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ADULTS' SERVICES **SCIE REPORT 62**

# Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare commissioners

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# Foreword

In April 2013, when primary care trusts (PCTs) cease to exist, their supervisory body responsibilities under the Deprivation of Liberty Safeguards relating to hospitals will pass to local authorities. This transfer will mean that local social services authorities and health institutions will have to adjust to new ways of working together to ensure that the rights of vulnerable patients are protected.

This report provides practical advice to those responsible for managing this transfer. It provides a flowchart for determining ordinary residence, a timeline for suggested tasks for PCTs, local authorities, and clinical commissioning groups (CCGs), together with checklists for quality assurance during the transfer. Implications for all these agencies and others, such as IMCA providers, are considered, together with the implications for Best Interests Assessors (BIAs) and medical assessors.

The target audience includes senior health and social care professionals from local authorities and PCTs who are responsible for ensuring robust compliance with the Mental Capacity Act in general and the Deprivation of Liberty Safeguards in particular. Directors of adult social care, as well as supervisory body managers and coordinators will welcome the clarity and practicality of this report, which is a useful and timely tool to assist a seamless and high-quality transition and transfer of responsibilities.

ADASS is pleased to be partners with the Social Care Institute for Excellence, the Department of Health, the Office of the Public Guardian, and many other organisations in improving practitioner awareness of the Mental Capacity Act 2005.

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# Part 1: Introduction

This report is intended to help people plan for the changes to the Deprivation of Liberty Safeguards, which comes into force from 1 April 2013. It describes the changes to the identity of the supervisory body in health settings and offers guidance on how local authorities, hospitals, primary care trusts (PCTs) and clinical commissioning groups (CCGs) can work together to ensure that the rights of vulnerable patients are protected.

## The importance of the Mental Capacity Act

The Mental Capacity Act 2005 (MCA) is the foundation for the Deprivation of Liberty Safeguards, and is designed to promote the empowerment of individuals and the protection of their rights. The MCA is built on five statutory principles that guide and inform all decision making in relation to the estimated two million people who may lack capacity in some aspect of their lives. The MCA underpins health and social care commissioning and practice.

A deprivation of liberty can only be authorised under the MCA when there is evidence that a person lacks capacity as defined by the MCA, and where the proposed arrangements that deprive the person of their liberty are made in their best interests. All providers and commissioners of health and social care must therefore have a good understanding of the MCA. This will ensure that appropriate assessments of capacity are carried out and that decisions made for those who lack the required mental capacity are made in their best interests. Any situation calling for a request for authorisation under the Deprivation of Liberty Safeguards must first meet the general requirements of the MCA.

# Part 2: The statutory background

## Summary

- Primary care trusts (PCTs) will be abolished from 1 April 2013.
- The supervisory body responsibilities held by a PCT will be transferred to the local authority where the person has ordinary residence.
- The supervisory body responsibilities of the National Assembly for Wales remain unchanged. The National Assembly is the supervisory body in all cases where care and/or treatment in hospital is commissioned by the National Assembly or a Local Health Board (LHB) unless the person has ordinary residence in England.
- Each hospital managing authority will need to continue to actively understand the wider requirements of the Mental Capacity Act 2005.
- Each hospital managing authority will need to become more familiar with practice concerning ordinary residence.
- In preparation for the transfer, the 'sending' PCT supervisory body will need to identify the 'receiving' local authority for each patient subject to a standard authorisation. This will not necessarily be the local authority the hospital is situated in.
- Each local authority will need to be prepared to receive applications from hospitals in Wales or any part of England.
- Clinical commissioning groups (CCGs) will be responsible for commissioning services in hospitals that comply with the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- CCGs retain responsibility for dealing with matters relating to authorisations granted by PCTs prior to 1 April 2013.

## Deprivation of Liberty Safeguards until 1 April 2013

On 1 April 2013 the way Deprivation of Liberty Safeguards (the Safeguards) are applied in health settings in England will change. The duties previously held by PCTs under the Safeguards will be transferred to local authorities. PCTs will be abolished and their commissioning function will be taken over by new bodies called clinical commissioning groups (CCGs)[1].

[1] For the statutory institution of the Deprivation of Liberty Safeguards, see the **Mental Health Act 2007**, sections 49, 50, 52, schedules 7, 8, 9 (part 1) and 11 (part 10). **Schedule A1 to the Mental Capacity Act 2005** was inserted by Schedule 7 of the Mental Health Act 2007. **Schedule 1A to the Mental Capacity Act 2005**, relating to the eligibility criterion of the deprivation of liberty safeguards, was inserted by Schedule 8 to the Mental Health Act 2007

For the statutory institution of Clinical Commissioning Groups see the **Health and Social Care Act 2012** , sections 10-28 and Schedule 2.

The Safeguards apply in England and Wales to situations when care or treatment is provided to a person who lacks the mental capacity to consent to arrangements proposed for the care or treatment, and the arrangements amount to a deprivation of liberty.

The Safeguards' provide a legal framework to prevent breaches of Article 5 of the European Convention of Human Rights (ECHR), which states:

> '1 Everyone has the right to liberty and security of person.
>
> No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> (e) the lawful detention ...of persons of unsound mind...
>
> 4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful[2].'

The Code of Practice for the Deprivation of Liberty Safeguards explains that

> 'The Deprivation of Liberty Safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983.
>
> The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests[3].'

The Safeguards require the managing authority (the person or body responsible for running the relevant care home or hospital) to request standard authorisation from a supervisory body to lawfully deprive a person of their liberty. The supervisory body will authorise a deprivation of liberty when a series of six assessed requirements are met. This is called a standard authorisation. When authorisation is required before the assessment process can be completed, the managing authority can grant itself an urgent authorisation for up to seven days. The managing authority can ask the

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[2] Council of Europe (1950) ***The European Convention on Human Rights Article 5,*** **Rome**

[3] Great Britain. Parliament. House of Commons (2009) ***Deprivation of Liberty Safeguards Code of Practice*****,** London: The Stationery Office, para 1.1

supervisory body to extend an urgent authorisation in exceptional situations for a maximum period of an additional seven days.[4]

The core duties and responsibilities of the supervisory body are to:

- Respond to requests for standard authorisation
- Respond to requests for an extension of an urgent authorisation
- Commission the relevant Independent Mental Capacity Advocacy service when required to do so
- Commission the six assessments required for a standard authorisation
- Grant the standard authorisation of deprivation of liberty if all assessments are positive, or
- Not grant the standard authorisation of deprivation of liberty if one or more assessment is not met
- Appoint the Relevant Person's Representative (RPR)
- Respond to requests to review a standard authorisation of deprivation of liberty and carry out a review when appropriate
- Suspend and, where appropriate, lift a standard authorisation if the person is detained under the Mental Health Act 1983 for up to 28 days[5]
- Terminate the deprivation of liberty standard authorisation when appropriate
- Terminate the appointment of an RPR when appropriate
- Respond to requests to investigate alleged unauthorised deprivations of liberty.

Schedule A1[6] originally stated that where the Deprivation of Liberty Safeguards are applied in a hospital setting, the supervisory body is:

- if a PCT commissions the relevant care and/or treatment (or it is commissioned on the PCT's behalf), that PCT
- if the Welsh Ministers or an LHB commissions the relevant care and/or treatment in England, the Welsh Ministers, or
- in any other case, the PCT for the area in which the hospital is situated.

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[4]The process to request a standard authorisation is described in chapter 3 of the **Deprivation of Liberty Safeguards Code of Practice**, urgent authorisations are described in chapter 6.

[5] **Schedule A1 to the Mental Capacity Act 2005** para 93 (2) does not specify who holds the responsibility to suspend the standard authorisation. The standard forms 14 and 15 issued for the suspension of the standard authorisation and the lifting of the suspension are listed as forms for the managing authority to complete. This guidance follows para 8.30 of the **Deprivation of Liberty Safeguards Code of Practice,** which specifies that the standard authorisation is suspended, and the suspension lifted, by the supervisory body.

