Title: Mental Capacity and Detention **IA No:** LAWCOM0055 **Lead department or agency:** **Law Commission** **Other departments or agencies:** **Department of Health**	**Impact Assessment (IA)** **Date:** 13/03/2017 **Stage:** Development/Options **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries: Tim Spencer-Lane** 020 3334 3758

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANDCB on 2014 prices)	**One-In, Three-Out?**	**Business Impact Target Status**
£6,233.85m	£m	£m	Not in scope	Qualifying provision

What is the problem under consideration? Why is government intervention necessary?

The Deprivation of Liberty Safeguards (DoLS) provide a legal process to authorise the deprivation of liberty of people in hospitals or care homes who lack mental capacity to make decisions about their care and treatment arrangements. The DoLS process is problematic in that it is complex, overly bureaucratic and fails to address deprivations of liberty in other settings, such as supported living and private and domestic settings. A Supreme Court judgment known as "Cheshire West" widened considerably what was understood to be the cohort of people deprived of liberty, leading to an increase in the number of assessments and authorisations required. The DoLS has been unable to cope with this extra demand. The result has been non-compliance with the law, and associated breaches of human rights. Law reform is necessary to provide an effective and sustainable authorisation process.

What are the policy objectives and the intended effects?

1. To create a new simplified legal framework which is accessible and clear to all affected parties;
2. To deliver improved outcomes for persons deprived of their liberty and their family / unpaid carers;
3. To provide a simplified authorisation process capable of operating effectively in all settings with the large numbers of people now considered to be deprived of liberty.
4. To ensure that the Mental Capacity Act works as intended, by placing the person at the heart of decision making and is compliant with Article 8 European Convention on Human Rights.

The intended effects are to ensure increased compliance with the law, improve care and treatment for people lacking capacity and to provide a system of authorisation in a cost effective manner.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 0: Do nothing.
Option 1: The DoLS fully operationalised.
Option 2: The Liberty Protection Safeguards including a referral to an Approved Mental Capacity Professional and reforms to other parts of the Mental Capacity Act 2005 (to make immunity from civil and criminal liability in respect of things done to or for people lacking capacity dependent upon compliance with safeguards).
Option 3: Option 2 (Liberty Protection Safeguards) without a referral to an Approved Mental Capacity Professional.
Our preference for implementation would be option 2 because this is a proportionate and cost efficient approach that not only directly resolves DoLS problems but also provides timely solutions to DoLS affected areas.

Will the policy be reviewed? It will/will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			Yes / No / N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes/No	**< 20** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes/No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ______________ Date: ______________

Summary: Analysis & Evidence Policy Option 1

Description: The DoLS fully operationalised.

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2015/16	2015/16	10	**Low -£12,888.39**	**High:-£19,594.99**	**Best Estimate: -£16,205.79**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	£7.03		£1,700.02	£14,145.43
High	£21.02	1	£2,617.72	£21,791.70
Best Estimate	£14.06		£2,154.56	£17,932.66

Description and scale of key monetised costs by 'main affected groups'

Transitional costs: training new health and social care professionals, best interests assessors, advocates and paid representatives: £14.06m [best estimate] to individuals, local authorities and the NHS.
Ongoing costs: authorisations under DoLS: £309.13m per year [best estimate] to local authorities; authorisations outside the DoLS: £609.5m per year [best estimate] to local authorities and the NHS; legal costs to incapacitated parties before court: £1,231.39m per year [best estimate] to families, the Official Solicitor and legal aid; cost of regulation and inspection: £4.54m per year [best estimate] to the regulators.

Other key non-monetised costs by 'main affected groups'

None

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	0		£151.15	£1,257.03
High	0	1	£264.14	£2,196.70
Best Estimate	0		£207.65	£1,726.87

Description and scale of key monetised benefits by 'main affected groups'

No transitional benefits identified.
Ongoing benefits: reduced exposure to damages for unauthorised deprivations of liberty in hospitals and care homes: £79.33m per year [best estimate] to the NHS, local authorities and other providers; reduced exposure to damages in domestic settings: £45.32m per year [best estimate] to local authorities, the NHS and other providers; improved health outcomes as measured by the gain in quality adjusted life-years (QALYs): £83.0m per year [best estimate].

Other key non-monetised benefits by 'main affected groups'

United Kingdom: greater compliance with international human rights obligations.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

Sensitivities are detailed throughout the evidence base, as are assumptions.
Risks:

- The court system simply cannot cope with the large numbers of court authorisations required and delays undermine the system.
- The system continues to be seen as inefficient and wasteful, and is not taken up by those who require it.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**In scope of OIOO?**	**Measure qualifies as**
Costs:	**Benefits:**	**Net:**	Yes/No	IN/OUT/Zero net cost

Summary: Analysis & Evidence   Policy Option 2

Description: The Liberty Protection Safeguards including referral to an Approved Mental Capacity Professional and our reforms to section 5 and 6 of the Mental Capacity Act 2005.

FULL ECONOMIC ASSESSMENT

Price Base Year 2015/16	PV Base Year 2015/16	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £4,165.77	**High:** £8,270.90	**Best Estimate:** £6,233.85

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£5.12		£192.69	**£1,602.91**
High	£18.75	1	£282.34	**£2,347.79**
Best Estimate	£11.36		£235.89	**£1,961.36**

Description and scale of key monetised costs by 'main affected groups'

Transitional costs: training new health and social care professionals, Approved Mental Capacity Professionals and advocates: £11.34m [best estimate] to individuals, local authorities and the NHS; recruitment of Approved Mental Capacity Professionals: £0.02m [best estimate] to local authorities.
Ongoing costs: cost of authorisations: £124.80m per year [best estimate] to local authorities and the NHS; referral to an Approved Mental Capacity Professional: £7.61m per year [best estimate] to local authorities and the NHS, cost of taking appeals to the Court of Protection: £87.1m [best estimate] to the Official Solicitor, Legal Aid agency and local authorities / NHS; cost of regulation and inspection: £6.94m per year [best estimate] to the regulators; costs associated with Sec 5 safeguards: £9.44m per year [best estimate] to local authorities / NHS.

Other key non-monetised costs by 'main affected groups'

None identified

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		£694.45	**£5,775.47**
High	0	1	£1,279.06	**£10,637.44**
Best Estimate	0		£986.77	**£8,206.58**

Description and scale of key monetised benefits by 'main affected groups'

No transitional benefits identified.
Ongoing benefits: reduced exposure to damages for unauthorised deprivations of liberty, £288.45m per year [best estimate] under the Liberty Protection Safeguards and £120.29m per year [best estimate] under the section 5 reforms to NHS, local authorities and other care providers; improved health outcomes as measured by the gain in QALYs, £471.39m per year [best estimate] under the Liberty Protection Safeguards and £106.64m per year [best estimate] under the section 5 reforms to NHS, local authorities and other care providers.

Other key non-monetised benefits by 'main affected groups'

Incapacitated adults: greater empowerment and equality and improved care outcomes.
United Kingdom: greater compliance with international human rights obligations.
Families and carers: greater certainty and empowerment.
NHS and local authorities: greater compliance with the law, freed up resources from efficiency gains.
Court of Protection: reduced case load leading to freed up resources and flow on benefits.

Key assumptions/sensitivities/risks   Discount rate (%)   3.5

Sensitives are detailed throughout the evidence base, as are assumptions.
Risks:

- Inadequate current compliance with the Mental Capacity Act will lead to substantial costs for the Liberty Protection Safeguards and wider reforms.
- Inadequate infrastructure in place in local authorities to provide for the new AMCP team structure, due to existing over reliance on freelance and independent staff.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	Yes/No	IN/OUT/Zero net cost

Summary: Analysis & Evidence Policy Option 3

Description: The Liberty Protection Safeguards and wider recommendations without referral to an Approved Mental Capacity Professional.

FULL ECONOMIC ASSESSMENT

Price Base Year 2015/16	PV Base Year 2015/16	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £3,036.49	**High:** £5,975.42	**Best Estimate:** £4,516.58

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	£5.09		£189.83	**£1,584.22**
High	£18.43	1	£269.06	**£2,255.78**
Best Estimate	£11.24		£228.28	**£1,909.67**

Description and scale of key monetised costs by 'main affected groups'

Transitional costs: training new health and social care professionals and advocates: £11.24m [best estimate] to individuals, local authorities and the NHS.
Ongoing costs: cost of authorisations: £124.80m per year [best estimate] to local authorities and the NHS; cost of taking appeals to the Court of Protection: £87.1m [best estimate] to the Official Solicitor, Legal Aid agency and local authorities / NHS; cost of regulation and inspection: £6.94m per year [best estimate] to the regulators; costs associated with Sec 5 safeguards: £9.44m per year [best estimate] to local authorities / NHS.

