Department of Health & Social Care

Liberty Protection Safeguards National Workforce and Training Strategy (England)

March 2022

Contents

Introduction

Purpose of this Workforce and Training Strategy

This strategy aims to support local, regional and national employers with their preparation for implementing the Liberty Protection Safeguards (LPS) in England. It offers advice on the workforce planning that will need to take place as well as the training, learning and development that is being made available ahead of implementation.

Relevant employers will include LPS 'Responsible Bodies' - NHS Hospital Trusts, Clinal Commissioning Groups (CCGs) and Local Authorities (which will include both Adult Social Care and Children's Services Directorates) - and providers of social work, social care, health, education, and Independent Mental Capacity Advocate (IMCA) services.

As part of their preparation for implementation, Responsible Bodies will need to consider their staffing requirements, including any new or changed job roles. All employers will need to consider learning and development that will be required for post-holders to fulfil the requirements of the LPS process.

Part 1 of this document focuses on workforce planning and will be of support to Responsible Bodies and IMCA service providers considering the organisational and workforce changes they will need to make in preparation for implementation. Part 2 focuses on learning, development and training planning. It aims to support all organisations to consider their staff development requirements as part of the preparation for implementation of the LPS.

Background

In March 2014, the 'Cheshire West' Supreme Court judgment widened the definition of a deprivation of liberty. The Court stated that an individual who lacks the capacity to consent to the arrangements for their care, is subject to continuous supervision and control, and is not free to leave their care is deprived of their liberty. Therefore, in cases where the person is in a care home or hospital they should be subject to the Deprivation of Liberty Safeguards (DoLS). This definition increased the number of DoLS cases and created a backlog of pending applications for local authorities, which meant that individuals were not always accessing the safeguards when they needed them.

The LPS were proposed by the Law Commission, following a review commissioned by the Department for Health and Social Care (DHSC) after a Select Committee on the Mental Capacity Act found, in 2014, that the predecessor scheme, the DoLS were "frequently not used when they should be, leaving individuals without the safeguards Parliament intended"

and care providers “vulnerable to legal challenge”. The LPS are designed to be more streamlined than the DoLS, operating alongside existing care planning processes. The scheme is intended to enable people who will be deprived of their liberty to access vital protections more quickly, putting the person at the centre of decision making. The LPS extends the same protections to 16- and 17-year olds and those deprived of their liberty in settings other than care homes and hospitals, without having to seek authorisation from the Court of Protection.

This LPS Workforce and Training Strategy has been developed for use in England, in preparation for the implementation of the LPS, to support Responsible Bodies with workforce planning and to support employers to plan for the learning and development needs of their staff. A separate LPS Training Framework has also been developed to complement this document, with the aim of encouraging the development and delivery of appropriate and consistent education and training to support the implementation and operation of the LPS. Organisations that are implementing the LPS may find it useful to read both documents alongside each other.

This strategy is in draft. This draft is provided by the DHSC for the purposes of public consultation, with a view to publishing a final version, ahead of full implementation of the LPS following a public consultation on the regulations and the Code of Practice. The Government is committed to supporting all relevant sectors to prepare for implementation. The Workforce and Training Strategy and the Training Framework constitute non-statutory guidance from Government, about the skills and knowledge that the LPS workforce will need.

The Liberty Protection Safeguards

The LPS is designed to replace the DoLS as the system that authorises arrangements amounting to a deprivation of liberty in order to provide care or treatment to an individual who lacks the relevant mental capacity to consent to those arrangements, in England and Wales. Though the LPS has the same overall purpose as the DoLS, the new system is different by design, in several ways.

The new system will be more streamlined and will put the person at the centre of the decision-making process. The LPS will introduce an explicit duty to consult with the person, and those interested in their welfare, as well as certain others, to establish the person’s wishes and feelings about proposed arrangements. Those who are close to the person will also be able to provide representation and support for them via a new ‘Appropriate Person’ role. In cases where there is no one suitable to act as an Appropriate Person, people can also be supported and afforded their rights by an IMCA. Furthermore, the rights of people at the heart of the most complex cases will be considered and upheld by new the new ‘Approved Mental Capacity Professional’ role.

The LPS will cover a wider range of settings than just hospitals and care homes, providing equal protections to people receiving care or treatment, for example, in their own homes or other private and domestic accommodation. This will make access to safeguards more straightforward, and quicker, for more people.

The new system has been designed to better integrate with other relevant legal frameworks. The aim is for LPS practice to become embedded into mainstream healthcare and social care assessments and planning, such as the Care Act 2014 care and support planning. This integration will make the overall process more straightforward for the person, ensure care and treatment arrangements are closely aligned with the LPS, and will reduce duplication for Responsible Bodies and other bodies.

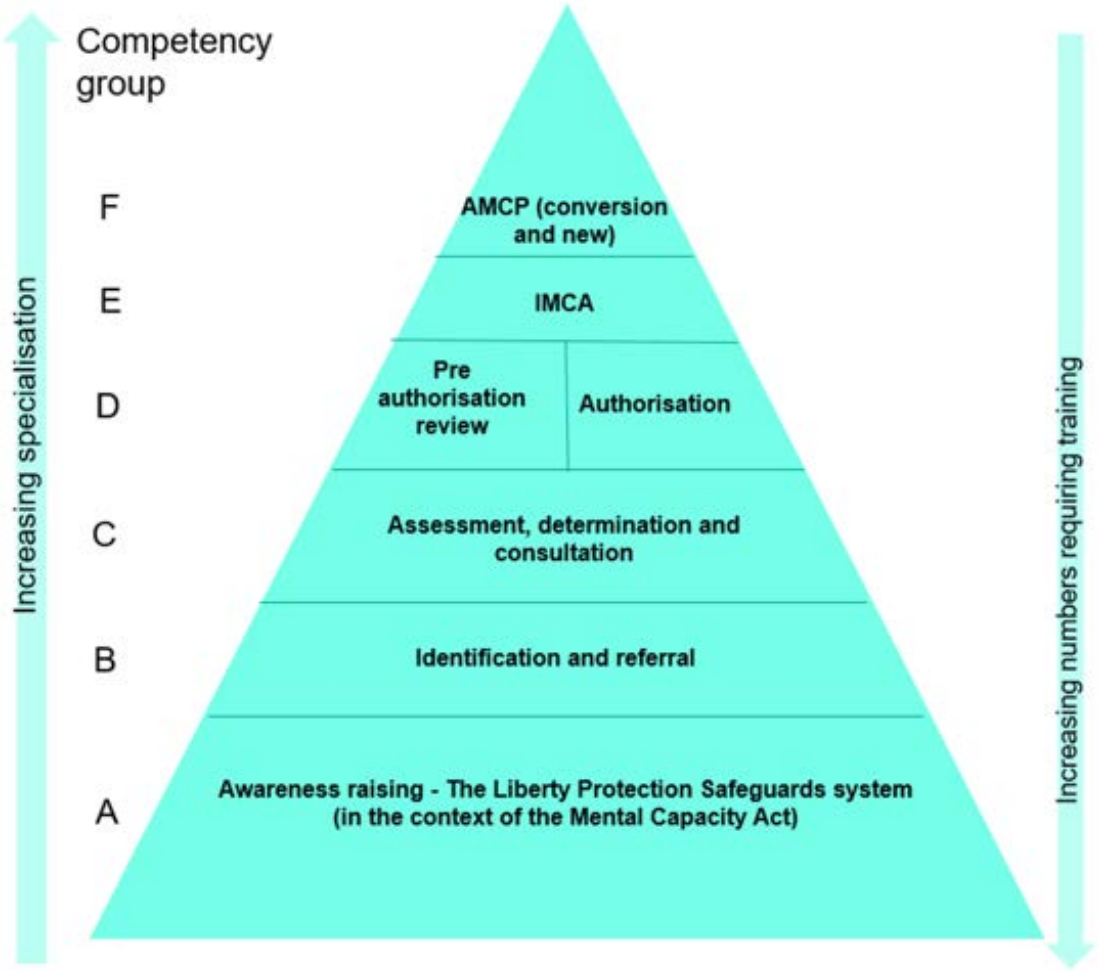
The core principles of the MCA are at the heart of the proposed design for LPS. This will help to further align mental capacity awareness and practice across different settings and professions. LPS will extend safeguards to 16- and 17-year-olds. This will streamline existing processes and improve access to safeguards for young people; for example, a decision from the Court of Protection will no longer be needed.

