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# Q&A from Liberty Protection Safeguards webinar

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# About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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## Introduction

SCIE produced an online webinar to discuss the introduction of the Liberty Protection Safeguards (LPS). This document contains the questions put to the panel on the issue during the webinar and their responses.

With a planned implementation date of April 2022, the new LPS will bring reform and a new system which will seek to further protect the liberty of those who do not have mental capacity to make decisions about their care. For the sector, this represents a significant shift in practice and requires both awareness and change for both individuals and organisations, as part of this journey to implementation.

The webinar provided an opportunity to learn more about the key changes under LPS, the journey and progress to date and how SCIE will be working with the sector to support this transition.

The panel:

- Simon Bayliss, Senior Practice Development Manager, SCIE
- Elaine Cass, Practice Development Manager, SCIE
- Paula Thompson-Butler, Associate Practice Development Manager.

You can view the **webinar**.

## Q&A

This is a list of questions put to the panel during the webinar from people working in the health and social care sector who will be affected by the changes being introduced. The panel offer their considered responses.

**Q: Does Article 5 apply in end of life care and does it uphold advance care plans?**

Article 5 does apply in end of life care. We have the freedom to make decisions and Article 5 prevents this liberty from being arbitrarily taken away. As such it does uphold advance care plans, assuming that the adult had the capacity to make the decisions contained in the plan at the time it was written.

The Mental Capacity Act (2005) not only provides a statutory framework for decision-making where there is a reason to questions a person's capacity to make a decision, it also provides a legal basis for an adult to make an advance decision to refuse treatment (ADRT) but also the opportunity to make an advance statement. Whilst an advanced statement is not legally binding as is the ADRT, they should be considered carefully when decisions are being made.

As the Liberty Protection Safeguards are not changing the Mental Capacity Act, this will remain practice moving forwards.

**Q: Is 'imputable to the state' no longer applicable?**

This will still be applicable under the Liberty Protection Safeguards (LPS), the difference will be that it will not be necessary for an application to Court of Protection to authorise the deprivation in terms of domestic care arrangements.

It is expected that under LPS, the deprivation of liberty will continue to be defined as:

- The person is confined for a non-negligible period of time
- They have been assessed to lack capacity and cannot give consent to the confinement
- The confinement is ‘imputable to the state’ in that either state professionals are aware of the care arrangements and/or provide services; or the state ought to know about the arrangements.

This will then trigger the state’s positive obligation to uphold the person’s rights for an assessment under LPS.

**Q: Would live-in care for someone with dementia trigger continuous supervision and control?**

If the adult’s dementia is to the point where the acid test is triggered, in that:

- the person lacks capacity to consent to care and treatment
- they are under continuous supervision and control
- they are not free to leave,

Then yes, the guidelines for DoLS/LPS are/will be triggered.

The question to answer would be, ‘If the adult tried to leave their home, would they be stopped from doing so OR would it be necessary for the adult to be accompanied by another

person?". If the answer to this is yes, then it is highly likely that both the 'under continuous supervision' and 'not free to leave' will be triggered.

**Q: Sometimes people may want to die at home, but confusion (biochemical imbalances etc...) as part of dying process may mean they need to be admitted in the last week or so to hospice/ hospital as they are unable to meet needs at home. We are often unsure whether this should be a DoLS in these last few days - it can often be extra stress for families. Will LPS change this?**

A DoL will exist if:

- the deprivation of liberty is likely to last for more than a negligible period of time
- the person is unable to give consent to what amounts to the 'objective' deprivation of their liberty
- the deprivation is imputable to the state. (The deprivation of liberty can be said to be one for which the state is responsible.)

Thus, even if the state, private or voluntary sector is carrying out a function of the state (i.e. health and social care support in a private hospice), the Acid Test conditions have been met if the person is:

- unable to consent
- under constant supervision
- not free to leave (if the individual is not physically free to leave, what would be the response of staff if family whom have a proper interest in the welfare of the adult tried to remove them).

These facts will not change under LPS but as deprivation of liberties are to be considered prior to individual being deprived, as part of the care and support planning process and not as an after-thought, it will potentially reduce the need for such interventions to take place during those last weeks of life.

