. 13 responses strongly agree and 21 somewhat agree with the question. Seven people disagree to some extent that the Workforce and Training Plan will promote and embed person-centred planning. 19 responses did not provide an answer to this question.

Figure 18a

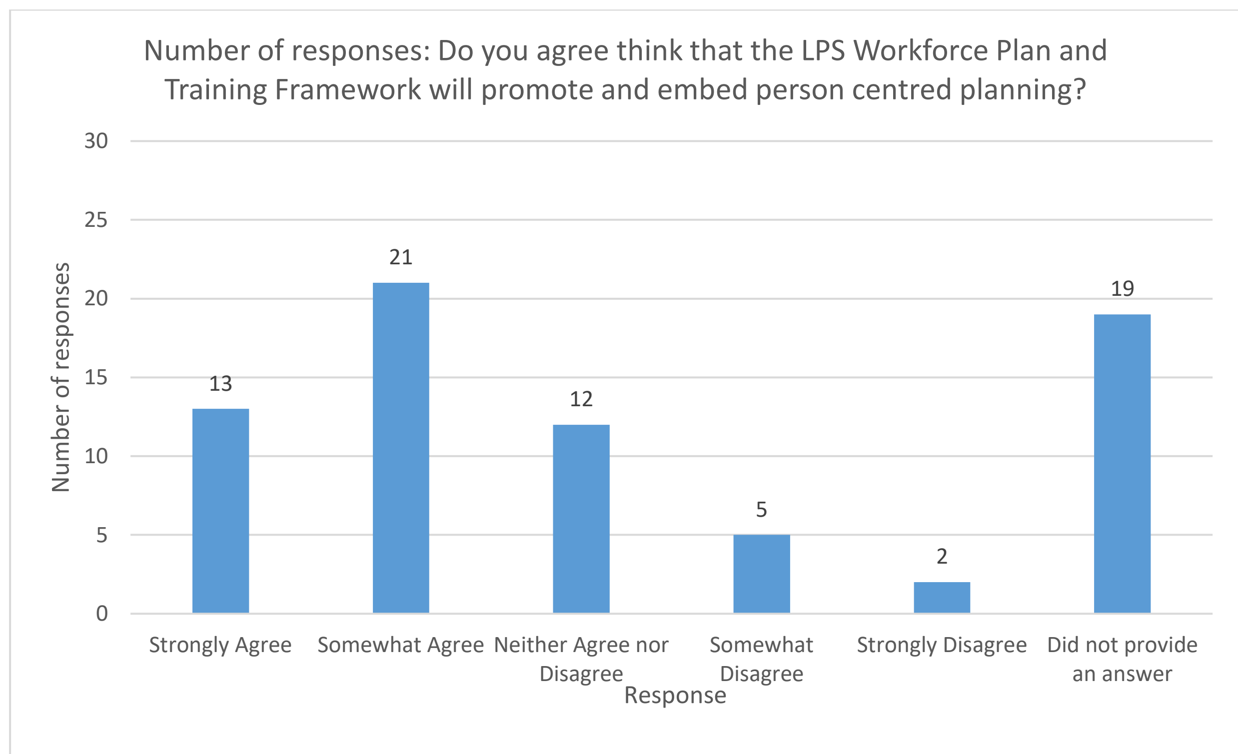
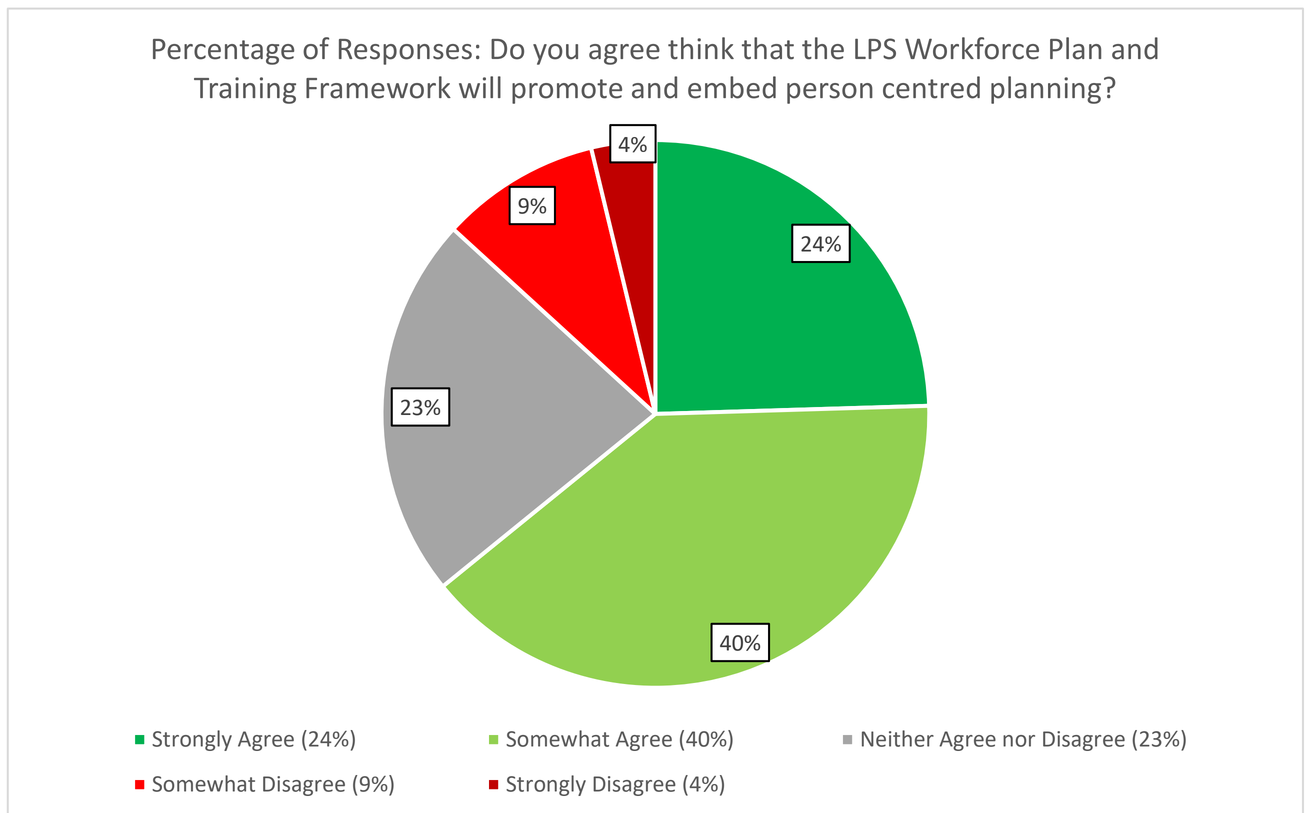


