Liberty Protection Safeguards: Client-wide support

Responsible Body Preparedness – Sharing Ideas

Over the last couple of months we have spoken to MCA/DoLS leads at 33 NHS organisations and Local Authorities and joined a number of implementation groups. Unsurprisingly, the COVID-19 pandemic has significantly impacted the amount of resource available to undertake planning for implementation of the Liberty Protection Safeguards.

However, the initial implementation date remains set as 1 April 2022. Therefore, it is imperative that organisations start to take the practical steps necessary for implementation.

We have identified 17 key areas of work and have utilised these as headings in the various papers we have produced to date to enable read-across.

Scoping	Project	Implementation networks
Electronic system	Administration	Approval of AMCPs
Governance	IMCAs	Process/procedure
Mental disorder assessment	Mental capacity assessment	Necessary and proportionate
Staffing	Training	Communications
Transition	Audit and monitoring	

Future papers will try to maintain these headings as far as possible, but we will amend them if necessary as further information comes to light.

Because we are still awaiting the draft Code of Practice and Regulations, for some of these key areas there are not a lot of ideas and suggestions to share, as discussions are not yet occurring in earnest.

In a number of key areas, detailed work also can't get started at an organisational level until it is decided whether aspects of the LPS process will be managed collaboratively between Responsible Bodies, in conjunction with other ICS partners (see: LPS - Questions for ICS/ICP).

1. Scoping

Defining Criteria for Scoping

Each of the different organisation types will have different considerations when trying to make an educated guess at the number of LPS applications they will be making/receiving. We have captured some of the suggestions made to us in the table below. Some overriding considerations when looking at current numbers are: How well do staff understand and apply

the MCA in everyday practice? Are there individuals meeting the 'acid test' possibly being missed?

Organisation type	Considerations and suggestions made
NHS Provider – acute	Starting point – current DoLS applications + any COP applications for 16/17 year olds. How liberally has the Ferreira judgment[1] been used? Therefore, are current DoLS application numbers a reliable indicator? Calculating a 'worst case scenario' (where can't trust current DoLS numbers) based on the admissions to wards of a particular type (eg stroke) or where particular diagnosis codes are used (eg dementia). Number of admissions of 16/17 year olds each year? Minus the number of these that are MHA admissions. Then pull the diagnosis code of each to make a judgment.
NHS Provider – mental health	Starting point – current DoLS applications + any COP applications for 16/17 year olds. Calculating a worst case scenario – how many informal admissions each year of individuals 16+? (NB: The concern amongst MH trusts seems to be the impact if/when the MHA proposed reforms are implemented).
CCG	Starting point - Number of DoLS in care homes currently that are CHC funded (obtain numbers from LA) + Number of COP applications for CHC funded individuals in the community. Some are working on a ball park figure of 1/3 of all CHC (fully funded) cases. (NB Joint funded packages and s117 funded packages will be referred to the Local Authority for authorisation of LPS (even where the CCG pay >50%). Similarly children's packages, even where 100% CCG funded would be referred to the Local Authority for authorisation as they are not technically CHC).
Local Authority	Number of DoLS from Independent Hospitals currently + Number of DoLS from care homes currently minus those that are CHC funded + A proportion (?%) of

[1] The Ferreira judgement [court of appeal, 2017 https://www.bailii.org/ew/cases/EWCA/Civ/2017/31.html, where it was judged that there was not a DoL at all] was applied differently across acute providers with some organisations interpreting this as applying to the majority of acute inpatients (as they are all receiving life-sustaining treatment) with others interpreting this narrowly as applying only in ICUs.

The wording of the new legislation is that any ensuing deprivation of liberty is authorised where the "steps are wholly or partly for the purpose of giving P life-sustaining treatment or doing any vital act" (where a vital act is one which is believed to be necessary to prevent a serious deterioration) and it is an emergency (defined as an urgent need to take the steps and not reasonably practicable to make an application for detention under the MHA or make the application for LPS authorisation to the Court or Responsible Body).

The Code of Practice may make clearer how this should be interpreted, but it is not guaranteed and we may still be reliant on the current case law.

Organisation type	Considerations and suggestions made
	joint funded packages, s117 packages in other settings and 16/17 year olds receiving any package (even where CCG funded).