Other key non-monetised costs by 'main affected groups'

None identified.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	0		£555.60	**£4,620.71**
High	0	1	£989.73	**£8,231.19**
Best Estimate	0		£772.67	**£6,425.99**

Description and scale of key monetised benefits by 'main affected groups'

No transitional benefits identified.
Ongoing benefits: reduced exposure to damages for unauthorised deprivations of liberty, £230.85m per year [best estimate] under the Liberty Protection Safeguards and £120.29m per year [best estimate] under the section 5 reforms to NHS, local authorities and other care providers; improved health outcomes as measured by the gain in QALYs, £257.29m per year [best estimate] under the Liberty Protection Safeguards and £106.64 per year [best estimate] under the section 5 reforms to NHS, local authorities and other care providers.

Other key non-monetised benefits by 'main affected groups'

Incapacitated adults: greater empowerment and equality and improved care outcomes.
United Kingdom: greater compliance with international human rights obligations.
Families and carers: greater certainty and empowerment.
NHS and local authorities: greater compliance with the law, freed up resources from efficiency gains.
Court of Protection: reduced case load leading to freed up resources and flow on benefits.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

Sensitives are detailed throughout the evidence base, as are assumptions.
Risks:

- Inadequate current compliance with the Mental Capacity Act will lead to substantial costs for the Liberty Protection Safeguards and wider reforms.

BUSINESS ASSESSMENT (Option 3)

Direct impact on business (Equivalent Annual) £m:			**In scope of OIOO?**	**Measure qualifies as**
Costs:	**Benefits:**	**Net:**	Yes/No	IN/OUT/Zero net cost

Evidence Base

1. Introduction

Background

Article 5 of the European Convention on Human Rights (ECHR) guarantees the right to personal liberty and security, and provides that no one should be deprived of their liberty in an arbitrary fashion. The Deprivation of Liberty Safeguards (DoLS), introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007, provide a legal process for authorising deprivations of liberty in hospitals and care homes.

The DoLS were a response to the European Court of Human Rights case of *HL v United Kingdom.*[1] The court held that the common law process in place did not provide the necessary procedural safeguards demanded by Article 5 of the ECHR. The DoLS were introduced in order to remedy the breaches of Article 5 outlined in *HL v United Kingdom* judgment.

The Supreme Court judgment *P v Cheshire West and Chester Council and P v Surrey County Council*[2] (known as "Cheshire West") gave a significantly wider definition of deprivation of liberty than that which had been previously understood. The Court held that a person who lacks capacity to consent to their confinement will be deprived of liberty where they are under continuous supervision and control and are not free to leave, irrespective of whether or not they appear to object to that state of affairs (subject to the deprivation of liberty being the responsibility of the state).

Since the judgment the DoLS regime has struggled to cope with the increased number of cases. In 2014/15 the Health and Social Care Information Centre reported a tenfold increase to 137,540 applications made to local authorities in England, whilst in Wales the Care and Social Services Inspectorate for Wales and the Health Inspectorate for Wales reported a 16-fold increase to 10,679 DoLS applications. In 2015/16 NHS Digital reported a further increase in the number of DoLS applications in England to 195,840.[3] Welsh data on the number of DoLS applications in 2015/16 are yet to be published, but the number is expected also to have increased. Furthermore, these figures do not capture people who are deprived of liberty in settings not covered by the DoLS, including supported living, shared lives and private and domestic settings – where the only available mechanism to provide Article 5 safeguards is via authorisation by the Court of Protection.[4] We estimate that there are around 53,000 cases involving deprivations of liberty in these settings.[5] Local authorities, NHS bodies and care providers report that they are presently unable to cope with this additional demand without significant additional resources.

Beyond resourcing issues, we have attempted to remedy further problems associated with the DoLS. In particular many problems arise as a result of the DoLS narrow focus on Article 5 of the ECHR, without encompassing safeguards for wider human rights. We have sought to remedy this by bolstering section 5 of the Mental Capacity Act to ensure adequate safeguards are put in place to protect to protect wider human rights, in particular focusing upon Article 8 of the EHCR (the right to family and private life).

In March 2014, the House of Lords Select Committee on the Mental Capacity Act published a detailed report describing various issues with the DoLS, including their complexity and inapplicability beyond care homes and hospitals, and ultimately concluded that they were "not fit for purpose". That report therefore recommended that the DoLS be replaced with a simpler system which would apply in a broader range of settings, including supported living.[6]

This project was included as part of the Law Commission's 12th programme of law reform following a

[1] (2005) 40 EHRR 32 (App No 45508/99).

[2] [2014] UKSC 19, [2014] AC 896.

[3] Healthcare Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2015-2016* (2016).

[4] At present, the DoLS only apply to hospitals and care homes. A deprivation of liberty in any other setting must be authorised by the Court of Protection. These settings could include care provided in the person's home, supported living (accommodation which has been adapted or intended for occupation of adults with needs for care and support) and shared lives accommodation (a service that normally involves placements of people in family homes where they receive care and support from a shared lives carer and have the opportunity to be part of the carer's family and support networks).

[5] We have estimated this figure by using estimates from the Association of Directors of Social Services of the number of deprivation of liberty cases in private setting placements commissioned by local authorities (see http://www.communitycare.co.uk/2015/06/17/councils-failure-make-court-applications-leaving-widespread-unlawful-deprivations-liberty-year-cheshire-west-ruling/), the numbers of persons falling under NHS continuing healthcare and estimates of the number of self-funders who would fall within our system.

[6] Consultation Paper, para 4.21.

request from the Department of Health. Ongoing meetings have taken place with the Department of Health and the Welsh Government to ensure that the Law Commission is aware of developing Government policy.

The public consultation period ran from 7 July until 2 November 2015. We attended 82 events across England and Wales and received 584 written responses from a range of different individuals and organisations (including local authority staff, health professionals, lawyers, academics and members of the judiciary).

2. Problem under consideration

The main problems associated with the DoLS are as follows:

The narrow focus on Article 5 of the ECHR

The DoLS were designed as a response to the *HL v United Kingdom* case. As a result, the DoLS provide a response to the issues raised in that case and focus on the presence of a deprivation of liberty and providing the necessary Article 5 safeguards. However, the legal concept of deprivation of liberty is often unclear for the person and their family or carers. It may also be difficult for practitioners to identify and respond to a deprivation of liberty. Most significantly, the focus on Article 5 may lead to other rights of the person and their family or carers being overlooked such as the person's Article 8 ECHR rights to a private and family life. We have recommended reform of sections 5 and 6 of the Mental Capacity Act to strengthen the protection of these.

Disconnect with the Mental Capacity Act

The House of Lords committee referred to a "disconnect" between the wider Mental Capacity Act and the DoLS, in that they are regarded as separate legislation with different histories. The House of Lords committee concluded that better implementation would not fix the fundamental problems identified with the DoLS.[7] Furthermore, there is also disconnect between the DoLS and other legal provisions governing health and social care provision. For example, the right to advocacy under the Care Act 2014 could result in a person subject to an authorisation being provided with a DoLS advocate and a Care Act advocate – for essentially similar issues – which is confusing for the person concerned and their family / unpaid carers, and is not an efficient use of resources.

Local authority conflicts of interest

There are concerns regarding the potential for conflict as local authorities acting as the supervisory body under the DoLS as well as undertaking their other statutory functions, such as commissioning the care and support which deprives the person of liberty. Similarly, a conflict may arise through safeguarding functions. In many authorities, the DoLS coordination / supervisory functions are hosted within safeguarding teams, reporting directly to the Safeguarding Adults Board, leading to the suggestion that the DoLS have been hijacked by safeguarding managers.

Limited Scope and cost ineffective

The DoLS apply only in care homes and hospitals, requiring the authorisation of deprivations of liberty outside these settings, such as in supported living and private and domestic settings, to be dealt with by the Court of Protection. This can lead to increased costs for local authorities and NHS bodies (as compared to authorisations under the DoLS), and increased stress for the person concerned and their family / unpaid carers.