CCGs and NHS Trusts will now have a role in arranging assessments and authorising arrangements, which will help lessen the administrative burden and bureaucracy that currently exists under the DoLS system.

The number of assessments required to grant a deprivation of liberty authorisation will also be reduced from six to three, and in some cases Responsible Bodies will be able to renew authorisations without having to restart from scratch.

Liberty Protection Safeguards ‘workforce and training triangle’ and ‘competency groups’

The ‘workforce and training triangle’ shows the ‘competency groups’ which will be involved in the delivery of the LPS, referred to as competency groups A to F.



Competency group A covers ‘awareness raising’ and will give an overview to all staff who need to know about LPS, whilst competency groups B to D cover specific parts of the LPS process and will prepare certain groups of staff within the workforce – e.g. nurses, doctors, and social workers – for the implementation of LPS

Competency groups E and F refer to specific roles (Independent Mental Capacity Advocates (IMCAs) and Approved Mental Capacity Practitioners (AMCPs)) within the LPS process.

Competency groups A, B and D will include a wide range of practitioners in health, social care and education. Competency group C includes registered professionals who meet the criteria required by regulations to undertake LPS assessments and/or determinations.

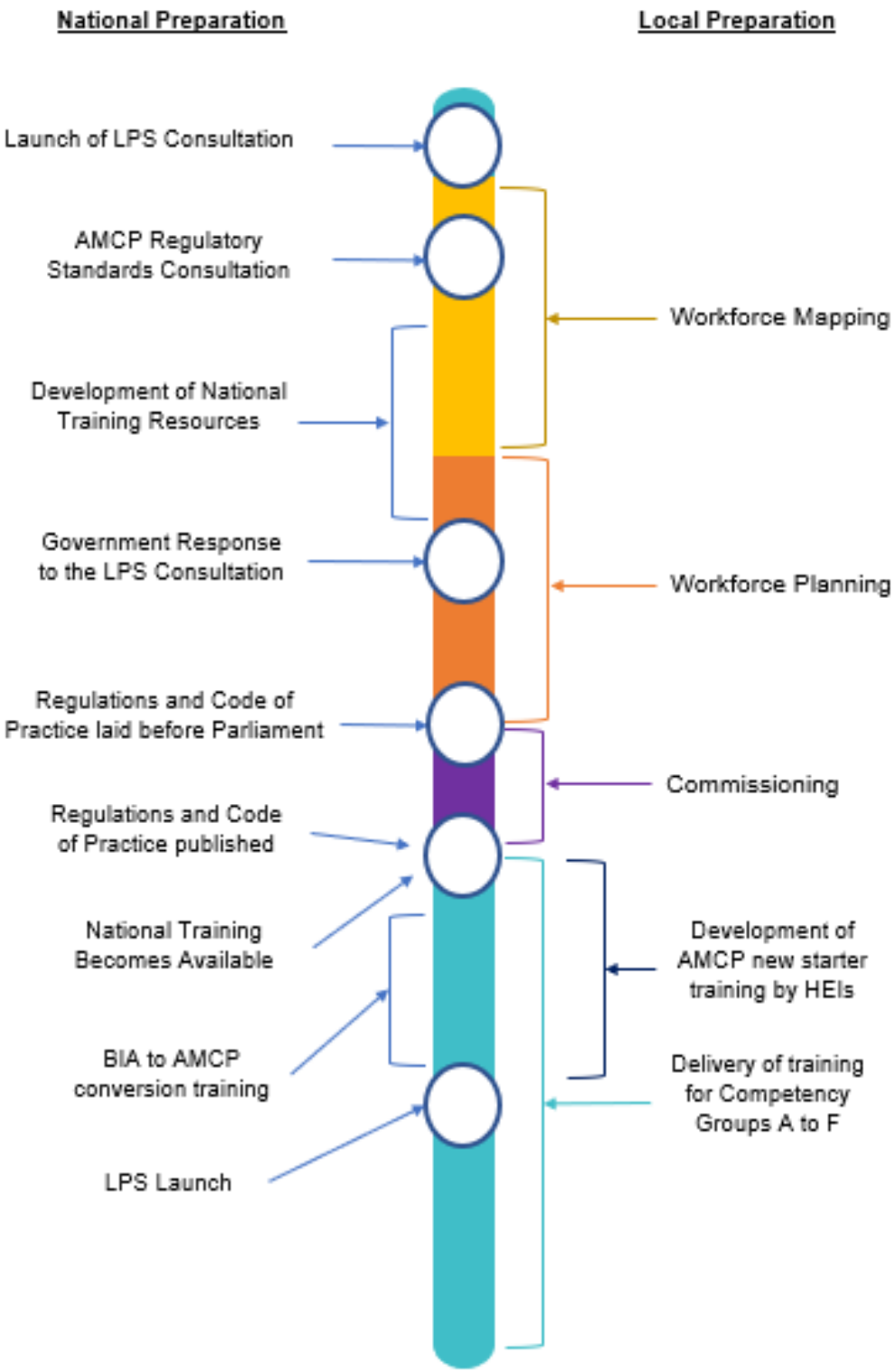
This diagram can be used to support employers with both workforce planning and planning for learning, development and training. For more detail about each competency group, see the table on page 10, in the section Understanding the roles required by the Liberty Protection Safeguards.

Key milestones

The timeline on the next page provides an overview of the key milestones and activities that will be taking place ahead of the implementation of LPS. On the left-hand side of the diagram are the key milestones for organisations at a national level; and on the right-hand side of the diagram, there is an indication of what activities organisations can be doing at a local level to prepare for the implementation of the LPS.

These key milestones include the launch of the LPS consultation, the launch of the AMCP regulatory standards consultation, the development of national training resources, the publication of the government response to the consultation, and subsequent laying of the regulations and Code of Practice before parliament. Once these steps have been completed, and the regulations and Code of Practice has been through parliament, the national training materials will be made available and training, including the conversion of Best Interest Assessors (BIAs) to AMCPs, will take place ahead of the launch of LPS.

The corresponding activities at a local level include workforce mapping and planning, developing and delivering training, and will vary depending on your organisation, what your organisation’s roles are, and how you need to prepare.


