



**Analysis of the Consultation on allocation options for distribution of additional funding to local authorities for Local HealthWatch, NHS Complaints Advocacy and PCT Deprivation of Liberty Safeguards (DOLS) in hospitals**

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## **Contents**

Introduction.....	4
Local HealthWatch .....	5
NHS Complaints Advocacy (ICAS).....	14
Deprivation of Liberty Safeguards in Hospitals .....	17
Annex A – Provisional DOLS allocations for 2012/13.....	24
Annex B – List of consultation responses .....	28

# **Analysis of the consultation on allocation options for distribution of additional funding to local authorities for Local HealthWatch, NHS Complaints Advocacy and PCT Deprivation of Liberty Safeguards (DOLS) in hospitals**

## **Introduction**

The Department of Health asked for views from stakeholders in local authorities (LAs) and the NHS, including Local Involvement Networks (LINKs), on options for distributing funding to local authorities for the additional functions proposed for Local HealthWatch, for NHS Complaints Advocacy and for PCT Deprivation of Liberty Safeguards (DOLS) in hospitals.

Subject to the passage of the Health and Social Care Bill through Parliament, the Department of Health (DH) will allocate the additional funding, which will pass from the NHS and DH to local authorities. In the consultation document, we set out the following provisional timetable:

<b>Funding</b>	<b>Transfer to Local Authorities</b>
Local HealthWatch signposting element from PCT PALS	From October 2012
NHS Complaints Advocacy	From April 2013
PCT Deprivation of Liberty Safeguards in hospitals (DOLS)	Potentially, from October 2012

The Department would like to thank those who contributed to the consultation. The Department received 181 responses from local authorities, LINKs, NHS bodies (including PCT PALS and Royal Colleges), and representatives from the community and voluntary sector about the proposed allocation options.

# Local HealthWatch

## Background

1. Subject to the passage of the Health and Social Care Bill through Parliament, Local HealthWatch will signpost people to information about health and social care services, which is one of a range of services currently provided by the PCT Patient Advice and Liaison Services (PALS). It is the signposting function of PCT PALS that Local HealthWatch will take forward. For more information, please refer to the consultation document available at [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_128429](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_128429).
2. The Department consulted on two main options for allocating the additional funding to local authorities for Local HealthWatch, to supplement the government funding made available through the Department of Communities and Local Government Formula Grant (currently for LINKs which will transfer to Local HealthWatch). The consultation also proposed a minimum allocation for the additional functions of Local HealthWatch for each local authority to reflect the costs of providing a signposting service.
3. This section provides a summary of the responses to the questions in the consultation about the allocation options for distributing the additional funding and the proposed minimum level of funding for each local authority; and the action the Department intends to take.
4. The consultation offered the following allocation options:

**OPTION LHW 1:** Adult working age population, adjusted for area costs

**OPTION LHW2:** The social care relative needs formula (This is the Department's preferred option).

## Question LHW1 – Allocation Options

5. The consultation asked:

*Do you prefer: Option LHW1: population based or Option LHW2: Adult Social Care Relative Needs Formulae?*

6. The table below sets out the responses to this question.

	<b>RESPONSES</b>
<b>Option LHW1</b>	51
<b>Option LHW2</b>	91
<b>Nil Responses</b>	39

7. In summary, a majority of respondents favoured the use of Option LHW2, the adult social care relative needs formulae, to allocate funding for the additional functions of Local HealthWatch.
8. Whilst some respondents commented that a whole population formula may cover the service of Local HealthWatch for the whole community, respondents supporting Option LHW2 commented that the adult social care relative needs formula reflected population characteristics and deprivation in local areas, and as such would reflect the changing needs of and demands on the service provided by Local HealthWatch.

**Question LHW2 – Minimum level of funding for the additional functions of Local HealthWatch**

9. Respondents were asked:

*Do you agree that there should be an allocation of at least £20,000, in respect of the additional functions for Local HealthWatch to each local authority in each financial year?*

10. The following table sets out the responses to this question.

	<b>RESPONSES</b>
<b>Yes, there should be a minimum level</b>	118
<b>No, there should not be a minimum level</b>	22
<b>Nil response to this question</b>	41

11. In summary, a large majority of respondents agreed that there should be a minimum allocation of at least £20,000 to each local authority

in each financial year for funding the additional functions of Local HealthWatch.

