What are Liberty Protection Safeguards?

This briefing for health and social care staff provides an overview of the Liberty Protection Safeguards (LPS), which will replace the Deprivation of Liberty Safeguards (DoLS). It summarises LPS and describes what is going to change, what is going to stay the same, and what health and social care staff can do to prepare for the changes. The briefing will be particularly useful to people working with individuals with cognitive impairment including frontline health and social care practitioners, those providing education for people over the age of 16 and commissioners, providers and managers.

Key messages

- LPS (formerly DoLS) is rooted firmly within the Mental Capacity Act 2005 (MCA) and all the key principles of the MCA fully apply.
- LPS will be about safeguarding the rights of people who are under high levels of care and supervision, but lack the mental capacity to consent to those arrangements for their care.
- LPS will apply to people in care homes, hospitals, supported accommodation, Shared Lives accommodation and their own homes.
- LPS will apply to everyone from the age of 16 years.
- LPS will need to be authorised in advance where possible by what will be termed 'the Responsible Body'
- Where a person is deprived of their liberty before an authorisation has been given, the MCA has been amended to provide the authority to continue to care for the person.

Why change from DoLS to LPS?

DoLS was introduced in 2009 to provide legal authority to care for people in care homes and hospitals who lacked the mental capacity to consent to their accommodation (or inpatient status), and were under high levels of care and supervision, prompting an assessment that they should be deprived of their liberty with the necessary safeguards applied.

DoLS has been criticised for being overly complicated and bureaucratic. Furthermore, following a case which went to the Supreme Court in 2014 (the 'Cheshire West' case), the number of referrals increased dramatically due to the reduced threshold for identifying deprivation of liberty. This combination of excessive bureaucracy and the increasing number of referrals led to criticism that the DoLS was no longer fit for purpose.

The UK Government asked the Law Commission to undertake a review of the DoLS scheme following a critical report from the House of Lords in 2014[1].

The Law Commission's report[2] concluded that DoLS:

- 'Are overly technical and legalised'
- 'Are not meaningful for disabled people and their families or carers'

[1] Mental Capacity Act 2005: post-legislative scrutiny. House of Lords 2014

[2] *Mental Capacity and Deprivation of Liberty: a consultation paper*. Law Commission 2015

- ‘Fail to secure buy-in from health and social care practitioners’.

The Law Commission commented that ‘the rights of people who are deprived of liberty and those supporting them are difficult to discern’.

The UK Government passed the Mental Capacity (Amendment) Act 2019, which extends to England and Wales, to replace DoLS with LPS. Some things will stay the same, some elements are reinforced, and some will change.

What challenges are the LPS designed to solve?

The UK Government’s intention is that LPS deliver the following changes:[3]

- Create a new simplified legal framework that is accessible and clear to all affected parties.
- Deliver improved outcomes for persons deprived of their liberty and their family/unpaid carers.
- Provide a simplified authorisation process capable of operating effectively in all settings.
- Ensure that the Mental Capacity Act works as intended, by placing the person at the heart of decision-making and is compliant with Articles 5 and 8 of the European Convention on Human Rights.
- Provide a comprehensive, proportionate and lawful mechanism by which deprivations of liberty for young people aged 16 and 17 can be authorised.
- Ensure increased compliance with the law, improve care and treatment for people lacking mental capacity and provide a system of authorisation in a cost-effective manner.

What is deprivation of liberty?

The definition of deprivation of liberty is based on past judgements made by the European Court of Human Rights. It is directly linked to Article 5 of the European Convention for Human Rights, which enshrines the person’s right to liberty, unless certain criteria are met.

It has been interpreted in the UK most recently by the Supreme Court in 2014; the ‘Cheshire West’ judgement[4], requiring that these criteria are met:

- The person lacks capacity to consent to the restrictions imposed
- The person is under ‘continuous supervision and control’
- The person is ‘not free to leave’.

Further information can be found in Deprivation of Liberty Safeguards (SCIE, 2020).

[3] Mental Capacity (Amendment) Act 2019. Impact Assessment. 2020
[4] P v Cheshire West and Chester Council, P & Q v Surrey County Council [2014} UKSC 19

What is staying the same?

- The threshold for deprivation of liberty as set by the Supreme Court is not changing.
- The person who draws on care and support needs to be involved in the process as much as possible, as far as their impairment will permit.
- Best-interest decisions will still need to be made before decisions are taken in relation to people who lack mental capacity to make the decision themselves. The statutory checklist *must* be followed in all cases.
- It must have been established that the person lacks mental capacity for LPS to be used.
- There will need to be some medical evidence of mental disorder (as defined in the Mental Health Act 1983).
- If a person is subject to certain elements of the Mental Health Act 1983, LPS will not be able to be used.
- The same range of relevant other people will need to be consulted to determine whether the deprivation of liberty is necessary and proportionate.
- A formal written authorisation will be needed to enable a person to be lawfully deprived of their liberty for the purpose of providing care or treatment.
- The person will still be able to challenge the authorisation in court.
- An authorisation only provides ***authority*** for the health or social care provider to deprive the person of their liberty. It does not ***require*** them to do so.

What existing elements of the legislation are being reinforced by LPS?

- Deprivations of liberty will need to be authorised in advance, where possible, by the 'Responsible Body'. This was always the expectation with DoLS but practice has not fulfilled that requirement.
- There is a clearer and more explicit requirement to involve the person in the process.
- The new legislation includes an explicit requirement to consult with others. This was always implied through the link to the MCA best interests process, but it is now laid out more clearly in the LPS.

What is changing from DoLS to LPS?