Lack of oversight

The DoLS have been criticised for lacking effective oversight and monitoring. For instance, in relation to monitoring compliance with any condition attached to a standard authorisation, the DoLS do not require a specific person to undertake this role. In practice, this has been left to the best interests assessor when

[7] House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139.

reviewing the authorisation or to the "relevant person's representative" (who is often a family member). Similarly, the person faces many practical obstacles to challenging decision makers and will often be reliant on others to do so.

Length and complexity

The legislation which set up the DoLS has been described as "tortuous and complex".[8] This has meant that it has not been understood by either those administering the scheme or those subject to it. Mr Justice Charles, Vice President of the Court of Protection, described the experience of writing a judgment in a case involving the DoLS as feeling "as if you have been in a washing machine and spin dryer".[9]

Ill-suited and outdated terminology

The terminology used in the DoLS – including terms such as "standard authorisations", "managing authority" and "supervisory body" – has been criticised as cumbersome and failing to reflect modern health and social care functions. The label "Deprivation of Liberty Safeguards" is also seen as stigmatising and may make care providers reluctant to seek authorisations.

Scale of the problem

The Government's original impact assessment considered that very few people who lack capacity would need to be deprived of liberty, with expected cases beginning at 5,000 in the first year but dropping to 1,700 in the following years. On a worst case scenario, it was assumed that a total of only 21,000 people in England and Wales would be subject to the DoLS. In fact, the number of cases was initially higher than expected, with 7,157 in 2009/10. This number then rose to 11,887 in 2012/13. However, since the Cheshire West judgment there has been a significant increase in DoLS applications, as noted above, with a tenfold increase in the number of applications in England alone last year and a reported further increase this year. In addition to this, there is a building backlog of applications not completed within the year they are received by local authorities. In 2014/15 there were 315 applications carried over from the previous year. In 2015/16 however there were 50,725 applications.[10] The DoLS were designed with a relatively small number of cases in mind, and were not intended to deal efficiently with the present levels of demand.

3. Policy Objectives

The Liberty Protection Safeguards and wider recommendations have the following objectives:

Simplification

The Liberty Protection Safeguards and wider recommendations aim to be clear and accessible to all users, including the person lacking capacity, their family / carers and health and social care professionals.

Improved outcomes

The Liberty Protection Safeguards aim to ensure that people are only deprived of their liberty if this is necessary and proportionate. Regular reviews are undertaken to check on whether arrangements are in their best interest. Our wider recommendations aim to improve decision making for all those who lack the requisite capacity (for example by placing greater importance on the person's wishes and feelings).

Cost effectiveness

The Liberty Protection Safeguards aim to provide a system able to cope with the significant numbers of people deprived of liberty, in a manner that minimises costs – where appropriate – to the public sector (especially local authorities and NHS bodies).

Compliance with human rights

The Liberty Protection Safeguards provide for an authorisation process and review scheme that is Article 5

---

8 J v A Local Authority [2015] EXCOP 5 at [27].

9 House of Lords Mental Capacity Act 2005 Select Committee, Oral and Written Evidence – Volume 1 (A-K) (2014) Q293.

10 There were 246,565 active applications in 2015/16 of which 195,840 were received in the same year. Therefore the surplus applications were received in the previous year and were not completed that year.

compliant and gives effect to rights under Article 8 of the ECHR and other relevant international human rights law such as the United Nations Convention on the Rights of People with Disabilities.

A comprehensive scheme

The Liberty Protection Safeguards extend beyond hospitals and care homes, to include authorisations in a wide range of settings including supported living, shared lives schemes and domestic settings. Rather than relying on the court system, the new scheme provides a more cost effective way of ensuring authorisations can occur.

Effective interface with existing legislative regimes

The Liberty Protection Safeguards aim to establish an effective interface with existing mental capacity, mental health, social care and NHS legislation. They remove duplication of functions where these regimes overlap.

4. Rationale for intervention

The conventional economic approach to government intervention is based on efficiency or equity arguments. In particular, the Government may consider intervening if there are failures in existing government interventions (e.g. waste generated by misdirected rules). Any proposed intervention should itself avoid creating a further set of disproportionate costs and distortions.

The current legal framework establishes a compelling case for reform. There are wider societal costs that accrue from the poorly functioning legal process. If the law is difficult to understand those in need of social care and medical intervention may not engage to the full extent required. The long term implications are that delays in treatment potentially exacerbate a medical condition and impose greater costs, financial and emotional, directly on the individual concerned and their support structure and also on NHS services that now confront more significant costs of treatment.

Inefficiencies in the administration of DoLS authorisation creates wastage. This can be ill-afforded under any circumstance, let alone during a time when local authorities and the NHS face significant budgetary pressures. The upward trend of an ageing UK population inevitably increases the likelihood of longer hospital stays and demands placed on care home beds – and with it increased administrative costs to the public sector.

5. Scale and scope

The DoLS have a significant impact on a number of different people. These include older people, people with learning disabilities and people with mental health problems as well as institutions, such as the NHS and local authorities, and health and social care professionals.

The number of DoLS assessments completed by region varies significantly depending on local authority size, demographics of the local population and resources. However in 2014/15 supervisory bodies received 137,540 applications in England and 10,679 applications in Wales for a DoLS authorisation.[11] In 2015/16 in England, applications rose once more to 195,840.[12] This demonstrates a tenfold increase in England and a sixteenfold increase in Wales from 2013/14. The region which received the most DoLS applications per 100,000 adult population in England was the North East, with 900 applications. The lowest was London, with 319 applications.[13] See table 1 below providing numbers in the aggregate.

[11] Health and Social Care Information Centre, *Mental Capacity (2005) Deprivation of Liberty Safeguards (England) Annual Report*, 2014-2015 (2014) and Healthcare Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care* 2014-2015 (2015).

[12] NHS Digital, *Mental Capacity (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2015-16* (2016).

[13] NHS Digital, *Mental Capacity (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2015-16* (2016) p 9.

Table 1: Number of DoLS applications in England and Wales, 2012/13-2014/15

Year	Number of applications received [England]	Number of applications [Wales][14]	Total Number of applications in England and Wales
2015/16	195,840	N/a[15]	N/a
2014/15	137,540	10,679	148,219
2013/14	13,715	631	14,382
2012/13	11,887[16]	526	12,413

This section describes the DoLS landscape and is structured as follows:

- Section 1 outlines procedure for authorising a deprivation of liberty.
- Section 2 identifies the main stakeholders.
- Section 3 provides our assessment of the costs incurred under the following subheadings:
    - costs to managing and supervisory bodies for deprivation of liberty under DoLS;
    - costs for deprivation of liberty outside DoLS settings;
    - costs to the Court of Protection and other courts;
    - costs to the regulators;
    - cost to train professionals; and
    - costs to managing and supervising bodies incurred in legal proceedings.
- Section 4 describes the training requirements.
- Section 5 provides an explanation of the basis for options 4 and 5.

1. DoLS Procedure

The DoLS scheme is used to assess and authorise deprivations of liberty which occur in care homes and hospital settings. Deprivation of liberty also occurs outside DoLS settings, for example in supported living and private and domestic settings.[17] Below we first describe procedure under DoLS followed by procedure outside DoLS settings.

A. Deprivation of liberty in care homes and hospital settings [DoLS scheme]

The DoLS require managing authorities (the hospital or care home where the deprivation of liberty will occur) to apply to supervisory bodies (generally the local authority or, in the case of Wales, also a Local Health Board) where they propose to deprive a person of their liberty (referred to as a DoLS application). The supervisory body, on receiving a DoLS application, must arrange a series of six assessments on matters including whether the person lacks capacity, and whether it is in their best interests to be deprived of liberty, and the deprivation of liberty is necessary to prevent harm to the adult and a proportionate response to the likelihood and seriousness of that harm. At a minimum, these can be completed by a best

[14] Healthcare Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care,* various annual reports.

[15] The CSSIW and HIW joint report on DoLS is published in January. Therefore the most up to data available for the purposes of this impact assessment is 2014/15 figures.

[16] https://hansard.parliament.uk/commons/2015-06-17/debates/15061741000002/DeprivationOfLibertySafeguardsAssessments

[17] See footnote 3.

interests assessor and mental health assessor. If all the assessments are "positive" the supervisory body must authorise the deprivation of liberty (referred to as a standard authorisation). A standard authorisation must authorise a deprivation of liberty for up to one year. If it is proposed to deprive the person of liberty for a further period, a fresh DoLS application and authorisation are required. The standard authorisation may be subject to a review by the supervisory body at any time (referred to as an internal review).