12. Some respondents shared their concern about setting a minimal level of funding for Local HealthWatch and commented that the proposed level of funding of at least £20,000 was not adequate to run a service even with low demand or did not understand the rationale for setting this. The Department would like to make clear that the proposed minimal level of funding is in relation to the additional functions for Local HealthWatch. The Department refers to paragraph 42 of the consultation document, which states that this is “on top of continuing and separate LINKs funding within the DCLG Formula Grant”. The intention of proposing a minimal level would enable the three small local authorities to receive a level of funding that would, otherwise, be significantly less.
13. Respondents supporting the proposed minimum level of funding did so in recognition that, irrespective of need and demand, there will be minimum costs associated with running the service for the additional functions of Local HealthWatch. Respondents also suggested that the Department review the proposed minimal level - with some suggesting that it should be viable for the three local authorities, whilst others suggested that it should be viable for all local authorities.
14. There are two reasons for a minimal level of funding for the additional functions of Local HealthWatch: that some costs need to be borne irrespective of population size and that because of small numbers, demand for signposting information in small local authorities is more lumpy and they have a higher chance of not being able to respond quick as larger areas.
15. In reaching the proposed minimal level of funding for the additional functions of Local HealthWatch, the Department tried to identify the fixed costs and estimate the cost of each. These include, for example, working with others to maintain of a directory of local services, contract monitoring and preparation for contracting/service evaluation. The total cost is estimated to be approximately round £13,000. In addition, modelling patterns (using the Poisson distribution to estimate arrival of signposting requests) of demand suggests that for the very smallest local authorities, to ensure they can answer 99% queries within one day would cost an additional £7,000. This would make the service broadly comparable across the

country. Therefore, the total proposed minimum level of funding for the three smallest local authorities to be £20,000.

16. 118 respondents were supportive of a minimum level of funding for the additional functions of Local HealthWatch and to ensure equity for small local authorities the Department confirms its view, expressed in the consultation document, that this should be at least £20,000 for each local authority.

### **Question LHW3 – Comments and suggestions**

17. The consultation asked:

*Why do you prefer the option selected above? Do you have any comments about the options or alternative suggestions for allocating the funding, or alternative costings for the minimum allocation amount?*

18. Whilst comments relating to the allocation options and minimum level of funding for the additional functions of Local HealthWatch have been dealt with in the relevant paragraphs above, some alternative suggestions from respondents are set out below.
19. One of the most cited issues was the use of younger adults' or working age (aged 18-64) characteristics under both Option LHW1 and LHW2. For example:

*“An alternative funding model would be to use total population.” – Essex Council. A similar point was made by Cambridgeshire Council and NHS Peterborough*

*“We can see the arguments for both options but on balance would agree with the view that LHW2 is the way to proceed. State provision of social care is closely associated with areas of high deprivation and often where people are least able / empowered to speak out for themselves reside. Thus the understanding that funding should be weighted in favour of such areas. However, this does not take into consideration the fact that there are more affluent (perceived affluent) areas of the country that are traditionally areas where people retire to and as such have a disproportionately high number of older people. With age related conditions such as dementia, frailty, age related physical & sensory disabilities. Both of these categories of our population*

*may require an independent champion / information provider. If LHW2 is the option chosen do we know that the top up adjustments within the RNF adequately reflect this – if not then it may be necessary to consider additional top up to the minimum allocation to reflect this.” – Devon County Council*

20. A number of responses also raised issues which are not included in younger adults RNF formulae, including self funders and the demands in rural areas compared to compact urban areas.
21. In response, the Department intends to include the characteristics of all adults when allocating funding for the additional functions of Local HealthWatch. The Department will do this by using the older adults (65 years +) and the young adults (18 to 64 years) relative needs formulae.
22. The older people’s relative needs formula takes into account the number of older people aged 65 or over in each local authority, based on characteristics of those aged over 65. It is structured in a similar way to the younger adults formula, but takes into account different characteristics. In particular, it weights for the proportion of people that are aged over 90 and the proportion of people who receive attendance allowance, live in rented accommodation, live alone or receive pension credit guarantee or income based jobseeker’s allowance. It also adjusts for areas with low income, areas with high costs and areas with a sparsely distributed population e.g. the extra costs of rurality and an adjustment to take account of differing abilities to raise income from charging user fees for social care. Finally, the formula weights for the overall size of the population aged over 65.
23. Other respondents suggested considering the characteristics of children in the allocation mechanism. For example:

*“As the formulae only takes into account those who are in receipt of state funded care and the self funding users of social care are not included , the funding level may not adequately reflect the demand for Local HealthWatch services. Could LAs end up subsidising this funding to provide for a contingency?  
HealthWatch, as an extension of LINK - which currently does not deal with Children and Young People, may primarily [be] seen as being about adults rather than children if it hasn't got a holistic approach to children's health and social care. HealthWatch would*

*need to use different methods to engage children and adults on health care issues and in signposting to children's social care services. The formulae does (not) include children and young people accessing state funded care in the calculation and therefore the costs of engaging with children and young people may be under represented.” – Halton Borough Council*

24. The Department welcomed comments on the importance of children's services. Although it is possible to incorporate the characteristics of children, by including the relative needs formula for local authority supported children's social care when the funding is allocated, the Department does not intend to do this for the initial allocation, because we do not know how much of the signposting function of Local HealthWatch will be used by children. The Department will keep this under review and will revisit this issue once there is more information on how much of these services are used by children.