[6] **Schedule A1 to the Mental Capacity Act 2005** (unamended) paras 180 & 181 cf http://www.legislation.gov.uk/ukpga/2007/12/schedule/7

Where the authorisation is needed in a care home[7], Schedule A1 provided that the supervisory body is

- the local authority for the area in which the person is ordinarily resident.
- If the person is not ordinarily resident in the area of any local authority (for example a person of no fixed abode) the supervisory body will be the local authority for the area in which the care home is situated

[7] **Schedule A1 to the Mental Capacity Act 2005** (unamended) paras 182 & 183 ibid.

# Part 3: Changes made by the Health and Social Care Act 2012

One of the changes effected by the Health and Social Care Act 2012 (HSCA) is the abolition of primary care trusts (PCTs). Schedule 5 to the HSCA amends the other laws affected by this, including Schedule A1 of the Mental Capacity Act 2005 (MCA).

## Summary

- The changes mean that the supervisory body for a hospital in England is no longer determined by the way the care or treatment is funded or commissioned.
- The identity of the clinical commissioning group (CCG) does not determine the supervisory body.
- If the National Assembly for Wales or a Local Health Board (LHB) commission the care or treatment and the relevant person is not ordinarily resident in England, the National Assembly for Wales is the supervisory body.
- Hospital managing authorities making requests for standard authorisation should identify the correct local authority supervisory body by determining the ordinary residence of the relevant person.
- CCGs will receive funding from the Department of Health for MCA implementation and training, (which includes ensuring a good understanding in hospitals of the Deprivation of Liberty Safeguards). The funding for implementation of the Safeguards will pass to local authorities.

## Changes to the identity of the supervisory body[8]

From 1 April 2013, the way a supervisory body for hospital settings is determined will change.

If a person is ordinarily resident in an English local authority (including the Isles of Scilly), that local authority will become the supervisory body. When they receive care or treatment in an English or Welsh hospital and arrangements for that care or treatment amount to a deprivation of liberty, the hospital must apply to that local authority for authorisation.

Where the relevant person is not ordinarily resident in an English local authority, the supervisory body will be the local authority that the hospital (or the greater or greatest part of the hospital) is in, except:

> 'Where the relevant person does not have ordinary residence in an English local authority and the National Assembly for Wales or a Local Health Board in Wales commission the treatment, the National Assembly for Wales will be the

[8] See **Schedule 5 to the Health and Social Care Act 2012** paras 134-136 for the amendments to paragraphs 180 & 181 of Schedule A1 to the Mental Capacity Act 2005.

supervisory body. When the identity of the supervisory body is unclear or needs to be investigated, the request should be sent to the local authority in which the hospital is situated or to the "best guess" local authority. A local authority that receives a disputed or unclear request must begin the assessment and authorisation process while attempts are made to identify the correct supervisory body. If this turns out to be another local authority, discussions should take place as to which authority should continue the necessary assessments.'[9]

## Implications of the changes to the supervisory body for hospital managing authorities in England and Wales

**Hospitals need to:**

- Continue to actively understand the requirements of the Mental Capacity Act and maintain best interests decisions
- Be aware when the National Assembly of Wales or a Local Health Board commission fund the care or treatment provided in hospital
- Be familiar with the regulations regarding ordinary residence in relation to a patient whose treatment is provided in circumstances that amount to a deprivation of liberty.[10]

## Change to the meaning of 'managing authority' in relation to a hospital

The HSCA makes one change to the meaning of 'managing authority' in relation to a hospital. The Secretary of State will be the managing authority where no Special Health Authority has responsibility for the administration for a hospital.[11]

## Implications of the changes to the supervisory body for local authorities

**Local authorities need to:**

- Be prepared to receive enquiries from hospitals on decisions about the supervisory body and ordinary residence. Local authority Deprivation of Liberty Safeguards teams should keep up-to-date lists of the contact details of teams in other local authorities. Local authority teams that have not already done so should also consider adopting an email address such as mca.dols@localauthority.gov.uk or dols@localauthority.gov.uk .

[9] See **Appendix 4** for further guidance on ordinary residence

[10] See **Appendix 4** for further guidance on ordinary residence

[11] See **Schedule 5 to the Health and Social Care Act 2012** para 136 (2c) (aa)

- Be prepared to receive applications from hospitals across England and Wales.
- Be prepared for the possibility of more disputes about ordinary residence supervisory body responsibilities, and be clear about the underlying responsibility that one of the involved supervisory bodies must continue to arrange appropriate assessments, etc.

## Funding for the Deprivation of Liberty Safeguards

### Current funding arrangements (pre-April 2013)

Under the pre-April 2013 arrangements, NHS resources for the MCA and the Deprivation of Liberty Safeguards are received in a single sum from the Department of Health. This is paid to the strategic health authorities and passed on to the PCTs.

Local authorities also receive resources for the MCA and the Deprivation of Liberty Safeguards through the Department of Health's Learning Disabilities and Health Reform grant. The funding is placed in this grant, which they receive from the Department for Communities and Local Government, for convenience and visibility.

Some local authorities negotiated a joint agreement with their PCT to administer the Deprivation of Liberty Safeguards. In return, the PCT forwarded their Deprivation of Liberty Safeguards funding to the local authority. Some PCTs awarded their entire MCA and Deprivation of Liberty Safeguards allocation to the local authority for overall implementation of the MCA and the Safeguards. Other PCTs retained their Deprivation of Liberty Safeguards allocation and set up their own supervisory body administration system to deal with applications solely from hospital managing authorities.

## Changes to funding arrangements from April 2013

From April 2013 the Department of Health will take the Deprivation of Liberty Safeguards element out of the resources allocated to the NHS, leaving only the element for the Mental Capacity Act. This consequently reduced amount, approximately 81 per cent of the pre-April 2013 sum, will be allocated to Clinical Commissioning Groups. From April 2013, the Department of Health will add the NHS Deprivation of Liberty element to the Local Authority allocation. Local Authorities will therefore receive an increase in line with their new responsibilities. This new amount will be paid through the Learning Disabilities and Health Reform grant from the Department for Communities and Local Government.

NHS bodies will no longer receive funding for the supervisory body function of the Deprivation of Liberty Safeguards. CCGs will only receive funding to implement the wider MCA. Local authorities will receive the entirety of the funding for the supervisory body function.

The Department of Health has recalculated the amount it will allocate for the new supervisory body responsibility based on current statistics. This includes the increasing number of authorisation requests and is based on up-to-date estimates of the costs of providing the Deprivation of Liberty Safeguards service. It has increased the national allocation from £1.3 million to £5.4 million. The Department of Health has issued a

factsheet explaining the funding for Deprivation of Liberty Safeguards in 2013–2014. The factsheet explains that: [12]

- Funding for existing MCA and the Deprivation of Liberty Safeguards responsibilities for local authorities is contained within the general local government Formula Grant. Since 2011/12, the Formula Grant has included approximately £29 million of funding for these functions. From next year, the Business Rates Retention Scheme (BRRS) will replace the Formula Grant as the main source of funding for local government. Funding within the Formula Grant is not ring-fenced.
- Funding for new responsibilities for the Deprivation of Liberty Safeguards in hospitals in 2013/14 will total £5.4 million, and will be allocated to local authorities. £1.35 million of this will be allocated as part of the BRRS through the Learning Disability and Health Reform grant. The remaining £4.05 million will be allocated as part of a new grant from the Department of Health. Neither amount will be separately identified within the grant allocations. The factsheet includes indicative allocations using data from the 2012/13 grant calculation to help local authorities understand the resources they have available for the Deprivation of Liberty Safeguards in hospitals. These should be treated as a guide only. They will be updated before the 2013/14 allocations.