In addition, in certain scenarios, an urgent authorisation may be granted in lieu of a standard authorisation request. This is typically in emergency situations, authorising the deprivation of liberty until a standard authorisation application can be completed.

To assist the person through this process, provision is made for the appointment of a relevant person's representative (RPR) and an advocate. The supervisory body must appoint the RPR as soon as practicable after a standard authorisation is given, normally following a recommendation by the best interests assessor. Their role is to support and represent the person and maintain contact. Normally, the RPR is a family member, but if there is no one able to undertake this role a paid RPR must be appointed. The duty to appoint an advocate applies when a person becomes subject to the DoLS, there is no person (other than a professional or paid carer) to consult to determine the person's best interests and a RPR has not yet been appointed. Furthermore, under the DoLS, there is a duty to appoint an advocate if an authorisation is in force, a request has been made by the person or the RPR to instruct an advocate, or the supervisory body believes that unless an advocate is appointed the person or the RPR would be unable to exercise a relevant right.

B. Deprivation of liberty outside care homes and hospital settings

Where a person is deprived of their liberty outside hospitals and care homes (for instance, supported living and private and domestic settings[18]) they are not eligible for the DoLS scheme. An application, where necessary, must be made to the Court of Protection for authorisation to deprive the person of liberty.

Similarly, people aged 16 or 17, or people whose lack of mental capacity results from a disorder of the brain (as opposed to a disorder of the mind) are not eligible for the DoLS. In such cases an authorisation from the court would be needed.

2. Key stakeholders

The main stakeholders are:

- Those lacking capacity (over the age of 16[19]) along with their family / unpaid carers;
- Health and social care professionals (such as doctors, nurses, and social workers);
- The UK Government and the Welsh Government;
- Advocacy organisations - there are estimated to be over 1,000 advocacy organisations in the UK.[20] Many are small local schemes and often user-led, whilst others are run and managed by larger charities such as Mind, Age UK and the Richmond Fellowship. Funding for advocacy comes primarily from statutory bodies, notably the NHS and local authorities. This is often supplemented by charitable funding from grant making trusts such as the Community Fund and Comic Relief;
- Providers of health and social care services, such as NHS hospital trusts, private care homes,

[18] See footnote 3.

[19] The Mental Capacity Act 2005 s 2(5) states no power under the Act is exercisable in relation to a person under 16. As our scheme will form part of the Mental Capacity Act, our scheme will only be able to authorise deprivations of liberty of persons over the age of 16. Further, in *Birmingham City Council v D* (2016) EWCOP 8, (2016) MHLO 5 it was held that a parent cannot consent to a deprivation of liberty on behalf of a child over the age of 16. Therefore at present, where this child lacks capacity, this must be authorised via the Court of Protection.

[20] Advocacy Consortium UK, *Investigation into the Feasibility and Desirability of Developing a National Strategic Framework for Advocacy* (2009).

domiciliary providers in supported living settings, and day service providers;

- NHS and local authorities - local authorities in particular have been significantly impacted by the DoLS, particularly in the current economic climate. Under the DoLS procedure, as the supervisory body in the vast majority of cases, a local authority is responsible for considering the application from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorise the deprivation of liberty. In addition, best interests assessors are typically social workers. This means many local authorities also face the costs associated with training social workers and allocating a significant proportion of their time to the completion of DoLS assessments, reducing the time available for front line social workers, which has a knock-on effect for other local authority duties. There are 174 local authorities in England and Wales.[21]

3. Costs of DoLS procedure

The following is an analysis of the costs incurred by these various groups under the present law. We have presented these costs in terms of five separate categories.

1. Managing authorities (care homes or hospitals) and supervisory bodies (either a local authority or a local health board in the case of Wales) regarding deprivations of liberty under the DoLS.

2. People who are deprived of their liberty outside hospitals and care homes (for instance, supported living and private and domestic settings) or lack mental capacity as a result of a disorder of the brain (as opposed to a disorder of the mind) and are not eligible for the DoLS.

3. Court of Protection in hearing reviews of cases under the DoLS and hearing applications for authorisation for people who fall outside the DoLS (as well as the High Court).

4. Court cases which require the involvement of the Official Solicitor, and incapacitated people and their families or unpaid carers.

5. Regulators with responsibility to monitor and report on the DoLS (the Care Quality Commission, Care and Social Services Inspectorate Wales, and Healthcare Inspectorate Wales).

<u>Basis for costs</u>

It should be noted that our analysis here estimates the annual cost that we estimate is actually being incurred currently in administering the DoLS. However, this analysis must be seen in a context in which the volume of applications and authorisations required significantly exceeds the ability of managing and supervisory bodies to process them. As a result, a large number of requests for authorisation of deprivations of liberty under the DoLS are not being processed and a growing backlog has developed, resulting in considerable delays as cases move slowly through the system. For instance, NHS Digital reports that between April 2015 and March 2016, only 46% of DoLS applications had been completed by supervisory bodies (of the 195,840 applications received, 105,055 applications were completed).[22] Of these applications, 50,725 applications were not received in the same year.[23] Compared to the 2014/2015, there were only 315 applications carried over from a previous year.[24] In addition, we have received evidence to suggest that not all deprivations of liberty are being referred for an authorisation. Hence the total number of applications reported by NHS Digital does not likely demonstrate the full capacity of the DoLS.

In addition, backlogs causing delays potentially give rise to litigation from affected persons leading to damages claims for breached rights. Currently, few people are taking legal action, however there is a high risk that with the rise in backlogs, growing numbers will be motivated to act. Under-utilisation of this facility is not presently represented in the cost of the DoLS because its effects are not being realised.

---

[21] http://www.lgiu.org.uk/local-government-facts-and-figures/#how-many-councils-are-there

[22] NHS Digital, *Mental Capacity (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2015-2016* (2016) page 15 and NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England), Annual Report 2015-16: Annex C – Applications Data Tables*, table 5.

[23] NHS Digital, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England), Annual Report 2015-16: Annex C – Applications Data Tables*, table 5.

[24] Health and Social Care Information Centre, *Mental Capacity (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2014-15: Annex A – Applications Data Tables,* table 5.

Backlogs potentially lead to harmful health consequences as required care, treatment and delivery of safeguards are delayed. Deterioration or improvement in health is measured by what is called a QALY- a quality adjusted life year. A QALY takes into account both the quantity and quality of life generated by healthcare interventions. It is assumed that the quality of life can be measured in increments along a continuum, where 1 is the best possible health state and 0 is death. The use of QALYs in resource allocation decisions gives an insight into the likely benefits that accrue under different law reform options.

Using the EQ-5D scale[25] health outcomes are measured across five dimensions (anxiety/depression, mobility, self-care, ability to perform usual activities and pain / discomfort). Each of the five dimensions has three levels, representing greater or lesser improvements, and to which coefficients are assigned to arrive at the total QALY change, where level 1 = no problem; level 2 = some problems and level 3 = major problems. The Department of Health assigns a value of £60,000 to 1 QALY.

We have sought to estimate the cost of DoLS as it is currently implemented, so as to compare our recommendations against existing costs. In arriving at the figures presented below, we have relied upon publicly available data published by Government and other bodies. In addition, where necessary, we have provided realistic estimates where data are not available. For instance, where figures are available either only for England or for Wales we have estimated a total by prorating in proportion to the populations of England and Wales. When making estimations of this kind, we have sought to include the key figures and assumptions that we have relied upon, without overburdening the document with detailed breakdowns. Some cost / saving estimates require the derivation of an hourly / daily rate. Unless otherwise indicated, we have used 225 working days to reflect the number of productive days a person would normally be expected to work assuming a 5 day working week, less 25 days holiday and 10 days public holidays / sick leave.

Improved data availability and consultee feedback have significantly bolstered our evidence base. As a result, we have revised previous cost estimates provided in our consultation paper. In particular our consultees indicated that we had significantly under-costed DoLS. Changes include providing the cost of training professionals, such as best interests assessors and advocates, adjusting the number of DoLS applications processed per year in line with more recently published information (both in England and Wales) and adjusting the number of applications made to the Court of Protection. As a result, the estimate of what the DoLS are costing at present is now significantly higher than we first estimated.

1. *Costs to managing authorities and supervisory bodies for deprivations of liberty under the DoLS*

The costs of a DoLS application and authorisation (along with associated advocacy and paid representation costs) in a care home or hospital fall on both supervisory bodies and managing authorities.

