Liberty Protection Safeguards: Client-wide support

Questions to be determined at the ICS level (by all LPS 'Responsible Bodies')

The Liberty Protection Safeguards, set to replace the Deprivation of Liberty Safeguards in 2023/2024, 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 given their current responsibilities.

Before individual organisations can confirm what they need to have 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 all Responsible Bodies (Local Authorities, ICBs and NHS Hospitals) or simply the NHS ICS partners or even a sub-set of these.

The draft Mental Capacity Act and Liberty Protection Safeguards Code of Practice (which was out for consultation between March and July 2022) at several points supports the concept of a joint/shared team of Approved Mental Capacity Professionals (AMCPs) (see for example paras 13.50 and 18.11). However, there are a number of other functions that will be required under the safeguards that could be delivered in partnership and NHSE have consistently reinforced that they recommend collaborative approaches.

The case for collaboration

The impact assessment figures suggest the annual costs of LPS will be significantly less than the current annual costs of managing the DoLS arrangements. Therefore, no new recurrent funding is likely to be made available. Although transition funding may be made available, this has not yet been confirmed.

Making arrangements to run aspects of the LPS system collaboratively, across Responsible Bodies, will undoubtedly be more cost effective than individual organisations each setting up their own systems and processes. This is most evident in staffing costs – eg one LPS Team Manager at an ICS-wide level will be less expensive than a lead within each of the Responsible Bodies (eg there are 12 Responsible Bodies in one of the ICSs in our geography).

It should also enable the safeguards to operate more effectively, as there will be less duplication and less potential for missed or mis-communication. In a collaborative model, LPS staff would always have other experienced staff available for support, guidance and supervision and no-one would work in isolation (as might happen in smaller Responsible Bodies if each employed staff separately).

The concern around collaboration

It will still be individual organisations who remain statutorily responsible for complying with the safeguards (with CQC and Ofsted as the regulatory/ monitoring bodies) so there would need to be genuine parity in terms of the criteria by which cases were identified, processed, allocated, prioritised and escalated (depending on what functions were done collaboratively) to ensure all partners to the arrangements were able to demonstrate compliance with statutory requirements. Individual organisations would need to be assured through robust partnership agreements/ MOU/ contracts etc and good relationships with the organisation hosting any pooled staff teams and resources.

Until individual organisations know what is likely to be done collaboratively between ICS Responsible Body partners, it feels like they are almost in a state of paralysis about what to do next (or conversely may over-commit to potentially unnecessary resource in panic).

The table below sets out a number of functions that form part of the LPS process that could be delivered collaboratively. All of these functions could be delivered by a single ICS-wide team hosted by one of the ICS partners. Alternatively, an ICS might choose to only work on a couple of functions (or even none) on a collaborative basis.

Our overriding recommendation is that ICS - wide LPS implementation groups put a proposal forward to their ICP statutory committee and each individual Responsible Body's Board at the earliest opportunity, which suggests a desirable but realistic level of partnership working for each of the functions identified.

Once it is agreed in principle at which level the intention is to operate each of these fundamental components, practicalities (such as hosting and funding flows) can then start to be arranged and individual organisations will be able to make firmer plans.

Background to be considered and questions to answer
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 (as well as current uncertainty about the definition of a deprivation of liberty given the Code of Practice case studies). 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. As indicated above, this is also the direction that the draft Code of Practice suggested. **Should AMCPs be pooled into a team:** • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**
Non-AMCP Pre-Authorisation Reviewers For those cases that do not require a pre-authorisation review by an AMCP, the pre-authorisation reviewer still needs to be independent of the team providing the care to the individual lacking capacity. Although this should be relatively easy to achieve within individual organisations, the same issues may arise as for AMCPs in terms of uncertainty regarding numbers required, potential de-skilling if not conducting reviews regularly, lack of specialist support and advice if working in isolation etc. Therefore, if a pooled AMCP team is established, it may make sense to extend this and cover all pre-authorisation reviews. As Non-AMCP pre-authorisation reviewers do not need to be clinically qualified, there could be a consideration of how this aligns with the administrative functions and whether a single structure with different bandings could cover both aspects. **Should pre-authorisation reviewers be pooled into a team:** • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**

Background to be considered and questions to answer
Administration There will be administrative duties which will be the same whichever organisation the LPS application originates from and/or is sent to. Currently it is common for acute trusts to contract with mental health trusts to provide an MHA administration service. This might work in a similar way for LPS. Having a single administrative team gives increased resilience and reduces variation amongst organisations within a geographical area. **Should there be a team administrative resource?** • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**
Electronic Recording System LPS authorisations are designed to be portable between settings (and therefore Responsible Bodies) in a way that DoLS authorisations aren'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 (or possibly wider) would have access to the same electronic systems for recording LPS authorisations. DHSC, NHS Digital and NHS England are planning to produce an Information Standards Notice (ISN) which will require every accredited and compliant healthcare system supplier to update their clinical records systems to allow for collection of the LPS Minimum Dataset and submission of that to the national portal for NHS Digital LPS information collection. However, this will not resolve the issue that different organisations within an ICS use different electronic systems and cannot easily access those parts of a system it would be beneficial to share. There are already significant issues between Local Authorities and NHS organisations accessing each other's clinical/patient records and even NHS organisations within an ICS geography often use incompatible electronic patient records systems. 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. This would also support the reporting of LPS data into the central portal being developed by NHS Digital in line with the minimum data set.

Background to be considered and questions to answer
Can current systems be altered to capture the necessary information easily and in a non-cost prohibitive way? Is this the same for all ICS Responsible Bodies? **If so, can information from these systems easily be shared across partners?** **If not, should there be a single secure database to capture the necessary LPS information in a way that can be shared between relevant partners:** • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**
IMCA contracts Currently Local Authorities are responsible for commissioning the IMCA services required to support the DoLS process. Local Authorities will retain responsibility for all IMCA commissioning, even when NHS organisations become Responsible Bodies. Already, under DoLS, some Local Authorities and ICBs have arrangements for developing and monitoring the contract in partnership. There may be benefits for both Responsible Bodies and the IMCA service provider to consolidating all IMCA requirements into one contract rather than have multiple contracts (with less certainty of figures for each) and for all relevant Responsible Bodies to have a combined monitoring approach. IMCA service providers will need time (at least 6 months) to increase their capacity and may find it easier to co-ordinate this across an ICS area. **Should there be a single IMCA contract that is jointly developed and monitored:** • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**
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.

Background to be considered and questions to answer
Should there be one set of policies, procedures, guidance, forms, templates etc: • **Across all Responsible Bodies?** • **Across some Responsible Bodies (and, if so, which ones)?**
Training Provision There will be many different groups of staff requiring training: • BIA > AMCP (conversion courses) • 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 • 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 (eg by shared trainer posts)?**

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).