**Responsibility for actions performed by the PCT supervisory body before 1 April 2013**

Section 7 of Schedule A1 (unamended) outlines the areas of responsibility in all situations where the supervisory body changes but the managing authority remains the same. Paragraphs 98-100 are copied below:

98 (1) This Part applies if these conditions are met.

(2) The first condition is that a standard authorisation –

(a) has been given, and

(b) has not ceased to be in force.

(3) The second condition is that there is a change in supervisory responsibility.

(4) The third condition is that there is not a change in the place of detention (within the meaning of paragraph 25).

99 For the purposes of this Part there is a change in supervisory responsibility if –

(a) one body ("the old supervisory body") have ceased to be supervisory body in relation to the standard authorisation, and

(b) a different body ("the new supervisory body") have become supervisory body in relation to the standard authorisation.

[12] **Deprivation of Liberty Safeguards Funding Factsheet 2013-2014** (24 September 2012)

Effect of change in supervisory responsibility

100 (1) The new supervisory body becomes the supervisory body in relation to the authorisation.

(2) Anything done by or in relation to the old supervisory body in connection with the authorisation has effect, so far as is necessary for continuing its effect after the change, as if done by or in relation to the new supervisory body.

(3) Anything which relates to the authorisation and which is in the process of being done by or in relation to the old supervisory body at the time of the change may be continued by or in relation to the new supervisory body.

(4) But –

(a) the old supervisory body do not, by virtue of this paragraph, cease to be liable for anything done by them in connection with the authorisation before the change; and

(b) the new supervisory body do not, by virtue of this paragraph, become liable for any such thing.

## Implications of the transfer of responsibility for historical authorisations from PCTs to CCGs

The CCG, via its MCA lead, must be aware of Section 7 of Schedule A1: they will inherit these specific responsibilities from the PCT as they arise.

The PCT supervisory body should identify any cases that are

- Open and where a review has been requested, or
- Closed and thought to be possibly subject to retrospective legal challenge.

The PCT should carry out reviews as requested or as appropriate. They should try to resolve any conflict before 1 April 2013.

The PCT must report to the CCG, via its MCA lead, on risk of legal action from past and current authorisations it has been responsible for assessing.

The PCT supervisory body and receiving local authority supervisory body should discuss if any of the cases the local authority is taking over are likely to lead to challenge. If so it is suggested that the areas of conflict be subject to review. They might also be suitable for mediation.

All risks of challenge should be identified by the time cases are handed over to the local authority supervisory body, together with any steps being taken to lessen the risks.

## Which supervisory body should carry out the review in such circumstances?

The PCT supervisory body retains all its responsibilities until midnight on Sunday 31 March 2013. It may decide to carry out any such reviews, or it may choose to commission the receiving local authority supervisory body to do these reviews. It may simply proceed with existing agreements where the local authority supervisory body has acted on behalf of the PCT.

Whatever it decides, both the PCT supervisory body and the receiving local authority supervisory body should be in agreement with process and how the conclusions will be implemented. If required, they should agree a framework for the review commissioning process. They should follow their usual protocols for commissioning Deprivation of Liberty Safeguards functions to be carried out by another supervisory body.

Any disagreement relating to the assessments or whether standard authorisation should be granted between supervisory bodies, or between an involved supervisory body and the relevant person, their relatives / friends, or any Independent Mental Capacity Advocate (IMCA) or RPR, must be escalated to senior management in both organisations. In these cases, the CCG MCA lead should be involved in discussions. If there is ongoing dispute and mediation does not provide a solution, urgent consideration should be given to requesting a decision from the Court of Protection[13].

[13] For authorisation requests in process of disposal during the second half of March 2013, See **Schedule A1 100 (3) and (4)** (above).

# Part 4: Transition and transfer

## Summary

- Local authorities, PCT supervisory bodies and CCGs will need to work closely together to ensure the smooth transfer of responsibility from the PCT supervisory body to the local authority. The following information aims to guide all supervisory bodies through these transition arrangements, in particular where the hospital and care home domains of the Safeguards have not been integrated, and the local authority is dealing with requests from hospitals for the first time.
- Where the responsibilities have not yet been integrated, supervisory bodies should consider how to transfer the knowledge held by the PCT supervisory body to the local authority. The two supervisory body leads should discuss the differences in implementation of the Safeguards between a hospital and a care home setting. The PCT supervisory body lead and authorisers should identify the knowledge they have about applying the Safeguards in hospital settings that local authority leads and authorisers may not yet know.

## Primary care trust accountability

Primary care trusts will remain responsible and accountable for the Deprivation of Liberty Safeguards until 1 April 2013:

> 'Until April 2013 SHAs and PCTs retain their statutory functions and governance arrangements. There will be no formal transfer of statutory functions, accountability, budgets or employment of staff before then.'[14]

Local health organisations have a number of options.

**Option 1:** A stand-alone PCT supervisory body continues with all the processes until 00.01 on 1 April 2013. If the PCT chooses this option, it may be worth considering a 'shadowing' arrangement so that assessors, leads and signatories from both the local authority and PCT can better understand the current process of receiving authorisation requests.

**Option 2:** At a determined time before 1 April 2013, a stand-alone PCT begins to commission independent assessors or a local authority supervisory body to carry out some elements of the process (e.g. assessments), but retains scrutiny and signing of standard authorisations.

**Option 3:** In some areas, the local authority already completes the assessments and prepares the forms for signing by the PCT supervisory body. The PCT should continue

[14]David Nicholson, Chief Executive of NHS, letter to NHS Chief Executives, 13 August 2012 **Gateway reference 17991**

to scrutinise the processes carried out on its behalf and ensure that it has sufficient signatories up to the transfer date.

## Key milestones for the transfer of responsibility for supervisory body functions from PCT to local authority

The formal transfer of supervisory body responsibility occurs on 1 April 2013, but preparations for the transfer need to be made in advance. The National Quality Board has published guidance on maintaining quality during the transition of wider responsibilities from the 'sending' PCT to the 'receiving' organisations. This includes useful checklists for the transition of tasks and responsibilities between the two organisations[15]. This guidance has been adapted for possible use during the transfer of supervisory body responsibilities.[16]

## Suggested timeline

The following timeline sets out the transfer of supervisory body responsibility between a PCT and its corresponding local authority (or local authorities), as the majority of standard authorisations and requests will be transferred in this way. However, due to the nature of ordinary residence, there will be some cases that require transfer to other local authorities. PCT Deprivation of Liberty Safeguards leads will need to identify authorisations and requests that become the responsibility of local authorities elsewhere in England or of the National Assembly of Wales.

**November and December 2012**

- PCTs and local authorities schedule face-to-face meetings between key individuals and representatives of organisations, including local CCG Mental Capacity Act leads, where identified or appointed.
- Where PCTs and local authorities have managed supervisory body functions separately, PCT Deprivation of Liberty Safeguards managers need to meet with their local authority equivalents to explain in detail how PCT Deprivation of Liberty Safeguards processes and information are currently managed and recorded.
- PCT and local authority Deprivation of Liberty Safeguards managers need to ensure that historical data (both electronic and hard copy) can be accessed after the transfer. For example, if a request for standard authorisation is made in relation to a person who has previously been the focus of a request, the local authority supervisory body needs to be able to read previous assessments to enhance the new Best Interests Assessor's knowledge of that person. The

[15] See the National Quality Board's guidance **Maintaining Quality during the Transition: Preparing for Handover** issued in May 2012

[16] See **Appendix 5** for quality checklists relating to the timeline.

PCT and local authority need to agree on the process and any data protection issues.