- There will be a slight change in the assessment of mental capacity, from:
    - capacity for their *accommodation* (or to be an inpatient in hospital), to
    - capacity for the *arrangements* (which we believe will mean the arrangements for care and treatment).
- 16- and 17-year-olds will come within the LPS framework. DoLS currently applies only to people aged 18 and over, and any authorisation to deprive younger people of their liberty must currently be made by a court.
- While DoLS applies only to people in care homes and hospital, LPS will also apply to people in supported accommodation, Shared Lives accommodation and their own homes.
- DoLS applies to a specific institution (such as a care home or hospital) and cannot be transferred. LPS will apply to the 'arrangements' for the person's care, so can consider a

wider range of settings a person accesses providing a more comprehensive consideration of their lives. This may include multiple settings included in the person's plan of care.

- The *responsible body* will replace the supervisory body. Local authorities are currently responsible for arranging all DoLS assessments. Under LPS:
  - NHS hospitals will be the responsible body for managing the process for their patients
  - CCGs or Local Health Boards will be the responsible body for managing the process for people primarily looked after by them (i.e., under continuing healthcare arrangements out of hospital)
  - Local authorities will be the responsible body for everyone else (people in care homes, supported accommodation, Shared Lives, their own homes and independent hospitals)
- The managing authority will cease to exist. Under DoLS, the care home or hospital to which the DoLS authorisation is granted is called the managing authority. Although this term will no longer be used, these organisations will need to be aware of the requirements of the LPS.
- The evidence of mental disorder does not need to be renewed afresh at every authorisation. Although if the person's circumstances have changed, there may need to be a further assessment. For example, if someone has advanced dementia, or a severe learning disability that is likely to be lifelong and the original assessment is likely to be valid, providing there have not been any significant changes in the person's presentation then the pre-existing evidence may be relied upon to renew an authorisation.
- For most cases, the decision to grant an authorisation under LPS will be made following a *pre-authorisation review,* which will be a review of the required documentation, without a best interest assessor (BIA) going out to see the person or their carers.
- BIAs will cease to exist. They will be replaced by Approved Mental Capacity Professionals (AMCPs), who will only be involved in specified cases:
  - If the person does not want to live at the specified place
  - If the person does not want the care or treatment to be provided at the place
  - Any person being deprived of their liberty in an independent hospital who is not subject to the Mental Health Act
  - If the Responsible Body refers a case to an AMCP, and they accept it (we consider that these will be complex and borderline cases which don't fall into any of the above categories).
- Authorisations will last for a maximum of one year for the first authorisation and the first renewal. Subsequent authorisations can be for up to three years (providing the renewals are continuous).

What do we think the draft regulations will include

- Whether authorisations will be able to include additional conditions, and what authority the Responsible Body will have to enforce any such conditions in the event they are not adhered to.
- Clarification regarding the "Acid Test" (not free to leave, under continuous supervision and control).

- Exactly who will be able to undertake assessments and who will be able to complete the pre-authorisation reviews.
    - Will capacity assessments and 'necessary and proportionate' assessments be required to be completed by registered professionals only?
    - What level and qualification of staff will be able to complete the pre-authorisation review?
- What sort of cases may be referred to an AMCP which do not fall within the mandatory criteria.
- What training requirements will be set out for AMCPs.

What can you do to prepare for LPS?

The principles of the MCA will underpin the LPS and they are well established. These principles must already be incorporated in all assessments and care, support and treatment planning, but you must prepare for LPS by consolidating them further into practice. This will help transition LPS into the way you work:

- Good-quality mental capacity assessments and legally robust recording will considerably reduce the time needed to review the documentation.
- Good-quality, best-interest decision-making and appropriate recording will reduce the work needed when it comes to evidencing an authorisation under LPS.
- Legally robust best-interest determinations always include consultation with people who provide care for the person who uses services and those people who are interested in their welfare. Ensuring consultation is a routine part of best-interests decision-making will reduce the risk of challenge and help to ensure legally defensible decisions.
- All staff need to be aware of the definition of deprivation of liberty and the threshold set by the Supreme Court in 2014. They should be able to understand the meaning of:
    - What constitutes lacking capacity
    - continuous supervision and control
    - not free to leave
    - in the context of provision of care, support and treatment in any setting.
- All staff need to be aware of the concept of restrictions and restraint as it applies within the MCA. Restrictions may be a necessary part of the arrangements for the person. Things to consider when applying restrictions:
    - From what harm are the restrictions designed to protect the person?
    - Do the restrictions continue to be necessary?
    - Are they proportionate to the risk of the harm? And its likelihood to occur?
    - Is there a less restrictive way of keeping the person safe from these harms?

Further reading

Liberty Protection Safeguards resources (SCIE, 2020)

Liberty Protection Safeguards: Looking forwards video (SCIE, 2021)

Mental Capacity Act resources (SCIE)

Mental Capacity Act at a glance (SCIE, 2020)

Mental Capacity Act 2005 (Department of Health, 2005)

Mental Health Act 1983 (Department of Health, 1983)

Care Act (2014)

Mental Health (Wales) Measure 2010

Social Services and Wellbeing Act (2014)

Keep up to date

We hope this briefing about Liberty Protection Safeguards has been helpful. Some aspects of the LPS are complex, and it is important that they are fully understood. Building on the Care Act and Mental Capacity Act, SCIE offers **e-learning**, **bespoke training**, and **consultancy support**, to make sure that you and your organisation are aware of good practice and legal duties in this area. Or if you would like to talk to our team about how we can help, please complete our **enquiry form**.