Figure 18b



91. Common themes were:

- **Support for how the Workforce and Training Plan takes a person-centred approach (raised in more than ten responses).**

➢ The Workforce and Training Plan is critical to the delivery of the LPS in Wales.

➢ Seen as a beneficial tool to promote and embed person-centred planning in settings.

➢ Having the person at the centre of the decision-making process increases participation, voice and control.

➢ Agreement with broad principles, but calls made for greater detail on how taking a person-centred approach would work in practice.

➢ Opportunities to build on training taking place for the education workforce on person-centred practice as part of the implementation of the ALN reforms.

- **Support for how person-centred planning has been prioritised through splitting staff into six key groups.**

➢ Agreement with the planned competency groups and professional learning opportunities identified within the Workforce and Training Triangle.

- Critical that the Workforce and Training Plan (and associated delivery plans) are coproduced with those who have lived experience.

- **Specific comments on the training framework (raised in more than ten responses).**

- Without knowledge of the training itself and materials used, it is hard to judge appropriately.

- Questions posed in relation to: Who will be training clinicians? Competency is needed to a good standard to train multiple professionals. What is the frequency and is this mandatory training to be set? Who will monitoring the quality of training?

- Welsh Government could mandate MCA and LPS training.

92. Responses also included:

- **Views on Mental Capacity Act training and a focus on core principles**. Calls were made for mandatory training on the MCA. The emphasis on MCA principles alongside the LPS implementation will promote an understanding of best interests within care and support planning. A significant amount of training will be required across the whole workforce to embed the MCA and LPS into person centred care and treatment plans**.**

- **Concerns that a person-centred approach has not been embedded into the Workforce and Training Plan.** Comments included that suggesting this will promote and embed person-centred planning is "incredibly ambitious" and suggests "a lack of understanding" of what person-centred planning is really all about. This will be dependent on the quality of the training and the continued mentoring, support and supervision of staff thereafter.

- **Views on how a person-centred approach is already a requirement of practice.** Comments stated that this is not new. Working in a person-centred way and embedding a culture of person-centred planning should be key to social work practice, especially given the implementation of the Social Services and Well-being (Wales) Act 2014.

- **Comments that training needs to be developed and delivered by those with lived experience.** It also needs to include a focus on Welsh Language, knowledge of learning disability, palliative care, assessing people's liberty from a social (rather than a medical) starting point, restrictive practices.

- **Views on resources and the need for significant time and financial investment.** The effectiveness of the Workforce and Training Plan (and ability to embed a person-centred approach) will be reliant on resources available. Workforce plans will require significant financial investment and extensive scoping of roles, responsibilities, current and future workforce resources and requirements, and training need analysis of each professional group.

Question 19 Do you agree with our assessment of the impacts of the LPS Regulations on Welsh Language?

93. 50 people answered this question (see Figure 19a). Just under two thirds (of responses 64%) either somewhat agree or strongly agree with our assessment of the impacts of the LPS Regulations on Welsh Language (See Figure 19b). Just under a third (32%) of responses neither agree nor disagree. The majority of those who agree were from health boards or NHS organisations, local authorities, third sector organisations, as well as individuals or professional bodies.

94. In addition, a small number of respondents noted that they felt they were not able to provide useful comments as they were not Welsh speaking themselves.

95. 14 of the responses strongly agreed and 18 somewhat agree with our assessments of the impacts on the Welsh Language. Sixteen neither agree nor disagree, and two people somewhat disagree.

96. Similar themes were raised across all three consultation questions on the Welsh Language, which are discussed further below.

