Portsmouth CITY COUNCIL

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Title of meeting: Health, Wellbeing & Social Care Portfolio Meeting.

Subject: The Liberty Protection Safeguards

Date of meeting: 1 November 2022

Report by: Jacquie Bickers, presented by Andy Biddle

Wards affected:

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1. **Requested by:** Councillor Matthew Winnington, Cabinet Member for Health, Wellbeing & Social Care.

2. **Purpose**

   To inform the cabinet member and spokespeople about the Liberty Protection Safeguards (LPS) that will replace the Deprivation of Liberty Safeguards (DoLS).

3. **Brief summary**

   LPS are designed to be simpler and more streamlined than DoLS by integrating the LPS process with the Care Act and the Children's Act mainstream assessment and care planning processes. This means vulnerable people will access the safeguards they need more quickly.

   As well as extending LPS to young people aged 16 and 17, in line with the Mental Capacity Act (MCA), a further key change is the extension of LPS into a wide range of settings. This includes supported living or the person's own home, places where previously an application would have been made to the Court of Protection to authorise a deprivation.

4. **Information Requested**

   To set out the scope of the LPS changes and the impact these changes will have upon adults and children's social care services.

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5. Legislative Framework

Deprivation of Liberty Safeguards were introduced in 2009 as a response to the findings of the European Court of Human Rights in the [1]*Bournewood* case concerning the deprivation of liberty of an autistic man with a profound learning disability.

A Deprivation of Liberty Safeguard is part of the Mental Capacity Act 2005 (MCA) framework to protect the European Convention of Human Rights (ECHR) Article 5 Rights (liberty and security) of people who lack capacity, because of a mental disorder or mental disability, to consent to their health and/or social care treatment.

Deprivation of Liberty legislation applies to people 18+ who are in hospital, residential and nursing care homes who do not have the capacity to consent to their care and treatment. The current DoLS process sets out that a managing authority (a hospital or care home) must seek authorisation from a supervisory body (local authority) in order to be able to lawfully deprive someone of their liberty.

6. The path to LPS

From the early years of DoLS, new case law had sought to give greater clarification on what amounts to a deprivation of liberty, owing to the fact that the MCA 2005 does not contain a detailed statutory definition of what constitutes a deprivation of liberty.

In March 2014, the Supreme Court handed down judgment in two cases: *P v Cheshire West and Chester Council* and *P&Q v Surrey County Council*, commonly known as Cheshire West. That judgement, set a new [2]'acid test' for determining whether a person was deprived of their liberty. This broadening of the definition led to significant increases in the number of people considered to be deprived of their liberty and corresponding backlogs across local authorities for DoLS authorisations with thousands of people being unlawfully detained.

In response to wide ranging criticism, the Department of Health, asked the Law Commission to undertake a fundamental review the MCA and DoLS. Following a public consultation in 2015, the Law Commission published a final report in March 2017, calling for the DoLS to be replaced as a matter of “pressing urgency” and set out a new scheme called the Liberty Protection Safeguards.

[1] Bournewood case | Equality and Human Rights Commission (equalityhumanrights.com)
[2] deprivation_of_liberty_after_cheshire_west_-_a_guide_for_front-line_staff.pdf (39essex.com)

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The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the current arrangements under Deprivation of Liberty Safeguards.

7. The current Deprivation of Liberty Safeguards Service in Portsmouth City Council

All referrals for a Deprivation of Liberty from care homes or hospital are made directly to the DoLS team. The team is comprised of one team manager, 10 Approved Mental Health Professionals who are all Best Interest Assessor (BIA) trained, one FTE BIA and 2.7 FTE administrators. Best Interest assessments can only be undertaken by a qualified BIA, who has to have a recognised qualification - Social Worker, Nurse, Occupational Therapist.

To supplement the work of the team, 14 social worker and two occupational therapy BIAs, based in different teams across adult services are allocated an assessment every six to nine weeks. The team also uses seven independent BIAs as needed and seven 'Section 12' approved doctors to assess mental capacity and mental disorder.

For the DoLS statutory return reporting year 2021/22, there were 1598 DoLS applications into the team, of which 1159 were new or initial applications and 439 that were renewals of previous applications. Unlike many other local authorities, the DoLS team does not carry a concerning backlog of cases, although there may be pinch points when a small backlog can build up. At the time of drafting this report, there are 55 cases pending allocation.

