Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Subordinate Legislation: Mental Capacity

23 January 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn
Mr John Stewart

Witnesses:
Dr Tomas Adell Department of Health

The Chairperson (Mr Gildernew): We will now pick up where we left off in this morning's session. I refer members to the Clerk's memo on pages 60 to 62 of the pack. We have 42 statutory rules on which we need to come to a view by next Thursday in order to comply with the statutory period for consideration. We have 26 on the agenda today, and we will consider them grouped into themes to make things easier to follow. Where possible, officials have been invited to brief us in respect of the substantive regulations. Should we have any questions that cannot be answered today, we can defer any decision until next week.

The first group of statutory regulations that we will consider today are mental capacity regulations. We are dealing with nine regulations, starting at page 63 and taking us up to page 229. The regulations deal with the deprivation of liberty under the Mental Capacity Act 2016. Given the complexity and the significance of the regulations, I invite Tomas Adell from the Department's mental health and capacity unit to brief the Committee on their net effect and update members on the implementation of the deprivation of liberty aspects of the Mental Capacity Act 2016. You are very welcome, Tomas. Please go ahead and brief the members on the regulations.

Dr Tomas Adell (Department of Health): Thank you very much for having me here. I will quickly give you some background on what the Mental Capacity Act is and why we are doing this, and then I will explain the statutory rules in a little more detail.

Article 5 of the European Convention on Human Rights provides the right to liberty and states that a person can be deprived of their liberty only for specific reasons and in accordance with procedures prescribed by law. A judgement by the UK Supreme Court in 2014 highlighted the issue and provided an acid test for when a person is deprived of liberty, which is when a person is under continuous supervision and control and not free to leave. The Supreme Court also noted that all such instances

must be authorised. Without these statutory rules and the deprivation of liberty safeguards found in the Mental Capacity Act, the only way of doing so is under the Mental Health (Northern Ireland) Order 1986, for people in hospital who are mentally unwell, or after a decision by the High Court in Belfast.

The Department of Health estimates that there are approximately 7,500 people in care homes, nursing homes and supported living facilities who are deprived of liberty every year and an additional 10,000 in hospital. That does not include mental health detentions. In recent years, fewer than 50 declaratory orders a year have been issued by the High Court, which means there is a gap between what is authorised and what is not authorised. That poses some significant risks to patients, residents, healthcare workers and to the system as a whole. Without a framework, there is a risk to the human rights of a person of arbitrary detention. Preventing someone leaving is common practice in care and nursing homes for very good reasons. It prevents someone from suffering harm when they do not know what they are doing. There is nothing wrong with the concept behind that. However, without the framework to make sure that only the right people are deprived of liberty, there is a risk that the wrong people might be.

There is also a risk to Health and Social Care workers — the staff on the front line who are carrying out the deprivation of liberty. Without a statutory framework or a High Court order, there is nothing to protect them from potential criminal or civil liability. There is also a risk to the system. The European Convention on Human Rights article 5 provides a right of compensation where there has been a breach of article 5. In a recent court case in England and in the European Court of Human Rights, compensation of approximately £100 per day per person was paid where there had been technical infringements of article 5.

To do something about that, the Department of Health has been seeking solutions for a number of years and has concluded that there are two options: it can seek High Court authorisations for all cases, or it can provide a statutory framework that can authorise such cases. It is estimated that the financial cost to the healthcare system of seeking High Court authorisations for all cases would be in the region of £45 million a year. That does not include cases in hospitals or costs that the High Court would incur in the legal costs of judges and so on. It would also take a significant amount of staff time — healthcare staff time — to go to the High Court to present cases. On the other hand, the costs of the commencing the Mental Capacity Act for the purpose of the deprivation of liberty is estimated at approximately £3 million per year. It is significantly cheaper.

Balancing the risks that we have with the lack of protections and the costs, the Departments of Health and Justice are working towards the commencement of the Mental Capacity Act, and, initially, in April last year, they took the decision to commence on 1 October last year. Commencement work began immediately. However, in the weeks before commencement, the Department of Health received strong representations from the trade unions that the trusts were not ready to commence on 1 October, and a decision was taken to delay commencement to 2 December to provide more time for the system to get ready.

To enable commencement, the Department of Health made a total of nine statutory rules, two commencement orders and seven regulations. Two of the regulations were revoked because of the delay in commencement, and one regulation was revoking those two regulations. The four remaining regulations made provision for research, money and valuables, deprivation of liberty and a small amendment to the deprivation of liberty regulations.

The main regulation is 2019/199, which is the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations. The regulations deal with practical and technical details for people who are carrying out deprivation of liberties and how it can happen. They specify who can provide certain duties — which professionals can make formal assessment of capacity, for example — the format and forms of applications, and it includes 15 statutory forms. They specify what information is needed and when it should be provided, so, if someone is deprived of liberty, they should be informed that they have been deprived of liberty. They specify how the trust panel would run their authorisation mechanisms, how they work and who the members are. It provides arrangements for when deprivation of liberty happens someone who is under 16 but will turn 16 — the Act only applies only to over-16s — and transitional arrangements for how the Mental Capacity Act relates to the Mental Health Order, to make sure that there are no overlaps and conflicts.