Figure 19a

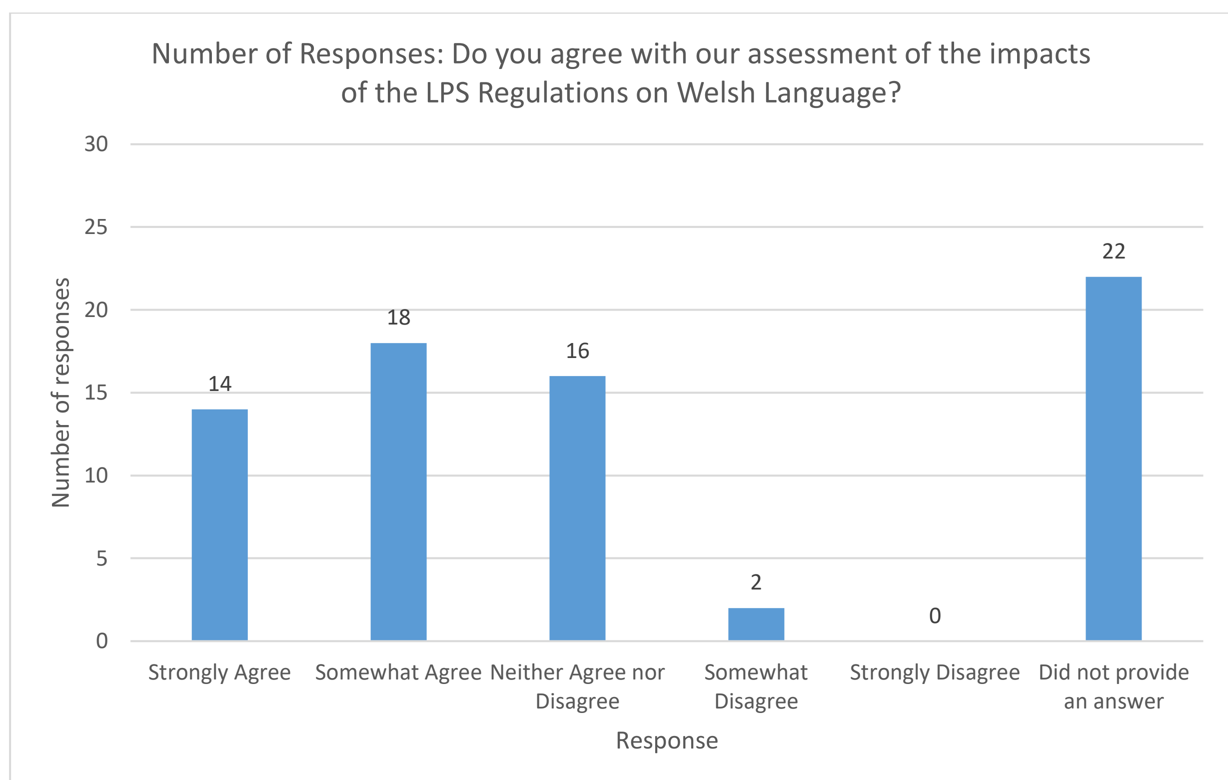
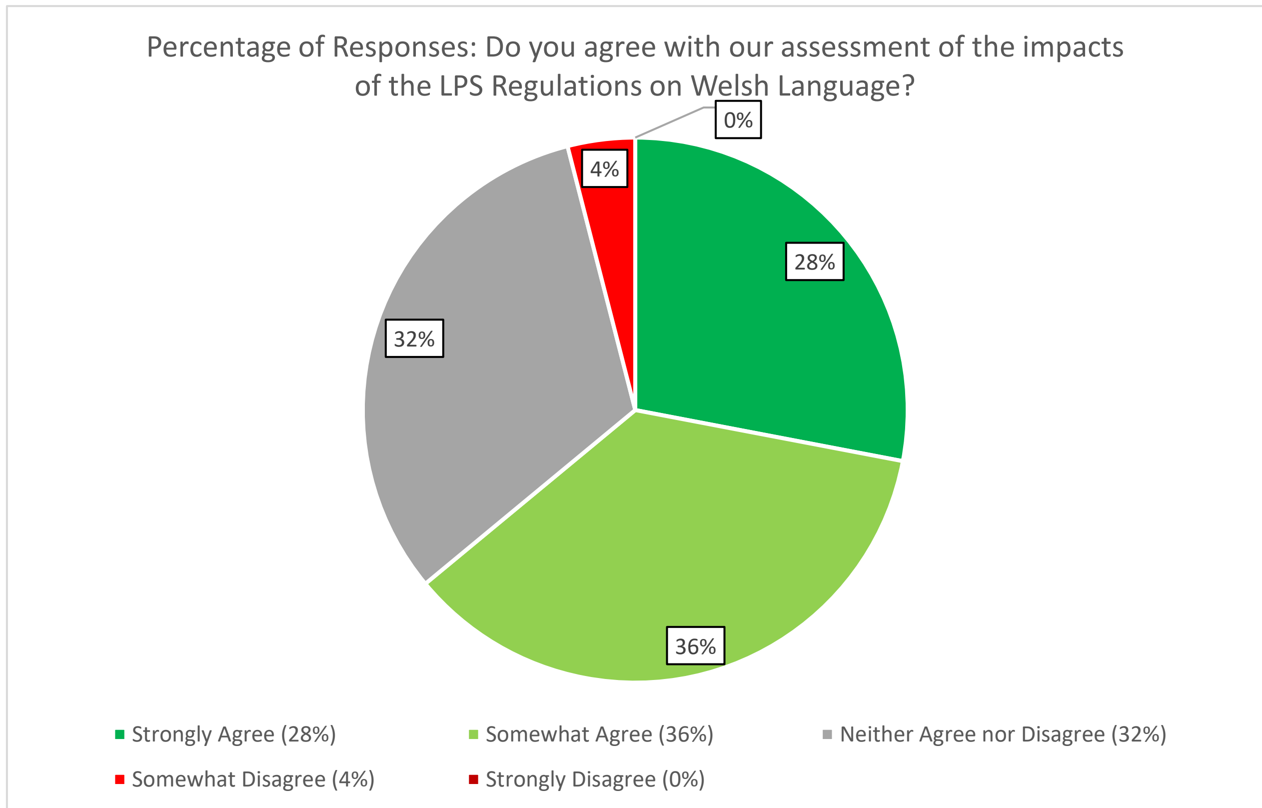