8. Key change from the current ways of working under DoLS

Under LPS, the legal framework expands significantly upon the DoLS system. The table below provides a summary of the key impactful changes:

From this … DoLS (Now)	**To this … LPS (New)**
Applies in care homes and hospitals only - shared lives and domestic settings must be applied for through the Court of Protection.	Applies in any setting (or multiple) without the need for the Court of Protection: people's own homes, residential and non-residential schools, shared lives, children's homes, supported living, day services
Applies from age 18	Applies from age 16 - no longer need to apply to the Court of Protection for 16/17 year olds
Care home or hospital identify 'acid test' is met	Frontline staff/anyone involved in person's care identifies 'Acid Test' is met
6 Assessments	3 Assessments - Medical; Capacity, Necessary and Proportionate

BIAs undertake capacity and/or best interests assessments once referral made	Registered staff - SWs, OTs, Physios, Nurses, SaLT, (Speech & Language Therapist) undertake Capacity and Necessary and Proportionate Assessments as part of other assessments, care planning or reviews.
Local Authority authorises	New Responsible Bodies authorise: In hospital - NHS Trust; CHC funded - the Integrated Care Board, (ICB); In all other situations, the local authority (usually based on Ordinary Residence or Education Health & Care Plan or S20/S37 Children Act.
AMCP Service	New Approved Mental Capacity Professional replaces BIA with responsibility for increased scrutiny and oversight of specific cases
Relevant Person's Representatives (including Paid Reps) support person in all matters related to DoLS	No Paid Reps - Appropriate Persons and Independent Mental Capacity Advocates (IMCAs) to support the person. New IMCA commissioning arrangements across adults and children's will be required.

9. Implications for Adults and Children's Services

9.1 Training

The new LPS framework is intended to simplify and streamline the assessment process by integrating LPS assessments with the Care Act and Children's Act statutory frameworks. The expectation is that LPS assessments, rather than be done retrospectively, as happens under DoLS, will be completed alongside other assessments or reviews.

This shift to make LPS 'everybody's business', entails designated front line practitioners (social workers, nurses, occupational therapist and speech and language therapists) rather than BIAs complete the LPS assessments. Equally, the extension of the settings in which LPS applies will affect a wide range of providers. The draft code makes clear that all health and social care professionals, staff members and care providers have a responsibility to be aware of the potential for a deprivation of liberty to arise and take appropriate action, including by making an LPS referral.

The upskilling and training of staff will be a significant undertaking. The groups of staff that will require awareness raising and specific or specialised training is set out in (appendix 1). The commentary boxes to the right of the Department of Health and Social Care's competency group triangle have been added to indicate how the training will be delivered and by whom.

9.2 Approved Mental Capacity Professional (AMCP) Role

Under LPS the BIA role will be replaced by the AMCP function. The AMCP role has been devised to be entirely independent from LPS assessors and to provide a robust process for scrutinising cases, which are particularly complex or where the person may be objecting to their care and treatment.
Existing BIAs will be able to complete an internal conversion course to become AMCPs. Designated professionals that wish to train as AMCPs will be required to complete an external course, which will have a similar approval criterion to that provided for Approved Mental Health Professionals.

The LPS draft code of practice has stipulated that the local authority will have lead responsibility for ensuring that there are sufficient AMCPs across all Responsible Bodies (see below) including their own. PCC is likely to be in a strong position with regard to having sufficient AMCPs; a questionnaire to BIAs about whether they would wish to become AMCPs suggests that of the 24/33 responses received so far, 20 would wish to. The role of PCC's AMCP service in supporting or supplementing the Integrated Care Board (ICB) and Queen Alexandra Hospital in the event there are insufficient AMCPs for them to deliver an AMCP service, however, is unclear. Further clarity on this matter is expected in the MCA/LPS Code of Practice.

9.3 New Responsible Bodies

LPS has identified Responsible Bodies (RB) under the new legislation to direct the responsibilities for LPS to the appropriate organisation:

- For people who are funded through Continuing Healthcare (CHC), the RB will be the ICB, ordinarily. *This may differ in Portsmouth City Council because of the S75 agreement and the Local Authority having a lead role for people in receipt of CHC in Nursing Homes. Further advice is anticipated on the delegation of RB roles;
- For people in an NHS Hospital including Mental Health, the RB will be Health.
- All other requests for an LPS assessment will be the responsibility of the Local Authority (Adult and Children's Social Care) as one RB, and this includes Independent Hospitals and self-funders for people aged from 16 years old.

The change in roles and responsibilities will necessitate new collaborative working arrangements with the other RBs. This will include application of a dispute mechanism for resolving disagreements about which RB is the correct authority to authorise.

9.4 Independent Mental Capacity Advocate (IMCA)

The IMCA role is fundamental to the LPS changes for ensuring vital safeguards to the person's human rights. PCC will have a responsibility to ensure that there are sufficient IMCAs for its local authority area regardless of the responsible body. Where there is not an 'appropriate person' to support the cared for person there is a duty to instruct an IMCA. An "Appropriate Person" can also make a request to be supported by an IMCA in certain circumstances and the responsible body must take reasonable steps to appoint an IMCA in these circumstances.