Numbers at an organisation level

Following conversations with organisational leads we have requested figures of number of DoLS, Court of Protection (COP) applications, MHA admissions, 16/17 year olds in service, BIAs employed etc in order to do some comparative benchmarking. It is interesting that not all organisations were able to provide these figures easily and some of the figures we have got back are inconsistent eg calendar years vs financial years.

A number of our requests are still outstanding. We will produce a comparison in a future iteration of this report.

CCGs have recently been asked by NHSE to complete a spreadsheet which captures similar data. The return date is 25 September 2021 so this should provide a national picture specifically for CCGs. We have asked for a copy from CCG clients from whom we were still awaiting data to prevent duplication.

We understand a similar request may be made from providers in due course.

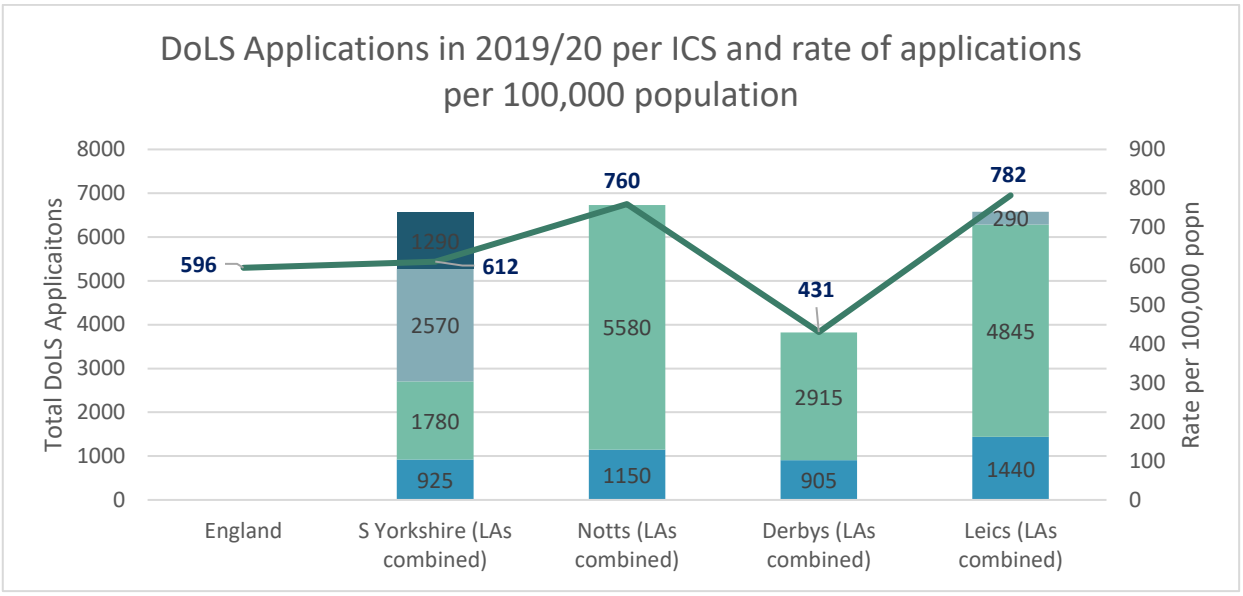
There have been very few COP applications for 16/17 year olds made by NHS providers.

Among CCGs and Local Authorities, there is almost a split between those that have decided to actively try to identify deprivations of liberty in the community and apply to the COP for authorisations (where there may even be a team supporting this) and those who have made a decision that the risk v resource position is such that they will only progress with applications to COP where there is a specific high-risk set of circumstances.