National Preparation
Local Preparation
Launch of LPS Consultation
AMCP Regulatory Standards Consultation
Development of National Training Resources
Government Response to the LPS Consultation
Regulations and Code of Practice laid before Parliament
Regulations and Code of Practice published
National Training Becomes Available
BIA to AMCP conversion training
LPS Launch
Workforce Mapping
Workforce Planning
Commissioning
Development of AMCP new starter training by HEIs
Delivery of training for Competency Groups A to F

Part 1 - Workforce planning

To transition from the DoLS system to the LPS there will be a requirement to both develop, evaluate and recruit to some new roles, in line with the requirements of the new scheme, and also to provide development and training opportunities for some existing roles, so that they can confidently take on new tasks (see Understanding the roles required by the LPS for more detail on roles).

For example, the DoLS only apply to care homes and hospitals for people aged 18 or over. Authorisation for those aged over 18 in other settings is granted by the Court of Protection, and for depriving a young person aged 16 or 17 of their liberty, authorisation is given by the Court of Protection or via other courts. Mainstream health, social care and education staff are first required to recognise a deprivation of liberty and the need for authorisation, before referring the case to either the local authority or to the Court. In the case of DoLS, specialist roles including Best Interests Assessors and Mental Health Assessors (doctors) undertake assessments and make recommendations about authorising the deprivation of liberty to the local authority acting as Supervisory Body.

Under the LPS, the same staff will still be required to recognise a deprivation of liberty and the need for authorisation. However, a wider range of registered health and social care professionals will be able to undertake the required assessments and determinations, following training, in line with regulations.

Similarly, as LPS is being expanded to include authorisations for young people aged 16 or 17, relevant training will need to be delivered in services that provide care and support or otherwise may come into contact with this group.

We expect that when LPS is implemented and the transition period ends, the DoLS roles of BIAs and relevant person's representatives (RPR) will cease. Where relevant and appropriate, the required assessments and consultation work will be built into the front-line practice of staff undertaking health and social work assessment and care or treatment planning or reviews. However, in some cases, for example when the person has privately funded care, standalone assessments and consultation may need to be carried out. Information gathered will be submitted for pre-authorisation review, prior to the Responsible Body authorising the arrangements. In specific circumstances, specialist expertise will be available from the new role of the AMCP, who will undertake the pre-authorisation reviews in certain specific situations. IMCA roles will be extended to enable the person, or their Appropriate Person, to have support and representation both before and during an authorisation. This means that the RPR roles which supported some relevant persons during an authorisation, will no longer exist. Current BIAs will need to consider whether they wish to re-train as AMCPs or will otherwise need to be consulted if moving to take up another role in the process.

Understanding the proposed roles as part of the Liberty Protection Safeguards

To understand the roles and when they are required, it will be important to understand the process as described by the Code of Practice and the requirements for some of the roles, as specified by the regulations.

The workforce and training triangle Diagram at p.5. introduces six workforce competency groups, from A to F. The following provides a summary of who will be included in the LPS workforce competency groups:

Competency Group	Description
Competency Group A: Awareness Raising	All stakeholders, including staff in health, care, education or other services, who may in the course of their work encounter a person who might lack the capacity to consent to arrangements that may give rise to a deprivation of their liberty, and who require general awareness of the LPS within the context of the wider MCA. This competency group may include non-operational roles that would benefit from a general understanding of the LPS and other roles, including carers, family, friends or advocates of a person who is subject to the LPS process and may wish to learn more about it.
Competency Group B: Identification and Referral	Clinical staff and supervisors or managers of staff or volunteers in Competency Group A, who may need to identify when a person may be deprived of their liberty, and when authorisation may be required to protect their rights under the LPS. Whilst the LPS process may be triggered as part of care or treatment planning, some individuals may need to know how to make a referral to the Responsible Body, so that it can arrange for the relevant assessments to be carried out. This might include managers of care homes or other adult social care services, children's residential care home managers or clinical staff in health services.
Competency Group C: Assessment, Determination and Consultation	All professionals that under the regulations might undertake assessments, determinations and consultation on behalf of a Responsible Body, within the LPS process (for details of who may fall into this competency group, see the Assessment and Determination, and Pre-Authorisation Review (England) regulations and the Code of Practice). This includes certain registered clinicians who may confirm a diagnosis of a mental disorder.
Competency Group D:	Designated staff in Responsible Bodies who might

Competency Group	Description
Pre-authorisation Review and Authorisation	undertake Pre-authorisation Reviews or make the decision whether or not to authorise a deprivation of liberty under the LPS on behalf of the Responsible Body.
Competency Group E: IMCA	Existing and new Independent Mental Capacity Advocates (IMCAs).
Competency Group F: AMCP	People who meet the requirements set out in regulations, to undertake full AMCP training, or BIA to AMCP conversion training and to be approved as an AMCP by the relevant local authority (regardless of who employs them) in line with the relevant regulations.

In addition to the LPS workforce competency groups, there will be a need for a wider range of roles to understand the LPS and the differences from other systems. This will include:

- those in health and local government responsible for commissioning health, care and education services from organisations whose staff may be involved in depriving individuals of their liberty

- senior and strategic managers responsible for their organisation's implementation and operation of the LPS

- Regulators and Inspectors of health, care and education services employed by the LPS 'monitoring bodies' (Care Quality Commission (CQC) and Ofsted)

- those in children's social care services and education settings, where the LPS may now be required

These roles will benefit from awareness of the LPS and may also benefit from training on the MCA more generally, since this will enable them to fulfil their job roles even though they may not be undertaking specific tasks within the LPS process.

In order to prepare for implementation, Responsible Bodies in each area will need to consider whether to implement shared or separate services, what new posts are required, where they will sit within organisational structures and how they will be structured and managed. There may be requirements for new or updated job descriptions and person specifications for a number of roles. Job evaluation may be required, and Responsible Bodies will benefit from human resources advice at an early stage.

Working with local partners to agree coordination and administration of the operational process

The introduction of the LPS presents an opportunity for future Responsible Bodies in a local area to explore whether they might want to develop a shared service.

It is likely that local areas will set up implementation planning or steering groups to prepare for the launch of the LPS. Such groups should include both Responsible Bodies and providers of services, to promote awareness and plan training for all parts of the system.

Organisations that will become Responsible Bodies under the LPS will need to consider the approach to running the scheme in the local area and plan for any associated workforce changes. In each area, the organisations that will become Responsible Bodies include:

- Local Authorities (both adult social care and children's services directorates)
- Clinical Commissioning Groups (CCGs)
- NHS Trusts that are responsible for hospitals

Senior managers within each of these organisations will need to come to an early decision about whether it makes sense for their area for one or more of the Responsible Bodies to join together in a shared service model. Each Responsible Body may wish to consider the size and footprint of their organisation and whether this lends itself to a shared or joint service. They may also wish to consider the anticipated activity levels and whether it makes economic sense to join forces or remain separate.

For Responsible Bodies that decide to join together in a shared service, there will be a range of implementation matters to consider that are outside the scope of this workforce strategy, such as project planning, the development of an S75 agreement, commissioning the IMCA service, funding and IT systems. In relation to workforce modelling, the Responsible Bodies may find it helpful to consider the following questions, to inform plans for the required workforce for the LPS:

- Which organisations will be involved?
- What will be the footprint of the proposed shared service?
- What should the shared service provide (for example, a shared AMCP service/information, advice and support/training/coordination of rotas for pre-authorisation review when an AMCP is not required)?
- What tasks would be undertaken by each Responsible Body?