25. One respondent suggested:

*“If we look at our own individual contacts to the PALS service where age was collected, less than 40% were of working age. Our highest number of contacts come from the 41-50 and 81-90 age groups. The majority of our contacts will not be using Social Services at the time of contact, in fact PALS frequently signpost to Social Services. From our own perspective therefore we cannot assume that current Social Service users will be the main users of HealthWatch. Our recommendation should be that funding is provided per capita in line with GP practices to ensure provision is in place to cover the whole local population. Until a decision has been made as to what the function of HealthWatch will be, as there currently seems to be a lot of confusion, it is difficult to specify who the main users will be.” – Sandwell PCT PALS*

26. The Department has no plans to use GP registrations to allocate funding to local authorities at present and to do so would require a substantial change from the options that were consulted on. The Department therefore will not take this suggestion further.

27. One respondent suggested that the funding was itemised at local authority level.

*“If the funding is to be part of the learning disabilities and health reform grant then it should be itemised within that for easy identification” – Bedford Borough Council*

28. The Government has radically simplified the funding that goes to local government, by reducing the number of grants and removing administrative burdens attached to funding streams. Authorities will now have greater freedoms in how they chose to use their resources to meet local needs and priorities, further enabling their ability to meet their population's needs. We do not, therefore, intend in future to identify separately each component of funding within the Learning Disability and Health Reform grant at a local level. Decisions on how much resource to allocate to each area of spend are the responsibility of local government.
29. Respondents commented and offered to help with developing the description for the Local HealthWatch signposting and providing information role, with some respondents helpfully provided the Department with information on staff time and costs that PCT PALS incur for their signposting role.

*“Information and advice queries represent 65% of contacts to PALS (in Cambridgeshire it is exactly 65% and higher in Peterborough at 76%). However, enquiry and advice calls take up a much smaller percentage of time – they are generally very quick and simple calls. In Cambridgeshire they take up only 26% of employee time, and in Peterborough 30%.” – NHS Cambridgeshire, Cambridgeshire Council,*

*“Whilst NPN applauds proposals to improve access to information advice and signposting for local communities, we are very concerned that substantial NHS funds will transfer to local authorities to commission LHWs to carry out an as yet ill-defined service. Unless real clarity and mutual understanding is quickly brought about, it is highly likely that LAs will come to ill-informed decisions about what they are commissioning.” – National PALS Network*

*“The "signposting" element of the PALS role as referred to in the consultation, only accounts for 35% of the PALS activity, by call volume, not by transaction time, which is less. Even using this broad analysis, and assuming that a PALS Officer is circa £30,000 , that would equate to £5000.” – NHS Berkshire*

30. Money will not be taken from the NHS to fund Local HealthWatch in 2012/13 and the Department will provide further information on the total amount that will be allocated to local authorities by the end of the year.
31. As part of the implementation stage of the HealthWatch development programme, work will be taken forward in partnership with PCT PALS representatives and HealthWatch stakeholders to develop a description of the signposting role. This will enable local authorities and HealthWatch stakeholders to understand this particular function to inform their planning assumptions.
32. In addition to these suggestions, others were suggested which were very specific to local areas. For example, dealing with high volume of commuters or consideration to be given to fulfil the desire to ensure Local HealthWatch has a preventative focus, the Department concludes from these additional suggestions that these are too specific to local areas and individual respondents' views and that to ensure equity to all local authorities, the Department remains of the view that the majority of respondents preferred funding allocation Option LHW2.

### **Summary of the Government's response**

33. Of the 181 responses received, the majority agreed with the Department's preference that the funding should be allocated using Option LHW2, the adult social care relative needs formulae. Taking into account that for some areas with the majority of working age adults, the Department therefore proposes to allocate the additional funding for Local Healthwatch by using the older adults (65 years +) and the young adults (18 to 64 years) relative needs formulae.
34. A large majority also agreed with placing a minimum on the amount of funding that local authorities could receive each year to pay for the additional functions of local HealthWatch. Although some respondents were guided by the illustrations at the annex of the consultation document, the Department want to ensure equity for small local authorities and therefore the Department confirms that the minimal level of funding should be at least £20,000 for each local authority.

35. The Department is currently considering the quantum of additional funding that will be allocated to local authorities for additional functions of Local HealthWatch. An announcement on 2012/13 provisional funding allocations for this additional funding will be made by the end of the year.

# NHS Complaints Advocacy (ICAS)

## Background

36. The Independent Complaints Advocacy Service currently provides client-centred support to people in England wishing to complain about the treatment or care they received under the National Health Service (NHS). The support ICAS offers can range from helping a client with initial preparation, attendance at resolution meetings through to helping people with correspondence dependent on their need.
37. From April 2013, subject to the passage of the Health and Social Care Bill, the Department of Health will allocate funding to local authorities for their new responsibilities to provide NHS Complaints Advocacy as part of the Learning Disabilities and Health Reform grant. The consultation has informed the Department's decision about how additional funding will be allocated to local authorities.
38. The Health and Social Care Bill 2011, currently in parliament, sets out the relevant responsibilities of local authorities and NHS complaints advocacy as follows:
  - Local authorities will be responsible for commissioning NHS complaints advocacy and can do this either from:
    - A Local HealthWatch organisation, or
    - A third party provider.