Numbers at an ICS level

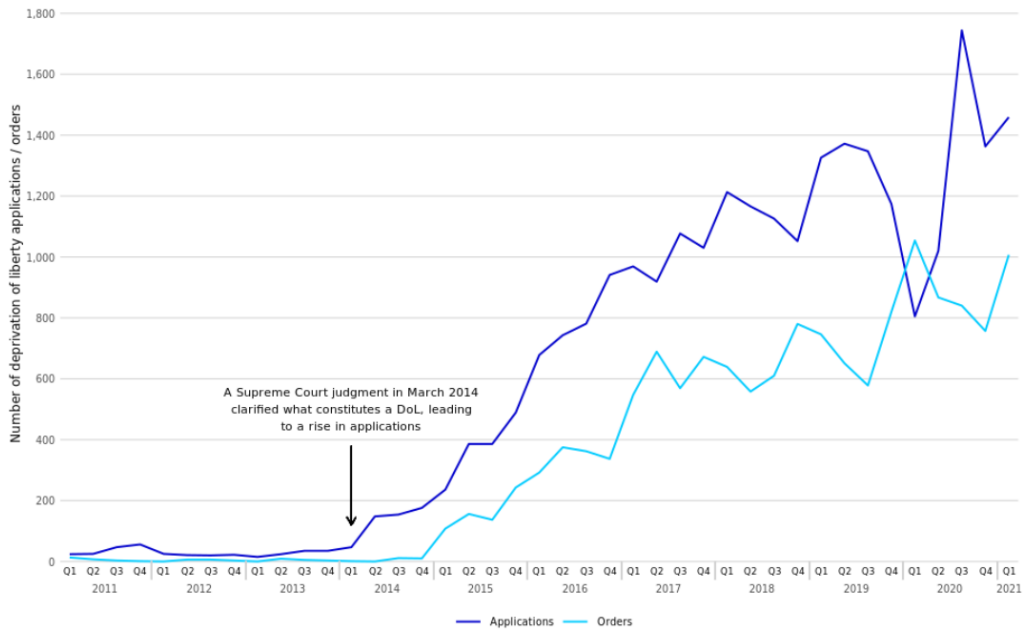
The graph below shows the numbers of DoLS applications per ICS in 2019/20[2] (stacked columns – where each colour is a different Local Authority within the ICS), along with the rate of DoLS applications per 100,000 of population (superimposed line graph).

[2] Figures available from https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2019-20 We have combined Local Authorities to create ICS-wide figures.



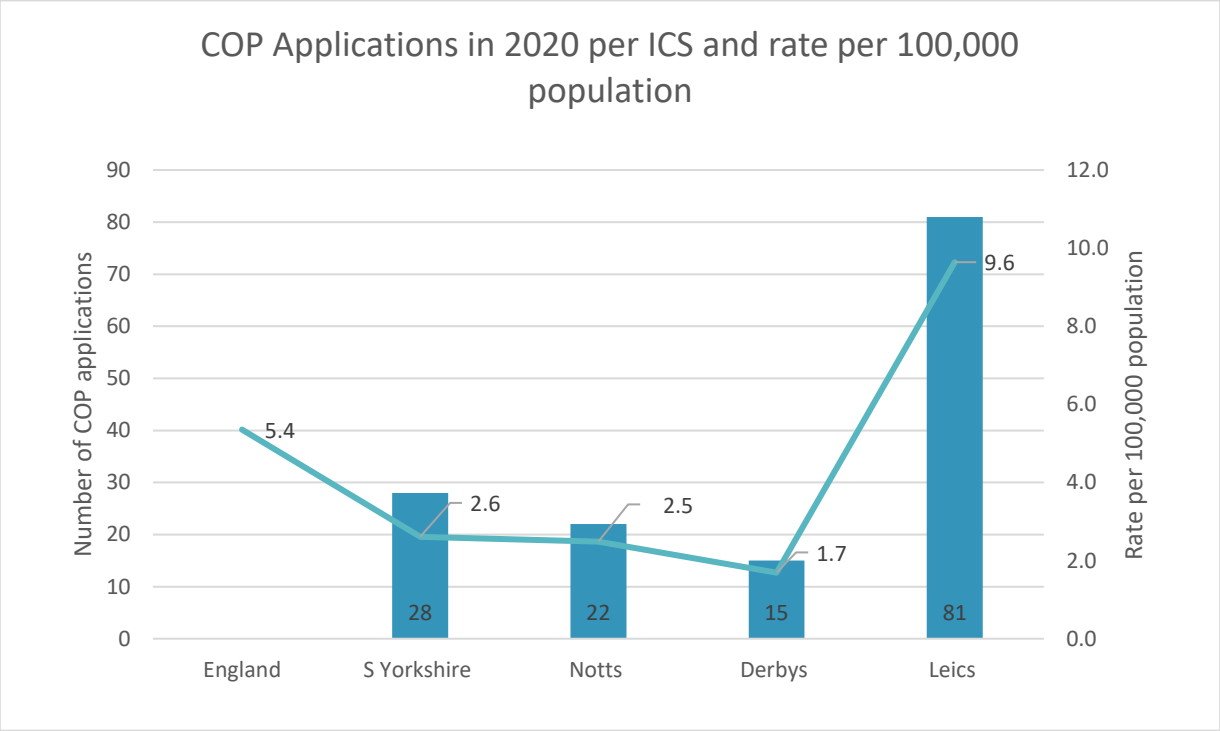
For circumstances amounting to a deprivation of liberty in settings other than a hospital or care home, an application for authorisation should be submitted to the Court of Protection (COP). Statistics published by the Court[3] show the total overall rise in applications and orders since 2011:

Figure 10: Deprivation of Liberty applications and orders, January to March 2008 to January to March 2021 (Source: Table 22)

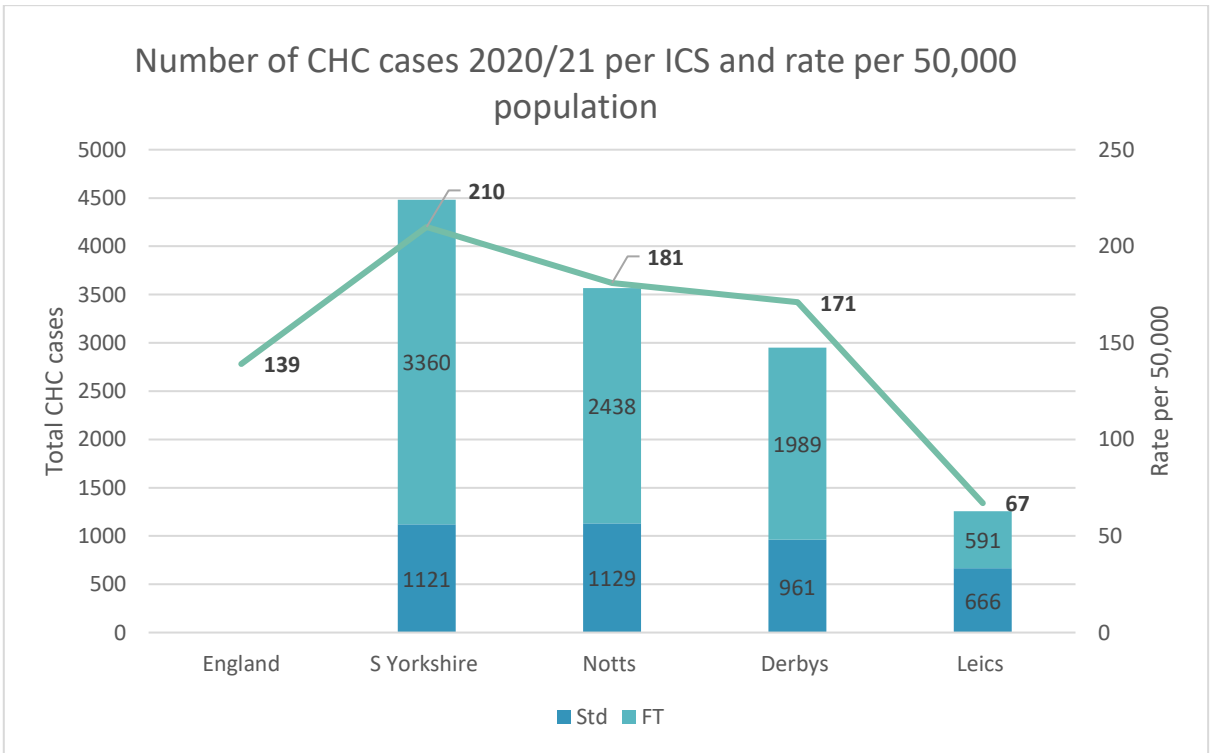


[3] Taken from the family court statistics for January to March 2021, available at: https://www.gov.uk/government/statistics/family-court-statistics-quarterly-january-to-march-2021/family-court-statistics-quarterly-january-to-march-2021#mental-capacity-act---court-of-protection

However, when this is broken down by region/ organisation it is incredibly variable across the country. The graph below shows the numbers of Court of Protection applications from the four ICSs we predominantly work with, along with the rate per 100,000 population.