Table 2: Costs for deprivations of liberty under DoLS [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Authorisation, advocacy and representative costs – under DoLS	98.22	152.69	211.89
B. Internal review of authorisations under DoLS	2.00	3.99	6.81
C. Cost to supervisory bodies of Court of Protection review of authorisations under DoLS costs	9.01	9.78	10.63
Total [A+B+C]	**109.23**	**166.46**	**229.33**

[25] EQ-5D makes use of scores, generated across different groups, that measures the ability of the individual to function in five dimensions using three levels – no problem, some problems and major problems - making a total of 243 possible health states, to which 'unconscious' and 'dead' are added to make 245 in total.

Assumptions:

- 111,142 DoLS applications processed per year, of which 80,974 are granted.[26]
- £1,420 per granted DoLS application, with an upper estimate of £1,928 and a lower estimate of £915.[27]
- £1,250 per DoLS application which was completed, but refused, with an upper estimate of £1850 and a lower estimate of £800.[28]
- 30,168 applications completed but not granted per year; 28,525 in England and 4,592 in Wales, according to annual reports by NHS Digital and others.
- 8.5% of granted DoLS authorisations lead to an internal review (6,883 reviews). We derive this figure from the internal review rate reported by the Welsh regulators.[29]
- £580 per internal review application, with an upper estimate of £990 and a lower estimate of £290. We have assumed that the cost of such reviews will be equivalent to the present cost of the best interests assessment component of a full DoLS assessment and authorisation, as we assume that this will be the sole focus of almost all internal reviews.[30]
- 850 applications to the Court of Protection for review of a DoLS authorisation per year. We derive this figure from Court of Protection data made available to us.[31]
- £11,500 incurred by supervisory bodies per Court of Protection review, with a lower estimate of £10,600 and an upper estimate of £12,500.[32]

We do not provide any costs associated with damages claims by those deprived of liberty without authorisation because, at present, there do not appear to be significant numbers of cases brought on this basis.

1. Costs for deprivations of liberty outside DoLS settings to local authorities and the NHS

Costs are incurred by local authorities, NHS bodies, and care providers where authorisations for deprivations of liberty are sought in settings that fall outside the DoLS, for instance, supported living and private and domestic settings.

Table 3: Costs for deprivations of liberty outside DoLS settings [£ million]

[26] NHS Digital, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Annual Report 2015-16* (2016) page 15 and Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2013-14* (2015). In England, 105,055 completed applications in 2015/16 of which 76,530 granted. In Wales 6,087 applications completed. The number of granted applications is not recorded but we have used the same proportion as England (73%) which totals 4,444 applications granted.

[27] A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232. We have deducted the costs associated with Court of Protection review from the headline figure reported in this study of £1277, as these are costed below, and inflated the total figure to 2014/15 values. As this study makes no provision for the costs of a paid RPR, we have factored in a component to represent this. In doing so, we have assumed that the cost of a paid RPR will be equivalent to that of an advocate as determined by Shah (£80 when inflated to 2016 prices), and we have assumed that 25% of people subject to the DoLS will receive a paid RPR. This averages out as £20 per granted application. In arriving at our upper and lower estimates for the total figure we have used the upper and lower average costs of a DoLS authorisation reported by Shah, with our additional component for paid representatives factored in, inflated to reflect 2015/16 prices.

[28] We have assumed that this totals the cost of the mental health and best interests assessments, alongside secretarial costs, estimated in the Shah study, excluding the cost of advocacy and the Court of Protection (as a refused application will not be entitled to safeguards under the DoLS).

[29] Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2013-14* (2015) p 11. We are not aware of the internal review rate in England.

[30] A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236. We consider that the best interests component is most likely to be reviewed as mental health, capacity, age, no refusals and eligibility assessments are most likely to remain the same once they have first been assessed. Whilst in some cases this will not be the case, in the vast majority it is likely that only what is in the person's best interests will be scrutinised and likely to change.

[31] There has been a significant increase in the number of section 21.A (DoLS) appeals. In 2015 there were 432 applications but in the first four months of 2016 there were 285 applications. If applications continue on this current trend, there will be 855 applications in 2016. We anticipate this will continue to rise, so have presumed that the latest figure is the most accurate.

[32] L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html.

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. CoP authorisation costs for settings outside DoLS	14.84	16.10	17.22
Total [A]	**14.84**	**16.10**	**17.22**

Assumptions:

- 1,400 cases per year for authorisation in the Court of Protection. We take this figure from Court of Protection data made available to us.[33]
- £11,500 per case brought, with an upper estimate of £12,300 and a lower estimate of £10,600.[34]

As above, we do not provide any costs associated with damages claims by those deprived of liberty without authorisation on the basis that few such claims have been brought to date.

We have also not made allowance for cases proceeding to the High Court rather than the Court of Protection, as we do not have figures regarding the number of such cases. As a result, the figures here should be regarded as an underestimation.

2. Costs to the Court of Protection and other courts

The Court of Protection incurs costs hearing applications to authorise deprivations of liberty in settings falling outside the DoLS, and in hearing reviews of authorisations in settings within the DoLS. In addition, the courts charge court users a fee to make an application. A Ministry of Justice report shows that the fees charged by the Court of Protection broadly achieve cost recovery in cases involving deprivation of liberty.[35] Of course, those who pay these fees incur costs, and these are reflected below.

Of the cases brought to the Court of Protection, 15% are subject to further appeal in the Court of Appeal, however this court does not fully recoup its costs from court fees.[36] Despite this, we have not included costs of further appeals, as we do not have estimates for the costs of these hearings. As a result, our analysis that the courts currently incur no net cost should be seen as conservative.

3. Legal costs to incapacitated people and their families, the official solicitor and legal aid

Cases which proceed to the courts, either for authorisation or review of a DoLS authorisation, involve costs to the various parties who then become involved. These may include the Official Solicitor, and incapacitated people and their families or carers, whether self-funded or funded by legal aid.

Table 4: Cost to incapacitated people, their families, the official solicitor and legal aid [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Legal aid	19.92	28.56	37.10
B. Incapacitated people and their families or carers	13.13	19.11	25.10
C. Official solicitor	4.77	6.47	8.30

[33] There were 426 section 16 DoLS cases and 641 Re X applications in the Court of Protection in 2015. In January to Sept 2016, there were 298 section 16 cases and 1019 Re X applications. Therefore we have estimated that in 2016 there will be 1359 Re X applications and 397 section 16 cases. We have assumed that on average there are therefore 400 section 16 cases and 1000 Re X applications; a total of 1400.

[34] L Series and others, *Use of the Court of Protection's Welfare Jurisdiction by Supervisory Bodies in England and Wales* (2015) p 22 to 23. See also: L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html.

[35] Ministry of Justice, *Impact Assessment: Routes of Appeal in the Court of Protection* (2014) para 1.16 http://www.parliament.uk/documents/impact-assessments/IA14-16.pdf

[36] Ministry of Justice, *Impact Assessment: Routes of Appeal in the Court of Protection* (2014) para 1.19 http://www.parliament.uk/documents/impact-assessments/IA14-16.pdf

Total [A+B+C]	37.82	54.14	70.50

Assumptions:

- 2,250 cases proceed to the court for authorisation or review per year. We have taken this figure from Court of Protection data made available to us (see above).
- £23,800 incurred in legal costs by legal aid per case, + / - 30% to reach an upper estimate of £30,900 and a lower estimate of £16,600.[37]
- 1200 cases per year receive legal aid. All section 21A cases get non-means-tested legal aid. This accounts for 850 cases. In the remaining 1400 cases, 25% of cases which proceed to the Court of Protection require legal aid funding (350 cases per year).[38]
- £18,200 in legal costs by the person or their carers per case, with an upper estimate of £23,900 and a lower estimate of £12,500.[39]
- 1,050 cases will involve self-funded litigants; 75% of cases which proceed to the Court of Protection (excluding s.21As).[40]
- 563 cases (25% of cases) will involve the Official Solicitor, with a high estimate of 675 cases (30%) and a low estimate of 450 cases (20%). The Official Solicitor will usually become involved where the person lacks capacity to litigate and there is no other suitable person able to intervene. We were informed that in 2016 (up until September) the Official Solicitor was involved in 321 section 21A DoLS cases; out of a total of 624 section 21A cases received by the Court of Protection. We were also informed that the Official Solicitor is not usually involved in Re X cases. We do not have estimates for section 16 DoLS cases. Re X cases make up approximately 50% of all DoLS cases. Therefore if we assume section 16 and section 21A cases involve the Official Solicitor equally, this would total 25%.
- £11,500 in legal costs by the official solicitor per case. We estimate those costs as equal to those incurred by local authorities when seeking authorisation from the Court of Protection (with an upper estimate of £12,300, and a lower estimate of £10,600).[41]

4. Costs to regulators

The Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales currently incur costs in monitoring and reporting on the DoLS.