## Consultation

39. Two options for allocating the additional funding to local authorities for the new NHS Complaints Advocacy model were identified.
  - **Option NHSCA1:** Adult population, adjusted for area costs
  - **Option NHSCA2:** The Social Care Relative Needs Formulae (This is the Department's preferred option).

## Question NHSCA1 – Allocation Options

40. Respondents were asked:

*Do you prefer: Option NHSCA1: population based or Option NHSCA2: Adult Social Care Relative Needs Formulae?*

41. The table below summarises the response to Question NHCA1. A majority of respondents favoured the use of the adult social care relative needs formula to allocate funding for NHS Complaints Advocacy services.

<b>Options</b>	<b>Number of Responses</b>
<b>Option NHSCA1</b>	53
<b>Option NHSCA2</b>	70
<b>Reject Both</b>	3
<b>No Preference</b>	18
<b>Nil Return</b>	37

#### **Question NHSCA2 – Comments**

42. The consultation asked:

*Why do you prefer the option selected above? Do you have any comments about the options or alternative suggestions for allocating the funding?*

43. We received a range of explanations for the answers given in Question NHSCA1. The below summarise these explanations:

*“Prefer option 2 - however we feel that we shouldn't have to choose from two imperfect options”.*

*“The adult social care relative needs formulae will give a better reflection of need in North Tyneside which has small areas of great deprivation”.*

*“The Adult Social Care Relative Needs Formulae more accurately reflects the level of demand than population only”.*

*“I consider that ICAS should be provided on a local need and requirement as there is little to be gained by having too many advocates in one area and another stretched with case loads. \*\*As*

*PALS also provides advocacy, again there is a lot of duplication of services and staff and in turn a cost element which may not be necessary”.*

*“The adult social care relative needs formulae (ASCRNF) use information on the size of the local population, population characteristics and area costs to predict the relative need for a local authority to provide social care. The formulae take account of indicators of deprivation and for older people's services, information on the proportion of very old people and whether old people live alone. Measures of deprivation are good indicators of need for health and social care - deprivation is clearly linked both to premature mortality and greater experience of ill health (see Coventry JSNA). Additionally, the formulae take account of and weight for demand from older people who make greater use of health services. Similarly, the formulae takes account of numbers of people in receipt of disability living allowance - a proxy for the number of disable people in the locality who are likely to make use of - and require support in respect of using - health and social care services. Coventry LINK believes that these indicators are the best measures of the likely level of complaints advocacy support that a population will require because it evidences the number of potential users of complaints advocacy”.*

### **Summary of the Government’s response**

44. A majority of respondents agree with the Department’s preference to use Option NHSCA2 (adult social care relative needs formulae) to allocate funding for NHS complaints advocacy services, when the responsibility transfers to local authorities.
45. We have therefore decided that NHS Complaints Advocacy should be funded proportionately to the relative need in each local authority using the total adult social care relative needs formulae.
46. Funding for NHS Complaints Advocacy will not be allocated this year, as the duty does not pass to local authorities until April 2013. We will set out the quantum of resource to be allocated for NHS Complaints Advocacy next year.

# Deprivation of Liberty Safeguards in Hospitals

## Background

47. The Department of Health consulted stakeholders on options for distributing additional funding to local authorities for the assessments and authorisations of Deprivation of Liberty Safeguards in hospitals. Subject to the passage of the Health and Social Care Bill, the Supervisory Role for the Deprivation of Liberty Safeguards in the NHS, will transfer from PCTs to local authorities.

## What are the Deprivation of Liberty Safeguards?

48. The European Court of Human Rights (ECtHR) in its October 2004 judgement in the Bournemouth case (HL v UK) highlighted that additional safeguards were needed for people who lack capacity and who might be deprived of their liberty in their best interests. As a result the Government amended the Mental Capacity Act 2005 and introduced the Deprivation of Liberty Safeguards.
49. These safeguards consist of a series of assessments which may lead to the authorisation of a deprivation of liberty where it is in the best interests of a person. This process strengthens the protection of a very vulnerable group of people.
50. Four questions were posed in this consultation:

DOLS1: Would you prefer the transfer of funding to happen in October 2012 or April 2013?
DOLS2: Which of the options do you prefer Options DOLS1 population or Option DOLS2 RNF?
DOLS3: Do you agree that there should be a minimum allocation in respect of PCT DLS funding of £2,000 for each financial year?
DOLS4: Why do you prefer the option selected above? Do you have any comments about the options or alternative suggestions for allocating the grant?

51. 181 respondents replied, spanning a range of local authorities, PCTs, Foundation Trusts, voluntary organisations, IMCA organisations and local LINKs organisations.