The other figure important in scoping for CCGs/ICSs is the number of individuals receiving Continuing Healthcare (CHC) funding. The graph below shows the total number of cases per ICS, split between Standard (Std) and Fast Track (FT) and the rate per 50,000 population.



Several CCGs seem to be working on a third of their CHC cases as potential LPS cases, but this ratio is not contained within the Government's impact assessment[4].

A number of CCGs use Commissioning Support Units (CSUs) to provide CHC assessment and case management. The level of involvement CCG officers have in Court of Protection applications currently varies. When the CCG (or the ICS) is having to authorise deprivations of liberty themselves under the Liberty Protection Safeguards, one question being raised is whether this will this change how much needs to be done in-house to be assured of the appropriateness of the authorisation.

2. Project

All organisations we have spoken to have an operational lead for LPS, normally the MCA lead (where applicable) and/or sat within the safeguarding structure. In mental health Trusts links are being made with the MHA administration team.

Most organisations have stood down any internal project groups that had been set up in 2019 but are looking to restart these once further information is available in the form of the draft Code of Practice and Regulations.

One of the main concerns expressed by individuals we have spoken to is trying to ensure Children's services are involved. Because they have not had to utilise the DoLS processes they will, to some extent, be playing catch-up on definitions and terminology, not to mention familiarity with the paperwork (draft standard LPS forms we have had sight of look very similar to DoLS forms).

3. Implementation networks

South Yorkshire

Place-level networks appear to be established in each of the four places (Barnsley, Doncaster, Rotherham and Sheffield).

However, our conversations revealed that an ICS-wide meeting had not been held. We have therefore arranged a meeting between NHS Responsible Bodies across South Yorkshire for the 5 October and would be happy to continue facilitating this if that is requested.

Nottinghamshire

At an ICS level, Nottinghamshire have established an LPS Steering Group that has met three times to date. 360 Assurance has been invited to sit on this group. There has been some

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956863/Impact-assessment-of-the-MCAA-final.pdf

discussion and consideration of AMCPs being employed at an ICS level to enable efficiencies across the system.

The group has an established Microsoft Teams Channel (set up by Nottinghamshire County Council) which all can access and share documents, updates and ask questions etc. A small working group was established to develop a project plan that could be used by different organisation types as part of their planning and preparation.

Derbyshire

There is a Derbyshire-wide LPS group, involving both health and Local Authorities. The last meeting was cancelled whilst awaiting the draft Code of Practice and Regulations. 360 Assurance has been invited to sit on this group.

Leicestershire

There is a Leicestershire-wide LPS group, involving health and Local Authorities. 360 Assurance has been invited to sit on this group, with the next meeting scheduled for the 30 September.

Overall

The main issue being experienced is that these groups do not yet have a formal route into the still emerging ICS-wide governance and decision-making structures (see: LPS - Questions for ICS/ICP).

Also to note is that on 25 June 2021 it was formally announced that there has already been a Local Government Implementation Support Programme established, led by the LGA and ADASS[5], which includes regional implementation champions for adults' and children's services. There has also been a Social Care Providers Implementation Support Programme established, led by SCIE and Skills for Care. The announcement noted that a further programme for Healthcare (including HEE) was planned. The NHSE National CRG has since identified that funding has been requested for seven regional coordinators, with a supporting team in each region.

4. Electronic system

To ease portability and reduce unnecessary duplication of applications, in an ideal world all partners within an ICS geography would be capturing LPS information in a single system.

Similarly, in an ideal world, this would be an existing patient/client record system that had been tailored to capture all of the necessary information.

[5] https://www.gov.uk/government/publications/liberty-protection-safeguards-implementation-support/liberty-protection-safeguards-support-for-national-training-and-readiness

However, most conversations about electronic systems identified numerous hurdles to organisations accessing each other's systems.

One Trust who use SystmOne indicated that they had negotiated with TPP to make the necessary changes to capture LPS information within the patient record as part of the contractual commitment.

An Information Standards Notice will be published and we understand that NHSD are working on the portal through which data submissions will be made by each Responsible Body.