The decision to commence was taken in April last year, with a commencement date of 1 October. That is a very short time, and the work on the statutory rules had been started before that but continued after that point. Throughout that period, the rules were co-produced with professionals, users, interest groups and significant others. The Department has a virtual reference group for the work with over 350

individuals, including organisations, individual people and representatives from the community and voluntary sector. The work on the rules, the code of practice and other documents was all done in conjunction with that group.

We also decided that we needed to learn from experience with similar legislation in England, and there has been significant preparatory work. We provided a code of practice that was meant to be as simple as possible and as short as possible, but it is still quite a significant document because of the scale of the legislation. We have tried to make it as short and simple as possible after consulting professionals and learning what they want to know about. We also provided significant training. The Department created a training programme consisting of e-learning and classroom-based training. To date, there have been over 40,000 hits to the e-learning training, and over 6,500 individuals have attended 16,000 classroom-based training instances. We also created a scenario booklet with real-life scenarios to help people get a flavour of what to do in certain settings that we continuously update as we get more information, and we provided leaflets and similar things for people who may lack capacity and their relatives.

It is undeniable that there has been some impact on health and social care services, staff and the sector in general because of the Act. The Department expects that there will be approximately 7,500 such authorisations in the community per year and 10,000 in hospital. Each deprivation of liberty requires consideration by a health and social care professional, which will take time. However, it is worth remembering why this is done: it is there to protect people from arbitrary detention and protect staff from liabilities that otherwise would occur. In the first six weeks since 2 December there have been 223 applications for community deprivation of liberty and 102 short-term detentions. That is kind of what we expect at this point, as we continue ramping up.

We continuously review implementation and have two regional groups that meet monthly to discuss issues and how we can take things forward. It is accepted that there will be teething problems. It is accepted, I think, that it will not work perfectly, but we are committed to reviewing the implementation as we go on and to having a formal review at some point later on this year or early next year.

I can talk about the details of the regulations as you see fit, and I am quite happy to answer any questions you may have.

The Chairperson (Mr Gildernew): You mentioned that two regional groups are involved. What is their make-up, Tomas, and who is involved in them?

Dr Adell: We have two formal groups. One is the health and social care trusts and the board and it is focusing on delivering this in practice, so it is a delivery question about how they work with their professional staff and so on. The second regional group consists of the Attorney General and the review tribunal, which has been looking at teething problems from the practical elements side. In addition, we work continuously, through other processes, with people who have experience and who work with people who lack capacity.

One of the problems we have, when it comes to user groups, is that this affects everyone to some extent. We cannot draw it into one box, therefore we are trying to work widely, with as many people as possible.

The Chairperson (Mr Gildernew): You also referred to having discussed with the unions issues that they had around training and one thing and another, and there was a mention of other groupings. Can you clarify what consultations were done in total or how you consulted on this with the sector?

Dr Adell: The regulations went through to the reference group for informal consultation at the end of spring last year, and that includes some of the trade unions. We recognised, when the main trade unions contacted us, that we could have been more proactive in working with them. We have met them a number of times since and continue to meet them as and when they want to meet us. We realise we could have done more. Hindsight is a great thing, but we are, at least, working with the trade unions at the moment.

The Chairperson (Mr Gildernew): What consultation was there with the public or people who are advocates or family members?

Dr Adell: The policy on deprivation of liberty itself was consulted on publicly as part of the Mental Capacity Bill in 2014, and the main policies are in the Act. The regulations are more technical. There are user groups on our reference group, and they were consulted through that process.

The Chairperson (Mr Gildernew): Thank you for that presentation. We all acknowledge the huge complexity and the important issues at stake here, and, I suppose, that will be reflected in members' questions because we are dealing with the serious issue of depriving people of their liberty. It is definitely a complex and challenging task for all health and care staff concerned, and we know they are already extremely stretched. I will open up the discussion to members.

Mr Stewart: Tomas, thank you very much for your presentation. I think we all agree it is a sensitive subject and not something that care workers or anyone in the medical profession would want to do unless the situation required it.

The Chair alluded to some of the consultation that you have done, and I am satisfied with the response on that. You referred to the code of practice that has been adopted from England, based on the experience of workers there. In terms of best practice, what have you learned from the experiences of other areas of the UK that have rolled this out, and how has that updated the regulations that we are looking at?

Dr Adell: One big thing we learned was that the code of practice in England was too big and too detailed on some things that professionals do not need, so the code of practice we have is much slimmer and much more straight to the point, with simple flow charts and similar things. We still have the document because of what we are dealing with, but we have tried to make it as slim as possible.

The big thing learned from England and other jurisdictions is support for the workforce. The regulations were not hugely affected by this, but the biggest effect was on the training programme we provided. We have trained a significant number of people — 6,500 or roughly 10% of our workforce — and made the training available free of charge to anyone who wanted to attend. That was the same for the statutory sector and the independent voluntary sector. The training was delivered in half-day modules, and there was a compromise between the length of training and how many people we could put through it. The view was that it was more important to get as many people as possible through the training so that they had an awareness of the issues. That is why the training was in half-day sessions.