52. Local authorities responded that '*it made sense*' to combine the Supervisory Body role for the Deprivation of Liberty Safeguards for hospitals and for care homes in one place. Many reported that PCTs and the local authorities were '*already working together*' in various ways, such as developing joint DOLS training. A few had *pooled budgets* under Section 75 partnerships and had joint teams of Best Interests Assessors.
53. At the same time, many local authorities stressed that the Deprivation of Liberty Safeguards were '*a high risk*' area. The legislation was relatively new, case law was evolving; and the issue of the human rights of people who needed to be deprived of their liberty in their best interests was regarded as a complex and emotive one. The Court of Protection was described as very active in developing case law.
54. Local authority and PCT respondents reported that there were risks to the human rights of people who lacked capacity, of deprivation of liberty without safeguards and also legal, financial and reputational risks to Supervisory Bodies. They suggested that this transfer of function was also a transfer of risk from the NHS to local authorities.
55. This was the context in which many local authorities and PCTs responded to the questions posed.

**DOLS1: Would you prefer the transfer of funding to happen in October 2012 or April 2013?**

56. Table 1 shows that fifty respondents reported they would prefer the transfer to happen in October 2012 and 66 reported they preferred the transfer to happen in April 2013. 65 respondents expressed no view on the date.

<b>Question DOLS1</b>	
October	50
April	66
Nil	65

57. The arguments for the earlier transfer included '*the sooner the better*' and '*the earlier the transfer takes place, the less uncertainty there is*' and the wish to keep the DOLS system separate from the changes arising for the end of PCTs. Many of the respondents who were currently working as a Mental Capacity Act (MCA) lead or as a DOLS lead reported that it would be extremely useful '*to work collaboratively*' on developing a LA

based Supervisory Body role for the NHS. They thought protocols needed to be developed and partnership arrangements set up with acute hospitals, psychiatric hospitals and private hospitals. Many respondents reported that this took time and that they needed to undertake preparation work.

58. The arguments for the later transfer included that in areas where there were no joint arrangements in place as yet, it would take time to develop these. Respondents in finance roles mainly preferred an April start as the start of a financial year appeared easier to account to. Many of those responding from local LINKS organisations preferred an April start, and some LINKS respondents were unclear whether the Department thought LINKS had a role to play in the Deprivation of Liberty Safeguards. (The Department considers these to be two separate issues.)

**DOLS2: Which of the options do you prefer Options DOLS1 (population) or Option DOLS2 (RNF)?**

59. There was support for both options for distributing the PCT DOLS resources. Forty respondents thought that a population based formula would be better while nearly twice as many, 77, thought that the Relative Needs Formula was preferable. Sixty four respondents had no views. Arguments for the population based formula included that with the large numbers of people in care homes being self funders, the relative needs formula was less relevant. Those in favour of the Relative Needs Formula stated that this formula appeared to be more flexible and responsive to local needs and changing needs and also to ‘age and deprivation’. Several stakeholders agreed that PCT caseload data was not an effective measure at this stage, as numbers appeared to be rising possibly due to greater awareness, Court of Protection messages or other factors.

<b>Question DOLS2</b>	
Population	40
RNF	77
Nil	64

**DOLS3: Do you agree that there should be a minimum allocation in respect of PCT DOLS funding of £2,000 for each financial year?**

60. The majority (101) agreed that there should be a minimum allocation. Several stakeholders commented that this was on the grounds of ‘equity

*for smaller local authorities*'. A few commented that the proposed minimum allocation was useful but not sufficient.

61. 14 respondents did not support a minimum – and several of these suggested a more effective alternative was for smaller authorities to pool resources with neighbouring authorities. 66 respondents reported no views.

<b>Question DOLS3</b>	
Yes	101
No	14
Nil	66

**DOLS4: Why do you prefer the option selected above? Do you have any comments about the options or alternative suggestions for allocating the grant?**

62. No alternative suggestions for allocating the grant were put forward. There was some suggestion of 'DOLS caseload' becoming more relevant in the future as an allocation method but, apart from two respondents, there was general agreement that it was too early to use it as such.

**Summary of other responses**

63. Some local authorities and PCTs reported that they had section 75 partnerships in place for joint DOLS arrangements.
64. Several respondents reported that these partnerships involved pooling more than the DOLS resources. In some cases PCTs had added resources from the PCT-Mental Capacity Act budget (a larger budget than the DOLS one).
65. The main message respondents raised was that this activity was regarded as an area of significant risk by some local authorities and the NHS. The risk was of breaches in human rights by not undertaking as many DOLS applications and authorisations as necessary, therefore leaving people unprotected. The risk was also described as Supervisory Bodies ending up with expensive court cases because families and others challenge the absence of authorisations or the quality of the assessments. And the risk was also regarded by some respondents as being about a new role – about local authorities authorising and challenging assessments within NHS environments. In addition, this risk was seen as compounded by what local authorities regarded were inadequate funding arrangements, which

not only did not cover current costs but would not cover the nationally expected increase in authorisations.