- How would the shared service be held accountable to each Responsible Body?
- How would each Responsible Body ensure it meets its own LPS authorisation duties?
- Which organisation would host the shared service?
- What would each Responsible Body contribute in terms of staff and resources?
- How will recruitment be done (jointly/separately? Are there any HR implications)?
- Is there a benefit to considering adjoining geographical areas?

If a Responsible Body decides not to join partners in a shared service, it will need to consider some of the same questions for its own organisation, including what will be carried out in mainstream practice and what, if any, tasks will be managed centrally. Within local authorities, adults and children's services may wish to consider whether to operate a joint approach to LPS.

The answers to the questions above will enable Responsible Bodies to consider management structures, staffing and funding required for both front-line practice and any central teams. Depending on the approach agreed, the following processes on workforce planning may be undertaken jointly or separately.

Understanding potential demand for Liberty Protection Safeguards authorisations to inform future workforce needs

The LPS allows Responsible Bodies to mainstream assessment, determination and consultation tasks that were undertaken by specialist staff under the DoLS scheme. However, there are some new roles, such as the AMCP, and other roles will need to be adapted in line with the new process. This section considers approaches to estimating the future staffing requirements based on the analysis of existing data and projecting future demand.

In addition to Responsible Bodies, other employers that will need to estimate required workforce changes are IMCA providers, whose role will change to continue to support the person post authorisation and to support the new Appropriate Person role. The post-authorisation (both paid and unpaid) relevant person's representative (RPR) role ceases.

Analysis of available data on anticipated demand

Some local authorities have been considering approaches to identify expected demand. These are set out below, as they may be helpful for other Responsible Bodies in their planning.

Analysing data on DoLS and Court of Protection applications

Councils have at their disposal data from the current DoLS activity, stretching from 2010 to the year 20/21. This can be used to project figures to be expected from care homes and hospitals and can be shared with other future Responsible Bodies in their area. The Court of Protection publishes data on applications for community deprivations of liberty, that is, those in settings other than care homes and hospitals. Councils and CCGs will need to work together to identify how many of the people involved in DoLS applications or authorisations in care homes receive those services under continuing healthcare. Councils and CCGs may also have their own data on Court applications they have made. Questions to be considered include:

- How many deprivation of liberty authorisation requests are currently being received by the local authority DoLS service per year?

- How many of those authorisation requests would go to different Responsible Bodies under LPS (that is, an NHS Trust, a CCG or its successor, or a different local authority)?

- Who is identifying that a deprivation of liberty is required?

- How many of these requests are requests for a new or initial authorisation and how many are requests for renewals of existing authorisations?

- What proportion of requests or applications go on to be authorised (this will inform review activity estimates and also IMCA commissioning requirements)?

Projections of these numbers into future years will support workload estimates to inform future workforce needs.

For CCG planning, once local authorities or CCGs understand how many current DoLS cases are for those who are eligible for continuing healthcare, local authorities will need to work with CCGs to develop a plan for transferring responsibility for those cases to the CCG.

In order to support this work and project numbers for the future, to inform staffing levels, CCGs should consider projections based on historic trends rather than just the current number of people in the system. CCGs will also need to look at projecting the numbers of community cases where they have sought a Community DoL Order from the Court of Protection.

For NHS hospital cases, local authorities and Trusts will need to work together to plan the transfer of responsibility for existing hospital cases to the correct NHS Trust. Information on DoLS authorised in hospital settings will be held by the DoLS teams in local authorities,

and NHS Trusts themselves should have data on the number of applications made and authorised, in order to notify CQC as a managing authority.

Similar to CCGs, NHS Trusts should also start to project the numbers into future years and give some thought to both applications for new authorisations and renewals.

For independent hospital cases, it will be important to develop an understanding of the numbers of people who use independent hospital services each year, including building-based hospice services.

Modelling potential future workforce requirements

Modelling will give Responsible Bodies projections and estimates of the number of new LPS processes that could be triggered each year, the numbers of authorisations, and the number of renewals to be expected each year. In turn, this will enable estimations of how many assessments, consultations, pre-authorisation reviews, authorisations and renewals should be expected, and the staff resource required to undertake that activity.

As suggested in the section “Understanding the roles required by the Liberty Protection Safeguards”, it will be useful to read the Code of Practice and Public Consultation documents, to develop an understanding of the job roles within the LPS. The LPS regulations will specify the requirements for some of the roles. Understanding this information will support planning and analysis of what is required to implement the LPS.

It will be necessary to develop some estimates of the number of staff Responsible Bodies will need in place to undertake the LPS work. Each Responsible Body should design its own local system, either jointly with other Responsible Bodies, or separately, as discussed above. There may be a central service that may undertake some of the administration and coordination on behalf of the Responsible Body(ies). This will inform what front-line registered professionals are required to do in each Responsible Body, but it is anticipated that new work for front-line practitioners may include the following tasks on behalf of the Responsible Body, each time the LPS process is triggered:

- Establishing who is best placed to provide representation and support for the person (IMCA or Appropriate Person) and arranging that representation.

- Checking if there are existing or equivalent mental capacity and medical assessments that can be relied on.

- Depending on the profession of the worker, either undertaking or arranging for someone else to undertake necessary and proportionate assessment and determination, and where required, mental capacity assessment and determination and medical assessment and determination of a mental disorder (note there must be two or more professionals involved in each case).

- Undertaking consultation of the person's wishes and feelings to inform the arrangements.

- Preparing and submitting the required evidence (assessments, determinations, consultation and draft authorisation record) for pre-authorisation review.

Once Responsible Bodies have projected figures for how many times the LPS processes might be triggered per year, they will need to agree assumptions to inform their workforce calculations. For example, the proportion of people where a new capacity assessment and/or medical assessment will be required and also the average time to be allocated for the various tasks. This will enable an estimate of the total average number of front-line staff hours required each time the LPS process is triggered. Similarly, an average time per renewal will be required. Multiplying the number of initial and renewal processes by the average time required for each will enable a calculation of the total time required, which in turn will inform the total number of full-time equivalent posts required.

A workforce calculator has been developed by Shropshire County Council, for adaptation by other Responsible Bodies, and uses a spreadsheet to calculate the number of full-time equivalent posts required, using various assumptions and estimates of time required for particular tasks and combining this information with the projected data on the numbers of LPS processes, authorisations and renewals. This was developed before the Code of Practice was published, and therefore some assumptions may change following the new guidance.

In addition to the tasks for front-line practitioners, there will be a decision required on which posts will undertake pre-authorisation reviews and authorisations. Projections from DoLS data may inform estimates of the proportion of new LPS processes that will continue to the point of pre-authorisation review and authorisation. This information can be used together with an estimate of the average time required for these tasks and how many full-time equivalent posts will be required. Responsible Bodies may choose to share these tasks across a number of posts adding these responsibilities into existing job descriptions, rather than devising totally new jobs to undertake these tasks. Responsible bodies can draw on evidence from the Government's impact assessment of LPS, to inform their own estimates. For example, the impact assessment estimates that 26% of pre-authorisation reviews that will require an AMCP. Alternatively they may have their own estimates based on their own data. The impact assessment suggests that each pre-authorisation review undertaken by an AMCP will take 5.4 hours.