We were trying to make it as streamlined as possible, so a big part of the regulations relates to the statutory forms that must be used. There were strong views from England that there should be statutory forms and regional forms so that it was not left up to each trust to make their own forms, because that caused confusion among professionals, people and relatives. The forms are statutory, but we tried to make them as short as possible to cut away any unnecessary information so that we capture the rights issues, the risk issues and the balance between those. They were developed with professionals in mind and with their input. There was some piloting on the forms before and after the decision to commence.

Mr Stewart: Thank you very much.

Ms S Bradley: Thank you for your presentation. I hope that you will appreciate that this is quite developed at this stage, so it is a bit overwhelming for us to take a first sight of it in terms of the volume of content. Some of my questions may go back to the original intent. One of the things that jump out to me is the formal assessment of capacity and the nominated persons. The logic is that a registered dentist, for example, would be able to make that assessment. I accept that that is not the report — it is the assessment — but can I be a bit more informed on that?

I notice that this is not the commencement part. When we move on to the money and valuables one, where elder abuse and things like that have to come to mind, I have some concerns that I will maybe raise as we work through it further. What about that first piece, where you have a person like a dentist making an assessment on mental capacity?

Dr Adell: When we worked with the professionals and others on who that group should be, we looked at the core competencies of professions. After looking at the training programmes and what they do in their lives, the conclusion was that the group that we have is the group of people who have the core

competence to be allowed to do that. In addition to being in that group of professionals, you have to go through the specific training for deprivation of liberty, which should be done only if it is relevant to your profession. You must also be nominated by your employer as a person who can make such assessments for the purpose of deprivation of liberty. It is accepted that it is very rare that a dentist would do a deprivation of liberty. There are, however, some circumstances, especially when it comes to people with severe learning disabilities who need significant dental treatment under general anaesthetic, where that may become relevant, so, instead of excluding a group that, we thought, had the core competence, we decided to include dentists with the expectation that most of them will have no involvement in this. For those few who will, they should be allowed to do so because they have the competence to do it.

Mr Carroll: Thanks, Tomas, for your presentation. I have two comments and two questions. My understanding is that there is still concern amongst at least some health staff that training is not there or they are not aware of it or there is confusion about whether they bring themselves forward for the training or whether it is down to management to instigate that. Will you comment on that, please? Obviously, it goes without saying that there are people in hospital beds who should not be there; they should be in other facilities. That is pretty much a given; it is an important thing to happen. It would, potentially, mean taking beds away from people who need them. For talk's sake, it could be deemed that somebody in a hospital environment should go elsewhere but they are maintained because there are no other facilities outside the hospital setting. I am concerned about that.

I have two other questions. I think that it is in the document, but will you just clarify, if there is an unlawful deprivation of liberty or a suggestion that it might be unlawful, how that can be challenged? There was consultation in 2016, I think, in England. Will you comment on the consultation? How many responses, to the best of your knowledge, were there? Were any other issues raised? As others have said, this is a serious issue, and it is coming at us quite rapidly. If you could answer some of those questions, that would be important for me.

Dr Adell: Of course. If I miss something, please correct me. First, on the workforce and the training, yes, it is a challenged workforce. The workforce is very stretched. We fully accept that. There has been some confusion on the training, and we tried to clarify that as we went on. The training was between September and December, so before commencement. The training was, necessarily, theoretical, because we did not have real-life cases to use in it. The feedback is that that has been the biggest problem. Satisfaction with the training has been very high — it is sitting at about 95% — but with the comment that it is theoretical, not practical. All health and social care trusts have made commitments that, as we move forward, they will adjust their training to make it more practical, because, now, there are practical cases to use in training. That was part of the problem that we had: significant legislation was being brought in without anything similar existing.

There has also been a lot of nervousness in the workforce that has been trained that they are doing something they are not used to. The experience so far has been that, when people do it, they certainly say, "Well, extra training makes sense", but, until you do it, it is hard for staff to get that reassurance. A lot of the work we are trying to do is to build confidence in the staff workforce and to have the trusts provide support and help for them. Twenty-one staff were seconded to the Department to deliver training. They have all gone back to their trusts. Some of them are delivering training in the trusts; others have been working as mental capacity champions in the trust as a resource to help other staff.

The Mental Capacity Act should not lead to delay in discharge. It should not lead to people staying in a bed just because there is no paperwork in place for the right thing. The Act provides for emergency provisions. "Emergency" should not be interpreted or read in the dictionary definition of "emergency". The emergency is when delaying the act — the deprivation of liberty — because the safeguards, the authorisations are not in place would cause an unacceptable risk of harm to a person. Then, the act can be done without the authorisation. If the case is about delaying discharge and it is better for the person to be, say, in a residential home than in hospital, if that is the decision taken — that there would be a risk of harm if the person were to stay in hospital — then they can be discharged and the paperwork and authorisations can be done retrospectively. That is allowed for in the Act, so that should not be a problem. There have been instances where that has happened and where we have quickly worked with guidance and extra support for the trusts and child and adolescent mental health services (CAMHS) to prevent it happening again.