5. Administration

There is a lot to learn from MHA admin teams and from Local Authority teams currently managing all DoLS applications about the administrative processes.

Several mental health Trusts that we spoke to are planning to utilise the existing MHA admin team to support the LPS process (where administrative functions do not end up being located in a central 'hub').

Similarly, a number of acute Trusts currently have contracts with their neighbouring mental health Trusts to provide an MHA administration service and similar contractual arrangements are being considered in respect of LPS.

6. Training and approval of AMCPs

It is assumed that this will function much as for Approved Mental Health Professionals. The difference being that whilst AMHPs can be employed by any organisation, when they undertake AMHP duties they are doing so on behalf of the Local Authority, whereas AMCPs (who can also be employed by any organisation) potentially could be acting on behalf of a number of Responsible Bodies, even though they will have to be 'approved' by the Local Authority.

The NHSE National Clinical Reference Group for LPS has confirmed that the contract to produce the training materials for conversion of BIAs to AMCPs has been awarded to Shropshire Council DoLS Team and Neil Allen and will then be made freely available to Local Authorities.

7. Governance

Internally, operational leads have been providing briefings and updates on LPS progress (or lack of it) through the same reporting routes as MCA/DoLS is currently reported through.

Governance at the wider, system-level is still establishing and therefore the routes for discussion and agreement of the way forward in respect of LPS are not clear.

8. IMCAs

Currently NHS providers may have contracts with IMCA service providers but these are likely to be of low value as IMCAs may only be required when there is a serious medical treatment decision to be made for which the patient lacks capacity and there is no-one suitable to consult with as part of the best interests decision-making process. Under LPS, NHS providers and CCGs/ICSs may have more need to refer to IMCAs and therefore need to consider the extent to which contracts will need to be updated and expanded (and the requisite time IMCA service providers will need to generate this extra capacity). This is an area where decisions need to be made at an ICS/ICP level before individual organisations should determine their own contractual obligations (see: LPS – Questions for ICS/ICP).

At the same time IMCA service providers will need a general idea of the scale of the potential increase in capacity being asked of them (without it initially needing pinning down to which contract it will be added to).

9. Process/Procedure

The legislation itself gives us quite a lot of information about what the new LPS process is going to have to look like. However, there is a lot of detail that it is anticipated the Code of Practice and the Regulations will add. Even if the Code and Regulations add the level of detail some are hoping, there will still be a number of decisions that are left to those implementing the safeguards to determine. The more the answers are aligned between ICS partners the easier it might be to port authorisations and also for staff to move between organisations, providing support and resilience where needed.

We have captured the overall process in a flowchart and created a supporting document that outlines *some* of the questions that will need to be answered in any process/procedural documents. We have highlighted those where the draft Code of Practice and Regulations are needed before these conversations can become meaningful (see: LPS – Overview flowchart and LPS – Process and procedure questions).

10. Medical assessment of mental disorder

The act identifies that the assessment and the determination do not have to be done by the same individual and that previous assessments can be relied upon.

Within NHS providers, the most common position is that any admission clerking documents may simply need to be adjusted such that they explicitly capture any mental disorder assessment and diagnosis and its source so that these can be used as the medical assessment of mental disorder. It is not generally felt that there will be requirements placed on medics which fall outside of their current contractual requirements.

Currently CCGs who are undertaking a number of COP applications have established template letters that they send to GPs to complete which provide sufficient evidence of a mental

disorder being present to satisfy the COP. Generally GPs appear to have provided the information willingly. These CCGs hope and anticipate that a similar system can simply be evolved to cover the medical assessment of mental disorder for CHC LPS cases for which they will be responsible, where there is not already an appropriate medical assessment of mental disorder on file.

The main struggle may be for Local Authorities, who may struggle to get the same responsiveness from GPs (unless contracts are altered) and who may therefore need to continue to rely on specifically commissioned 'mental health assessors' as are currently used under DoLS.

11. Mental capacity assessment

The act identifies that the assessment and the determination do not have to be done by the same individual and that previous assessments can be relied upon.

As for the medical assessment of mental disorder, NHS providers are assuming that the required assessment of mental capacity can be undertaken by clinical staff (nurses most likely) and facilitated by a change in the standard paperwork.