Figure 19b



97. Common themes were:

- **Strong support for the Active Offer in relation to the LPS, which is highlighted in the Welsh Language Impact Assessment (raised in more than ten responses.**
  - ➢ Stakeholders stressed the importance of the Active Offer throughout the LPS process.
  - ➢ This is critical for the cared for person (whose first language is Welsh) where individuals are making challenging and potentially distressing decisions.
  - ➢ Advocacy support in Welsh is fundamental.
- **Concerns regarding the delivery of the Active Offer.**
  - ➢ It is vital that the Active Offer is planned for and that there is capacity in the workforce.
  - ➢ Resources were highlighted as a key issue.
  - ➢ Responses commented specifically on the lack of Welsh speakers able to deliver assessments in Welsh.

- Responses highlighted a shortage of Welsh speakers to fulfil the IMCA and AMCP roles.

- Staff may not feel competent enough to carry out assessments in Welsh, even when they are Welsh speakers.

98. Responses also included:

- **Support for the assessment of impacts set out in the Welsh Language Impact Assessment.** Responses agreed that there was an adequate assessment of impacts that links to the aims of *More than just words*. Responses also noted that other language should also be considered.

- **Concerns over the assessment of impacts set out in the Welsh Language Impact Assessments (including from the Welsh Language Commissioner).** Calls were made for Welsh Government to strengthen the Regulations in terms of the requirements on Responsible Bodies to ensure that there are sufficient professionals who can carry out the LPS process through the medium of Welsh, and the requirements on Monitoring Bodies to ensure that the LPS process meets the needs of Welsh speakers. Specific calls were made in relation to the Workforce and Training Plan and for this to be strengthened – to ensure the needs of Welsh speakers are better protected. Specific calls were also made in relation to the LPS Monitoring and Reporting Strategy for Wales and the National Minimum Data Set – and for this to be strengthened – to be able to monitor Welsh language provision and contribute to service and workforce development.

Question 20 We would like to know your views on the effects that the draft Regulations for Wales supporting the implementation of LPS would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

99. 31 responses (43%) provided a response to this question. The majority of those were from health boards, local authorities and third sector organisations. We also received responses from individuals and professional bodies.