If the detention is unlawful, there are ways to challenge that. The Act that comes into force on 2 December this year makes unlawful detention a criminal offence. That is obviously the nuclear option: someone calling the police and reporting unlawful detention. We hope that that would not be used, because there should not be unlawful detentions. Otherwise, there are the normal civil remedies, such

as seeking compensation for false imprisonment or taking those actions. In general, in the health service, if laws are not followed, there is a judicial review.

The Regulation and Quality Improvement Authority (RQIA) is implementing this as part of its inspection regimes. While they may not look at individual cases, if they find systemic errors when carrying out their inspections, they will raise that. It is possible that the Department can seek RQIA's views to do a formal review on the work, and the Department is certainly monitoring what happens on a systemic level to make sure that there will not be unlawful detentions.

The work on a lot of the regulations started immediately after the enactment of the Mental Capacity Act 2016, so there was a lot of policy work behind them. At that point, we were formally consulting a large number of people. In the initial round, we got over 1,500 individual comments, which were used to shape the next set. This version is the fourth draft of the work that we started in 2016. We have been trying to work with the sector, with users, care groups and others to make sure that this is right. Comments on our last set of informal consultations were largely positive. There were no significant concerns about the competence of the regulations. The issue is the concept of the Mental Capacity Act, not the contents of the technical aspects of who can do what on the forms and so on.

Mr Carroll: Were groups associated with vulnerable people involved in that consultation process? Did they have input into this, to the best of your knowledge?

Dr Adell: Yes, there was significant input from a number of people. The list is large. It includes such groups as Action Mental Health, Inspire, MindWise, Alzheimer's Society and Compassion in Dying. There are 350 groups, and a lot of those groups are voluntary groups and charities working with vulnerable people or carers who work with vulnerable people.

The Chairperson (Mr Gildernew): To follow up on Gerry's first question, what percentage of staff are currently trained in this and, if not 100%, when is that due to be completed?

Dr Adell: We do not track individual people, but the latest data I have on our e-learning packages is that there have been over 40,000 hits on the e-learning. That is a significant number of the existing 65,000-strong workforce. Some 6,500 individuals went through the training that the Department provided for free. That is 10% of the workforce. In addition to that, training has been provided by the trusts, and they continue to develop and deliver training. The independent sector is also delivering training. We know that at least 10% of the workforce has gone through formal classroom-based training; but we also know that there has been a significant number of others that we do not have numbers for.

The Chairperson (Mr Gildernew): I presume that does not cover for all eventualities, so what plans are in place to expand that from 10%?

Dr Adell: We think 10 to 15% of the sector should be trained using classroom-based training because they are the ones who will be directly involved in making the decisions. We want the e-learning and the general training to bring that up to 100%, and we are close to getting there. We are providing the e-learning for free. We are providing the e-learning training materials for free for the trust and the independent sector, and, by doing that, we are encouraging them as much as we can to take it up. We think we are close to getting there. The awareness among independent sector nursing and care homes is very high, so it is about getting all their staff to know the details. The awareness in the trust is very high. All trusts have created implementation leads, and they have a lead director appointed to drive this work. We want to provide carrots, not sticks, to encourage the organisations, and, by providing the materials for free, we are doing the best we can.

Ms Bradshaw: Thank you, Tomas. First, my broad question is about any differences between what is being proposed here and what is in England and Wales. Secondly, you mentioned the financial savings from not having to make the order in the High Court, but what are the time savings from these protocols for getting the orders in place?

Dr Adell: I will start with England and Wales. The system in England is significantly different, and the biggest reason for that is the integrated healthcare system we have here. In England they have different authorisation routes depending on where the person is. We have two options: either in hospital, or, if someone is not in hospital, it can be short-term authorisation for less than 28 days, or it has to go through a trust panel that approves the authorisation for up to six months, and that can be

extended. In England, they are reviewing the Mental Capacity Act and the deprivation of liberty safeguards, and that passed through Parliament last year. The intention is to bring that into force on 1 October this year. While it is a much better system than they have now, we still think that our system is more streamlined and straightforward. We have put the responsibility for all the paperwork to the trusts: the trust does the paperwork, the trust makes assessments and the trust considers the case, with independent checks by the Tribunal, which means that one organisation is responsible for one system, and that is a significant piece of learning we have taken from the confusion in England.

We also have strict timelines. After a trust receives an application, it has seven working days to make a decision, and there is no leeway for exceptions or acceptable delays. In England, there are no set timelines, and they have a significant number of cases that have been delayed for a long time. Obviously, we will work with the trust and make sure they can meet the timelines.

Sorry, the other question was about —?

Ms Bradshaw: I think you have pretty much answered it in the second part about the differences in the time it takes to go to court.

Dr Adell: A big problem with courts is that the cost we have for going to court is an estimated cost because it does not happen. It is not a real cost at this point. It is accepted that, if we make 7,500 applications to the High Court, the High Court probably could not cope. We know from looking at the cases that go to court, that staff spend significant time just attending court, in addition to all the reports and assessments that have to be done. We estimate that the Mental Capacity Act will save significant staff time. It is hard to quantify exactly, but we think that there would be a significant saving of many hours per case by using the Mental Capacity Act rather than going to court for every case.

