Liberty Protection Safeguards: Client-wide support

Questions to be determined at the ICP/ICS level

The Liberty Protection Safeguards, set to replace the Deprivation of Liberty Safeguards in April 2022, will mean significant changes for NHS organisations who take on new powers and responsibilities. Changes will also be required within Local Authorities, although the extent of these changes will be less.

Before individual organisations can confirm what they need in place and start to enact these plans, decisions need to be made about what, if anything, will be done across the integrated care system geography and whether any collaborative arrangements are across the full partnership (including Local Authorities) or simply the health partners.

Although we are still awaiting the draft Code of Practice and draft regulations to be published for consultation (due "September"), it is important that discussions commence as soon as possible.

Until individual organisations know what is being done collaboratively between Integrated Care Board (ICB) or Integrated Care Partnership (ICP) partners, it feels like they are almost in a state of paralysis (or conversely may over-commit to unnecessary resource in panic).

Our overriding recommendation is that ICS - wide LPS implementation groups put a proposal forward to their ICS Board at the earliest opportunity (which they could discuss and prepare before the draft Code of Practice and Regulations come out and then simply check and tweak as necessary), which covers the following questions.

Once it is known at which level the intention is to hold each of these fundamental components at, practicalities can then be arranged such as hosting and funding flows.

Background to be considered and questions to answer	Across all ICP Responsible Bodies	Across NHS Responsible Bodies only	Each organisation individually
AMCPs Specially qualified and registered AMCPs will only be required where the individual lacking capacity seemingly objects to being accommodated in the place(s) where the LPS is to apply. Individual organisations may struggle to quantify the numbers of AMCPs they are likely to require due to uncertainty about the numbers of cases that will be categorised as 'objecting' and uncertainty about the length of time each case may take. Where numbers in a particular organisation are low there is a risk that the AMCP may become de-skilled. There may therefore be benefits to organisations pooling AMCP resource to be able to call off as required. This would also provide greater 'independence' from the care delivered by an individual organisation. **Is there a desire to pool AMCP resource?**			
IMCA contracts Currently Local Authorities hold the contract with the IMCA services required to support the DoLS process. Individual NHS provider organisations will hold much lower value contracts with an IMCA service provider to cover the need for an IMCA in 'serious medical treatment' cases where there is no appropriate person to consult. There may be benefits for both Responsible Bodies and the IMCA service provider to consolidating all LPS IMCA requirements into one contract rather than have multiple contracts with less certainty of figures for each. IMCA service providers will need time (at least 3-6 months) to increase their capacity and may find it easier to only have to negotiate one contract variation within each ICS area. **Should there be one IMCA contract?**			
Administration There will be administrative duties which will be the same whichever organisation the LPS application originates from and is sent to. Currently it is common for acute Trusts to contract with mental health Trusts to provide an MHA administration service. Having a single administrative team gives increased resilience and ensures reduced			

Background to be considered and questions to answer	Across all ICP Responsible Bodies	Across NHS Responsible Bodies only	Each organisation individually
variation amongst organisations within a geographical area. **Is there an appetite for a single administrative resource?**			
Electronic Recording System LPS authorisations are designed to be portable between settings (and therefore Responsible Bodies) in a way that DoLS authorisations weren't. Therefore, it is important that different organisations are aware of LPS authorisations already in place for individuals who enter their care to prevent duplication. Ideally all organisations within an ICS geography would have access to the same electronic systems for recording LPS authorisations. There are already significant issues between Local Authorities and NHS organisations accessing each other's records and even NHS organisations within an ICS geography often use incompatible electronic patient records systems. There is a further complication that any electronic patient records system providers may erect barriers to adjusting the fields to enable LPS info to be captured effectively (financial or time barriers). An alternative might be a web-hosted database which all partners can access to log their LPS data, look up new admissions/referrals on and retrieve reports from. Through The Internal Audit Network (TIAN) we have access to an individual who could create this if there was an appetite. Alternatively, a simple Access database could be created that each organisation uses individually, but at least it would ensure that all organisations are capturing exactly the same info in the same format so if queries are raised and authorisations ported the accompanying data easily copies across. **How much time could potentially be saved if papers did not have to be emailed between individual organisations because they were all stored on a single system?**			
Commissioning of Assessments In inpatient settings, there should be no requirements to commission specific medical assessments of mental			

Background to be considered and questions to answer	Across all ICP Responsible Bodies	Across NHS Responsible Bodies only	Each organisation individually
disorder or mental capacity assessments as these would naturally form part of the roles and responsibilities of clinical staff caring for patients. For patients in the community (where applications for LPS authorisations will be directed towards CCGs/ICSs or Local Authorities) the individual may not be under the care of specialist clinical staff who could be expected to complete these assessments. **Can arrangements be made with GPs, through GMS contracts or otherwise, to complete the medical assessment of mental disorder, particularly in non-complex cases?** The Government's impact assessment suggests that the individual completing the care plan in CHC cases (normally the CHC nurse assessor/case manager) will complete the necessary and proportionate assessment. Therefore, it is likely to be a member of ward staff who completes this in NHS providers. There may be cases in the community though (particularly for self-funders) where a social worker or appropriately qualified individual (if Regulations dictate specific qualifications/registration are required) is not involved. **Could there be a pool of social workers available to undertake mental capacity assessments where there is no other suitable individual involved in the particular case?**			
Training Provision There will be many different groups of staff requiring training: • BIA > AMCP • New AMCPs • Pre-authorisation reviewers (non-AMCPs) • Authorisers • Staff responsible for completing mental capacity assessments which will be relied on • Staff responsible for completing mental health assessments (medical assessment of mental disorder) which will be relied on			

Background to be considered and questions to answer	Across all ICP Responsible Bodies	Across NHS Responsible Bodies only	Each organisation individually
• Staff responsible for completing necessary and proportionate assessments (often as part of care planning) • IMCAs • Administrators **How much of this training can be jointly commissioned/delivered by shared trainer posts?**			
Process/Procedure Depending upon the answers to the above will depend upon the extent to which there will be one set of guidance/process/procedure documents to support staff through the process. There are a number of procedural questions that will need to be answered – see our flowchart and process and procedure questions to accompany flowchart. Even if formal collaborative arrangements/ joint contracts etc are not put in place, the more of these questions that organisations have the same response to the easier implementation will be in the ICS as a whole due to shared knowledge and understanding. **Are you happy to adopt LPS steering group decisions on the answers to most process and procedure questions?**			

This paper will be updated on an iterative basis and at no stage is intended to be 'definitive'. If you believe any of the content to be inaccurate or if you believe there is further information that could enhance its usefulness then please do get in contact: Elaine Dower (elaine.dower@nhs.net, 07342 081522) or Kristina Dickinson (Kristina.dickinson@nhs.net, 07748 622985).