- Both PCTs and local authorities should consider workforce issues and likely changes among PCT supervisory body staff, authorisers and assessors. They will then need to agree arrangements for the hand-over of information and how supervisory body functions and responsibilities will be met in the run-up to 1 April 2013.
- The PCT supervisory body Deprivation of Liberty Safeguards lead should inform the CCG Mental Capacity Act lead of any cases authorised by the PCT that are likely to come before the Court of Protection.
- PCTs ensure that there are enough sufficiently briefed senior officers available to sign standard authorisations up to 1 April 2013. Any new or replacement authorisers are identified and briefed in time to shadow current authorisers before they leave the organisation.
- Discussions are held between PCT and local authority supervisory body management on how to manage requests (with or without urgent authorisations) that may still be in progress on 31 March 2013[17].
- PCT and local authority supervisory body managers jointly review conditions set on existing authorisations. It would also be valuable to go through all conditions set by the PCT supervisory body in the previous year to gain an understanding of the issues raised by Deprivation of Liberty authorisations and conditions that are likely to be set in hospital settings.
- Prospective CCGs[18] need to demonstrate how they will meet MCA requirements of the CCG authorisation process.
- Section 75 agreements relating to the MCA should be reviewed by the CCG and the local authority, and continued where agreed.
- Local authorities may choose to prepare a business case to provide CCGs with ongoing training and support to hospital managing authorities on the MCA in general and their responsibilities under the Deprivation of Liberty Safeguards in particular.

**January and February 2013**

- Face-to-face scheduled meetings should continue.
- Arrangements can be made to shadow the PCT assessment and authorisation process or to talk through a sample of hospital-based assessments and authorisations.

[17] See the **options** listed above

[18] See below for explanation of **Clinical Commissioning Groups**

- The PCT supervisory body Deprivation of Liberty Safeguards lead
    - identifies all authorisations that will probably be in effect on 1 April 2013 and notifies the local authority of these examines authorisations for evidence of possible or actual challenge and reviews these cases as necessary, also considering mediation
    - discusses with the legal department whether to ask the Court of Protection to resolve any situations of disagreement or conflict with the relevant person or their representative
    - alerts the CCG MCA lead to any deprivations of liberty authorised by the PCT that may go to the Court of Protection after 1 April 2013
    - drafts and sends letters to affected individuals.[19]
- Relevant hospital staff should have the contact details of their local authority supervisory body, as this is likely to be the supervisory body for the majority of patients.
- Where the PCT supervisory body has been working separately, the local authority supervisory body will need evidence:
    - (including dates) that any assessors used have completed the required training, completed mandatory refresher training, have appropriate insurance arrangements and enhanced CRB clearance
    - of the clinical expertise of assessors, including whether the assessor is authorised to carry out the eligibility assessment.
- The local authority supervisory body arranges a face-to-face meeting in mid-April to assess the handover and identify any ongoing issues. Attendees might include: local authority supervisory body governance lead, supervisory body management, CCG MCA lead, hospital MCA leads and other relevant individuals, and representatives of the IMCA service.

**February and March 2013**

- Face-to-face discussions should continue.
- Both ‘sending’ PCT and ‘receiving’ local authority supervisory bodies:
    - review arrangements and ensure that all information transfer is robust, accessible by the new supervisory body, and properly understood by them
    - confirm arrangements for redirecting phone calls, post and emails that are still sent to the PCT supervisory body

[19] See **Appendix 2** for template letters.

    - review the accuracy of contact details of CCG and hospital MCA leads, and the local authority supervisory body arranges meetings to confirm a smooth hand-over and discuss any issues, in mid-April.
- Local authority supervisory bodies should check with individuals (assessors, Relevant Person's Representatives, managing authorities, etc.) that the information held on them is correct.
- As PCTs still retain supervisory body status up to 1 April 2013, they also retain the responsibility to inform health managing authorities of the new protocols. Together with hospital MCA leads they should ensure that relevant staff know how to proceed when they believe a request for standard authorisation is needed.
- The 'sending' PCT should consider how hospitals will identify the supervisory body for individual patients finding out which local authority the person has ordinary residence in.[20] They might discuss with hospital MCA leads the possibility of collecting this information on admission to wards, where Deprivation of Liberty Safeguards authorisations have historically been requested. This may more effectively be done in partnership with the receiving local authorities.

**1 April 2013 onwards**

- 1 April 2013: formal transfer of all responsibilities.
- CCGs confirm that safe implementation of the MCA, including the Safeguards, is considered in all relevant commissioning processes and specified in all relevant contracts.
- Mid-April: Face-to-face meetings take place (arranged earlier) to discuss handover and any identified difficulties. Attendees might include: local authority supervisory body governance lead, supervisory body management, CCG MCA lead, hospital MCA leads and other named individuals, and representatives of IMCA service.
- July: Joint three-month review of new arrangements, involving local authority Deprivation of Liberty Safeguards leads, best interests assessors, mental health assessors, authorisers, IMCA, managing authorities and Relevant Person's Representatives. This review should not just look back at the transition arrangements, but should seek any further procedural changes that would develop a stronger human rights component in health and social care.

[20] See **Appendix 4** for further guidance on ordinary residence

# Part 5: Professional and practice issues

## Joint working

The MCA resources and Deprivation of Liberty Safeguards resources are interlinked. For hospitals to make safe and appropriate requests for standard authorisation under the Safeguards, and for local authorities to receive, assess and authorise requests for standard authorisation under the Safeguards, they need a workforce that understands the MCA through ongoing MCA training that includes these Safeguards. Many local areas have developed effective joint working on the MCA and the Deprivation of Liberty Safeguards, and have underpinned this by formal Section 75 agreements. The Health and Social Care Act specifically allows CCGs to continue section 75 agreements and to start new ones. These agreements should always be considered where they are meeting the needs of the local population.

## Clinical commissioning groups: roles and responsibilities for MCA

The Health and Social Care Act 2012 abolishes the NHS strategic health authorities and primary care trusts. Clinical commissioning groups (CCGs) will take on responsibility for commissioning the majority of local healthcare.[21] These clinically led organisations involve a range of professional groups and stakeholders. To become established, the CCG must follow an authorisation process that involves the NHS Commissioning Board being satisfied that they meet the requirements for authorisation across six domains[22]. CCGs are required by the authorisation process to have a named MCA lead together with relevant policies and training.[23]

The CCG will be accountable for all authorisations granted by the former primary care trust that ceased on or before 31 March 2013. Any challenge made in regard to these historic authorisations will be made to the CCG.

The CCG also has responsibility for commissioning appropriate healthcare in compliance with the MCA for those residents who may not have the capacity to consent to treatment. The CCG is therefore also responsible for ensuring that the services it commissions can demonstrate compliance with the MCA and the Deprivation of Liberty Safeguards. The CCG will receive funding to support the implementation and understanding of the MCA. This will partly be achieved through the provision or commissioning of training in the MCA and the Safeguards.

## Mental health assessors

The local authority will be responsible for ensuring that sufficient mental health assessors are available. Mental health assessors already carry out assessments under the Safeguards in both care homes and hospitals, and any local problems with

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[21] See section 10 and schedule 2 to the **Health and Social Care Act 2012** .

[22] NHS Commissioning Board (October 2012) **Clinical Commissioning Group Authorisation: Draft Guide for Applicants**

[23] **ibid** p32.

accessing appropriately experienced mental health assessors should have already been identified. In some areas a small number of mental health assessors do all - or almost all - of the appropriate assessment work for a range of local authorities and PCTs. This situation carries risks, as retirement or other events can lead to a sudden shortage of assessors. There is also a potential risk to the integrity of the Safeguards when the opinion and interpretation of a small number of assessors, however well informed, is relied upon. It may also become harder to identify a suitable different mental health assessor to carry out a review of assessments.