Ms Flynn: Before I ask Tomas a question, I want to check whether we can ask a question on any of the statutory rules. Do we need to do it in a certain order, or is it OK to cover the issue as a whole?

The Chairperson (Mr Gildernew): Within this section?

Ms Flynn: On mental capacity, yes.

The Chairperson (Mr Gildernew): Yes, absolutely.

Ms Flynn: Thank you.

There were a few wee things. Some of the safeguards that will be put in place are referenced a few times in the document. Some of the ones that stood out for me in particular were the transitional arrangements for a seamless transition for a 16-year-old or someone who has not quite reached 16. There is reference to additional safeguards being in place to allow the process to be seamless. Is there any more detail on what those safeguards will consist of? Is there a benchmark for what safeguards have to be used?

In relation to finances, there was reference to a residential care home or nursing home being allowed to manage someone's money. Again, this term is used:

> *"in certain circumstances if certain safeguards are in place."*

I wanted to see whether there was a wee bit more detail on that.

I did not see it mentioned anywhere — I am sure that there is a reason for that — that family or next of kin would have access to any money. It just refers to "residential care" or whoever is staffing the "nursing homes". Is there a reason why families or next of kin are not referenced? That is the first issue on the safeguards.

On the consultation process, I know that the Department briefed the parties informally around the time that those issues were flagged up, so I know that that was done. Was there any consultation at the time with the Human Rights Commission? I know that the Clerk and the Chair explained earlier that we will get the technical examination report next week. Was any consultation done with the Human Rights Commission at the time of drafting the statutory rules?

You mentioned that one of the main unions was not heavily involved at the beginning but you are speaking to it now. It is quoted that, during the consultation, no significant issues were raised, but, since having those conversations with the union in question, has it raised any significant issues that may have been missed at the time?

Finally, there was something that stood out for me, again from a human rights perspective, but I could be off course with this. In relation to research being carried out, it states:

> *"If the person lacks capacity ... he or she is unable to consent [but] the research can go ahead without the person's consent".*

I was wondering whether you could elaborate on that a wee bit for me. I know that that was a lot, so sorry.

Dr Adell: If I miss anything, please correct me.

Ms Flynn: Thank you.

Dr Adell: I will start with the issue of being under 16 or over 16. The Mental Capacity Act is age-neutral for anyone who is over 16; it applies to anyone over 16. It applies to a 16-year-old in the same way as it does to an 85-year-old. We have arrangements for people under 16 who come into a situation under the Mental Capacity Act that mean that the safeguards can be applied and the process can happen in the month before the person's sixteenth birthday. That is for practical reasons so that, on their birthday, if they need to be deprived of their liberty and are in some other setting or it is known that they will be deprived of their liberty, you can ensure that the process is in place before they turn 16. That does not mean that the deprivation of liberty can happen before they are 16, but you can make assessments and give consideration to a trust panel application. That is a big difference.

The Act provides for additional safeguards for people under 18 who are treated for mental illness in hospital, and that is specifically for mental illness or mental disorder in hospital. There must be age-appropriate accommodation. That means that hospital management must consider the age-appropriateness of where the person is, so they should be treated in an adult ward only if it is appropriate to do so. It might be, for example, that the adult ward is closer to their home than the specialist children units and the family ties are more important, or there might be other specific things. There must be consideration of their age so that children cannot be put in adult wards when they are being treated for mental illness. It is very specific about mental illness, not deprivation of liberty in general.

The money and valuables regulations are very specific. They relate to care/nursing homes receiving or holding money and valuables only and expending or using them in the person's best interests. It does not allow the managing authority access to bank accounts, benefits or any such matters. The money or valuables cannot be used to pay fees or anything that would normally be included in fees. The purpose is, essentially, if the person turns up or is taken into a care home and they have cash in their pockets or, say, an expensive wedding ring, the care nurse can hold those legally, which they cannot do without the regulations. They are also liable if they lose the money or valuables. That is a very small, narrow and specific purpose. For the family or other relatives, there is provision through the enduring power of attorney and in normal court processes to appoint controllers and make court orders, and that is the safeguard for that. This is a very narrow purpose. That is why it is for managing authorities only.

As regards consultation with the Human Rights Commission, it is on our reference group and had all information copied to it to be included at all points. I believe that we have comments from them, but I cannot guarantee that, because there have been a lot of comments. However, they would certainly have been copied into information.

When it comes to the trade union side, some of the trade unions were involved on the reference group from the beginning. When they approached us, we realised that we had not included some of them. Their biggest concern was not about the concept of the Act or regulations but when they would be commenced and the readiness of staff. It was about training, timelines, workforce pressures and pressures on the health service in general. The unions were not negative to the concept but concerned about how it would be done. We have been working constructively with them. They have been invited to our regular meetings.

The research provisions relate to people who lack the capacity to consent to intrusive research that is not a clinical trial. There is a big separator straight away: clinical trials are regulated separately. If it is a clinical trial for testing medication or procedures, it is not covered by the Mental Capacity Act. The regulations cover things that would normally require consent, such as using their data, blood samples or tissue samples, but the person cannot consent and it is not a clinical trial. Those are the main areas. While it is called "intrusive research", it is not intrusive in the same way as clinical trials, testing new surgical methods or those kinds of things. That would be a clinical trial. Any research must be done in the person's best interests and must weigh their interests over those of science. The person is always at the centre so that their rights are protected.

