



LPS Webinars - Questions and Answers

Where we have staff who provide a lot of care, and family provide some of the care, if acid test is met, does it matter who provides the care for authorisation to be required?

No. LPS allows for a mixture of settings and focuses on whether or not the 'arrangements' amount to a deprivation of liberty. In the same spirit, an authorisation can cover transporting the person, for example from their own home to a day care service.

Who should be notifying home care providers of LPS being in place?

If an LPS authorisation is being assessed for someone in their own home when your staff already provide a service, you should have been part of the consultation process. This is because your staff will have valuable information about the level of restrictions and how they affect the person. In this situation, you will be notified of the outcome, and sent a copy of the authorisation by the responsible body.

In the future, if you start providing a new service to someone who seems to lack capacity to consent to a restrictive care package, I suggest you enquire of any involved social workers, say, or relatives whether there is an authorisation, so that you can ask the responsible body for a copy, and let them know that you will be providing some of the care. If you think that the care amounts to a potential deprivation of liberty, and you are not aware of any authorisation, contact your local authority responsible body and discuss your concerns with them.

Child locks on vehicles: I'm thinking these are not an LPS issue as their use is a necessary and proportionate action against someone getting out of a moving vehicle or a stationary vehicle in a line of traffic?

If the person is 16 or over and lacks capacity to consent to the use of the child locks, the situation you describe is a 'restraint' as defined by the Mental Capacity Act: it is restricting the person's freedom of movement. It is lawful if it is in the person's best interests, the least restrictive option to meet a defined need and, as you point out, a necessary and proportionate action.

To know if it is part of a collection of restrictions on this person's freedom, to the point where they are deprived of their liberty, would require a lot more information. Of itself, and used on a relatively short journey, it is unlikely to be a deprivation of liberty, but ensure it is recorded as a restraint.

Does the LPS cover traditional day centre services?

Yes, LPS will cover someone who lack capacity to consent to (or refuse) the arrangements for giving them essential care or treatment, in any setting, when those arrangements amount to a deprivation of liberty. A person may be deprived of their liberty in their own home but potentially not within a day service because they have far more freedom there; but of course for many people they will be deprived of their liberty in more than one setting where they receive a care service.

It is likely that the day centre care would be part of a package that also covers other settings.

Who will be responsible if an individual is joint funded?

Who would be the responsible body for a nursing home resident fully funded by CHC?

Who will be the RB if the individual is part CCG & part social care funded?

For someone receiving full Continuing Health Care (CHC) funding, the responsible body will be the Integrated Care Board. It says in the Act and in the draft Code that it is the Clinical Commissioning Group (CCG) but of course these have now been replaced by the Integrated Care Services, overseen by the Integrated Care Boards.

The draft code of practice will undoubtedly be revised extensively, but it does seem clear on how it sees these more complicated packages of care. Note in what follows, the LHB is the Local Health Board, in Wales only, and for 'CCG' we need to understand 'Integrated Care Board':

In all cases, the legal test is whether the arrangements are carried out mainly through the provision of NHS CHC. Given that the person has a primary health need and is in receipt of NHS CHC, it almost by definition follows that in such cases the CCG or LHB would be the Responsible Body.

If a person is not eligible for NHS CHC, they may potentially receive a joint package of health and social care. This is where an individual's care or support package is funded by both the NHS and the local authority. In these cases, the Responsible Body is the local authority.

If a person is not eligible for NHS CHC but has a need for care from a registered nurse and their overall needs would be most appropriately met in a care home with nursing they may be eligible for NHS-funded Nursing Care. All other care needs may be subject to an assessment under social care legislation such as the Care Act. Irrespective of whether or not their needs are being assessed or met by a local authority, in such cases the Responsible Body will be the local authority is (assuming that the arrangements are not being carried out mainly in an NHS hospital). Draft code 14.22

Clear? If not, remember the 'no wrong door' principle: it is up to the responsible bodies to decide which is the right one.

Who would be responsible for the application if the person lives at home and accesses the service for day support or short break, the LA or the provider?

It is the shared responsibility of anyone, especially if paid to provide services, to trigger the LPS process by notifying the responsible body if they think that the person might be deprived of their liberty. This means it might be the local authority social services or commissioning staff, the GP or community nurse who visits the person or the provider, or even a neighbour or relative if they are concerned.

Will the Responsible Bodies have the time and resources to manage applications as currently they do not?

We must all hope that the LPS system is a success; the human rights and happiness of many service users will depend on it. And in many ways the new LPS will be simpler, more flexible, and (somewhat) less bureaucratic than DoLS. However, the widening of scope to all community settings and to younger people must impose burdens especially on local authorities. The draft Impact Assessment has been accused of underestimating the costs to local authorities and other responsible bodies. We look forward with interest to the final versions of the code of practice and the Impact Assessment.