If local authorities identify problems of either quantity or quality with mental health assessors, these should be discussed with the CCG MCA lead and/or leads for the MCA from local mental health trusts. The possibility and advantages of training as a Deprivation of Liberty Safeguards mental health assessor could be promoted locally among, in particular, s12 approved doctors working in the areas of older adults' mental health, learning disability, and acquired brain injury or neurology. These advantages include an enhanced knowledge of human rights law in general and of deprivation of liberty in particular. The Royal College of Psychiatrists offers free training online, and sometimes face-to-face, but arrangements to provide additional face-to-face training may have to be made regionally or locally. There is no longer specific funding for this from Deprivation of Liberty Safeguards Implementation funding, so the local authority would be responsible for its provision. Again, a business case might be presented for the use of CCG MCA resources.

## Eligibility assessments in psychiatric hospitals

Particular problems can arise in mental health settings if a deprivation of liberty has been identified and there is disagreement on the appropriate legal mechanism to use to protect the relevant person's ECHR Article 5 rights.

Considering using the Mental Health Act is the most appropriate first step in almost all circumstances, as the relevant person will have been admitted for assessment and treatment of a mental disorder.

The local authority supervisory body will need to establish a protocol to address situations when a deprivation of liberty has been identified and the patient has been assessed as ineligible for both the Safeguards and the formal powers of the Mental Health Act.

## Health-employed Best Interests Assessors

Best Interests Assessors (BIAs) employed by hospital trusts have played an important role in the implementation of the MCA and Deprivation of Liberty Safeguards. They have provided formal and informal MCA expertise to trusts, and have often been seen as lead practitioners of human rights-based practice in their day-to-day roles. They also carry out and facilitate best practice in best interests decision-making both generally within the MCA and as part of the Deprivation of Liberty Safeguards process.

The cost of training a BIA is not insignificant (usually around £3,000 for initial training, plus mandatory refresher training and supervisory body supervision). However, hospitals would benefit greatly from having trained and practising BIAs, as they can

provide a good understanding of the MCA in general and of human rights law relating to restrictions of liberty in particular. Patients - subject to restrictions or not - benefit from being treated within a clear human rights framework, and colleagues value the BIA's expertise as it helps to keep the hospital's practice lawful.

Trusts need to decide how to ensure the continuation of such expertise following the transfer. They may already have a well-tested system of MCA and Human Rights Act champions helping them to comply with the MCA in the treatment of patients who may lack capacity to consent to arrangements for their care or treatment. However, Clinical Governance Teams often find that BIAs on the staff enable them to ensure compliance with the law.

There are several options open to local consideration:

**Option 1:** Hospital-employed BIAs are made available by their employing trust to serve on a rota or as otherwise according to local arrangements; the local authority supervisory body then pays back-fill for their time if required.

**Option 2:** Hospital-employed BIAs no longer practise, are no longer part of the BIA training/supervision system, and are not able to keep up their registration through practice and by attending refresher training. Hospitals will also lose the expertise and the ongoing value of their investment. They will need to ensure that these skills and expertise are continued through other means. Hospitals will need to develop alternative ways of ensuring that everyday practice complies with the law.

**Option 3:** Hospital-employed BIAs carry out assessments, if required, in their own time, as independent practitioners. The Regulations to the MCA (Deprivation of Liberty) lay out the conditions they will have to meet:

> **The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008**
>
> **Section 3**
>
> (1) In addition to any requirement in regulations 4 to 9, a person is eligible to carry out an assessment where paragraphs (2) to (4) are met.
>
> (2) The person must—
>
> > (a) be insured in respect of any liabilities that might arise in connection with carrying out the assessment; and
> >
> > (b) satisfy the supervisory body that he or she has such insurance.
>
> (3) The supervisory body must be satisfied that the person has the skills and experience appropriate to the assessment to be carried out which must include, but are not limited to, the following—
>
> > (a) an applied knowledge of the Mental Capacity Act 2005 and related Code of Practice and

> (b) the ability to keep appropriate records and to provide clear and reasoned reports in accordance with legal requirements and good practice.
>
> (4) The supervisory body must be satisfied that there is in respect of the person—
>
> (a) an enhanced criminal record certificate issued under section 113B of the Police Act 1997 (enhanced criminal record certificates); or
>
> (b) if the purpose for which the certificate is required is not one prescribed under subsection (2) of that section, a criminal record certificate issued pursuant to section 113A of that Act (criminal record certificates).

Independent BIAs would also need to set up the necessary systems to be paid and to pay tax on these earnings and make arrangements to attend mandatory refresher training and BIA supervision. Their employers would have to agree to these arrangements.

Employers may expect independent BIAs to do this in their own time and at their own expense, as supervisory bodies do not generally offer to pay independent BIAs or mental health assessors for their time or the costs incurred in attending training. However, employers might consider the advantages detailed above of employing a practising BIA in the hospital, and agree to their BIA employees undertaking training and supervision in work time as part of their recognised continual professional development.

Local authorities that are both supervisory body and managing authority of a care home cannot use their own BIAs to carry out assessments[24]. They must make other arrangements – for example, they may negotiate reciprocal assessments with a neighbouring authority or use independent BIAs. As a result, BIAs working in health settings are invaluable for carrying out assessments in care homes owned by the local authority.

## Best Interests Assessors and assessments in hospitals

Most jointly-managed supervisory bodies have experienced little or no difficulty in identifying competent BIAs to carry out assessments in hospitals, even where all the BIAs are local authority staff. Many BIAs from the four qualifying professions (social work, occupational therapy, nursing and psychology) have experience in hospital settings, across a range of specialist health provisions. The BIA's role is not to authorise or scrutinise clinical decision-making in any way. Their role is to look at the conditions surrounding the provision of care or treatment and decide whether or not those conditions deprive the relevant person of their rights to liberty and security of person under Article 5 of the Human Rights Act 1998. The role also requires the BIA to consult

[24] See **Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments, and Ordinary Residence) Regulations 2008** para 12(2)

with the managing authority, the relevant person and others in considering whether the identified care or treatment could be carried out in a less restrictive way.

The BIA role remains the same whatever the nature of the managing authority and the requirements for the selection of Best Interests Assessors are consistent and make no reference to the nature of the managing authority.[25]

However, although the task is essentially the same and similar issues will arise, some local authority BIAs may be carrying out assessments in hospitals for the first time. As with care homes, the assessor will need to understand the environment in which the assessment is taking place. The assessor should also understand the legal context of hospital treatment and case law relevant to hospital settings. A BIA should also be able to recognise when it may be appropriate for the hospital to make an application to the Court of Protection under Practice Direction 9e (applications relating to serious medical treatment)[26].

[25] **Schedule A1 to the Mental Capacity Act 2005** specifies that the BIA must appear suitable to the supervisory body to carry out the assessment having regard to 'the type of assessment and the person to be assessed' (para 129(2)). The regulations on the selection of a BIA only state that the supervisory body must not select a person to carry out a best interests assessment who is involved in the care, or making decisions about the care, of the relevant person; or where the managing authority and supervisory body are both the same body, the supervisory body must not select a person to carry out a best interests assessment who is employed by it or who is providing services to it. No reference is made to the nature of the supervisory body. See also **Deprivation of Liberty Safeguards Code of Practice** chapter 4.

[26] See **Appendix 1**.

# Appendix 1: Serious medical treatment decisions

Practice Direction 9E – applications relating to serious medical treatment [27]

General

1. Rule 71 enables a practice direction to make additional or different provision in relation to specified applications.

Applications to which this practice direction applies

2. This practice direction sets out the procedure to be followed where the application concerns serious medical treatment in relation to P.

Meaning of 'serious medical treatment' in relation to the Rules and this practice direction

3. Serious medical treatment means treatment which involves providing, withdrawing or withholding treatment in circumstances where:

(a) in a case where a single treatment is being proposed, there is a fine balance between its benefits to P and the burdens and risks it is likely to entail for him;

(b) in a case where there is a choice of treatments, a decision as to which one to use is finely balanced; or

(c) the treatment, procedure or investigation proposed would be likely to involve serious consequences for P.