Until we transition over to LPS, we would suggest that as part of the advance care planning (ACP) discussions, this could be explored in that whilst the adult would wish to die at home, there may be unforeseen circumstances which could require admission to hospital/hospice. At this point, it could then be written in the ACP, with the adult's consent. An application for a DoL would not be required as consent has been given in advance, so long as any arrangements constituting a deprivation of liberty in the hospital/hospice had been included in that ACP. If additional forms of restraint/restriction not included in the ACP are subsequently needed, application for a DoL would be required. ACP can only waive the requirement for a DoL in these end of life situations.

The Department of Health published guidance in October 2015 in response to the Supreme Court Judgement/Deprivation of liberty safeguards, it notes:

> *"Specifically relating to individuals in the last few weeks of life, the Department's guidance is that if an individual had capacity to consent to the arrangements for their care/treatment at the time of their admission or at a time before losing capacity, and did consent, the Department considers this consent to cover the period until death and that hence there is no deprivation of liberty.*

> *"It is important that those professionals working in palliative care and end-of-life settings understand where it is not appropriate to make a DoLS application. Professionals should feel confident of their position if they are following good MCA principles, this guidance and are keeping good records of decisions made."*

The final paragraph would suggest that if appropriate and proportionate discussions with relevant parties and accurate recording of the conversations take place, that it may be viewed by the DHSC as appropriate to not subject a family to the intrusion of a full assessment during the final week/s of the individual's life. The above guidance continued:

> *"The Department has heard of one example of a Best Interest Assessor being instructed to assess an individual in the final hours of life. Clearly this can be highly distressing for the individual and their family. We would urge local authorities, providers and DoLS professionals to consider carefully and use their professional judgment as to whether a DoLS assessment in such a situation is appropriate and adds any benefit to the individual.*
>
> *"We would suggest that the Managing Authority should submit a request for an urgent authorisation in any instance, especially if the care package to which the individual consented were to change in a manner that imposed significant extra restrictions or which included care contrary to the previously expressed wishes and preferences of the individual. The supervisory body will then need to make the decision as to if it is appropriate and proportionate to continue to a full assessment."*

Further guidance for practice from the Law Society Deprivation of liberty safeguards: a practical guide gives some good advice for end-of-life care from pages 47-49. We are not yet aware that the 2015 Department of Health guidance will be changed in light of the introduction of the LPS, thus until such a time, we would recommend continuing to follow this.

**Q: Could you outline the broader MCA reforms?**

Find out more by going to:

- Law Commission report Mental Capacity and Deprivation of Liberty
- Government response to Law Commission report

**Q: As the law has been passed, do we have to wait for the code of practice?**

We do need to wait until the code of practice is released so that we are able to understand both the letter and the spirit of the law. Until they are released, we need to continue working under the DoLS guidelines, however, we can begin to prepare ourselves for the transition.

- Familiarise the workforce with the impending changes to depriving a person of their liberty
- Encourage a positive attitude to the change and remind the workforce that the LPS is designed to reduce the complexity of the current process
- Begin to draw up a plan for workforce development, in partnership with other key partner agencies where appropriate
- Run workshops to explore the likely implications of LPS in your setting for your client group/type of work (which may assist with increasing staff confidence)

- Ensure staff are confident and competent in practice under the Mental Capacity Act 2005 and its relationship with human rights
- Appoint MCA champions in your setting/workplace to ensure key people develop excellent expertise and can be there to support other staff
- Set up peer-support networks within and between agencies for problem solving, providing information, advice and guidance.

**Q: What if someone has capacity to make some decisions but not others?**

A deprivation of liberty assessment is required if a person:

- lacks capacity to consent to care and treatment, **and**
- are under continuous supervision and control, **and**
- are not free to leave

Thus, if the person lacked capacity and it triggered the necessity for them to be under continuous supervision and were not free to leave, it would require the deprivation of liberty safeguarding process to be triggered; DoLS/DoLICS (Deprivation of Liberty in the Community Safeguards), soon to be LPS. That being said, there may still be elements of simple day-to-day decisions that the individual does have the capacity to make and as such, should be supported to make those decisions.

If the individual's lack of capacity to make decisions for some elements, for example, around accommodation, care and treatment, management of finances, but it does not result in the necessity for them to be under continuous supervision and/or they were free to leave, then this would be addressed under s.4 (Best Interests) of the Mental Capacity Act. This will not be changing when we transition to LPS from DoLS/DoLICS.