66. Local authorities reported concern about the new funding for the following reasons:
- a. The assumption 5 years ago was that DOLS in hospitals would be relatively few in number. The majority of DOLS cases were thought to be in care homes. Several responses to the consultation reported that DOLS in hospitals were now escalating. In Essex, for example, there were reportedly now more hospital based DOLS assessments and authorisations than care homes ones.
  - b. Local authorities reported that being a LA supervisory body for the NHS requires the LA having the necessary skills, expertise and authority to challenge hospital practices, including those in mental health hospitals, about their practices, which are depriving patients of their liberty. They argued that this is not the same role that was assessed and costed 5 years ago in relation to DOLS in care homes.
  - c. The original impact assessment estimated a) that there would be higher numbers of DOLS applications originally than has been the case and b) that the numbers would decline sharply over the first 5 years. The actual figures are lower, but show that the numbers are increasing steadily.
  - d. Several respondents raised the issue over the actual costs of a DOLS assessment. The original DH costings suggested £600 but up to £1,000 in complex cases. Several local authorities now reported that they thought that the true cost to them was near £1,200.
  - e. There are a number of existing local partnership arrangements between PCTs and LAs, using section 75 arrangements to fund joint DOLS services.
  - f. Some of these are based on PCTs investing their MCA resources as well as their DOLS resources because they consider DOLS to be a high risk area requiring higher levels of resource than Government allocated.

## Summary of the Government's response

67. PCTs and LAs responded to the consultation questions on the proposed DOLS transfer. They raised concerns about the need for additional work to manage the successful transition of responsibility, and the need to look again at both the unit costs and the trend data. The Department has listened carefully and considered each of the points raised.
68. The Department has set the date for the transfer of the DOLS Supervisory function, and the resources, as April 2013. This means PCTs will remain responsible for arranging the Deprivation of Liberty Safeguards in hospitals during the year 2012/13. PCTs will receive the resources for this, as in the current year.
69. However, the Department expects local authorities, PCTs and hospitals to start working together during 2012 to prepare for the transfer. The later transfer date was chosen to allow local areas maximum choice about when and how the DOLS transfer takes place. Some PCTs and local authorities will wish to delegate the functions and transfer the corresponding resources earlier, for example in October 2012, and they can do this, using a section 75 partnership agreement. Some will build on existing partnership arrangements and these can be continued during 2011/12.
70. The Department accepts that additional resources are needed for the development of the new role for local authorities during 2012 to ensure that, by 1 April 2013, all parties understand their respective roles and the responsibility is transferred smoothly. Hospitals are responsible for ensuring that NHS staff understand the new role of the local authority in relation to the hospital-based Deprivation of Liberty Safeguards. It is likely that all parties will need clear, shared agreements about how the arrangements will work in practice.
71. The Department accepts that unit costs may be higher than envisaged in our original assessment and that many cases, needing thorough assessments and effective scrutiny, may cost up to £1,200.
72. Taking account of this evidence on higher costs the Department is now proposing to allocate £1.35 million to local authorities for the development of their new role during 2012/13 (the original figure was £700,000). We expect that local authorities will use this during 2012 /13 to agree referral and authorisation systems. In undertaking this work local authorities will need to consider the implications of the judgement

from the Court of Protection on the Neary case, that the authorisation process must be thorough and considered.

73. The Department will use the adult social care relative needs formulae to allocate the resources. This is the choice of the majority respondents who expressed a view to the consultation.
74. The Department will ensure that no local authority receives less than £2,000.
75. Provisional allocations of DOLS funding for 2012/13, which will form part of the Learning Disability and Health Reform grant, are included at Annex A.

## Annex A – Provisional DOLS allocations for 2012/13

Local Authority	Deprivation of Liberty Safeguards £
Barking and Dagenham	4,974
Barnet	8,059
Barnsley	7,075
Bath & North East Somerset	4,101
Bedford	3,508
Bexley	4,988
Birmingham	31,707
Blackburn with Darwen	4,200
Blackpool	5,014
Bolton	7,680
Bournemouth	4,789
Bracknell Forest	2,015
Bradford	12,983
Brent	6,990
Brighton & Hove	6,761
Bristol	11,550
Bromley	6,578
Buckinghamshire	9,435
Bury	4,600
Calderdale	5,253
Cambridgeshire	13,058
Camden	7,126
Central Bedfordshire	4,721
Cheshire East	8,123
Cheshire West and Chester	8,199
City of London	2,000
Cornwall	16,108
Coventry	8,743
Croydon	7,695
Cumbria	14,440
Darlington	2,828
Derby	6,618
Derbyshire	20,791
Devon	20,122
Doncaster	8,406
Dorset	10,683
Dudley	8,865
Durham	15,987
Ealing	7,691
East Riding of Yorkshire	8,292
East Sussex	14,283
Enfield	7,184
Essex	33,608
Gateshead	6,316