An approach used by Leeds Teaching Hospitals NHS Trust over the last year has been to keep a running total of all their applications to the local authority for a DoLS authorisation and recording, at the time of the application, if the person, or those representing them, are expressing or indicating that the person does not "wish to reside in, or receive care or treatment in" the hospital. This has given them projections not only of the number of authorisations they may have to process, once they become a Responsible Body, but also

an idea of how many may require an AMCP to undertake the pre-authorisation review. This should, however, be considered in line with the guidance in the Code (see AMCP chapter).

Responsible Bodies should also consider estimating how many other cases may be referred to an AMCP by the Responsible Body, including whether there is one or more independent hospital in the area.

Considering numbers of people who may be “in scope” for LPS

One scoping approach, developed by Surrey County Council Adult Services, and adapted for use elsewhere, has been used to help one local authority plan for LPS implementation by considering the number of people in various settings. This information considers the number of people by needs group and setting, and uses the following data to consider who may be 'in scope' of LPS:

- The number of beds in care homes (with or without nursing) registered in area for dementia, learning disability or mental health care is available from CQC data. Local areas can apply an occupancy percentage, based on local market experience, to estimate how many people may be occupying those beds and may be in scope for LPS. This enables a consideration of the total number of people who may be in scope in care homes, including those who fund their own care in care homes as well as those known to the council.

- The number of people with dementia or learning disability that the council funds in supported living or with a package of support at home. This information is usually available from council financial services. Percentage can be applied from national prevalence data (such as POPPI and PANSI) to estimate the total numbers in an area, including those that are not funded by the council. Data is also provided on the proportion who may have moderate to severe needs.

- The number of independent hospitals in an area (CQC data) is available, although this covers a wide range of hospital types and it is difficult to estimate how many people in these settings.

- The number of young people in transition from Children’s Services to Adult Social Care who may have high-cost packages (for example at a weekly cost of over £1,000), may provide a proxy figure for 16- and 17-year old young people who may be in scope (although it is recognised that this may include young people with physical needs who do not lack capacity so would not be in scope).

However, it is important to note that not everyone who is considered as part of this process would require an LPS authorisation. Decision makers should always be working with the person to enable them to make their own decisions, as far as possible, and considering

less restrictive options. Likewise, the Code of Practice explains the definition of a deprivation of liberty, which should be considered in every case.

Another approach for considering the number of young people who may be in scope, developed by a number of councils, in collaboration with Council for Disabled Children (CDC), includes a consideration of all those currently living in the following settings who lack the capacity to consent to arrangements:

- Residential schools and colleges
- Short breaks/community settings
- Domestic settings including family homes

Planning for young people in those settings who may turn 16 in the next year could include whether the arrangements would amount to a deprivation of liberty once they turn 16, to enable a running total to be maintained of the numbers of young people who will come into the scope of LPS, once it is implemented. It will also highlight the requirement for applications to be made to the Court for authorisation of arrangements prior to LPS implementation. It may be useful to consider the same points for young people who may turn 16 in the next year and lack the mental capacity to consent to arrangements to enable care and treatment, when reviewing any of the following:

- Child in Need plans
- Child Protection plans
- Looked after child plans and or pathway plans
- Education health and care plans

Some Responsible Bodies may find it useful to review a random sample to predict the percentage that would be deprived of liberty and would therefore be in scope for LPS. As above, this should be considered by reference to the definition chapter within the Code of Practice, and less restrictive arrangements should always be considered.

Responsible Bodies should, however, note that there may be some people, including young people, who will not fall under the scope of the LPS, because although they do not consent to the arrangements, they do not actually lack the mental capacity to make decisions about their care and treatment. Where the LPS authorisation conditions are not met, other alternative approaches may need to be considered including the Mental Health Act.

IMCA demand

Responsible Bodies will all be responsible for funding IMCA services and the local authority in each area will commission the services. Under the LPS, IMCAs will provide support and representation to individuals after authorisation, during the authorisation period and any subsequent renewal periods, in addition to during the initial process. The impact assessment estimates that an IMCA would be able to provide 38 hours in either direct support to a person, or to their Appropriate Person. Responsible Bodies and IMCA service providers may have their own agreed working practices. Responsible Bodies will need to work with their IMCA providers to agree revised specifications for services and share projections of the anticipated number of times the LPS process might be triggered in a year, so that IMCA employers can prepare for increased numbers of IMCAs and the phasing out of the RPR role.

Understanding your current workforce - analysing and mapping

The LPS system will be more streamlined and will reduce duplication by working better alongside existing care planning. Some organisations will experience efficiencies once LPS is implemented, due to the introduction of a simpler authorisation process. Additionally, since LPS, NHS Trusts and Clinical Commissioning Groups will be Responsible Bodies, and will have a role in arrangement assessments and authorising arrangements, this will reduce the administrative burden on local authorities, who were previously responsible for all DoLS authorisations.

As such, in many cases, particularly in local authorities, it should be possible to adapt existing job roles to reflect the new system. Yet it may be necessary in some organisations to increase the number of post-holders undertaking these job roles to accommodate new tasks.

In order to decide whether any new staff will need to be recruited to meet the future demands of the LPS, Responsible Bodies and providers across health and social care will need to establish how much the current workforce can accommodate the new requirements.

It should be noted that with the retirement of the BIA role, there may be capacity freed up that can accommodate some of the new tasks. Many BIAs may move into the new specialist AMCP posts. Others may undertake pre-authorisation reviews without becoming AMCPs, or undertake assessment, determination and consultation roles, offering a wealth of expertise based on experience of working as assessors under the DoLS.

To understand what can be accommodated by the existing workforce, senior staff across Responsible Bodies and providers across health and social care may find it necessary to map their workforce. Suggested questions to ask are:

- How many people work in relevant service areas? What are their current roles, job titles and responsibilities? What knowledge do they have?
- Who is involved in making DoLS decisions?
- Who is involved in applying to the Court for authorisation in community settings?

It will also be useful to map the number of:

- Best Interests Assessors, including:
    - directly-employed BIAs
    - people who are employed in other roles but who take on BIA duties on a rota basis
    - Independent BIAs or agency BIAs who operate in the area, if known
- Staff who undertake needs assessments and care planning, both registered professionals/clinicians and non-professional staff. It may be useful to identify the number who have experience of preparing assessments for community deprivation of liberty cases, whether in the local authority or the CCG including:
    - social workers (in both children's and adult services), occupational therapists, nurses, speech and language therapists, psychologists
    - staff who undertake continuing healthcare assessments
    - nurses and clinicians who undertake treatment planning
    - Section 12 doctors
- Managers who currently act as DoLS authorisers
- Staff in Responsible Bodies that could take on the role of pre-authorisation reviewer when an AMCP is not required. The Code of Practice states that these should have an applied understanding of the MCA and the LPS process, although they do not need to be registered health or social care professionals
- IMCAs
- Paid Relevant Persons Representatives

There are tools available, which will assist with workforce planning, workforce redesign and workforce transformation.

For those working in the healthcare sector, the Workforce Repository and Planning Tool (WRaPT) and HEE Star are just two examples of tools that can help you to map who works in your area and plan for the changes to be implemented.

