### Points for Consideration

**Planning and Preparation for Implementation of the new Scheme (LPS)**

- Strategic Planning for your area:
  - Liaison with local CCGs and Hospital Trusts – Hospitals and CHC
  - Liaison with Children’s services – Thinking about 16 and 17 year olds
  - Project approach?
  - Setting up a new system and team(s) for your patch. Separate teams in each responsible body? Or some pooling of staff/funding?
  - Commissioning IMCA services
  - Who will do assessments and determinations?
  - Who will do pre-authorisation reviews?
  - How will this work when care home manager coordinates, and there is no previous local authority involvement e.g. self funders – independent social workers?
  - How will you manage training (Preparatory and ongoing)?
  - Production of public information, leaflets etc.
  - After LPS goes live will you retain some BIAs to do reviews under the old system?
- Current DoLS cases and Court of Protection cases – Analysis to inform planning:
  - On LPS Day 1 how many people/current authorisations of a deprivation of liberty do you have under DoLS? These will stay under DoLS until renewal, unless there is a change. Then they will move into the LPS scheme/process.
  - If the person is in a care home, consider whether the care home might be able to coordinate the process prior to pre-authorisation review. Is this potentially a saving? If so, how much could this reduce required expenditure for the Local Authority?
  - How many will transfer to hospitals (national average as a rule of thumb is that 20% relate to hospital settings)? Is this potentially a saving? If so, how much could this reduce required expenditure for the Local Authority?
  - How many are CHC funded and would transfer to CCG? Is this potentially a saving? If so, how much could this reduce required expenditure for the Local Authority?
  - When are reviews due? Reviews can be done under DoLS, unless there is a change. Then they will move into the LPS scheme/process. If the person is in a care home, consider whether the care home might be able to coordinate the process prior to pre-authorisation review?
  - On Day 1 how many people/deprivations of liberty are currently authorised by the Court of Protection (community deprivations of liberty)? These will stay under that Court authorisation until renewal, unless there is a change. Then they will move into the LPS scheme/process. How many will transfer to the Local Authority? How many will transfer to the CCG (CHC)?
**Points for Consideration**

- When are renewals due? These will move into the LPS scheme. If the person is in a care home, consider whether the care home might be able to coordinate the process prior to pre-authorisation review.
- How much do you currently spend on relevant persons representative (RPR) services (note - some LAs do not use paid RPRs)? This will be absorbed into IMCA services, this should be cost neutral as any saving will be required to fund expanded IMCA services.
- IMCA services will need to expand. Expected to support person throughout authorisation, not just at the beginning. How much more will IMCA services cost under LPS

**Backlog Analysis**

- 2018/19 data to be submitted to NHS Digital by Wednesday 22nd May 2019
- Consider timing of analysis - when is best to do the analysis and then how to ensure numbers are kept up-to-date and relevant. Need to continue business as usual as well as reduce the backlog
- How many applications in the backlog will transfer to hospitals or CCG (national average as a rule of thumb is 20% relate to hospital settings)?
- How many in the backlog are in a care home where the care home might be able to coordinate the process?
- On Day 1 how many are on urgent authorisations, awaiting a standard authorisation under DoLS? When urgent authorisation expires they will move into the LPS scheme/process.
- How many are in independent hospitals (long-stay Transforming Care), or in the process of moving out into the community, who may be subject to a DoL, or need to be? Note slight change in rules on which Local Authority will be the Responsible Body (ordinary residence no longer to be used as the basis) and note that an AMCP is always required to do pre-authorisation review in independent hospital cases.
- Note if resources and staffing allow, the assessments and consultation can be done before Day 1, so that the deprivation of liberty can be authorised under LPS on Day 1.