Gloucestershire	14,064
Greenwich	7,204
Hackney	7,562
Halton	3,558
Hammersmith and Fulham	5,120
Hampshire	26,385
Haringey	6,122
Harrow	5,383
Hartlepool	2,733
Havering	5,522
Herefordshire	4,918
Hertfordshire	22,895
Hillingdon	5,644
Hounslow	5,296
Isle of Wight Council	4,432
Isles of Scilly	2,000
Islington	6,711
Kensington and Chelsea	5,681
Kent	33,858
Kingston upon Hull	8,451
Kingston upon Thames	3,149
Kirklees	10,385
Knowsley	5,627
Lambeth	8,205
Lancashire	31,112
Leeds	19,363
Leicester	8,798
Leicestershire	13,420
Lewisham	7,553
Lincolnshire	18,896
Liverpool	16,744
Luton	4,242
Manchester	15,278
Medway	5,355
Merton	4,243
Middlesbrough	4,303
Milton Keynes	5,039
Newcastle upon Tyne	8,536
Newham	7,318
Norfolk	23,686
North East Lincolnshire	4,358
North Lincolnshire	4,238
North Somerset	5,310
North Tyneside	5,804
North Yorkshire	13,738
Northamptonshire	15,216
Northumberland	8,604
Nottingham	8,811
Nottinghamshire	20,030
Oldham	6,285
Oxfordshire	12,728
Peterborough	4,311

Plymouth	7,341
Poole	3,524
Portsmouth	5,010
Reading	3,171
Redbridge	6,052
Redcar and Cleveland	4,065
Richmond upon Thames	3,655
Rochdale	6,185
Rotherham	7,604
Rutland	2,000
Salford	7,475
Sandwell	10,244
Sefton	8,585
Sheffield	15,745
Shropshire	7,780
Slough	2,832
Solihull	4,773
Somerset	14,033
South Gloucestershire	5,243
South Tyneside	5,168
Southampton	6,433
Southend-on-Sea	4,596
Southwark	8,891
St Helens	5,482
Staffordshire	19,931
Stockport	7,243
Stockton-on-Tees	4,732
Stoke-on-Trent	7,611
Suffolk	18,329
Sunderland	8,983
Surrey	21,974
Sutton	4,108
Swindon	4,223
Tameside	6,575
Telford and the Wrekin	4,398
Thurrock	3,784
Torbay	4,810
Tower Hamlets	7,685
Trafford	5,358
Wakefield	9,521
Walsall	7,968
Waltham Forest	5,694
Wandsworth	7,107
Warrington	4,666
Warwickshire	12,560
West Berkshire	2,731
West Sussex	18,227
Westminster	8,082
Wigan	9,037
Wiltshire	10,059
Windsor and Maidenhead	2,581
Wirral	10,158

Wokingham	2,218
Wolverhampton	7,745
Worcestershire	13,493
York	4,159
TOTAL	1,350,000

## Annex B – List of consultation responses

Organisation	Type of Organisation
Advocacy (Essex) Services Ltd	Other
Advocacy Rights Hub	Other
Arthritis Care	Other
Barking and Dagenham Council	Local Authority
Barking and Dagenham PCT	PCT
Barnsley Metropolitan Borough Council	Local Authority
Bath and North East Somerset Council	Local Authority
Bedford Borough Council	Local Authority
Birmingham City Council	Local Authority
Blackburn with Darwen Borough Council	Local Authority
Blackpool Council	Local Authority
Bournemouth Borough Council	Local Authority
Bradford LINK	LINK
Bristol City Council and South Gloucestershire Council HealthWatch Pathfinder	Local Authority
Buckinghamshire County Council	Local Authority
Bury Council	Local Authority
Calderdale Metropolitan Borough Council	Local Authority
Cambridgeshire Community Services NHS Trust	PCT
Cambridgeshire County Council	Local Authority
Cambridgeshire County Council	Local Authority
Cambridgeshire County Council (This is a joint response from Cambridgeshire County Council, Cambridgeshire LINK and NHS Cambridgeshire)	Local Authority
Cambridgeshire Local Involvement Network (This is a joint response from Cambridgeshire LINK, Cambridgeshire County Council and NHS Cambridgeshire)	LINK
Central Bedfordshire Council	Local Authority
Cheshire East Council and Central & Easter Cheshire PCT	Local Authority and PCT
Citizens Advice	Other
City of Bradford Metropolitan District Council	Local Authority
City of London	Local Authority
City of London LINK	LINK
Cornwall Council	Local Authority
Council of the Isles of Scilly	Local Authority
Coventry City Council	Local Authority
Coventry LINK	LINK
Croydon Shadow HealthWatch	LINK
Cumbria County Council	Local Authority
Darlington Borough Council	Local Authority