We currently have a number of DoLS applications pending. If these applications are not authorised before the LPS implementation date, will we have to reapply? In the transition period, will applications that have been submitted for a DoLS authorisation have to be resubmitted under the LPS process or will they be converted? If DoLS applications have not yet been authorised by the LA would we be expected to submit a new LPS application?

My understanding is that you will **not** have to do a further referral. I believe that this will be sorted out as an administrative exercise within the local authority DoLS team (probably the same people who will administer the LPS system). They should then notify you of what they are doing, either getting the DoLS assessments done, or changing your application to an LPS one.

There may be some situations where your earlier application has vanished into some fourth dimension, so if you are concerned, you might re-send a copy of your original DoLS application in good time ahead of LPS implementation.

Would we raise a safeguarding alert if the LA are non-responsive and we know we are depriving someone?

It's always open to you to raise a Safeguarding alert, but if you are happy that the service you are providing is the least restrictive option to meet the person's needs, and that it is necessary to prevent harm to the person, and a proportionate response to the likelihood and seriousness of that harm, it is probably worth pushing at the non-responsive local authority a bit harder. You might approach the head of department in the local authority, or use their complaints procedure, or, since this is a matter of deprivation of liberty, a phone call to their legal department might work wonders! In addition, do keep a clear and full record of your ongoing attempts to get the local authority to recognise its responsibilities.

Hypothetically, suppose an LPS authorisation is granted by the CCG or, now, by the Integrated Care Board. Suppose the funding changes post authorisation to the local authority, do we apply once again mid authorisation because of this RB change?

The duty will lie with the two responsible bodies (RBs) to sort this out. It could of course happen that you might need to remind them, probably by suggesting that the existing RB needs to review this authorisation due to the changes.

But I cannot see that you should need to re-apply, since with LPS the responsibility to trigger the process does not rest with the care provider, as it does with DoLS. There is a more general duty that 'anyone' who recognises that someone might be deprived of their liberty should help to get the process properly under way. In the case you imagine, I would seriously hope that the LPS implications of the funding change would be recognised early in both those possible responsible bodies.

In the field of learning disability, the assessment of the person's LD is usually historic and there is no actual assessment available, will this need to be redone?

The majority of people living with a learning disability are assessed for diagnostic purposes before they reach 18. There should be records in the local learning disability team, or held by the GP, of these assessments. It is very likely that they will not need to be re-done: a learning disability is recognised as a lifelong condition.

It is important to recognise that the diagnostic test is not the same as the capacity assessment. It is of course possible that some people with a learning disability can be given training and education so that, for example, they gain the capacity to go out to the local shops alone, or to gain the capacity to engage in personal and sexual relationships. These significant gains may affect the level of restrictions in their care plans, so that they may no longer be deprived of their liberty. LPS are part of the wider framework of the Mental Capacity Act, with its empowering ethos.

Do you have any recommendations for training or resources on recognising restraints, which detail more than the obvious restraints, please? Or will this be in the government planned training?

There will be sufficient good and comprehensive training material published on LPS by Skills for Care, SCIE, Health Education England and others. We will publicise these free materials when they are available. Until then, making decisions within the five principles of the Mental Capacity Act is an essential framework for human rights-compliant care.

Will CQC continue to be informed by the provider when the LPS has been authorised or not?

It is onerous for care homes to have to notify CQC in real time of any DoLS activity, and it certainly appears that this will not apply to LPS. We have, however, asked DHSC to spell out clearly in the final code that this duty will **not** apply to LPS.

The LPS draft code puts the duty to inform CQC, and the other regulators, Ofsted for people aged 16 and 17 and, in Wales, CIW and Estyn, firmly onto the Responsible Bodies, and not on the providers. These are the bodies who manage the LPS process, and they have to complete full returns to government of all their LPS activity. The code says:

20.16 Under the LPS, Responsible Bodies are under a duty to regularly notify the monitoring bodies of when they have received a LPS referral and are considering whether to authorise arrangements or not. They should also notify the Responsible Body when authorisations are given, not granted, renewed or come to an end.

A footnote to this says: *This replaces the duty on providers to notify CQC directly of an authorisation under the Deprivation of Liberty Safeguards (the system that LPS replaced).*

if person is privately funded they won't necessarily get a Care Act Assessment, so unless we flag with the RB, how else would they know?

The DoLS process sets a specific duty on care homes and hospitals to 'set the ball rolling' by requesting an authorisation. The good news is that this is dropped for LPS.

Instead, there is a duty on anyone who suspects that someone may be deprived of their liberty to notify the responsible body (RB). The draft code of practice suggests that potential deprivation of liberty is very likely to be recognised early on in the care planning process. If it has not been, then any doctor or district nurse, housing officer or social worker, or of course the care provider has an equal duty to notify the right responsible body.