Under the Mental Capacity Act, best interests shift slightly from clinical best interests to holistic best interests. There must be special regard to the person's wishes, feelings, beliefs and values. That means that, if someone is very much in favour of research in general, it might be deemed, when they lack capacity, that they would probably have said yes because they liked research. They can then take part in research under the Act, but their interests rather than the interests of research or science are always paramount: it is what they would want to happen if they had the capacity to consent. It focuses on that aspect. We think that human rights protection for people now is stronger than it would have been before when it was based on common law, and more focused on clinical decision-making and decision-making around people on a different scale.

In general, it says that research can be done when people lack capacity only if is not practicable to do the research on people who have capacity. If the same research can be done without including people who lack capacity, you cannot include those people. The focus is always to find people who can consent. If that is not possible, consideration should be given to whether the research will benefit the patients. If it cannot benefit the patients, it cannot be done anyway. I hope that I have answered all your questions.

Ms Flynn: Yes, you did. Thank you very much.

Ms S Bradley: I want to move on to the section on research. I know that we have not had the Examiner of Statutory Rules, but I was a little alarmed that the appropriate bodies would be:

> *"an HSC trust or a university".*

I would like your thoughts on the fact that a university could intervene. I could understand it if it were from a medical perspective but not a university. I want clarity on that.

In the document, on 225, on mental capacity, it cites the amounts and refers to section 276(3)(a) of the Act. I do not know the scale. How proportionate is that? How much can be held under the regulations? It also refers to a:

> *"nominated person (if one is appointed ...)".*

How exhaustive is the process in ensuring that a nominated person is appointed in every case where it is possible?

Finally, regulation 7 states:

> *"countersignature of another person witnessing the signature in sub-paragraph (k)."*

Sub-paragraph (k) referenced the person in the place wherever the patient might be, but it does not seem to pin down whose countersignature that is or could be. I am thinking about the vulnerability of the patient. It does not even stipulate that it has to be another member of staff in that place. Is there a reason behind that? Am I missing something there?

Dr Adell: When it comes to the research regulations, the people who carry out research that is relevant in Northern Ireland are the universities and the health and social care trusts. The bodies that approve research in Northern Ireland are the HSC research ethics committees that sit under the PHA and the ethics research bodies that sit under the two universities: UU and Queen's. They have research bodies and operations to approve the research as research. It was the policy intent that those people would be allowed to approve the research in this aspect as well as part of their ethical consideration of the research in general. They would be bound by the normal ethics considerations

that they have when they carry out research. Those bodies are the experts in the ethical consideration of research in Northern Ireland.

The amount is set at £20,000 in section 276 of the Act — the primary legislation. The intention is not that they can regularly hold £20,000 but that they are permitted to hold up to that amount. Someone could come into a care/nursing home with a wedding ring that might be worth £10,000. If the wedding ring cannot fit on the person's finger because the finger is swollen, the care/nursing home should be allowed to keep that wedding ring in a safe. If there is a painting on a wall that belongs to a resident, unless they have the power to keep those, they cannot keep them in the home, and there is no responsibility for the home to keep them safely. That is the reason for the values. The value was provided through a full public consultation process for the Act in 2014 when it was a Bill. My recollection is that, at that point, £20,000 was deemed a suitable figure for care/nursing homes to hold without approval from the RQIA. That figure is set in the legislation, not in regulations.

Ms S Bradley: Yes, I appreciate that.

Dr Adell: On the appointment of nominated persons, for the purpose of releasing money and valuables, you need to consult people when they are considering best interest. The best interest requires that all relevant people are consulted. If a nominated person is appointed, they are one of the relevant people and must be consulted if it is appropriate and practicable to do so. That is in the Act. If a decision requires a nominated person, there is a default list in the Act. You start with the person's primary carer, if that is a non-paid carer, and then it goes to spouse and child and so on. There is a default list, so the nominated person is defined.

When it comes to countersignature, are you referring to regulation 7(2)(k)? I just want to be sure.

Ms S Bradley: Sorry: (l).

Dr Adell: Yes, sub-paragraph (l) and the signature in (k). The intention behind that is that the person must keep a record of what they are keeping and that one person cannot make a decision; it must be someone signing for it and someone countersigning for it. It can be difficult to find exactly who they are. If there are agency staff, for example, they are not employees of the home. The policy view was that, if someone signs for it and someone else countersigns, it is still the managing authority's responsibility that the right people sign, and the managing authority is responsible for what happens with that fund. If someone has signed for it and it is used inappropriately, the managing authority is responsible, not the person signing. It is in their interests to have only the right people signing.

Ms Dolan: Thanks, Tomas. I have three quick questions. On the trust panel, the regulations state:

> *"Duty to record and retain information and records".*

It says to keep the records for "as long as is relevant". Who decides what is "as long as is relevant"? Sometimes, we have come up with issues around detention and safeguarding. This could be an issue. I know that it says at least one year from the panel decision, but, after that, who decides what is relevant?