10. Financial Implications

A key driver for LPS is to reduce the costs associated with DoLS. The Department of Health and Social Care's LPS Impact Assessment indicates that implementing LPS would save over £200 million per annum on the current spend.

Some national funding is anticipated to support implementation of LPS but the Draft Impact Assessment was unclear to the extent of funding available. The [3]Joint Response on behalf of ADASS, ADCS and the LGA on the DHSC and Ministry of Justice MCA/LPS Draft Code of Practice LGA's highlighted the need for further evidence-based and accurate information in the Draft Impact Assessment to enable planning for new financial burdens.

It is to be expected that once the LPS Code of Practice and Regulations are finalised, the financial implications for the Council will then become clear.

11. LPS Implementation Planning

The implementation of LPS was delayed from April 2022 owing to the Covid pandemic. The consultation on the MCA/LPS Draft Code of Practice closed on 17 July 2022 and the consultation feedback results are due to be given late Autumn 2022. Based on the government timings for any amendments to the Draft Code of Practice to be made and for the LPS bill to move through parliamentary stages to pass into law, the earliest date that LPS will be implemented is October 2023. From the point of implementation, there will be a transition year when DoLS and LPS will run side by side.

Some of the early scoping work and discussions with the other RBs has started. An Adults and Children's LPS implementation project steering group with representation from the RBs is in the process of being established to commence late October 2022.

[3] ADASS_ADCS_LGA_LPS_Public_Consultation_Joint_Response.pdf

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Appendix 2 sets out the draft proposed work streams and task groups required to implement the new legislation.

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Signed by (Director)

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
MCA/LPS information web page	Changes to the MCA Code of Practice and implementation of the LPS - GOV.UK (www.gov.uk)

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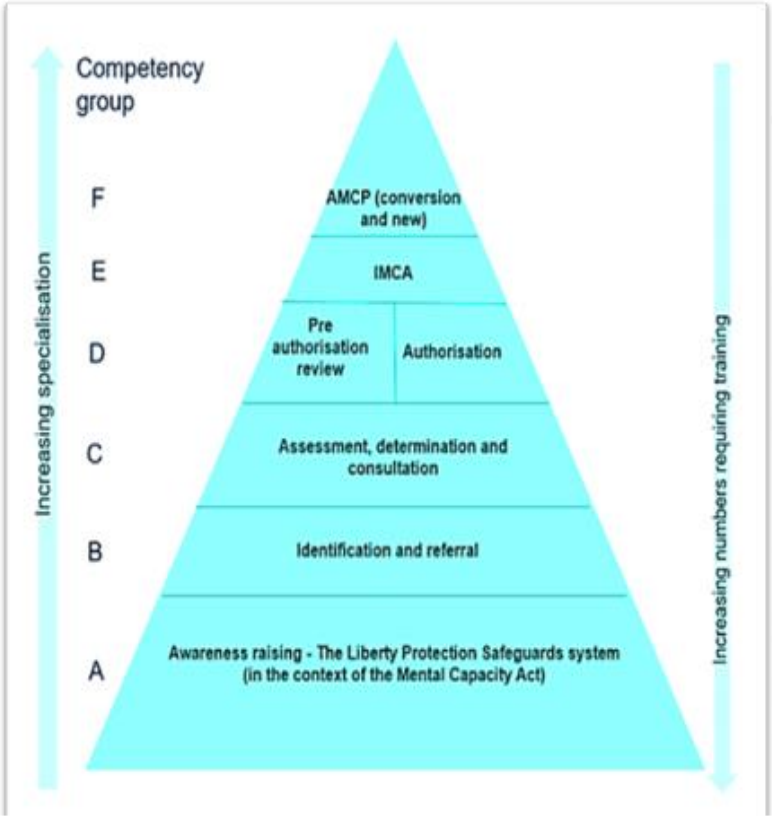
Appendix 1: DHSC Training Triangle

Workforce Development Planning



F: New role similar training to AMHP delivered by HEIs – approx. 6 months.
BIA Conversion course approx. one week in total.
Registered staff only. LA led

E: DHSC working with Indpt providers to develop training materials – no training role for LA but will need to commission new service

D: Signatory/Pre-authorisation review training - for Team Managers/Deputy TMs – LA led approx. 3 hours

C: Specialised training – assessments, determinations and consultation. Registered staff only. DHSC and DfE developing training materials – LA led approx. 1 day

B: Specialised training – identification and referral. Provider Managers and others – approx. 5 hours. SCIE and Skills for Care in partnership with the DHSC will be developing resources and training materials for A and B

A: Awareness training for affected support staff in care and education settings – approx. 2.5 hours.

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Appendix 2: Draft LPS Project Workstreams

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