CCGs have indicated that it will most likely become part of the CHC nurse assessor's role to assess capacity (where they are not already doing so).

The main concern seems to be from Local Authorities who will be the Responsible Body in situations where there may not be an individual involved in the case who is able to complete the mental capacity assessment and/or determination and therefore may need to specifically commission this (situations where there is no social worker eg self-funders).

12. Necessary and proportionate assessment

The act identifies that the assessment and the determination are to be made by the same person. Therefore, previous assessments cannot be relied on and the specific circumstances and current care plan need to be considered or the assessment and determination done as part of their development.

13. Staffing

The scoping exercise to identify likely numbers of LPS applications will provide a platform for estimating the numbers of: individuals who might be needed to complete necessary and proportionate reviews, non-AMCP pre-authorisation reviewers, AMCPs, authorisers, IMCAs and administrators. The impact assessment estimates 26% of pre-authorisation reviews will require an AMCP. However, this percentage will clearly depend on the setting.

Non-AMCP pre-authorisation reviewers

Although the Regulations will clarify whether this staff group require particular qualifications or experience, organisations are working on the assumption that they will be registered professionals (nurses, AHPs, social workers). If this is the case, the dominant thinking seems to be that this will be a band 6 role (£32-£39k).

However, some organisations (especially where overall numbers of LPS applications may be low, but even one Local Authority) are considering having AMCPs undertake all pre-authorisation reviews as this may actually work out more efficient than having a split eg 0.5WTE band 6 + 0.5WTE band 7.

AMCPs

It is anticipated that the pre-requisite qualifications and experience to become an AMCP will be similar to that of a Best Interests Assessor (BIA) and the status is intended to be equivalent to an AMHP. Therefore, a typical banding will be a band 7 (£40-£45k), although this may be dependent on other responsibilities placed on the particular role.

One mental health Trust indicated that if there is not an ICS-wide 'hub' or pool of AMCPs, they are unlikely to employ one themselves given the low numbers of LPS applications they are expecting and they will simply enter into a contractual arrangement, most likely with the Local Authority, to commission an AMCP on an ad-hoc basis. The numbers of AMCPs required for inpatients in mental health hospitals should indeed be very low as if the patient is objecting and the arrangements are "for P to be accommodated in a hospital for the purposes of being given medical treatment for mental disorder" it is unlikely they will be eligible for LPS.

Authoriser

The individual authorising a deprivation of liberty has an incredibly important role – this should not be seen merely as an administrative/rubber-stamping duty.

However, there is clearly a balance to be struck between seniority (and therefore accountability on behalf of the Responsible Body) and an in-depth knowledge and understanding of the process and requirements. In our discussions with NHS organisations this authorisation is being considered at a band 7 or 8a (£47-£53k) level by some (specialist practitioners/the individual who will manage the AMCPs and non-AMCP pre-authorisation reviewers/matrons) and 8c (£65-£75k)/8d (£78-£90k) by others (with one Trust considering the Deputy Medical Director authorising all applications).

There is nothing in the legislation itself to suggest that the pre-authorisation reviewer (AMCP or non-AMCP) cannot sign the authorisation themselves – if this is not contra-indicated by the Regulations or Code then this would be up to each organisation if they were happy to delegate this 'power' (by way of comparison, many NHS providers allow the nurse in charge of a ward, who may be a Band 5 nurse at times, to accept a patient under MHA detention in the name of

the Hospital Managers (Board) or consider the level at which a COP application might be signed).

Within Local Authorities there was encouragement to have quite senior managers be the DoLS authorisers. One Local Authority suggested to us that the quality of the authorisations went up when the seniority of the authorisers was reduced in response to COVID-19.

General

In general, where organisations have already brought additional staff in, this may be under the guise of implementing Liberty Protection Safeguards but is being used, very wisely, to shore up the underpinning knowledge around the Mental Capacity Act.

14. Training

LPS implementation comes on top of a national picture of the Mental Capacity Act not yet being consistently applied across health and social care.