And if you're not sure which is the right one, there is an overarching duty on responsible bodies to work together, by bringing a 'no wrong door' principle. You or someone else spots possible deprivation of liberty; you, or someone else, notifies the responsible body, hopefully the right one but they must send it on if you've got it wrong. Then it is up to that RB to commission the specific assessments and carry out the rest of the process.

All local authorities use their own forms for submitting DoLS applications, which causes challenges to providers working across geographical areas. Is there an appetite to streamline this through the guidance by provision of single pro forma?

You identify a real issue, and I think there is indeed an appetite to make it all simpler. Draft template forms are currently out for comment among stakeholders. So far, they look simpler than DoLS forms and I share your hope that they will be widely used.

If it can take 72 hours for the family/PoA to be informed of an LPA, and i think the aim is to get the authorisation in within 21 days, how is a care home covered for that time if there is an emergency/quick admission?

A provider is covered by the Mental Capacity Act section 4B in this situation, because the responsible body is alerted to the need for it to act. As the draft code puts it:

- *Four conditions must be met for the legal authority of section 4B to be relied upon. These are that:*
 - 1. the steps consist of, or are for purpose of, giving a life-sustaining treatment or carrying out a vital act,*
 - 2. the steps are necessary in order to give the life-sustaining treatment or carry out the vital act,*
 - 3. the decision maker believes that the person lacks capacity to consent to the steps taken, and*
 - 4. a relevant decision is being sought from the court, a Responsible Body is determining whether to authorise arrangements under the LPS, or there is an emergency.*

Acts by care providers can be recognised as 'vital acts', though providers should be cautious about relying on this. However, it does give legal protection even if the responsible body takes longer than 21 days to make a decision on the LPS authorisation: the 21 days is 'guidance' rather than, like the requirement to notify the person and their relatives within 72 hours, being part of the law. Always ensure that any restrictions are the least restrictive that can be thought of to keep the person safe.

Can you clarify who will be able to carry out assessments? Will this be restricted to registered professionals?

Can the provider still assess capacity for people or does it now have to be health professionals?

LPS regulations say that only certain registered professionals can carry out the three specific LPS assessments, including assessing the person's capacity to consent to, or refuse, the arrangements to give them necessary care and treatment, when these arrangements amount to a deprivation of liberty. For this specific capacity assessment, these are: social workers, doctors, psychologists, occupational therapists (OTs), nurses, and speech and language therapists (SALTs.)

But care providers still need to carry out capacity assessments for all other purposes, such as capacity to consent to acts of care and treatment, capacity to be safe on the road, and so on.

Just going back to Capacity Assessments, currently they are decision and time specific, does this change with the introduction of the LPS?

You are quite right that capacity assessments must always be decision and time specific, and this applies to LPS. The draft code suggests that the appropriate assessments of capacity will usually be carried out at an earlier stage than the placement into a care service, for example, during Care Act assessments. In the case of LPS, the question for the assessor to decide is, does the person, with all help that can be provided, have the capacity to consent to the arrangements that will amount to a deprivation of liberty. Many people subject to LPS will lack capacity for this decision and are unlikely to regain or gain capacity for it. This means a capacity assessment might well remain valid for some considerable time. The process can only begin if the person lacks this capacity; and, if the person gains or regains capacity, then LPS cannot go ahead, and any existing authorisation must end.

Regarding the AMCP, is this a specialist role or will the role be picked up by current health professionals?

The answer is 'both'. This is because, like the DoLS best interests assessors (BIAs), these must be registered professionals in health and social work - social workers, nurses, occupational therapists, psychologists, and Speech & Language Therapists (SALTs) – but will also have to go through detailed extra training for their role. Their training is being developed by the College of Social Work, which will monitor them and ensure they have appropriate refresher training during their practice.

We have been advised that AMCP's will have to work in statutory sector whereas BIA's do not - this seems to fly in the face of being 'less bureaucratic' - what are your thoughts on this (as a vol sector organisation we may have wanted to train some SW's as AMCP)

The workplace situation regarding AMCPs is still, as I understand it, somewhat open for discussion, particularly as some may want to practise independently. They will however be 'approved', rather like Approved Mental Health Professions (AMHPs) are, by the local authority. The draft code of practice is promoting the idea of a dedicated AMCP team, within the local authority, though many stakeholders are not keen on this idea.

However, the AMCP must above all have no conflict of interest, so an employee could not carry out assessments or AMCP determinations in any of your settings. Also, they must not have a close relationship with any care home. The assessment and determination regulation 10(1)1(a) might prevent your employees being eligible to carry out any LPS assessments or to being an AMCP: it reads:

10. (1) For the purposes of paragraph 24(1)(b) of Schedule AA1 (pre-authorisation review), a person has a connection with a care home if that person—

- 1. (a) works at that care home, or for a company connected with that care home, whether under a contract of employment, under a contract for services or otherwise than under a contract; ...*

But I agree that it is a pity to exclude people from the opportunity to enhance their professional skills. You might consult your legal advisors on this.