**Analysis – those awaiting a decision from the Court of Protection**

- Consider when is best to do the analysis and then how to ensure the analysis is kept up-to-date and relevant.
- How many have started the process and should stay in the Court process.
- How many in Court waiting list will transfer to the Local Authority
- How many in Court waiting list will transfer to CCG?
- Do you contract for Rule 1.2

**Ensuring sufficient AMCPs**

- Need system for Approving AMCPs (similar to AMHP approval)
- Training (see below)
### Points for Consideration

- Spread and experience/expertise of current BIAs who wish to convert to AMCP (NHS Hospitals, CCG/CHC, Independent Hospitals, Adult social care, learning disability, acquired brain injury, dementia, other)
- Agreeing with fellow responsible bodies the approach for the area (funding, employment, referral of cases to AMCPs for pre-authorisation review)

- **Commissioning sufficient IMCAs**
  - Developing revised contracts to include new LPS IMCA duties
  - Ensure inclusion of “Rule 1.2” duties where a case goes to the Court of Protection for a decision
  - Agreeing with fellow responsible bodies the approach for the area (Commissioning, funding, instructing in specific cases).
- Note that relevant persons representatives (RPRs) and Paid RPRs will not be part of the new scheme. Paid RPR roles will be replaced by the new IMCA services. Appropriate persons can request IMCA support. It **will** be possible to use volunteers as Appropriate Persons. These would not be paid.

- **Training strategy**
  - Conversion Training for BIA to AMCP
  - Training for new AMCPs
  - Training for front line staff and managers in Adult Social Care teams
  - Ensuring Care Homes have training, both registered care home managers and other care home staff
  - Ensuring other service providers have training, both managers and staff

### Smooth Transition from old (DoLS) to new (LPS) – Letting Go of DOLS

- Agree approach for working through the DoLS Backlog – What is the biggest barrier to reducing the backlog to zero prior to LPS Go Live on Day 1?
- What would help?
  - Tackling it as a project with extra funding?
  - Extra BIAs, time-limited, to work through cases under DoLS?
  - Early training and time-limited additional social worker/care manager time to undertake LPS assessments prior to LPS implementation, ready to authorise on day 1
  - What would it cost?
- Do you have social workers you could train up early to do the new three assessments and consultation to get backlog cases ready for authorisation under LPS on Day 1? If so how will you choose which?

- What support would DASSs want and how would that work best?
  - Day 1 minus 3 months
  - Day 1 minus 6 months
  - Day 1 minus 12 months
Implementation Costs and Potential New Burdens/Impact Assessment

Transitional costs to Implement the new scheme:

- Planning and project management
- Analysis of data
- Additional staff hours to reduce the backlog (whether under DoLS or LPS)
- Training: conversion of BIAs to AMCPs
- Training new AMCPs
- Training and backfill costs: front line staff and managers on the LPS in CCGs, NHS Hospitals, Social Services and Providers, including independent hospitals and care home managers.
- Production of public information, leaflets etc.

Costs to Local Authorities of running new scheme:

- Need to estimate the number of:
  - 16 and 17 year olds new costs
  - Additional cases that will come to councils from the Court of Protection
  - Reduction in cases due to transfer to NHS Hospitals (Estimated 20% of existing DoLS cases on average. Is there a saving?)
  - Reduction in cases due to transfer to CCGs
  - Reduction of cases – partial – that will be coordinated by care homes – these still need LA involvement (agreeing AP/IMCA, pre-authorisation and authorisation will council staff be asked to do assessments?)
  - Increase in care home fees to cover costs of coordination of LPS process
- Costs of medical assessments to determine if the person has a mental disorder. Impact assessment assumes no cost. This is not accepted.
- Ongoing training costs (turnover of staff): new AMCPs, front line staff and health and care staff
- Costs added in to care home fees by care homes for coordinating the process.
- Impact assessment includes figures for reviews and N&P assessments in care homes, but also needs to include the same for community settings or hospitals
- IMCA: IMCA service potential new costs to LAs. This has changed since original Bill.
- The impact assessment includes IMCA for 30% of cases. Note: Will also have IMCAs for Appropriate Persons. It assumes 28 IMCA hours per case. Is this realistic? Calculations are based on how many full-time IMCAs will be required nationally. Assume 52-weeks at 35 hours. No allowance for holiday or down time (team meetings etc).
- Assumptions made in Impact assessment about LPS assessments being part of care act work, and therefore not requiring much extra cost.
- Ongoing training costs for AMCPs and frontline staff and managers