In social care settings, Skills for Care owns an Adult Social Care Workforce Data Set (ADC-WDS) which can help you to understand who makes up your workforce.

The Local Government Association Workforce team has a ‘workforce planning offer’ which councils can apply for to help you understand your supply and demand and what specific actions you need to take to plan your future services.

Once Responsible Bodies have this information, you can then consider how existing roles might change to accommodate the new requirements, acknowledging that the job roles and structures used in the implementation of LPS may look different in different Responsible Bodies. It may be useful to ask what existing staff think could be done differently.

Matching existing workforce to future workforce requirements

Once Responsible Bodies have established the required size and make-up of your future workforce, mapped your existing workforce, and considered how existing job roles could evolve to accommodate new tasks, you will be able to consider how the size of your existing workforce will match the workforce required to implement the LPS. Some of the tools mentioned above can support this stage.

Staff carrying out this mapping exercise will find it necessary to involve human resource advisors to seek advice at the earliest opportunity regarding job roles that may change or cease. Job evaluation will be required for brand new roles and consultation will be required with staff whose jobs are changing.

Identifying future workforce gaps

As noted in the section on Understanding your current workforce, organisations are expected to experience efficiencies once LPS is implemented, due to the introduction of a simpler authorisation process and reduction in the number of overall assessments needed.

Nonetheless, if workforce gaps have been identified, Responsible Bodies will need to decide whether they can fill these gaps through recruitment.

The number of new posts that Responsible Bodies will be able to recruit will be constrained by their budgets and by what is affordable. The number of potential applicants will be constrained by the supply. For example, Responsible Bodies in health as well as local authorities may wish to attract BIAs to apply for their AMCP roles. Where gaps may exist, it may be possible, and Responsible Bodies may wish to discuss, sharing posts or collaboration between partners.

Planning and implementing the transition to new roles and structure

IWhen the LPS are first implemented, it will be important to be mindful that DoLS authorisations and authorisations made by the Court can be for a period of up to one year. Any authorisation that has been made prior to the implementation of the LPS, which then extends beyond the implementation date, will still be valid when the LPS begins. Consequently, two systems will be running alongside each other once the LPS is implemented, with any new authorisations or renewals falling under the new system. This period, of up to one year, will be known as the transition year.

To plan for this period, providers will need to ensure that staff continue to receive training on DoLS, where necessary, and be aware that the principles of the MCA and the safeguards provided by DoLS will still apply.

Certain staffing groups that are crucial to effective running of the DoLS system will need to be maintained until the implementation of the LPS, and some will be required to remain available alongside the LPS for the transition year. For example, local authorities will need to ensure that there are sufficient numbers of BIAs available to undertake any Part 8 reviews that may be required under the DoLS process.

Planning will need to happen within each organisation and among Responsible Bodies in an area to think about when different post-holders will need to be trained, what should be commissioned, and when any new roles will start or existing roles will change to operationalise the LPS. The length of time required for this planning will depend on the organisation. The workforce and planning timeline should assist organisations in planning for these changes.

The DHSC will be working closely with training providers to ensure that training is kept up-to-date and that LPS learning will be embedded as part of standard DoLS learning, to help with the transition.

If working with 16- and 17-year olds, or in settings that are not covered by DoLS, referrals should still be made to the Court or relevant body wherever a deprivation of liberty is needed, until the point that the LPS begins.

National and regional support

The DHSC aims to ensure that all sectors are suitably supported in preparing for the LPS implementation, both ahead of the implementation date and during the year of transition. DHSC is working closely with the sector over the next year to make sure that the support required for implementation, including training, is there.

Within Government, the Code of Practice and Public Consultation has been developed jointly between DHSC and the Ministry of Justice (MoJ), and we are working closely with the Department for Education (DfE) to ensure that the needs of 16- and 17-year olds, and the services that cater for this age group, are met. A national working group has been arranged to oversee this area of work, as we recognise that the introduction of the LPS will change how the system works for this age group and that the services will be doing things in a different way once the LPS is implemented.

To support the sector more broadly, centrally produced information resources on the LPS covering a wide range of topics and for a variety of different audiences will be produced. These will be available for adaptation by Responsible Bodies and other groups. For example, DHSC has produced LPS factsheets on a range of different topics, from an overview of the LPS process to information on authorisations, renewals and reviews.

Recognising that the LPS will lead to changes across many settings, key organisations have been involved right from the beginning in preparing for the LPS implementation. These partners include the Care Provider Alliance, Local Government Association (LGA), Skills for Care (SfC), the Social Care Institute for Excellence, Health Education England, the Association of Directors of Adult Social Services (ADASS), and the Association of Directors of Children's Services (ADCS).

DHSC has been working closely with colleagues across the NHS, including NHS England and Improvement and NHS Providers, to ensure that health providers are prepared for the changes that the LPS will bring, which include new roles for Trusts and other healthcare organisations as Responsible Bodies.

To help make sure that both England and Wales are prepared and that the LPS is implemented effectively, the Government has been working closely with the Welsh Government, who have prepared their own workforce and training plan.

DHSC, with support from DfE, has recently been establishing the following implementation support programmes for organisations in England. This work is not yet completed, but once set up, these will include the following:

1. Local government implementation programme:

This programme, proposed by the LGA and ADASS, with support from ADCS, is made up of a number of deliverables which DHSC is committed to supporting. The proposed programme of work is expected to:

- Develop exemplar training products for the sector, for the conversion of BIAs to AMCPs. BIAs under DoLS are to be are replaced with the statutory AMCP role, under LPS. BIAs that wish to convert to AMCPs would need to undergo training, which will be delivered by local authorities. Exemplar training will help local authorities prepare and deliver high quality training.

- Appoint 'regional implementation champions', separately for adult and children's services across each of the English regions.

- Provide targeted support to local authorities, to facilitate implementation planning and activities.

- Work through established regional structures across both adult and children's services to develop and disseminate key information about LPS, to inform local authority planning for implementation.

In support of this work, surveys will be carried out to assess readiness across the regions. This will help inform the work of the regional co-ordinators and enable best practice to be shared across regional networks, and further assistance given where it is required.

A predictive planning tool will also be developed and rolled out across the regions, helping councils to predict the numbers they may receive and plan accordingly.

2. Social care providers implementation programme:

This programme will be led by the Social Care Institute for Excellence and Skills for Care, in partnership with the DHSC. It will:

- Establish how the social care sector is planning for LPS, and what national support it needs to make implementation a success.

- Develop and disseminate key information about LPS, to inform social care providers' planning for implementation. This will include exemplar guidance, resources and training for people working in social care.

3. Health implementation programme:

The government is working with the NHS in England, including Health Education England, on plans for a third implementation support programme for health that will:

- Establish how the health sector is planning for LPS, and what national support it needs to make implementation a success.

- Develop and disseminate key information about LPS, to inform the health sector's planning for implementation. This will include exemplar guidance, resources and training for people working in the NHS.

Part 2 Learning, Development and Training Planning

National Training Framework

The National LPS Training Framework (working title) will provide a consistent framework of learning outcomes to inform the development of training courses and materials to support the learning and development of staff. This is intended to support training providers to develop consistent course materials. The training framework describes the learning outcomes across a number of subject areas for each competency group.

In addition to paid staff, awareness raising will be important for family members and friends who represent and support people who may be deprived of their liberty as an Appropriate Person.