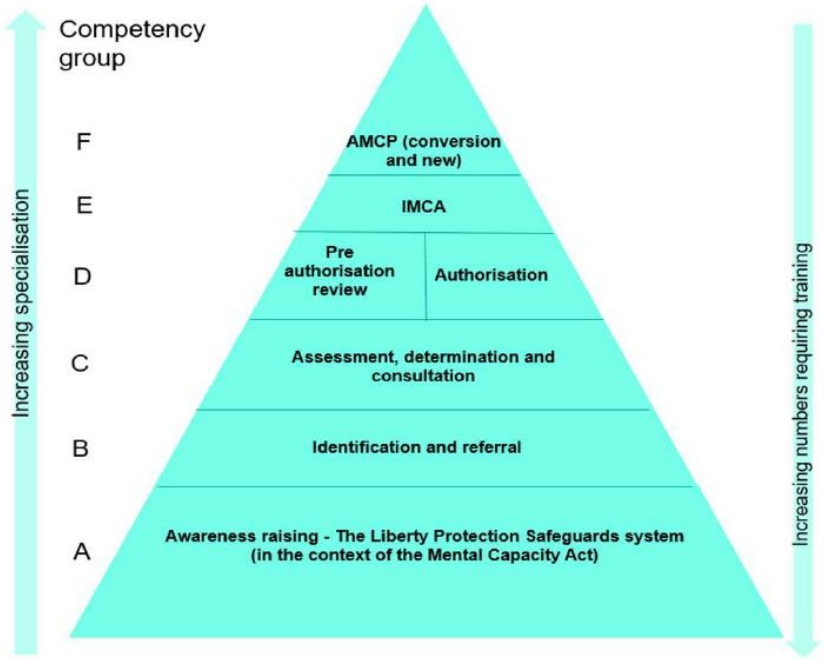
LPS will only be implemented effectively and consistently if all relevant staff are embedding the wider MCA in their day to day practice and considering this at every stage of a cared-for person's journey.

Conversations we have had with organisations have highlighted the need for enhanced MCA training, replacing current e-learning packages with role play or scenario-based training within teams. Organisational leads seem hopeful that the introduction of LPS will provide a route for organisational commitment to increasing resources to making this training effective. 360 Assurance are keen to support our clients in any way we can with this and it has been suggested that we might produce a series of 6 x 10 minute videos covering mental capacity, best interests and deprivation of liberty to supplement any training organisations have in place. We have also offered to develop an assessment workbook which could be used to evidence increased knowledge and understanding as a result of training.

The following diagram[6] illustrates the different training competency levels specifically identified for LPS. Administration staff are not included in this diagram, but it could be suggested that their level of knowledge will need to be equivalent to level C.

[6] From: *NHS preparation for implementation of the Liberty Protection Safeguards* (LPS) produced by the Safeguarding Adults National Network

Liberty Protection Safeguards (LPS) Workforce and Training Triangle



Training probably represents the biggest practical hurdle to overcome, given the numbers of staff involved.

15. Communications

Paragraph 14 of Schedule AA1 sets out the list of requirements for published information, which must be "accessible to, and appropriate to the needs of, cared-for persons and appropriate persons". Most organisations are hoping that, as for DoLS, there will be centrally produced information leaflets which can be provided to individuals subject to LPS and their relatives. This is something 360 Assurance have said they would be happy to develop if NHSE or DHSC do not do this centrally.

Most organisations commenced internal comms back in 2019 but these then stopped. This now needs to recommence to raise awareness.

16. Transition

It looks likely that there will be an 18 month to two year implementation period. Therefore, there will be a number of transition arrangements to be made, such as the point at which CHC care home cases are transferred from the Local Authority to CCG/ICS. There remains a backlog of cases in all Local Authority areas so decisions may also need to be made about whether cases are only handed over to alternative Responsible Bodies after they have been processed.

17. Audit and Monitoring

Monitoring of compliance with the MCA has always been harder than monitoring compliance with the MHA.

Many operational leads felt that staff had a good understanding of the MCA (but it may still be pulled up as a concern in CQC reports because the CQC use particular terminology which staff may not understand). The difficulty was identified as being a translation of this understanding into application in practice.

Our experience of auditing cared-for persons' records consistently demonstrates a huge variability in the recording of mental capacity assessments and best interests decision-making.

Currently, there seems to be very little audit of DoLS but there is seemingly a greater expectation that LPS will be monitored and audited.

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).