**Q: What about self-funders who arrange their own care without involvement of the local authority or NHS? How will we be aware of them?**

On the balance of probability, if a person's health and/or social care needs result in them lacking capacity to consent to care and treatment, requiring continuous supervision and not being free to leave their place of residence, it is highly likely that either state professionals are aware of the care arrangements and/or provide services, or the state ought to know about the arrangements.

If the self-funder has arranged state-regulated services to provide care and support (i.e. service providers registered with CQC) then from our view, best practice will be for the service provider to notify the Supervisory Body (or Responsible Bodies under LPS) that there is evidence to suggest the self-funder is subject to a deprivation of their liberty to ascertain if the deprivation is authorised via an assessment.

**Q: Does this mean that there will be different processes in different LA areas?**

Technically, yes. However, there has been a strong lobby from the sector for consistency, if possible, in the templates used by the Responsible Bodies. We understand that there is a workstream looking to develop a national minimum data set that will require specific data to be recorded by the Responsible Body and submitted nationally, which should standardise to some extent, the process within each LA. However, the local operation of LPS will require a wider range of information, which will need to be recorded and shared at specific points in

the LPS process. We envisage that there may be a set of recommend templates issued but that it will not be mandatory for them to be used.

**Q: If a person receives care in the community and they have a Court of Protection deputy who agrees with the arrangements for their care, does the process stop there so no further action is needed regarding Liberty Protection Safeguards?**

A Court-appointed deputy (CAD) does not have the authority to agree to a deprivation of liberty. If a CAD/LPA is in place for Health and Welfare, they are able to give consent for care and treatment under s4 (best Interest) of the Mental Capacity Act but once the deprivation of liberty threshold is met, they:

- lacks capacity to consent to care and treatment, **and**
- are under continuous supervision and control, **and**
- are not free to leave

Then an assessment will be required under LPS. Currently in such circumstances a DoLS or DoLICS will need to be requested.

**Q: The threshold for DoLS sounds like the conversation that would take place at a Best Interest meeting. In my understanding, the hospital can discharge someone who lacks capacity when family, NHS and local authority come together to make the decisions. Is that different?**

The situation you describe can be addressed under Best Interests if the individual lacks capacity to consent to the hospital discharge. In such circumstances, a separate decision would need to be made in terms of capacity to consent to care, treatment and where this is to be provided; and if this would amount to a deprivation of liberty, this would require the DoLS to be triggered (individual lacks capacity to consent to care and treatment, are under constant supervision (although not necessarily in the line of sight), and is not free to leave their environment independently).

**Q: If a client receives continuous care in their own home, who has to apply to the Court of Protection for the DoLS?**

This will depend upon who is funding the care and support plan.

For personal budgets fully funded by the LA or jointly funded with Continuing Health Care, it will be the LA for which the person is ordinarily resident.

Where care and support is provided via a personal health budget, it will be the CCG.

If the adult is self-funding then the service providing care and support, keeping the individual under constant supervision (not always in the line of sight) and would prevent the adult leaving the home (without support), the service provider would be responsible for referring to the Supervisory Body under DoLS/DoLIC or the Responsible Body under LPS.

**Q: Where a person is in receipt of part funding by the NHS i.e. FNC (Full Nursing Care) or joint packages, will the Responsible Body still be the LA?**

Based on current process we assume that the Responsible Body will continue to be the LA. Currently, unless a package is fully funded by the Clinical Commission Group via Continuing Health Care, the LA retains care management oversight via the personal budget.

**Q: How would a private hospital apply for an LPS?**

The private hospital would need to apply via the Responsible Bodies, presumably in this instance it would be the NHS trusts who would support with this.

**Q: Will the SCIE training for assessments and pre-authorisation reviews be free or be fee based? Will SCIE be developing training for social workers to conduct the assessments and the pre-authorisation review?**

In partnership with Skills for Care and the Care Providers Alliance, SCIE is working to produce and provide a range of training material to support with the transition and implementation of LPS as a free service.

**Q: For young people, are orders made under inherent jurisdiction affected in any way by the move to LPS?**

This scenario would not be affected under LPS as the inherent jurisdiction pathway has been used due to the young person being assessed as having capacity to make the decision.