4. 'Serious consequences' are those which could have a serious impact on P, either from the effects of the treatment, procedure or investigation itself or its wider implications. This may include treatments, procedures or investigations which:

(a) cause, or may cause, serious and prolonged pain, distress or side effects;

(b) have potentially major consequences for P; or

(c) have a serious impact on P's future life choices.

Matters which should be brought to the court

5. Cases involving any of the following decisions should be regarded as serious medical treatment for the purpose of the Rules and this practice direction, and should be brought to the court:

(a) decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state;

[27] See **Practice Direction 9e Applications relating to Serious Medical Treatment**

(b) cases involving organ or bone marrow donation by a person who lacks capacity to consent; and

(c) cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.

6. Examples of serious medical treatment may include:

(a) certain terminations of pregnancy in relation to a person who lacks capacity to consent to such a procedure;

(b) a medical procedure performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation to another person;

(c) a medical procedure or treatment to be carried out on a person who lacks capacity to consent to it, where that procedure or treatment must be carried out using a degree of force to restrain the person concerned;

(d) an experimental or innovative treatment for the benefit of a person who lacks capacity to consent to such treatment; and

(e) a case involving an ethical dilemma in an untested area.

7. There may be other procedures or treatments not contained in the list in paragraphs 5 and 6 above which can be regarded as serious medical treatment. Whether or not a procedure is regarded as serious medical treatment will depend on the circumstances and the consequences for the patient.

# Appendix 2: Draft template letters

**RELEVANT PERSON**

Dear

I am writing to you because you are subject to a Deprivation of Liberty Safeguards authorisation. This means that you can be stopped from leaving the hospital when you want to, but it also means that you can challenge this.

As you may know, there are big changes to how the NHS is managed. Primary care trusts will all cease to exist at the end of March 2013.

So if you want to challenge any of the assessments that led to the authorisation, please in future get in touch with the [local authority], which we understand is where you were living when you were admitted to hospital, or ask your Representative to do this.

The contact details for matters to do with the Safeguards are:

[full address,

phone number,

email address].

The name of the manager is [full name]

Please don't hesitate to contact [him/her] if you have any queries about the content of this letter or about any other matters related to the Safeguards.

There will be no other changes that will affect you or [title, surname]. . [name of RPR] will still be your Representative, unless you or [she/he] wish to change that, for as long as the authorisation lasts.

With all best wishes,

Yours sincerely,

[Full name]

**RELEVANT PERSON'S REPRESENTATIVE**

Dear

I am writing to you because you are the Relevant Person's Representative (RPR), under the Deprivation of Liberty Safeguards, for your [state relationship, or 'friend'] [Title, Full Name] who is currently a patient at [hospital].

As you may be aware, primary care trusts will all cease to exist at the end of March 2013. If [she/he] is still subject to authorisation at that time, the supervisory body responsibility for [Title, Full Name]'s authorisation will therefore change, from 1 April 2013, to [local authority], which we understand is the local authority where [he/she] was living before being admitted to hospital.

The contact details for this supervisory body are:

[full address,

phone number, ]

email address].

The name of the manager is [full name]

Please don't hesitate to contact [him/her] if you have any queries about the content of this letter or about any other matters related to the authorisation.

There will be no other changes that will affect you or [title, surname]: you will remain the RPR, unless you choose to relinquish the role, for as long as the authorisation lasts.

I'd like to take this opportunity to thank you for the care with which you have carried out the role of Representative for [title, surname], and to wish you well for the future.

With all best wishes,

Yours sincerely,

[Full name]

# Appendix 3: Useful definitions

**Schedule A1 to the Mental Capacity Act**

**Definition of a local authority**

For the purposes of the Deprivation of Liberty Safeguards, a local authority is considered to be a:

- council of a county; or
- the council of a district for which there is no county council; or
- the council of a London borough; or
- the Common Council of the City of London; or
- the Council of the Isles of Scilly[28].

**NHS Act 2006: definition of 'hospital'**

**s.275 (1):**

In this Act (except where the context otherwise requires)—

- 'health service hospital' means a hospital vested in the Secretary of State for the purposes of his functions under this Act or vested in a Primary Care Trust, an NHS trust or an NHS foundation trust,
- 'hospital' means—

  (a) any institution for the reception and treatment of persons suffering from illness,

  (b) any maternity home, and

  (c) Any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation,

  and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and 'hospital accommodation' must be construed accordingly,

[28] See **Schedule A1 to the Mental Capacity Act 2005** para 136 (4).

- 'illness' includes mental disorder within the meaning of the Mental Health Act 1983 (c. 20) and any injury or disability requiring medical or dental treatment or nursing,

**Health and Social Care Act 2008 Part 1 Chapter 2**

**8. 'Regulated Activity'**

1) In this Part 'regulated activity' means an activity of a prescribed kind
2) An activity may be prescribed for the purposed of subsection (1) only if –
    a) the activity involves, or is connected with, the provision of health or social care in, or in relation to, England, and
    b) the activity does not involve the carrying on of any establishment or agency, within the meaning of the Care Standards Act 2000 (c.14), for which Her Majesty's Chief Inspector of Education, Children's Services and Skills is the registration authority under that Act

The Health and Social Care Act 2008 (Consequential Amendments No.2) Order 2010

**5.**—(1) The Mental Health Act 1983(**1**) is amended as follows.

(2) In section 24 (visiting and examination of patients), in subsection (3)(b), after 'Part II of the Care Standards Act 2000' insert 'or Part 1 of the Health and Social Care Act 2008'.

(3) In section 34 (interpretation of Part 2), in subsection (1), for the definition of 'registered establishment' substitute—

''registered establishment' means an establishment which would not, apart from subsection (2) below, be a hospital for the purposes of this Part and which—

(a)in England, is a hospital as defined by section 275 of the National Health Service Act 2006 that is used for the carrying on of a regulated activity, within the meaning of Part 1 of the Health and Social Care Act 2008, which relates to the assessment or medical treatment of mental disorder and in respect of which a person is registered under Chapter 2 of that Part; and

(b) in Wales, is an establishment in respect of which a person is registered under Part 2 of the Care Standards Act 2000 as an independent hospital in which treatment or nursing (or both) are provided for persons liable to be detained under this Act;'.

…

(5) In section 145 (interpretation)—

(a)for the definition of 'independent hospital' substitute—

''independent hospital'—

(a) in relation to England, means a hospital as defined by section 275 of the National Health Service Act 2006 that is not a health service hospital as defined by that section, and

(b) in relation to Wales, has the same meaning as in the Care Standards Act 2000;'

**(a) Amendments of the Mental Capacity Act 2005**

**(b)**

**17. -**(1) The Mental Capacity Act 2005 is amended as follows.

…

(3) In section 38 (provision of accommodation by NHS body), for subsection (7) substitute—

(7) 'Hospital' means—

(a)in relation to England, a hospital as defined by section 275 of the National Health Service Act 2006; and

(b)in relation to Wales, a health service hospital as defined by section 206 of the National Health Service (Wales) Act 2006 or an independent hospital as defined by section 2 of the Care Standards Act 2000.'.

(4) In section 49 (power to call for reports), in subsection (7)(c), after 'Care Standards Act 2000 (c. 14)' insert 'or Chapter 2 of Part 1 of the Health and Social Care Act 2008'.

(5) In section 58 (functions of the Public Guardian), in subsection (5)(c), after 'Care Standards Act 2000 (c. 14)' insert 'or Chapter 2 of Part 1 of the Health and Social Care Act 2008'.

(6) In section 61 (Court of Protection Visitors), in subsection (5)(c), after 'Care Standards Act 2000 (c. 14)' insert 'or Chapter 2 of Part 1 of the Health and Social Care Act 2008'.