Table 5: Costs to regulators [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Conducting inspections and preparing reports	2.63	3.95	6,58
Total [A]	**2.63**	**3.95**	**6.58**

Assumptions:

37 L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html. This inflationary figure is roughly based on the range of legal costs reported as incurred by private parties. We have since been informed that this figure may be an over-estimate. However as this figure is used throughout our different options, the relative increase / decrease in the cost of legal aid should remain the same.

38 Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008).

39 L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html.

40 Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008).

41 L Series and others, *Use of the Court of Protection's Welfare Jurisdiction by Supervisory Bodies in England and Wales* (2015) p 22 to 23. See also: L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html.

- 8,352 DoLS related inspections per year. We derive this figure from the Care Quality Commission's annual report for 2015/16, which noted there were 15,293 inspections last year in adult social care locations and 516 in hospitals.[42] This is a total of 15,809 inspections in settings where a DoLS may occur. We have then reduced this by 50% to account for inspections in settings where there are no DoLS applications in place. We have then adjusted these figures to include inspections and reporting in Wales (a multiplier of 1.0566).
- £472 per inspection to regulate and monitor the DoLS. £3,149 is the total cost per inspected facility.[43] As these settings are already required to be inspected by CQC, whether or not they have a DoLS application in place, and the content of an inspection covers more than merely checking the DoLS authorisations, we have then reduced this figure to reflect the amount of time spent on DoLS. We have estimated this to be a low estimate of 10% of the total inspection time (assuming that inspections may last, on average, 2 hours and around 15 minutes) would be required to check DoLS authorisations, a high estimate of 25% (around 30 minutes) and a best estimate of 15% (approximately 20 minutes). This totals £472 per inspection (or £315 as a low estimate and £787 as a high estimate).
- We have not costed producing annual DoLS reports, but we were informed by CQC that this cost is minimal.

4. Training

Best interests assessors are required to complete a qualification course at university and then refresher training every 12 months, which can delivered by a university or training company. There is no single standard of training across England and Wales but course lengths are usually on average five days, with a further day for assessed work. This is either taught part time, one day per week, or taught in "study blocks" over the course of a week. This does not include time for further independent study.

Consultees informed us that the cost of best interests assessor training is, on average, between £1200 - £1500. This, however, does not include allowances for travel and accommodation costs, as well as the cost of taking staff away from front line work.

Training is also compulsory for advocates. All independent advocates are required to obtain the City and Guilds Level 3 Independent Advocacy Qualification (IAQ). This consists of four core units (Purpose and Principles of Independent Advocacy, Providing Independent Advocacy Support, Maintaining the Independent Advocacy Relationship and Responding to the Advocacy Needs of Different Groups of People) and at least one specialist unit, which may include Independent Mental Capacity Advocacy or training on the DoLS. This costs between £1200-£2000 per advocate. Any additional specialist unit then costs a further £550-£850.

We do not have details of training costs for paid relevant persons representatives. However, paid representatives must undertake training on the DoLS. We have assumed that this is similar to the cost of providing training for advocates.

We have therefore accounted for these costs as follows:

Table 6: Costs of training [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Costs to train best interests assessors	1.78	3.56	5.34
B. Costs to train advocates	0.09	0.19	0.28

[42] Care Quality Commission, *Annual report and accounts 2015/16* (2016) p 21.
[43] Care Quality Commission, *Annual report and accounts 2015/16* (2016) pp 47.

C. Costs to train RPRs (relevant persons representatives)	0.09	0.19	0.28
Total [A]	1.96	3.94	5.90

Assumptions:

- 111,142 DoLS applications processed per year in England and Wales, of which 80,974 are granted.
- 2,159 best interests assessors required to authorise current levels of processed DoLS applications, with a high estimate of 3,239 and a low estimate of 1,080. Best interests assessors require on average 12 hours per DoLS assessment.[44] Presuming that there are 1,800 working hours in a year and 80,974 applications are authorised per year, 540 best interests assessors working full time would be required each year. However, as best interests assessors generally work on a rota basis, we have multiplied this by four to reflect the number of assessors needed working one or two days per week. At a low estimate, we assume that best interests assessors will have greater capacity to work half weeks of two to three days a week and, at a high estimate, we assume that advocates work less than once a week.
- £1500 per new best interests assessor to provide training.
- £150 per year per best interests assessor to provide refresher training.
- £1500 to train each new advocate and paid relevant persons representative.[45] We have assumed, in line with the demand reported in an academic study authored by Shah and others, that 25% of people subject to the DoLS satisfy the statutory criteria for the right to an advocate.[46] This totals 20,244 applications. We have then assumed that only 10% of this group will take up this right to advocacy, due to lack of resources and referrals by supervisory bodies.
- 124 advocates required, with a high estimate of 186 advocates and a low estimate of 62 advocates. We estimate 27.5 hours per advocacy referral. Presuming there are 1800 working hours a year, this will require 31 advocates. However, as advocates do not always work full time, their capacity is reduced. We have presumed that on average advocates work once or twice a week. We have therefore multiplied the total number of advocates required by four to a total of 124 advocates. At a low estimate, we assume that advocates will have greater capacity to work half weeks of two to three days a week and at a high estimate we assume that advocates work less than once a week. We have made the same assumptions as for paid relevant persons representatives.

6. Public Consultation Exercise

We received a range of views from consultees. The majority of people were in favour of replacing the DoLS, and most people supported our proposed scheme – called "protective care". Consultees, especially those from the public sector, highlighted the resource constraints facing local authorities. They emphasised that any new system needs to realistically consider what local authorities, and more generally health and social care budgets, can afford.

A majority of consultees supported our proposal to create a tribunal system for reviews of DoLS cases. However, there was opposition from legal stakeholders, such as Court of Protection judges and lawyers.

Our proposal to introduce a system of supportive care, which applies before a person moves into a care home or other setting, was supported by a majority. Most consultees agreed that this scheme would help ensure that protections are delivered at an early stage and deprivations of liberty are prevented wherever possible. They also felt that the scheme would ensure greater compliance with existing legislation, such as the Care Act and Mental Capacity Act. However, some consultees were also concerned by the costs and

[44] The Deprivation of Liberty Safeguards: A Best Interest Assessor Time Study, Emma Goodall and Paul Wilkins at Cornwall Council (Nov 2015).

[45] http://www.seap.org.uk/training/cg-qualification-in-advocacy-qia/.

[46] A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232.

duplication generated by the new scheme.

We also proposed a system of restrictive care and treatment which would provide safeguards to people deprived of liberty (as well people in other situations – such as those whose contact with family members and friends is being restricted). This system would apply in care homes, supported living and shared lives accommodation, and be designed around a new professional role, the Approved Mental Capacity Professional, which would be responsible for authorisations. There would also be rights to advocacy and reviews of care and treatment. Restrictive care and treatment, as a whole, was supported by a majority of consultees. However, concerns were raised about the cost implications and whether there were a sufficient number of professionals to deliver the new scheme.

We proposed that a separate scheme for authorisations in general hospitals – whereby a person could be deprived of liberty or up to 28 days based on two medical assessments. In psychiatric hospitals we proposed that the Mental Health Act would apply to all mental health treatment necessitating a deprivation of liberty (and that a new admission process would be established in order to facilitate this). Our hospital schemes were supported by a majority at consultation, but there was some concern about the complexities of having a separate hospital scheme and whether a new Mental Health Act admission process was necessary.

7. The Options considered

We have considered four options for reform:

- Option 0 – Do nothing;
- Option 1 – The DoLS fully operationalised;
- Option 2 – Our full recommendations, including the Liberty Protection Safeguards, and reforms to sections 5 and 6 of the Mental Capacity Act 2005; and
- Option 3 – Our full recommendations (set out above), including the Liberty Protection Safeguards without referral to an Approved Mental Capacity Professional.

Option 0: Do nothing

The table below provides a summary of the key features and the identified problems with option 0.