**Q: I am responsible for commissioning advocacy contracts for a local authority. We are approaching the end of contracts and are unsure what it is we will be commissioning. Could you offer some advice?**

The most recently published impact assessment included much more information about IMCA costs. IMCAs will replace the paid RPR role. The role of Appropriate Person will replace the unpaid RPR role. It is expected that IMCAs will be available, where needed, from the beginning of the process, that is, when the LPS process is first triggered, right through the authorisation periods and renewal periods, continuing to support and represent the person as required, and where necessary supporting them to challenge the authorisation in the Court of Protection.

This will be more expensive than paid RPRs supporting the person during the authorisation period, as RPRs do not have to be qualified IMCAs. So an increased cost is expected. But no information is available from Government yet on how much will be provided by them towards this cost. There is an expectation that all local Responsible Bodies should contribute financially, but that the local authority will have the commissioning task and the responsibility for ensuring that there are enough for all Responsible Bodies.

**Q: Do you feel there is likely to be an increase in demand for advocacy?**

Yes, as stated above.

**Q: In the training reviews, would awarding organisations presenting diplomas/unit courses update their resources or change the qualification frameworks?Close**

The Independent Advocacy Practice (level 4) has recently (effective from January 2021) been changed to the new level 4 course, with core modules and a set of optional modules. It is hoped that this has been future proofed enough. It will be useful to know if this is the case.

**Q: Is there any information on training requirements for IMCAs specifically?**

The LPS Training Framework, which is currently being produced, includes learning outcomes for IMCAs. This will be published for comment during the public consultation period. A final version will then be published.

The new City & Guilds Independent Advocacy Qualification (level 4) has been designed to enable the new LPS requirements to be built in once required.

**Q: With LPS, would this mean there would be no advocate (independent organisation) involved? Would decisions and reviews be completed by social workers?**

It is expected that IMCAs **will** be available, where needed (i.e. there is nobody suitable to be an Appropriate Person), from the beginning of the process, that is, as soon as the LPS process is first triggered, right through the authorisation periods and renewal periods, continuing to support and represent the person as required, and where necessary, supporting them to challenge the authorisation in the Court of Protection. The RPR role, including the paid RPR role will stop, and be replaced by the IMCA (paid) and Appropriate Person (unpaid) role.

**Q: Is there a role for independent BIAs?**

There is no BIA role in the new scheme. People who are currently operating as BIAs may wish to apply to become Approved Mental Capacity Professionals. They would need to do a conversion course, and would also have to apply for posts (likely to be in all Responsible Bodies) and approval by the local authority.

Alternatively, there may well be a continuing market for independent assessors, as some councils may not have enough workforce to undertake all those required so, as now, may use agencies to provide assessment capacity. BIAs will be ideally placed and very suitably skilled to take on assessments under the new framework, although they would operate as registered professionals, rather than as BIAs.

**Q: Do we know if the AMCP is a 're-branded' BIA or a different role with additional training requirements entirely?**

The AMCP role is **not** primarily an assessment role. The expectation is that assessments will be undertaken by frontline professionals within the needs assessment and care planning work they do, whether under the Care Act, CHC framework or treatment planning in hospitals. In this sense the assessment work is being mainstreamed. Specialist skills and knowledge are being reserved for the pre-authorisation review stage, where there are specific circumstances or when the Responsible Body would like an AMCP to undertake the pre-authorisation review for some reason.

The AMCP role is more of a scrutiny and trouble-shooting role. An AMCP is specifically required to do the pre-authorisation review when a person is indicating that they do not wish to reside or receive care or treatment in the proposed place, or where a person is in an independent hospital. The responsible body can also refer other cases to an AMCP. But it is not expected that AMCPs would be involved by default. When an AMCP does the pre-authorisation review, they are required to meet the person and discuss the situation, particularly if the person is indicating they do not wish to reside or receive care or treatment at the proposed place.

The AMCP may be able to unblock an issue, adjust the arrangements or accommodate the person's wishes and feelings in some way. They can also take other actions or suggest actions to be taken by others, for example, more frequent reviews of the arrangements than might have been suggested.

Some Responsible Bodies may choose to use the expertise of AMCPs to provide advice and guidance to frontline staff. This is not a requirement of the role, but AMCPs will be seen as the experts on LPS, and may be ideally placed to support colleagues, whether professional and clinical or non-registered practitioners.