100. Common themes were:

- **The Regulations could have a positive impact on the Welsh language, providing there are resources allocated to build capacity and the cared for person is at the centre of the process (raised in more than ten responses).**
  - However: Concerns over whether in reality, there will be enough services to deliver the Welsh language with all aspects of the LPS process.
  - Some local authorities and health boards may need to rely on the use of interpreters.
- **The cared for person should be supported in their first language.**
  - Everyone should have access to Welsh language (and BSL).
  - For Welsh speakers, it is critical that assessments are carried out with a fluent Welsh speaking assessor, so that they are able to communicate and express their wishes and feelings in their language of choice.
  - Specific calls for Regulations around eligibility to carry out assessments to consider the Welsh language.
  - Responses commented that it Could be detrimental to the cared for person if assessments are not carried out in Welsh / their preferred language.
  - A lack of Welsh speaking professionals might mean that individuals are assessed by people they do not know.
  - It may also impact on the outcome of the assessment if the person is not supported to communicate in their preferred language (this is seen as especially important for people with dementia).

- **Active recruitment being key for positive impacts on the Welsh Language to be realised.**

    - ➢ Active recruitment of Welsh-fluent assessors will reduce the need for interpretation / translation services. However: There are challenges with recruiting Welsh speakers, particularly to specialist roles.

    - ➢ Calls for the planned focused engagement on the LPS Workforce and Training Plan to include planning for the provision of IMCAs who speak Welsh.

    - ➢ Suggestion made for staff to be trained in Welsh. In addition, other ways of supporting staff to use Welsh in general practice needs further consideration.

101. Responses also included:

- **Views that the Regulations will have little or no effect on the Welsh Language.** One response stated that having materials in bilingual format will satisfy legislation but raised doubts over whether this will increase uptake of the language. Some felt that the practicality of using the Welsh language will create a layer of complexity around the process.

- **Calls for accessible information on the LPS, support and services available for the cared for person (in Welsh)**. All Once for Wales forms and public information materials need to be available bi-lingually.

- **Views on ongoing monitoring and reporting – with a specific focus on Welsh Language.** The Regulations around the requirements of Monitoring and Reporting need to be strengthened. Welsh Government need to strengthen how the success of the policy is to be measured in terms of the Welsh language, and make changes to the proposed data items in the NMDS. Monitoring Bodies have a key role to play with calls for a thematic report on Welsh Language.

Question 21 Please also explain how you believe the proposed draft Regulations could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

102. 22 responses (31%) answered this question. The majority of those who responded were from local authorities, individuals or third sector organisations. We also received responses from health boards and professional bodies.

103. Common themes were:

- **Positive effects could be increased by providing training for staff on the LPS in Welsh and ensuring the Code of Practice fully reflects the position in Wales regarding access to services and support in Welsh / Active Offer.**
  - Provide the AMCP conversion and AMCP initial training and AMCP further training in Welsh.
  - Provide training on undertaking assessments in Welsh.
  - Advocacy staff should be empowered to deliver services in Welsh.
  - Training courses on the Welsh language should be planned for, monitored, and reported in the implementation of the LPS.
  - Code of Practice must fully reflect the position in Wales regarding the Welsh Language.
- **Positive effects could be increased through workforce planning: the increased recruitment of Welsh speakers (and compliance with Welsh Language requirements) is critical and especially important in terms of the role of the IMCA and AMCP.**
  - Positive effects would be increased through recruitment of Welsh speaking staff.
  - Important that AMCP teams can offer a bilingual service to enable the friend or family member to communicate needs, or if required an IMCA that can converse in the language of choice.
  - Consider the need for all local authorities to employ at least one Welsh speaking AMCP.

- ➢ Positive effects would be increased by being able to identify Welsh speakers within each Department and promote the use and development of the Welsh language.

- ➢ Questions posed around how to ensure there are enough Welsh speakers able to provide advocacy support for young people

104. Responses also included:

- **Comments that there is already legislation in place for the promotion of the Welsh Language.** Implementation of the LPS would be based on the Active Offer and health boards and local authorities would carry out assessments in Welsh.

Question 22 We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

105. 43 responses provided information for this consultation question.

106. Common themes were:

- **The test as to whether there are good outcomes for people in terms of human rights – will be in operation of the LPS.** Everything depends on how things work in practice. The principles of the LPS uphold a person's rights, but it is too early to say if they will when the LPS is implemented. The Regulations are only as robust as the people who implement them.