The other issue is in Part 5:

> *"Arrangements When a Deprivation of Liberty is Proposed Before a Person is 16."*

The time is one month. What was the rationale for one month and not three months, considering some of the issues around waiting times and waiting lists? That is me, actually. Just two.

Dr Adell: On the first thing — the trust panel's duty to record and keep information — they have to keep it for at least one year or for as long as is relevant. The intention is to keep it in line with normal retention procedures in the trust. As long as a detention is ongoing, they must keep the records, but, after detention has ended, they must still keep it for a year after authorisation. They can then destroy the records as they would normally destroy records in the health service. It is the normal retention procedures.

When it comes to the one-month transitional provision, the one month is the time in which you can make a decision and make assessments to decide to deprive someone of liberty. We would want

those assessments to be done as soon as is practicable before the decision to deprive someone of their liberty. If someone is 15 years and nine months, their condition might change when they are 15 years and 11 months, especially as things can change quite quickly for young people. We would want the assessment to be as recent as possible. We would not want to go more than a month because they might have assessments that are outdated. That is why there is a one-month period.

Ms Dolan: OK.

Mr Easton: Thank you for your presentation. I have just one question on panel decisions, which is on page 88 — it is a bit confusing, this — regulation 46(2):

"The panel is not required to provide formal justification of its decision."

I do not agree with that. They should justify their decisions.

Dr Adell: The reason is that they do not need to make a formal judgement in the same way as a judge or a tribunal would. The evidence why a trust panel should authorise must be in the paperwork. If they are not content that the paperwork provides enough evidence, they cannot authorise the deprivation of liberty (DOL), so the reason for the DOL is in the paperwork that comes to them. We have developed regional paperwork that the trust panel has to use with comment boxes in which they say why they are doing what they are doing, but it is not a formal judgement in that sense.

Mr Easton: OK, but, say the panel goes against the decision that has already been made, should there not be some documentation to explain that?

Dr Adell: There is documentation. There are comment boxes with the reasons why.

Mr Easton: Just boxes.

Dr Adell: Yes, expandable boxes. There are reasons why, but it is not a formal written judgement that a tribunal would have, because they are healthcare professionals. The panel is not a legal panel; it is a trust second-opinion system rather than formal scrutiny. For that, we have the tribunal system, and the Attorney General should be in the system that comes after the panel. The regional documentation that provides the format for the trust panel documentation includes justifications, but it is not the formal statement in that sense.

Mr Easton: Say, in theory, somebody is held and the trust wants them to be held, and it goes to the panel to make a decision. The panel decides to hold him — we will call them "a patient" — but a patient decides to go down the legal route. Are the legal representations allowed to have access to the paperwork on the panel?

Dr Adell: They are, yes. However, the tribunal would look at the original paperwork — the paperwork that came down from the professional assessments. The panel does not make assessments. The panel does not see the patients. They base their decision on the paper that has gone to them. If the decision is challenged or taken to the tribunal, they look at the paperwork — the original paperwork: medical reports, the formal assessment of capacity made by a healthcare professional — because they have seen the patient. That is what the tribunal bases its understanding of the trust panel's decision on. They will not base it on the trust panel decision itself, because the trust panel is a review mechanism in the trust.

Mr Easton: No problem. That will do, thanks.

Mr Stewart: Thank you for letting me back in, Chair. My question relates to "Money and valuables" at regulation 2:

"For the purposes of section 276 of the Act if it appears to a relevant authority".

To me, the word "appears" sounds quite subjective and broad. Is there anything more tied down in that, in terms of a process for the assessment, as to how that "relevant authority" would make that assessment, rather than just "appears" to be? You talked about flow charts earlier, within training. How is that decision informed and decided on?

Dr Adell: They have to assess capacity in line with a capacity test, which is in the first sections of the Act. There is a statutory capacity test that they have to consider. They have to have a reasonable belief that the person lacks capacity; that is where the word "appears" comes from. However, they still have to follow the statutory test that is in the Act.

Mrs Cameron: Thank you, Tomas. I do not have a question, but I wanted to say that I had the misfortune of sitting on the Ad Hoc Committee that scrutinised the Mental Capacity Bill. It was an absolute minefield. It was so complex. I want to thank you for your time today, because it is incredibly detailed legislation. The regulations will, naturally, follow suit and be very complicated, so thank you for your patience with us.

Dr Adell: Thank you.

The Chairperson (Mr Gildernew): I have a couple of things as well, Tomas. In your presentation, you mentioned a cost of around £3 million annually: has that additional funding been allocated at this stage? Does it allow for backfill into the teams that will be affected?

Dr Adell: Yes. We have allocated £1·56 million this year, which is, in effect, in-year, and we have fully committed to fund it next year as well to backfill the posts. We have agreed with the trust to review costs at the end of this financial year and continuously throughout the next financial year, as there are some uncertainties about exact volumes. At this stage, that is unknown to all of us, but we are providing funding to backfill costs. There is, obviously, a problem with staff availability to backfill, as we are all fully aware, but the funds have been provided.