Shared Lives supports young people under 18 at times. This is ok with CQC. Will Ofsted monitor these cases or will CQC in Shared Lives which is a predominantly adult service?

Ofsted (and Estyn in Wales) will monitor all LPS authorisations that apply to young people aged 16 and 17, in any and all settings. Once the young person reaches 18, it appears from the draft code of practice that this will change to CQC.

It is likely that some young people in Shared Lives schemes will be deprived of their liberty, and that this will be in their best interests, and the restrictions on their freedom will be 'necessary and proportionate'. This will bring them into the LPS system.

If you, or anyone else providing health and care services, suspect that LPS might apply, you should contact your local authority responsible body: draft template forms are currently in circulation. Once you have made the notification, it is the duty of the responsible body to explore the situation and decide whether this young person's care arrangements do deprive them of their liberty, and, if so, to authorise it if the three assessments all support this.

Is the LPS scheme intended to be location specific or will it follow the individual to other locations?

LPS is far less strictly location specific than DoLS, in that flexibility can be built in to an authorisation, but only if it is foreseen. This means that a care plan can cover, for example, regular day care or respite, or a monthly overnight hospital stay for routine treatment; provided it is likely that the person will be deprived of their liberty in all these settings, the authorisation can be drafted to cover them.

But if a person unexpectedly, say, falls and fractures a bone, this admission is not planned, and any deprivation of liberty in the hospital would need to be covered by a specific authorisation. The draft code of practice suggests that an existing authorisation, covering,

say, the person's own home or various care settings, could simply be paused until they returned. But for this level of detail, I think it is wise to wait for the final code and guidance from government.

Has the government made any resource plans, or guidance in place to deal with the LPS referrals? The DoLS referrals in some LA's have a backlog of years to deal with the referrals made. It is a concern that there won't be enough resource for LPS.

This is a good question, and I can only say that we have warned the DHSC of this (I believe that ADASS and the LGA have also done so). Many local authorities are doing well at addressing their backlogs, but the current draft Impact Assessment does seem very optimistic. It is concerning that a major aim of the LPS was that the new scheme should be cheaper to run than DoLS.

You mentioned that LPS authorisations can be extended. Can you elaborate on how long they will last as currently Dols need renewing annually, despite often no changes

This is a definite advantage to the LPS system over DoLS. Provided that the person's condition and care plan are stable, and there are no changes, such as the person regaining capacity, or now needing lots of new restrictions, the rules are:

- First authorisation can be for a maximum length of 12 months.
 1. Subject to review, this can be renewed once for a further 12 months.
- If no change is likely, the authorisation can then be renewed, for a further 36 months at a time, and this can also be renewed for this length of time in the future.

Reviews are built in, at least annually for the 3-year authorisation periods but more frequently if needed, or always for young people. Unscheduled reviews can be requested by anyone if it seems appropriate, including by the care provider.

I joined this session to find out if Day Care Services will need to do an LPS in the future as I have not seen day care services mentioned anywhere?

People using your service will be eligible for LPS authorisation if they are deprived of their liberty while they are there. It is likely that they would also be deprived of their liberty in other settings, so that your day services would be covered in an authorisation covering different settings.

Is it known how CQC will monitor non-registered services?

CQC has no right to enter non-registered services, or people's own homes. They can, and will, request to come in, to examine records and interview the person if this is appropriate. The inspectors will no doubt often be allowed in, but the owner/tenant/proprietor can refuse, for example, on the grounds that it would unduly upset the person. Like anyone else, the CQC inspector can raise a Safeguarding alert if they are worried about the person.

Our day care services support older people, the majority over 70 years old and living with dementia; the services are not regulated by CQC. I'm assuming in this case the RB will be the local authority?

Yes you're right; the local authority where the person lives will generally be the responsible body. The only times when it wouldn't be the local authority are if the person's care plan, covering the use of the day service, is NHS Continuing Health Care. Interestingly, though your day service is not regulated by them, CQC will still oversee any LPS authorisation applying to the person's time at your day service.

This is because they have a duty to report on all situations in health and social care where a person is deprived of their liberty, because CQC is part of the UK's National Preventative Mechanism, for the Optional Protocol for the Prevention of Torture and Inhumane treatment (OPCAT for short).

So responsible bodies will have to notify CQC of any settings covered by authorisations, and CQC has a duty to report annually on how the system is working to protect people's rights. CQC inspectors have no right to enter your premises (or someone's private home) but they may ask to visit your service to look at records or to speak to someone subject to an authorisation covering your service.

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18 July 2022