Training will be required for staff working for the LPS monitoring bodies, (CQC and Ofsted). These bodies will monitor the operation of authorised arrangements that amount to a deprivation of liberty in England, to ensure that the arrangements are being carried out safely and appropriately.

There will also be training required for administrative and management staff within Responsible Bodies, and for legal professionals, to ensure that the LPS provisions are operated, recorded and reported effectively.

The expectation is that the learning outcomes for competency group A, Awareness Raising, will be relevant for many people, and can be incorporated into role-specific training, where appropriate.

Nationally available training materials

Competency groups A to D (See page 10)

Using the training framework as a basis, DHSC intends to work with national providers across local government, social care and health to develop national training materials covering workforce competency groups A through to D that can then be used by employers and training providers, across a variety of settings, to deliver training on LPS ahead of the implementation date. The partners involved in this work are outlined under the earlier section on national and regional support.

DHSC intends to provide some training materials which will be freely available and accessible to staff across health and social care until at least the end of the year of transition. Providers may still wish to develop their own training materials, either based on the training framework or depending on their need.

IMCAs

With competency group E, (covering IMCAs), the DHSC is working with those responsible for producing training materials covering these specialist roles under LPS.

Training for both new and existing IMCAs will be provided in a similar way to how the system works now, with organisations that are currently experts in Independent Advocacy delivering this learning. IMCAs will undertake training through courses that meet the requirements of City & Guilds national independent advocacy qualification, to show that they are of the required standard.

AMCPs

All training for new AMCPs, and refresher training, will be delivered by Higher Education Institutes (HEIs). The regulatory framework for this learning is being developed currently by Social Work England (SWE) and will be consulted on separately. As such, the length of training for AMCPs will be detailed at a later date.

For BIAs that wish to train as AMCPs, training will be delivered by local authorities through a course approved by the Secretary of State for Health and Social Care. Recognising that training enough AMCPs ahead of the implementation date will be a challenge, the

DHSC is committed to supporting local authorities effectively. DHSC therefore plans to fund the delivery of approved training materials ahead of implementation and will help enough AMCPs to be trained in time. Further information about the training and how organisations can access this learning will be announced in due course.

DHSC will work closely with SWE to ensure consistency in course delivery and that sufficient support is in place for HEI and HEI-accredited organisations to develop and deliver learning following the initial phase.

Further information will be released over the coming year, detailing how learning will be cascaded across regions and organisations, through events, webinars, and other forms of communication.

Understanding the learning and development needs of your organisation

Each organisation will have a range of roles that will need training to support transition into the new system. In addition to the LPS learning outcomes in the national LPS Training Framework, each organisation will need to train staff on the new recording requirements, and in the use of the local IT systems and associated workflows. A national minimum data set is being developed for national reporting and any local data recording will need to satisfy the requirements of the national minimum data set. In addition, national templates are being developed to support consistency in the transfer of information between organisations and from organisations to individuals who may be deprived of the liberty and those representing and supporting them.

The needs of your organisation will depend on whether it is:

- A Responsible Body (staff working in hospitals, NHS Continuing Health Care teams, adult social care, children's social care and education services)
- An organisation whose staff may be involved in delivering arrangements that may amount to a deprivation of liberty (health, social care, education or transport)
- An organisation that may employ IMCAs
- An agency that may supply independent professionals to Responsible Bodies
- A monitoring body
- An organisation providing legal services

It is likely that all types of organisation will need to ensure that awareness-raising training is made available for staff. Organisations that will carry out the arrangements will need to ensure that those tasked with making referrals into the new process are trained to fulfil their legal requirements. Whilst care home providers and hospital providers may be quite experienced with the DoLS, and will want to focus on the differences with the new system, other providers including schools, colleges, supported living or domiciliary care providers may need a more thorough introduction. IMCA organisations will need to understand what is new in comparison to DoLS, and will also need to ensure their staff are trained in supporting and representing 16- and 17-year olds. Agencies that supply registered professionals to Responsible Bodies will need to ensure their staff are up to date with requirements. For the different types of Responsible Body, the development needs will be different.

NHS Trusts that run hospitals have been managing authorities under the predecessor system and have made applications for authorisation to the local authority. They also have

experience of notifying the monitoring body about applications and authorisations. The learning needs for these Responsible Bodies will include learning about what is different or new about the LPS. They will also need to understand what is required to ensure the appropriate response when the LPS process is triggered, and who within their organisation will take on the various roles within the process. They already have experience of instructing IMCAs under the MCA but will need to understand their responsibilities under the LPS in relation to both IMCAs and Appropriate Persons. They will need to plan for any employed BIAs to undertake training to become an AMCP, if they wish to apply for the role, and for AMCP training for any staff who will move into the new role without having been a BIA.

For CCGs, the staff who have been most closely involved with the MCA and the DoLS may not have been in the continuing healthcare service. Many CCGs include their MCA/DoLS leads, if they have them, within their safeguarding function. These staff may be familiar with the MCA and deprivation of liberty, but it will be necessary for MCA and continuing healthcare leads to work together to consider the training needs for those working in continuing healthcare about the LPS process. Some continuing healthcare leads will have experience of applying to the Court for authorisation, but most are unlikely to have been very involved with the DoLS process. Training will need to cover new roles and responsibilities that continuing healthcare staff will need to undertake, including identifying the need for an IMCA or Appropriate Person, for assessments, determination, consultation, pre-authorisation review and authorisation, as well as about the required interface with those who are carrying out the arrangements. In some areas continuing healthcare assessments are sub-contracted to community health care services, and MCA and continuing healthcare leads will need to consider who will require training on assessment, determinations and consultation for the LPS. They will also need to plan for any employed BIAs to undertake training to become an AMCP, if they wish to apply for the role, and for AMCP training for any staff who will move into the new role without having been a BIA.

Local authority adult social care services will be familiar with DoLS, having been the supervisory body, but will need to consider the training needs of front-line staff to undertake assessment, determination and consultation, rather than BIAs. Managers of front-line staff will also need to be familiar with requirements in order to supervise those they manage. Local Authorities will lead on the training in their area for BIAs who wish to become AMCPs regardless of which Responsible Body will employ them. Although these Responsible Bodies have the most experience of both DoLS and of applying for Court authorisations, it will be important not to make assumptions about transferrable knowledge, and to ensure that a comprehensive training needs analysis is undertaken. Local authority children’s services are the least likely to have experience of the predecessor systems except in the transitions services. Staff who will work in the new process will require a thorough understanding of the LPS process and how it fits with other legislative frameworks for young people aged 16- or 17-years old. Children’s services will

also want to ensure that those in NHS services or in generic LPS teams (across both adult and children's age ranges) who work with 16- and 17-year olds have a good understanding of any specific requirements in relation to children's legislative frameworks.

Undertaking training needs analysis for your staff, by competency group

Having considered the organisation's training needs, each employer will need to consider the competency groups in the workforce and training triangle at p.5, and the descriptions of each competency group at p.6. Employers will need to consider how many people require training in each competency group.

The starting point with LPS training should be the principles of the MCA. The implementation of the LPS is a good opportunity for services to either refresh or reinforce their staff's understanding of the provisions and principles of the MCA, which underpin the LPS.