Daschange	Other
Derbyshire County Council	Local Authority
Devon County Council	Local Authority
Dorset County Council	Local Authority
Dorset PCT	PCT
Dudley Council	Local Authority
East Riding of Yorkshire Council	Local Authority
East Sussex County Council	Local Authority
Enfield Council	Local Authority
Essex County Council	Local Authority
Essex County Council	Local Authority
Gateshead Council	Local Authority
Gateshead LINK	LINK
Gloucestershire County Council	Local Authority
Gloucestershire Local Involvement Network	LINK
Greenwich LINK	LINK
Halton Borough Council	Local Authority
Halton Borough Council	Local Authority
Hampshire County Council	Local Authority
Haringey LINK	LINK
Hertfordshire County Council	Local Authority
Hertfordshire LINK	LINK
Hull LINK Steering Group	LINK
Humber and Wolds Rural Community Council	LINK
Isle of Wight Council	Local Authority
Islington Council	Local Authority
Islington LINK	LINK
Kent County Council and NHS Kent and Medway Cluster	LA and PCT
Knowsley MBC	Other
Lambeth Council	Local Authority
Lambeth LINK	LINK
Lancashire County Council	Local Authority
Leicestershire LINK	LINK
Leeds City Council	Local Authority
Leeds LINK	LINK
Leicester LINK Host Staff	LINK
Leicestershire Council	Local Authority
Lincolnshire Council	Local Authority
LINK in Cornwall	LINK
LINK members of the HealthWatch Advisory Board, 'Transition' and 'Local HealthWatch' workstreams	Other
Liverpool County Council	Local Authority
London Borough of Barnet	Local Authority
London Borough of Bexley	Local Authority
London Borough of Camden	Local Authority
London Borough of Croydon	Local Authority

London Borough of Hillingdon	Local Authority
London Borough of Lewisham	Local Authority
London Borough of Richmond upon Thames	Local Authority
London Borough of Sutton	Local Authority
Medway Council	Local Authority
Merton Council	Local Authority
Middlesbrough Council	Local Authority
Milton Keynes Wheelchair User Group	Other
National Association of LINKS Members	LINK
National PALS Network	PCT
N-compass and East Lancs Advocacy	Other
Newcastle City Council	Local Authority
Newcastle Local Involvement Network	LINK
Newham Council	Local Authority
Newham LINK	LINK
NHS Bedfordshire	PCT
NHS Berkshire	Local Authority
NHS Confederation	Other
NHS Cornwall and Isles of Scilly	PCT
NHS County Durham and Darlington PALS Team	PCT
NHS Coventry	PCT
NHS Devon	PCT
NHS East Riding of Yorkshire	PCT
NHS Gloucestershire	PCT
NHS HMR Mental Health and Wellbeing Commissioning Core Group	PCT
NHS Kent and Medway	PCT
NHS Lincolnshire	PCT
NHS Mid-Essex	PCT
NHS North of Tyne	PCT
NHS Outer North East London	PCT
NHS Peterborough (This is a joint response from Peterborough City Council, Peterborough LINK and NHS Peterborough)	PCT
NHS Sheffield	PCT
NHS South East London	PCT
NHS South Gloucestershire	PCT
NHS South of Tyne and Wear	PCT
NHS Suffolk	PCT
Norfolk County Council	Local Authority
North East Lincolnshire Local Involvement Network (LINK)	LINK
North of Tyne PALS	PCT
North Somerset LINK	LINK
North Tyneside Council	Local Authority

North Tyneside LINK	LINK
Northamptonshire County Council	Local Authority
Northumbria Healthcare NHS Foundation Trust	Other
Nottingham City Council and NHS Nottingham City	PCT and LA
Nottinghamshire County LINK	LINK
Oxfordshire LINK	LINK
Peterborough LINK	LINK
Poole Borough Council	Local Authority
Portsmouth City Council	Local Authority
Reading Borough Council	Local Authority
Reading Link	LINK
Redcar and Cleveland Borough Council	Local Authority
Rotherham Metropolitan Borough Council	Local Authority
Royal Borough of Kensington and Chelsea, and Kensington and Chelsea LINK	LA and LINK
Royal College of General Practitioners	Other
Royal College of Nursing	Other
Sandwell Joint Supervisory Board	Local Authority
Sandwell LINK	LINK
Sandwell PCT Patient Advice and Liaison Service (PALS)	PCT
Sefton Council	Local Authority
Sefton LINK Steering Group	LINK
Sefton PALS	PCT
Sheffield City Council	Local Authority
Sheffield LINK	LINK
Shropshire Council	Local Authority
South Gloucestershire Council	Other
South Tyneside Council	Local Authority
South Tyneside NHS Foundation Trust	PCT
St Helens Council	Local Authority
Staffordshire and Stoke On Trent Adult Safeguarding Partnership	Other
Staffordshire County Council and Staffordshire LINK	LA and PCT
Stockport Council	Local Authority
Stockton on Tees Borough Council	Local Authority
Sunderland City Council	Local Authority
Sunderland, Gateshead and South Tyneside Council	Local Authority
Tameside Metropolitan Borough Council	Local Authority
Telford and Wrekin LINK	LINK
The National LGB&T Partnership	Other
The Patients Association	Other
Torbay Care Trust	PCT
Tower Hamlets LINK	LINK
Trafford LINK	LINK
Trafford LINK	LINK

Voluntary Action Sheffield	Other
Wakefield LINK	LINK
Wakefield District NHS	PCT
Walsall Council	Local Authority
Wandsworth HealthWatch	Other
Warwickshire County Council	Local Authority
West Midlands DoLS Leads	PCT
West Sussex County Council	Local Authority
West Sussex LINK	LINK
Westminster City Council	Local Authority
Westminster Local Involvement Network	LINK
Wigan Council	Local Authority