The Chairperson (Mr Gildernew): I have one final question. In passing, you mentioned a review in your presentation. Given the complexity of the issue and given that we all hope to see significant improvements in how this area of life is managed as a result of the statutory regulations and the more substantive Act, when is that review planned to take place?

Dr Adell: There are two ongoing reviews. One is a continuous review, and we will carry out a formal review as well. We are not going to set a date for a formal review yet, because it depends slightly on how the ongoing reviews go. We do not see the need to review something that, we know, is not working well or when we know where the problems are. There will be a formal review and a post-project evaluation, as there is with all projects.

I envisage that we will look at it formally at least no later than a year after commencement; so we will look at how it is going in December, but I do not want to set a date, because we might want to do it more quickly, if we feel there is a need to do so. We might want to delay it slightly because we have initial teething problems that, we know, we will come across. Instead of setting fixed dates, we are committing to do it but just not committing to exactly when.

The Chairperson (Mr Gildernew): OK. Thank you for that. I suppose, despite whatever the decisions are today, it is such a significant issue for the community that we will continue to keep an eye on it. Thank you for your comprehensive presentation and for dealing with all the questions very directly. Thank you for your time; we appreciate it.

Dr Adell: Thank you.

The Chairperson (Mr Gildernew): OK, members. Thank you for that. Before we start to put the Question on each of the individual regulations, do members wish to make any further comments at this stage?

Ms S Bradley: Will the Question have built into it that we are referring to the examination? That is a big piece of work for us now — the technical scrutiny — and it is pending that decision. We should make that clear. That is inbuilt in the Question, as I understand it: is that right? Yes? OK.

The Chairperson (Mr Gildernew): It is built into each one.

Mental Capacity (2016 Act) (Commencement No. 1) Order (Northern Ireland) 2019

The Chairperson (Mr Gildernew): The regulations provided for substantial provisions of the Mental Capacity Act 2016 to come into effect from 1 October 2019. They were, as discussed, amended to provide for a later commencement date of 2 December 2019. Are members content to note the statutory rule?

Members indicated assent.

Mental Capacity (2016 Act) (Commencement No. 1) (Amendment) Order (Northern Ireland) 2019

The Chairperson (Mr Gildernew): These are the regulations that deferred the commencement of certain provisions from 1 October 2019 until 2 December 2019. Are members content to note the statutory rule?

Members indicated assent.

Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): These were the principal regulations providing for the procedure around deprivation of liberty, including suitably qualified persons to make capacity assessments, and the required forms. As discussed, they were subsequently revoked. Although they have been revoked, the regulations are for noting and have been included in the pack for the record. Are members content to note the statutory rule?

Members indicated assent.

Mental Capacity (Deprivation of Liberty) (Amendment) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): The regulations added an additional form to the principal regulations. Both were subsequently revoked. Although they have been revoked, they are for noting and have been included in the pack for the record. Are members content to note the statutory rule?

Members indicated assent.

Mental Capacity (Deprivation of Liberty) (Revocation) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): As discussed, the regulations revoked the principal regulations ahead of their replacement in later regulations. Are members content to note the statutory rule?

Members indicated assent.

Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): These are the revised principal regulations providing for the procedure around deprivation of liberty, including suitably qualified persons to make capacity assessments, and the required forms. Are members content with the statutory rule?

Members indicated assent.

The Chairperson (Mr Gildernew): I ask members to agree formally that the Committee for Health has considered SR 2019/199, the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (NI) 2019, and, subject to the Examiner of Statutory Rules' report, has no objection to the rule.

Question put and agreed to.

Mental Capacity (Deprivation of Liberty) (No. 2) (Amendment) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): The regulations amend the revised principal regulations to substitute form 6, which relates to medical reports. Are members content with the statutory rule?

Members indicated assent.

The Chairperson (Mr Gildernew): I ask members to agree formally that the Committee for Health has considered SR 2019/232, the Mental Capacity (Deprivation of Liberty) (No. 2) (Amendment) Regulations (NI) 2019, and, subject to the Examiner of Statutory Rules' report, has no objection to the rule.

Question put and agreed to.

Mental Capacity (Research) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): The regulations define the:

> *"Appropriate body for the purpose of research"*

as a body appointed by the Health and Social Care trust or a university. Are members content with the statutory rule?

Members indicated assent.

The Chairperson (Mr Gildernew): I therefore ask members to agree formally that the Committee for Health has considered SR 2019/193, the Mental Capacity (Research) Regulations (NI) 2019, and, subject to the Examiner of Statutory Rules' report, has no objection to the rule.

Question put and agreed to.

Mental Capacity (Money and Valuables) Regulations (Northern Ireland) 2019

The Chairperson (Mr Gildernew): The regulations extend to any managing authority the power that trusts have to hold and manage money and valuables on behalf of residents and patients lacking

capacity. The regulations also make provision as to the issues to be considered and formalities to be observed. Are members content with the statutory rule?

Members indicated assent.

The Chairperson (Mr Gildernew): I therefore ask members to agree formally that the Committee for Health has considered SR 2019/200, the Mental Capacity (Money and Valuables) Regulations (NI) 2019, and, subject to the Examiner of Statutory Rules' report, has no objection to the rule.

Question put and agreed to.