- **Significant challenges to the effective implementation of the LPS remain.** Potential for an insufficient timeframe provided to build capacity (IMCAs), recruit (AMCPs) and adequately train and prepare the workforce, along with insufficient time to translate documentation into Welsh. More general concerns were raised in relation to the complexity of the system and the LPS process – and impacts on staff and workforce, as well as the need for good management practices.

- **The LPS was supposed to simplify the DoLS process, but it seems to complicate things even further. Proposals do not align with the principles of the Mental Capacity Act.** Specific concerns raised that the LPS is diluting the safeguards for the cared for person. The LPS is not addressing bureaucracy. Specific consideration needed in relation to the supporting LPS forms, and the impacts of collecting the proposed National Minimum Data Set. Concerns also raised regarding the Regulations on assessments and determinations, and what the Code of Practice says about medical assessments and determinations; the extent to which a GP would be able to carry out the medical assessment; concern that existing medical assessments for the purposes of the LPS do not exist (and new ones will be needed); and concerns over the anticipated costs associated with medical assessments (given that they can only be carried out by a doctor and practitioner psychologist).

  "The general feeling throughout the UHB is one of concern about how the LPS will be implemented in practice. At present the process seems complex and confusing and there is worry about placing further pressure and demand upon an already overstretched workforce." (Health Board)

- **Concerns raised that the cared for person is not front and centre: Calls for written information on the LPS to be more accessible.** Calls for easy read documents for all ages, as well as specific groups.

- **Specific issues for Welsh Government to raise with the UK Government:** Definition of a deprivation of liberty – and needing clarity around thresholds.

Lack of clarity in relation to alignment and relationship between the Mental Capacity Act and the LPS, and the Mental Health Act. Cross border issues: Wales seen as “an add on” in the Code of Practice.

Welsh Government Response and Next Steps

107. The UK Government has recently announced their decision not to implement the LPS within this Parliament. Welsh Government has issued a Written Statement expressing disappointment at this decision.

108. The consultation responses from stakeholders in Wales on the draft Regulations and supporting impact assessments have provided a wealth of information that will help inform future policy decisions, when any planned implementation of the LPS is confirmed by the UK Government. It may be necessary to undertake a further consultation on the Regulations following any decision by UK Government to progress with the LPS in the future.

109. We all share the goal to continue to integrate and embed the principles of the Mental Capacity Act 2005 and the Mental Capacity (Amendment) Act 2019 into everyday care, support or treatment arrangements to avoid unnecessary duplication and bureaucracy for individuals and their families, and equally for practitioners, enabling them to share and use information legally and appropriately. Despite the recent decision of the UK Government, this remains our goal and our ambition for the people of Wales. As highlighted in the recent Written Statement, the views and the work of everyone who helped us develop and shape the consultation products, as well as everyone who offered views on the consultation, are not wasted. They have been recorded and retained to support us to protect and enhance people’s rights.

110. It has been widely recognised that there are number of challenges associated with the current DoLS system, particularly in light of the increases in the number of DoLS applications – which have been seen across England and Wales.

111. In light of the UK Government decision, we will need to consider how we strengthen the current DoLS system in Wales and continue to protect and promote the human rights of those people who lack mental capacity. Stakeholders in Wales have provided significant evidence and support to help us shape the LPS for Wales. Welsh Government will be re-engaging with stakeholders so that we can listen and hear what we can do now to address some of the current challenges within DoLS. This will support the current application of DoLS, and strengthen the position that Wales will be in to transition to the LPS in the future.

112. It is imperative that the momentum generated through the contributions of stakeholders in Wales is not lost. Welsh Government will continue to work with stakeholders to improve services for those who lack mental capacity, whilst preparing for any future decision by UK Government to implement the necessary reforms identified in the Mental Capacity (Amendment) Act 2019.