PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

MENTAL CAPACITY (AMENDMENT) BILL [*LORDS*]

First Sitting

Tuesday 15 January 2019

(Morning)

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Saturday 19 January 2019

The Committee consisted of the following Members:

Chairs: Mark Pritchard, † Ian Austin

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

Adam Mellows-Facer, *Committee Clerk*

† attended the Committee

Public Bill Committee

Tuesday 15 January 2019

(Morning)

[Ian Austin *in the Chair*]

Mental Capacity (Amendment) Bill [*Lords*]

9.25 am

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

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

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

Ordered,

That—

(1) the Committee shall (in addition to its first meeting at 9.25 am on Tuesday 15 January) meet—

(a) at 2.00 pm on Tuesday 15 January;

(b) at 11.30 am and 2.00 pm on Thursday 17 January;

(c) at 9.25 am and 2.00 pm on Tuesday 22 January;

(d) at 11.30 am and 2.00 pm on Thursday 24 January;

(2) the proceedings shall be taken in the following order: Clause 1; Schedule 1; Clauses 2 to 4; Schedule 2; Clause 5; new Clauses; new Schedules; remaining proceedings on the Bill;

(3) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 5.00 pm on Thursday 24 January.—*(Caroline Dinenage.)*

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

Resolved,

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

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

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

Clause 1

Deprivation of liberty: authorisation of arrangements enabling care and treatment

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

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

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

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

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

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

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

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

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

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

Question put and agreed to.

Clause 1 accordingly ordered to stand part of the Bill.

Schedule 1

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

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

"if a person objects to arrangements"

and insert "in certain cases".

This amendment is consequential on Amendment 9.

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

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

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

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

Government amendments 8 and 9.

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

"(c) the arrangements include the use of physical restraint, or

(d) the arrangements include the use of sedating medication, or

(e) a person interested in the cared-for person's welfare has objected to the arrangements, or

(f) the cared-for person owns or has the right to occupy a different property to the property in respect of which the arrangements apply, or

(g) the cared-for person is receiving covert medication, or

(h) the cared-for person is restricted from having contact with named persons, or

(i) the cared-for person is being detained in a mental health establishment for the purposes of treatment of a mental disorder, or

(j) there is a less restrictive option for the cared-for person's care or residence available, or

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

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

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

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

(d) it is reasonable to believe that the cared-for person does not wish to receive care or treatment overall."

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

Government amendment 10.

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

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

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

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

[Caroline Dinenage]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Caroline Dinenage: I understand where the hon. Lady is coming from. The code of practice will be a living document. It will go alongside the Bill and have case studies. It has to be put together in a very co-operative and collaborative way. It will have to come before both Houses to be signed off before it can be published and released, so there will be plenty of opportunity for Members to get involved in drawing it up. I have committed to providing a list of what we have already agreed will be part of it. Members will get a chance to vote on it before it is published, and it will need the approval of both Houses because it is a statutory document.

9.45 am

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

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

The Chair: I call Barbara Keeley.

Barbara Keeley: I have nothing to add.

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

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

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

[Alex Norris]

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

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

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

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

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

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

Alex Norris: I share that view completely. On my first day here, if my hon. Friend had stopped me and said, "You've just come from Nottingham, where you were the adult social care lead. What was your situation with DoLS? Why did you have a backlog? Are the regulations too cumbersome?" I would have said that they probably were, but that that was about our assessor capacity, because there have been eight years of growing demand in social care, while the council has experienced extraordinary reductions in resources. That toxic cocktail meant that we were increasingly stretched to the point where we really struggled to keep up with our responsibilities. There is concern that, while we could write the best legislation, if we do not understand the context, we will not deliver what we are trying to.

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

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

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

Alex Cunningham: I am north.

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

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

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

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

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

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

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

The two recommendations from the commission's report were that

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

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

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

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

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

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

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

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

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

10 am

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

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

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

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

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

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

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

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

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

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

"Extremely complex rules govern the interface between the MCA and the MHA."

We will return to that. She goes on:

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

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

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

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

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

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

In the meantime"—

and that is where we are with the Bill—

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

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

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

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

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

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

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

"to help local authorities prioritise the DoLS applications and manage the backlog,"

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

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

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

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

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

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

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

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

10.15 am

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

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

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

[Alex Cunningham]

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

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

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

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

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

Let us remember what vulnerable young people can be subjected to if and when we apply the provisions of the Bill to their lives. Some of them are spelled out in amendment 37; among them are physical restraint, sedation and covert medication, and a ban on seeing particular people. We cannot have a situation in which some people in our nation can have these things done to them or restrictions placed on them without the strongest possible protections, of which the decision makers must always be mindful.

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

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

Mencap confirmed in its briefing that:

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

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

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

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

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

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

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

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

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

"takes the rights of disabled people backwards."

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

Steve McCabe: Yes, I agree.

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

Sometimes these things take time. I do not want there to be unnecessary repeat authorisations. The Minister mentioned that to me recently and I accept that it is just pointless bureaucracy, but it is possible to try too hard to limit it. One of the reasons why protections and safeguards are built in is to stop us from trampling over people. It was a long time ago now, but I should confess that in my dim and distant past I was once a social worker, and I know what happens when people are under pressure. The case load of an average social worker these days is unbelievable compared to 30 or 40 years ago, and they are under enormous pressure to get things done with insufficient resources.

10.30 am

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

The Chair: Does anyone want to speak now?

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

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

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

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

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

[Barbara Keeley]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alex Cunningham *rose—*

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

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

10.45 am

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

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

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

[Barbara Keeley]

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

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

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

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

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

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

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

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

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

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

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

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

Amendment 2 agreed to.

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

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

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

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

Barbara Keeley: That is helpful, Mr Austin.

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

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

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

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

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

Among the companies running these institutions—these places have been called bedlam-like, which I believe is appropriate—are two large US healthcare companies, a global private equity group and a Guernsey-based hedge fund, as well as two British firms. These companies pay their executives half a million pounds or more, and their profit margins are as high as 31%. One director of a British firm was paid more than £1 million over two years. One director of American company Universal Health Services, whose UK operation is run by Cygnet Health Care, earned £39.5 million in a single year.

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

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

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

11 am

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

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

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

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

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

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

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

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

To quote my colleague Baroness Thornton, how can someone

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

Responsibility simply should not lie in their hands.

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

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

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

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

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

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

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

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

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

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

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

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

Many organisations with an interest in the Bill have raised concerns with me. The consensus among them appears to be that the cared-for person will be at serious risk if responsibility for authorising their deprivation of liberty is placed in the hands of the detaining private hospital, because the managers have a vested interest in a particular outcome. As Mencap notes, it would be a serious conflict of interest because there is a huge financial incentive for the independent hospital to keep people.

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

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

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

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

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

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

11.14 am

Adjourned till this day at Two o'clock.