Table 7: Option 0 – Key features and associated problems

Key features	Associated problems
A focus on deprivation of liberty	Other relevant rights are omitted
A complex interface with the Mental Health Act	Confusion amongst practitioners and inconsistent interpretation
Scope restricted to care homes and hospitals	Cases outside these settings are dealt with by courts at much greater cost
Uniform approval scheme	Fails to recognise that different cases warrant different treatment
No clear accountability for compliance with authorisations and conditions	Lack of effective oversight, and poor compliance
Relies on ill-suited and cumbersome terminology	Reluctance to make referrals and out of kilter with modern health and social care functions
DoLS designed with expectations of a relatively small number of cases	Cases are not being assessed within the required timeframes or at all, and a significant back log of cases

For the reasons already noted above, we ultimately do not consider option 0 to be a viable option. The DoLS are overly complex, and not well understood by both those subject to them and those applying them. In addition, the current system cannot keep pace with the high demand for DoLS authorisations.

Option 1: The Deprivation of Liberty Safeguards fully operationalised

Option 1 assumes that the DoLS work as intended. It would mean, for example, that assessments take place within the statutory time limits, cases are taken to court when they should be and referrals are made (when they should be) by managing authorities. This would of course require the legal system to be provided with adequate resources to allow it to keep pace with present demand for authorisations post Cheshire West. In estimating this demand we use figures reporting present numbers of applications, but appreciate that this is on the rise and so may in fact be an underestimate.

Option 1 would therefore involve a significant amount of additional funding being allocated to the DoLS in order for local authorities and care homes to be able to deal with the administrative costs of authorising deprivations of liberty in care homes and hospitals, and to the Court of Protection to process the large number of deprivations likely required outside these settings. In this way, this option would cure the current backlogs in processing applications, though would retain all of the inefficiency in the present system. It would therefore cost a hugely disproportionate amount. For this reason, it is not our preferred option.

Option 2: Our full recommendations, including the new scheme to replace the DoLS (the Liberty Protection Safeguards) and reforms to section 5 and 6 of the Mental Capacity Act 2005

Option 2 delivers our replacement DoLS scheme, called the Liberty Protection Safeguards. This scheme aims to provide the maximum benefit for the minimum cost. Following feedback from consultation the scheme will focus solely on authorising deprivation of liberty. It would also apply in all settings, including general hospitals and community settings, and would include 16 and 17 year olds, as well as those aged 18 and over.

The responsibility for authorising arrangements which would amount to a deprivation of liberty will in most cases be placed on the body responsible for commissioning or arranging the relevant care or treatment. This will generally be hospital trusts, Local Health Boards, clinical commissioning groups, or local authorities. The required evidence for an authorisation would include a capacity assessment and objective medical evidence. The body would also be responsible for ensuring that an advocate is instructed and that family members are fully involved.

The responsible body can authorise arrangements initially for up to 12 months. It would be possible for the authorisation to cover arrangements in more than one setting (for example, to enable a care home resident to be admitted to hospital).

In some cases the arrangements must be approved by an Approved Mental Capacity Professional. In very broad terms this requirement would apply mainly in cases where there is a reasonable belief that the person does not wish to move to, reside in or receive treatment at a specified location. The evidence could be provided through their actions, verbally, or by reference to previous wishes feelings, beliefs and values.

All those whose arrangements have been authorised under the Liberty Protection Safeguards would receive safeguards to secure the protection of their rights, including those under Article 5 of the ECHR (such as rights to a review, access to a court and rights to advocacy).

This scheme would not enable arrangements to be authorised for the purpose of mental health care or treatment in hospital settings. In these cases the Mental Health Act 1983 could be used.

Option 2 also includes our recommendations to reform section 5 and 6 of the Mental Capacity Act 2005.

Our reforms to sections 5 and 6 of the Mental Capacity Act 2005 would mean that professionals when undertaking certain decisions for a person lacking capacity would be provided with statutory protection against civil and criminal liability only on the basis that certain steps have been undertaken. These include supported decision making, providing a capacity assessment, documenting the best interests determination, and instructing an advocate or appropriate person. Our intention is to maintain some of the protections contained in our proposed supportive care scheme, but in a more cost effective way.

Option 3: Our recommendations including the new scheme (Liberty Protection Safeguards) without referral to an Approved Mental Capacity Professional

Option 3 retains almost all of the substantive elements of option 2, with the single exception that it does not provide for approval of the arrangements by an Approved Mental Capacity Professional. This option does

not represent our preferred option for reform. It is included because some consultees questioned whether a role similar to that currently undertaken by the best interests assessor is cost effective and provides sufficient benefits for the person concerned and their family / unpaid carers.

8. Cost benefit analysis

This impact assessment identifies both monetised and non-monetised impacts of reform, with the aim of understanding the overall impact on society and the wider environment. The costs and benefits of our proposed reform will be measured against the do nothing option, representing the cost of the DoLS at present.

Impact assessments place a strong emphasis on valuing costs and benefits in monetary terms. However, there are important aspects of the present law, and of our proposed reforms, that cannot sensibly be monetised. These might include either a positive or negative impact on care outcomes, equity, or fairness, public confidence, and flow on benefits from freed up resources.

Ultimately, the impact assessment process requires that we make an assessment of the quantifiable costs and benefits, even when there is insufficient material on which to base those calculations. As with our approach above, we have relied upon publicly available data published by Government and other bodies to inform our assessment. In addition, where necessary, we have provided realistic estimates for data that is not available. In such cases we have taken a conservative approach, and have tended to use figures that we considered likely to underestimate benefits and overestimate costs. When making estimations of this kind, we have sought to include the key figures and assumptions that we have relied upon, without overburdening the document with detailed breakdowns.

When calculating the net present values for the impact assessment we have used a time frame of ten years, with 2016/17 being year 0.[47] We have assumed that the transitional costs and benefits occur in year 0, and ongoing costs and benefits accrue in years 1 to 10. A discount rate of 3.5% has been used in all cases, in accordance with Treasury guidance.[48] Unless otherwise stated, all figures are in 2015/16 prices, and have been uprated using the GDP deflator.[49]

Option 0: Do nothing

Option 0 is the base case against which our other options are measured. This estimates the existing cost to the scheme, on the basis that only existing levels of completed DoLS applications are passing through the system.

Costs

The ongoing costs of maintaining the DoLS have been described above. There would be no transitional costs associated with their retention.

The main non-quantifiable cost of the DoLS is that people are being unlawfully deprived of their liberty in large numbers. As a result, do nothing is not a viable option as it does not address the potential breach of human rights which results from the current system.

We have costed the quantifiable costs of the DoLS above (see pages 12-17). A summary of these costs is set out below.

1. Summary of costs

The monetised costs of the current system are summarised in the table below.

Table 8: Summary of costs of DoLS at present [£million]

47 The net present value is the discounted stream of benefits less the discounted stream of costs. The present value of an annual cost is the discounted stream of that cost.

48 HM Treasury, *The Green Book: Appraisal and Evaluation in Central Government* (July 2011).

49 For presentation purposes values have been rounded to the closest £100,000, present values have been estimated on the basis of actual values.

	Low estimate (£)	Best estimate (£)	High estimate (£)
1. Cost to managing and supervisory bodies	109.23	166.46	229.33
2. Costs of deprivation of liberty outside DoLS settings	14.84	16.10	17.22
3. Legal costs to incapacitated people and their families, the official solicitor and legal aid	37.82	54.14	70.50
4. Cost to regulatory bodies	2.63	3.95	6.58
5. Training costs	1.96	3.94	5.90
Total costs (per annum)	**166.48**	**244.59**	**329.53**

Benefits

Retaining the DoLS scheme in its current format and with existing levels of funding would avoid the costs associated with our recommended reform.

Net present value

Because the do-nothing approach is compared against itself, its net present value is zero. Therefore the costs estimated above will be viewed as zero against the costs of our various options (see summary table at page 43).

Option 1: The Deprivation of Liberty Safeguards fully operationalised

Option 1 assumes that the DoLS work as intended: assessments take place within the statutory time limits, cases are taken to court when they should be and referrals are made (when they should be) by managing authorities. In estimating this demand we use figures reporting present numbers of applications, but appreciate that this is on the rise and so may in fact be an underestimate. As this option would retain all the inefficiency in the present system, it is not our preferred option.

Costs

To note, the costs of DoLS fully operationalised has changed since our consultation paper's impact assessment in line with the calculation changes made above. The estimated number of people deprived of liberty (and therefore needing an authorisation) has also been increased to reflect the changes above as well as the increase in the estimated numbers of people deprived of their liberty in hospitals and care homes and other settings.