(7) In Schedule A1 (hospital and care home residents: deprivation of liberty)—

(a)in Part 9 (assessments under this Schedule), in paragraph 131(c), after 'Care Standards Act 2000' insert 'or Chapter 2 of Part 1 of the Health and Social Care Act 2008'; and

(b) in Part 13 (interpretation)—

(i)for paragraph 175(3) substitute—

'(3) Independent hospital'—

(a)in relation to England, means a hospital as defined by section 275 of the National Health Service Act 2006 that is not an NHS hospital; and

(b)in relation to Wales, means a hospital as defined by section 2 of the Care Standards Act 2000 that is not an NHS hospital.',

(ii) for paragraph 177, substitute—

'**177.** 'Managing authority', in relation to an independent hospital, means—

(a)in relation to England, the person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and

Social Care Act 2008 in respect of regulated activities (within the meaning of that Part) carried on in the hospital, and

(b)in relation to Wales, the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of the hospital.'.

(iii) for paragraph 179, substitute—

'**179.** 'Managing authority', in relation to a care home, means—

(a)in relation to England, the person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and Social Care Act 2008 in respect of the provision of residential accommodation, together with nursing or personal care, in the care home, and

(b)in relation to Wales, the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of the care home.'.

# Appendix 4: More about ordinary residence

## Ordinary residence in relation to hospitals

The Health and Social Care Act does not make any changes to the meaning of ordinary residence, which stems from the National Assistance Act 1948[29]. Issues of ordinary residence have mostly arisen in reference to a local authority's responsibility to provide accommodation and welfare services. Where a local authority has made arrangements to provide a person with accommodation in a care home, the person's ordinary residence is deemed to be the place where they were ordinarily resident immediately before they went into the home.

The ordinary residence provisions have been used to identify which local authority holds supervisory body responsibility in relation to applications for authorisation from care homes. This now extends to the identification of the supervisory body responsibility for managing the Deprivation of Liberty Safeguards in hospital settings.

The National Assistance Act did not provide a statutory definition of ordinary residence, and while there are special cases where the Courts have had to interpret the meaning[30], in general, the term can be understood in its common sense meaning: the place where the person ordinarily resides.[31]

In the case of Shah v London Borough of Barnet (1983), Lord Scarman clarified that 'ordinarily resident' refers to a person's 'abode in a particular place… which [the person has] adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration'.[32]

Where a local authority has made arrangements to provide a person with accommodation in a care home, the person's ordinary residence is deemed to continue in the place where there were ordinarily resident immediately before they went into the home. This 'deeming' rule does not apply where the person makes their own arrangements for accommodation in a care home. Therefore in this situation the normal rules apply and a person's ordinary residence depends on the facts, in accordance with the test in the Shah case.

---

[29] **Section 21** and **Section 29** of the **National Assistance Act 1948** set out the responsibility for the provision of accommodation and community care services. Section 29 was amended by the **Local Government Act 1972 (schedule 23 para 2(4))** to make reference to "persons ordinarily resident in the area of the local authority".. See also **Section 148 of the Health and Social Care Act 2008**. However, no statutory definition of 'ordinary residence' has been supplied: its meaning is assumed to be the natural meaning subject to interpretation by the courts and determinations by the Secretary of State.

[30] The Department of Health maintains ***an archive of determinations on ordinary residence***

[31] The Department of Health has issued **Ordinary residence: guidance on the identification of the ordinary residence of people in need of community services**. It is likely that this guidance will require revision to reflect the changes made by Schedule 5 to the Health and Social Care Act 2012

[32] Regina -v- Barnet London Borough Council, Ex parte Nilish Shah; HL 1983

In cases where ordinary residence is unclear or in dispute, local authorities should apply the Department of Health guidance[33] or, in more complex cases, seek determination from the Secretary of State.

## The hospital is situated in Wales

If the hospital is situated in Wales, the National Assembly for Wales is the supervisory body unless the relevant person is ordinarily resident in the area of a local authority in England, in which case the supervisory body is that local authority.

## The hospital is situated in the area of an English Local Authority

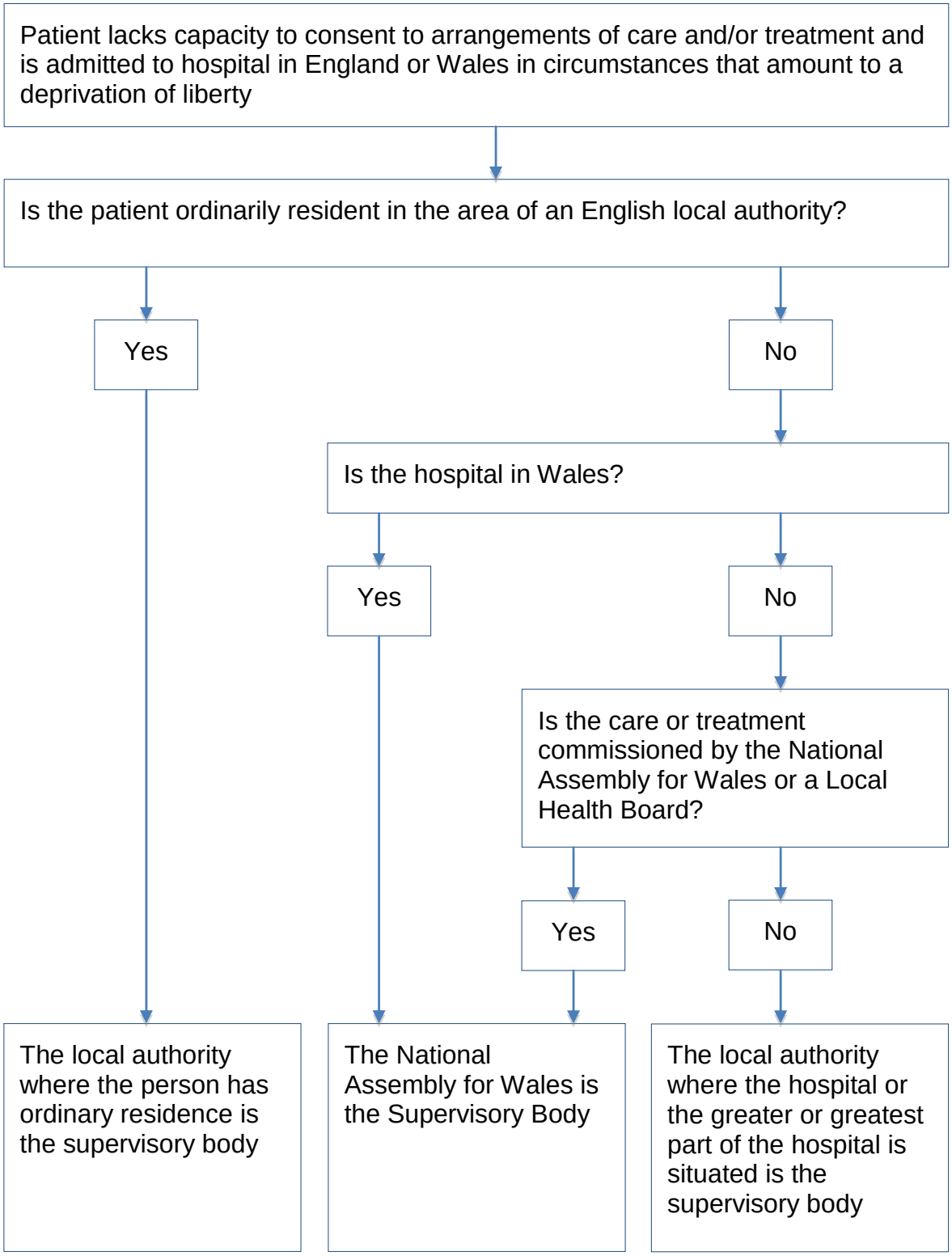
If the hospital is situated in England, the supervisory body is the local authority in which the patient is ordinarily resident.