The government's ambition is for all staff across health, care, education and other services, who may in the course of their work encounter a person who lacks the capacity to consent to arrangements that may give rise to a deprivation of their liberty, to receive awareness raising training – or competency group A. Note that awareness-raising training is likely to be appropriate for a wide range of roles, including some senior managers, NHS Board members or elected councillors. It will also be of value to staff in the monitoring bodies and legal professions.

For competency group B, services will need to be aware that more staff will be involved in identification and referral than under the current DoLS programme, since more settings and services will be involved in carrying out the arrangements that are authorised under the LPS. Staff across all settings who are already familiar with DoLS will therefore need to be trained on what will change when DoLS is replaced by the LPS, and may benefit from undertaking e-learning or training as outlined in the Considering Types of Training, Learning and Development opportunities to be used.

In competency group C, it will be necessary to develop staff understanding and skills for a wide range of posts in the concepts of the MCA and the requirements of assessments, determinations and consultation. It will also give staff an understanding of how the process will be managed and administered within the Responsible Body.

For competency group D, there will be training required for all staff who will undertake pre-authorisation reviews. Any people who have been BIAs but choose not to convert to an AMCP may continue as assessors, in which case they will be included in competency group C. Some may become "generic/standard" pre-authorisation reviewers or carry out authorisations, rather than being approved as AMCPs. Staff who have been authorised

DoLS arrangements, and will continue to authorise under the LPS, will need to understand what the changes are between DoLS and the LPS. Those who are entirely new to the role will need to understand the role under the LPS and what is required on behalf of the Responsible Body.

For existing IMCAs there will be a need for conversion training to ensure familiarisation with the new process and the extension of their role within the LPS post-authorisation. For new IMCAs who have not practised under DoLS, the new national advocacy qualification will equip them to operate under the LPS.

Young people aged 16 to 17 must be provided with appropriate representation and support where necessary and must be made aware of what advocacy services are available, how they may access such support and any entitlement they may have to advocacy provision. This advocacy provision should adhere to the National Standards for the Provision of Children's Advocacy Services, alongside any other standards or expectations required of IMCAs.

For AMCP training, local authorities will need to identify how many AMCPs will require training as they will have a statutory duty to ensure that there are enough AMCPs in their area. Local authorities should identify which BIAs in their area plan to convert to AMCPs, so that they can undertake the conversion course. For those who have not practised as BIAs, new university level training will be developed in line with the professional standards being developed by SWE, in consultation with the Nursing and Midwifery Council (NMC) and the Health and Care Professionals Council (HCPC). Further information about this will be provided later this year.

Considering education and training for other roles

Awareness raising (Competency Group A) training will provide a useful overview for non-operational roles that need a general understanding of the LPS process. It may also be useful, and of interest, to other roles, including volunteers, Healthwatch visitors, self-advocacy groups, carers, family and friends of a person who is subject to the LPS. It will be of value to anybody who agrees to take on the role of Appropriate Person.

Considering types of training, learning and development opportunities to be used

The government's intention is for training and learning, across each of the competency groups, to be made available in a range of formats and in a way that reflects how users learn best. Our ambition is for all training to be based on the LPS Training Framework. The subject areas and learning outcomes across each competency group in the LPS Training

Framework should be used as a guide for all training providers looking to develop and deliver learning on LPS, be it online, face-to-face, or otherwise.

As such, the Government has commissioned training materials for health, social care and education staff and will put in place the right support to ensure that the workforce is suitably trained on the LPS.

The local government implementation programme will develop exemplar training products, supporting the conversion of BIAs to AMCPs. This programme of work will also help local authorities prepare and deliver high quality training by facilitating implementation planning and activities across regions.

For healthcare staff, the healthcare implementation programme and training that Health Education England is developing will include a suite of e-learning resources covering competency groups A to D, based on the training framework. These resources will be similar to resources currently used across their MCA programme and will be a fully responsive, accessible learning resource that includes curated materials, interviews and case scenarios that will help re-enforce learning and provide professionals with the right skills, based on the learning outcomes in the training framework. These resources will be peer-reviewed by a range of different professionals in the field, ensuring that they are suitable for health and other staff groups.

For social care staff and local authorities, the social care implementation programme, which Social Care Institute for Excellence in collaboration with Skills for Care and other providers will be developing, will provide training to support the social care sector in the implementation of the LPS. This training will draw on the learning outcomes in the LPS Training Framework and will recognise that for different stakeholders, the requirements and preferences for accessing training relevant to their role will vary and relate to a number of factors including working environment, computer literacy, learning method/preference, availability and accessibility.

Services will be able to access these nationally developed training materials later this year and will be able to access them whilst the LPS is implemented. Services should consider whether these materials meet their needs before commissioning any resources of their own.

Beyond the nationally-developed training materials, how training from competency groups A to D is delivered within each organisation will be left up to individual training providers and employers, as the Government recognises that a variety of learning interventions are used to deliver training on both the MCA and DoLS currently. You may wish to work with people who have or may have experience of the Mental Capacity Act in your area to consider how to co-produce the training that you plan to deliver.

Services should recognise that people learn best in different ways and that a variety of learning interventions may be needed to deliver training to staff that is effective for them. Face-to-face, classroom learning, or other support (including remote learning) may therefore be needed.

What you can do now

The draft Code of Practice and the regulations for the LPS have now been published for consultation. If you have any views on the LPS, then please respond to this public consultation.

If you are interested in the AMCP professional standards, these will be subject to consultation led by Social Work England.

Following the close of the consultation, the Government will take any views into consideration and final amendments will be made to the regulations and Code of Practice before they are laid before Parliament, as shown in Figure 2, in Part 1, “Liberty Protection Safeguards Workforce and Training Preparation Timeline”.

Whilst the public consultation is ongoing, local organisations should start thinking about what learning, development and training is needed and when any training should be scheduled to ensure that enough staff are ready to operate the LPS across your organisation, when it is implemented. This could include working with people who have or may have experience of the Mental Capacity Act in your area to consider how to co-produce the training that you develop. It is anticipated that this will be informed by workforce planning for your area and organisation (see Part 1 – Workforce Planning).

It is not expected that all staff will have to be trained before implementation, as information and awareness training is expected to continue to be rolled out across organisations over time. That said, it will be important to ensure that enough staff are trained in advance to enable the LPS to go live from “Day One”. This will be particularly important for all organisations that will be Responsible Bodies, as they will also need to provide advice to health, care and education providers about how the process is expected to work in their area. This will include identifying or referring possible cases, arranging assessments, determinations and consultation, undertaking pre-authorisation reviews and authorising arrangements.

As this strategy details, some national training materials covering workforce competency groups A to D for health and social care are being developed. Nonetheless, your organisation may wish to commission the delivery of training of specific areas of LPS policy, using the training framework as a guide, to ensure there are enough staff with expertise in the new system by the time that LPS is implemented.

Right now, you may wish to undertake a review of staff understanding of the MCA, to inform and underpin the training to be arranged on operating the LPS.

After the LPS is implemented there will be no new DoLS authorisations or authorisations of a deprivation of liberty by the Court. However, during the transition year, some people will have a DoLS authorisation or an authorisation from the Court. Expertise on the previous systems will still be needed for that year. Health and social care staff will therefore need to prepare for implementation of the LPS whilst maintaining some competency in current DoLS learning.

Adult Social Care

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