**Q: Our LA is working on the impact for young people 16-18 in a residential educational setting where they do not have capacity. The Children and Families Act 2014 puts a high priority on parental wishes and we have seen this played out in tribunals where residential settings have been ordered. Do you have any thoughts on changes for the SEND tribunal or considerations for LAs in agreeing residential settings for young people with SEND?**

The code of practice is expected to cover this. There will be a young person's chapter in the code. Where a young person has an authorised deprivation of liberty, there will be an authorisation record, which will be made available to the young person and their representative. If they also have an education, health and care (EHC) plan, there may be some matters which are relevant to both. Whilst the authorisation record and EHC plan are separate documents, any information in an LPS authorisation record that is relevant to meeting a young person's special educational needs should be included in their EHC plan. When reviews are due it may be helpful to review them both at the same time.

If there is an appeal against an EHC plan at a SEND tribunal where an LPS authorisation is being considered or already in place, consideration will need to be given to the implications of any changes that are made, including whether those changes require a new LPS process to be triggered.

**Q: If the family of an adult in the community has a lasting power of attorney, would LPS still apply?**

Lasting power of attorney (LPA) is relevant to any adult, including in the context of LPS. If authorisation of a deprivation of liberty is proposed under the LPS, those with LPA (and those with enduring power of attorney or EPA) and Court-appointed deputies must be consulted about the person's wishes and feelings about the arrangements. A person with LPA may offer to be the person's appropriate person and may support the person to challenge a deprivation of liberty.

A person with LPA **cannot consent** to a deprivation of liberty of a person. So authorisation is required, even when there is someone with lasting power of attorney or a Court-appointed deputy.

**Q: How will LPS impact on children in care when they have capacity but are currently subjected to a DoL?**

Whilst a child may have an authorised deprivation of liberty, this is not under the DoLS scheme. That scheme is only open to over 18s in care homes and hospitals. At the moment, people in other settings or people aged under 18 must have a deprivation of liberty authorised by the court. For adults this will be the Court of Protection. For under 18s it can be the Court of Protection, but it can also be other courts.

If a child in care has the mental capacity to decide about care and treatment, but is still deprived of their liberty, it is quite important not to use the term 'DoLS' as this only applies to people who do not have capacity. This may have been authorised under the inherent jurisdiction of the court.

Note that although for those aged 15 or under, their parents or those with parental responsibility for a young person may have consented to a deprivation of liberty, this is not lawful for those aged 16 or 17. If a person is 16 or 17, or approaching the age of 16, and a deprivation of liberty is being considered to enable care or treatment, it is essential to consider mental capacity, in order to inform which legal basis must be used for any

authorisation, and also to consider whether DoLS (or Court of Protection) will be required at age 18, or, once LPS comes in, whether LPS authorisation will be required from age 16.

**Q: In respect of the role for the care home manager with the Government suspending that part of the Act in England for now, will that apply to managers working in Welsh care homes?**

Yes, we believe so.

**Q: Are GPs aware that they are expected to be doing the medical element in the community (possibly for free!)**

NHS England has a clinical reference group (CRG) that is overseeing the preparation for implementation of LPS in the NHS. This should include the information, advice and training needs of all NHS clinicians and practitioners, including GPs.

The CRG is closely linked to the NHSE/I Safeguarding Adults National Network (SANN) and is reporting into the SANN.

NHS clinical commissioners have also a communication role in this.

**Q: Can LPS be used for protection of other people, for patients who are detained under forensic sections of the MHS alongside s41 restrictions?**

No, it cannot.

**Q: How does DoLs apply in mental health units if detained?**

If the person objects to the detention, they would be detained under the MHA and DoLS does not apply. If the person lacks capacity, and is not objecting, DoLS might be used currently. This matter is being further considered as part of the Mental Health Act reforms. It is likely that LPS will be informed by those reforms, but until decisions are made, it is likely that LPS will be used in a very similar way to DoLS in mental health inpatient settings.

**Q: The role of RPR with DoLs was fairly restricted - will this change with the introduction of LPS?**

There is no RPR role in the LPS scheme.

Under the new scheme there will be two ways to offer support and representation to the person at the centre. They can either have an (unpaid) Appropriate Person, who may be a family member, friend or volunteer, or they can have an IMCA. Under LPS, both types of support are available from the earliest point in the process and continue after authorisation, throughout the authorisation period and any subsequent renewal periods.

It is possible to change from one sort of support to the other, if this is required for some reason. An IMCA can also be appointed to support the Appropriate Person (throughout). The Responsible Body has to decide if an IMCA is required, and to appoint one, if so.


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