If the patient is not ordinarily resident in the area of an English Local Authority, and the treatment is commissioned by the National Assembly for Wales or a Local Health Board, the National Assembly for Wales is the supervisory body.

Otherwise, where the patient is not ordinarily resident in the area of an English Local Authority, the supervisory body will be the local authority in which the hospital, or the greater or greatest part of the hospital, is situated.

[33] The Department of Health has issued **Ordinary residence: guidance on the identification of the ordinary residence of people in need of community services**. This is to be read in conjunction with **Ordinary Residence Disputes (Mental Capacity Act 2005) Directions 2010**) It is likely that these will require revision to reflect the changes made by Schedule 5 to the Health and Social Care Act 2012, however, however it is important that supervisory bodies recognise that any dispute must not delay disposing of an authorisation request. In general, the body receiving the disputed request is required to arrange and carry out assessments until the dispute is resolved.

**Flowchart for the determination of the supervisory body**



## Examples of determining the supervisory body for hospital managing authorities

The following examples are for guidance only, since determination of ordinary residence depends on the facts in each case. The area where someone is living at the precise moment they go into hospital will not automatically be their place of ordinary residence. For example, if their stay is very temporary or they have only been there a short time (such as on holiday or work placement) they might not have acquired ordinary residence in that area.

| | **A patient lacking capacity to consent to arrangements for treatment is admitted in circumstances believed to amount to a deprivation of liberty** | **Supervisory body** |
|---|---|---|
| 1 | Patient is admitted to a hospital in Wales and treatment is commissioned by the National Assembly for Wales or a Local Health Board | The National Assembly for Wales is the supervisory body |
| 2 | Patient is admitted to a hospital in England and the treatment is commissioned by National Assembly for Wales or a Local Health Board | The National Assembly for Wales is the supervisory body |
| 3 | Patient is admitted to a hospital in Wales and has ordinary residence in the area of an English local authority | The English local authority for ordinary residence is the supervisory body |
| 4 | Patient is admitted to hospital situated in the same English local authority area where they live in their own home or with their family | The local authority is the supervisory body |
| 5 | Patient is admitted to a hospital situated in a different English local authority to the one that they live in, in their own home or with their family (that is, the one they have ordinary residence in) | The local authority for ordinary residence is the supervisory body |
| 6 | Patient is admitted to a hospital situated in the same local authority that made arrangements to provide them with accommodation in a care home (see the ‘deeming’ rule above) | The local authority is the supervisory body |
| 7 | Patient is admitted to a hospital in the area of one local authority while a second local authority has made arrangements to provide them with accommodation in a care home (see the ‘deeming’ rule above) | The second local authority is the supervisory body |

| | | |
|---|---|---|
| 8 | Patient funds their own admission (perhaps through validated lasting powers of attorney) to an independent hospital in the area of one local authority. They also fund their own placement in a care home in the area of a second local authority and have no other home | The second local authority is the supervisory body |
| 9 | Patient is admitted to a hospital situated in the area of an English local authority and has no fixed abode | The local authority in which the hospital is situated is the supervisory body |
| 10 | Patient lives in a care home situated in one local authority. The accommodation is provided as an 'out of area' placement by a second local authority (see the 'deeming' rule above). Their local CCG commissions treatment in a hospital in the area of a third local authority | The second local authority is the supervisory body, under the 'deeming' rule |
| 11 | Patient is a foreign national with no residency entitlement in England or Wales | The supervisory body is decided by where the hospital is sited: the National Assembly for Wales if in Wales, the English local authority if in England |

## Disputes around ordinary residence

There are circumstances where the determination of ordinary residence becomes complex and disputed, such as where a person has applied for asylum or is an overseas student. These cases may require more considered determination.

Hospital managing authorities are required to make reasonable attempts to identify the supervisory body. Where this is complex or unclear the hospital may apply to its own 'host' local authority i.e. the local authority in which it, or the greater part of it, is situated, to assume the responsibility of determining ordinary residence if it wishes to dispute its presumed status as the supervisory body. In the meantime, it should continue with processing the request for authorisation.

The Secretary of State will handle all unresolved disputes about ordinary residence. Until a decision is made, the local authority receiving the request or the local authority that the hospital is situated in (the 'host' local authority) must assume responsibility as the supervisory body[34].

[34] See **Deprivation of Liberty Safeguards Code of Practice** para 3.3 footnote 8

# Appendix 5: Checklists for ensuring quality during the transfer

The following questions are intended to prompt further questions regarding quality during the transition. They should be used to supplement the tasks laid out in the timeline, and can be referred to at any point in the timeline to monitor the quality of arrangements[35]. Although the checklists are laid out as if the supervisory body responsibilities have been kept separate, they should also be useful for 'integrated' supervisory bodies to monitor quality during the transition[36].

**Checklist for the 'sending' PCT supervisory body lead**

- How do I know which local authority will receive transfer of responsibility for each standard authorisation given or request made for authorisation after 1 April 2013?
- What information will the receiving local authority need to know and how can I provide that information in the most useful way?
- What information do I have that the local authority will need to know about the Deprivation of Liberty Safeguards in health settings?
- What processes do I need to put in place to monitor, evaluate and mitigate risks?
- Are there any historic issues that have been resolved but may need action planning or recommendations implemented? Are there any historic issues that I should alert the new supervisory body to in case of reoccurrence?
- Am I clear about the requirements of Freedom of Information record keeping? Do I know which organisation will hold responsibility after 1 April 2013?
- Do I have a system to check from other sources and verify information I am sending to the new supervisory bodies?
- Have I allocated enough time for meetings between key people to ensure face-to-face discussion?
- Do I have processes in place to ensure that key staff do not leave before documenting their knowledge and taking part in a handover conversation?
- Do I have a resilience plan in light of possible workforce changes to maintain responsibilities up to the transition date?
- Have I identified contacts within the organisation who can contribute to the continuation and delivery of processes following the transition?

[35] See suggested **Timeline** above

[36] The checklists are adapted from those contained in the National Quality Board's guidance **Maintaining Quality during the Transition: Preparing for Handover** pp 10-12

- Is my team clear that current responsibilities should be maintained until 1 April 2013? Do I have processes and people in place to keep data live until 1 April 2013?
- Are my records and data easy to navigate?
- Do I have sufficient safeguards in place to ensure integrity during the process? Am I keeping senior officers informed of the transition?

**Checklist for the 'receiving' local authority supervisory body lead**

- Am I clear about what responsibilities I have for maintaining quality before and after the transition and how I will carry them out?
- Who currently holds those responsibilities and relevant information?
- Who do I need to contact to ensure quality is maintained before and after transfer? Have I done so?
- Have I identified a Deprivation of Liberty Safeguards transition lead within the PCT? How can they help me and my team understand the experience of the safeguards in health settings?
- Am I clear about how and when I will gain access to records and documents and what I will do with them?
- Have I reviewed PCT or joint work in progress documents and are we ready to receive and exercise responsibilities for quality on 1 April 2013? Have the authorisers been briefed and informed of their new responsibilities?
- Do I have a system in place to check and assess, wherever possible, from other sources data and intelligence received from the PCT and other bodies?
- What processes do I need to put in place to monitor, evaluate and lessen risks?
- Have I identified how I will ensure ongoing integrity in the safeguards? How will senior management be briefed about new responsibilities after the transfer?

**NOVEMBER 2012**

# Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare commissioners

This resource is intended to help people plan for the changes to the Deprivation of Liberty Safeguards, which comes into force from 1 April 2013. It describes the changes to the identity of the supervisory body in health settings and offers guidance on how local authorities, hospitals, primary care trusts (PCTs) and clinical commissioning groups (CCGs) can work together to ensure that the rights of vulnerable patients are protected.

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