Transitional costs

1. Training costs

A fully operationalised DoLS will involve various training costs. The increased prevalence of DoLS authorisations will mean that a number of additional health and social care professionals will need to be become familiar with the DoLS. It will also require that many more best interests assessors be trained to meet authorisation demands. Increased authorisation will also lead to greater uptake of advocacy rights, requiring that these supporters be trained.

Table 9: Training costs [£million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Training health and social care professionals	0.76	1.52	2.28
B. Training best interests assessors	2.92	5.84	8.77
C. Training advocates	1.67	3.35	5.02
D. Training paid representatives	1.67	3.35	5.02
Total [A+B+C+D]	**7.02**	**14.06**	**21.09**

Assumptions:

- 146,102 additional assessments will need to be completed per year. This reflects the total number of active applications in 2015/16 (257,244) minus the number of completed assessments (111,142). We have referred to active applications as opposed to applications received in the year in order to reflect the additional work load required to catch up with the backlog of applications.
- £22 per person to train general health and social care professionals. This reflects the costs of existing awareness training courses on the DoLS.[50]
- Our best estimate is that 69,085 doctors and social workers will require training, with a high estimate of 103,628 and a low estimate of 34,543. We estimate this figure as there are presently 233,371 registered doctors and 112,055 social care workers (88,725 in England and 23,780 in Wales).[51] We have assumed that 20% of these professionals within England and Wales would require training on the DoLS if it were fully operationalised with +/- 10% for upper / lower estimates.
- £1,500 to train a new best interests assessor.[52]
- 3,896 additional best interests assessors will be required to meet the additional number of people under a fully operationalised DoLS with a high estimate of 5,844 and a low estimate of 1,948. We have made the same assumptions as under DoLS at present using the figure 146,102 more people will receive assessments under the DoLS who would not otherwise if it were not fully operationalised (this figure represents the present reported numbers of people who have been referred for a DoLS authorisation though not yet completed in the same year). On the basis of these figures, we estimate that 974 new full time best interests assessors will be required to meet the additional demand. However, because not all best interests assessors are full time, we have assumed in practice that there will be four times as many individuals requiring training (3,896), a low estimate of twice as many (1,116) and a high estimate of six times as many (3,348).
- £1500 to train each new advocate.
- 225 new advocates will require training. We assume that there will be increasing uptake of existing rights to advocates and paid representatives amongst the additional people falling under a fully operationalised DoLS. We have assumed, in line with the demand reported in an academic study authored by Shah and others, that 25% of people eligible for the DoLS have a right to an advocate.[53] We assume that 146,102 additional people will require an assessment under a fully operationalised DoLS. This leads to a figure of 36,526 additional people having a right to an advocate. Using the same figures regarding the number of working hours in a year (1,800) and 27.5 hours per advocacy referral, we therefore assume that 56 full time advocates will be required to meet this increased demand. However, not every advocate works full time and so we have assumed that there will be a need for four times as many individual advocates (225). A high estimate would be 336 and a low estimate would be 112.

---

50 EDGE Training, http://www.edgetraining.org.uk/half-day-courses.php and http://www.edgetraining.org.uk/deprivation-liberty-safeguard.php.

51 General Medical Council, *List of Registered Medical Practitioners*, http://www.gmc-uk.org/doctors/register/search_stats.asp and Health and Care Professionals Council, *Statistics* http://www.hpc-uk.org/aboutregistration/theregister/stats/.

52 University of East London, Post-qualifying Social Work - Best Interests Assessor: Deprivation of Liberties Safeguards, see: http://www.uel.ac.uk/study/courses/pqsw-biadols.htm.

53 A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232.

- £1,500 to train each new representative.
- 225 new representatives will require training. We have made the same assumptions as regarding representatives as we have made regarding advocates.

Ongoing costs

1. Costs to managing and supervisory bodies for deprivations of liberty under the fully operationalised DoLS

If the DoLS were fully operationalised each of the costs outlined above would increase as a result of the larger cohort of people being processed.

Table 10: Costs for deprivations of liberty under the fully operationalised DoLS [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Authorisation, advocacy and representative costs – under DoLS	257.93	283.78	318.36
B. Internal review of authorisations under DoLS	3.72	7.43	12.69
C. Cost to supervisory bodies of Court of Protection review of authorisations under DoLS costs	15.98	17.34	18.84
D. Refresher courses for best interests assessors	0.29	0.58	0.88
Total annual cost [A+B+C]	**277.92**	**309.13**	**350.77**
Present value over 10 years	**2,308.93**	**2,566.07**	**2,909.94**

Assumptions:

- 206,519 applications under the DoLS each year. This is based on the total number of applications received in 2015/16 (see NHS Digital and CSSIW and HIW's annual reports).
- In estimating the increased costs associated with authorisation, internal review, and review by the courts we have used exactly the same reasoning as our calculations of the cost of the current DoLS (option 0), albeit using this increased figure.
- We have assumed that 1% of all granted applications will lead to an application to the Court of Protection. Approximately 73% of completed applications are currently granted. Therefore we expect, if all applications were completed, that 150,759 would be completed. 1% is 1,508 cases.
- £150 per year per best interests assessor to provide refresher training. 4,000 additional best interests assessors plus 2,200 existing best interests assessors (low estimate of 4,680 best interests assessors and a high estimate of 7,640 best interests assessors).

2. Costs for deprivations of liberty outside DoLS settings to local authorities and the NHS under the fully operationalised DoLS

Again, if the DoLS were fully funded, the costs outlined above would be incurred with respect to a greater cohort of people.

Table 11: Costs for deprivations of liberty outside DoLS settings under the fully operationalised DoLS [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. CoP authorisation costs for settings outside DoLS	561.80	609.50	651.90
Total annual cost [A]	**561.80**	**609.50**	**651.90**
Present value over 10 years	**4,672.27**	**5,068.97**	**5,421.60**

Assumptions:

- 53,000 people require authorisation in settings outside the DoLS. This is calculated on the basis of an ADASS study, which estimated the number of people in domestic settings potentially deprived of their liberty, uplifted to reflect that it is an underestimation, plus estimated numbers of people in continuing healthcare or self-funders.
- In estimating the cost of a single Court of Protection authorisation we have used exactly the same reasoning as above regarding the present DoLS.

3. Costs to the Court of Protection and other courts under the fully operationalised DoLS

As above, we have assumed that the fees charged by the Court of Protection broadly achieve cost recovery in these matters, meaning no additional cost would be incurred under a fully operationalised DoLS.

4. Legal costs to incapacitated people and their families, the official solicitor and legal aid under the fully operationalised DoLS

Table 12: Cost to incapacitated people, their families, the official solicitor and legal aid under the fully operationalised DoLS [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Legal aid	244.98	351.23	456.01
B. Incapacitated people and their families or carers	496.88	723.45	950.03
C. Official solicitor	115.56	156.71	201.13
Total annual cost [A+B+C]	**857.42**	**1,231.39**	**1,607.17**
Present value over 10 years	**7,130.72**	**10,240.98**	**13,366.18**

In estimating the cost under the fully operationalised DoLS, two assumptions would change. Otherwise, we have used the same assumptions outlined above.

Assumptions:

- 54,508 cases per year will proceed to the court for review of a DoLS authorisation. In estimating that number, we have used the estimated number of people who require an authorisation in settings outside the DoLS and the number of applications to the Court of Protection, estimated at 1% of granted DoLS applications (1508 cases).

5. Costs to regulators under the fully operationalised DoLS

The regulators under the fully funded DoLS will incur costs in inspecting care homes and hospitals more regularly and in taking regulatory action where appropriate.

Table 13: Costs to regulators under the fully operationalised DoLS [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Conducting inspections and preparing reports	2.89	4.54	7.89
Total annual cost [A]	**2.89**	**4.54**	**7.89**
Present value over 10 years	**24.06**	**37.73**	**65.62**

Assumptions:

- 15% greater regulatory costs will be expended under a fully operationalised DoLS as compared to the present estimated costs with +/- 10 percent for upper/lower estimates.

6. Summary of costs

The various transitional and ongoing costs are summarised in the table below.

Table 14: Summary of key costs for a fully operationalised DoLS [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
Transitional			
A. Training costs	7.03	14.06	21.09
Total transitional [A]	**7.03**	**14.06**	**21.09**
Ongoing			
B. Costs for deprivations of liberty	277.92	309.13	350.77
C. Costs for deprivations of liberty outside DoLS settings to local authorities and the NHS	561.80	609.50	651.90
D. Legal costs to incapacitated people and their families, the official solicitor and legal aid	857.42	1,231.39	1,607.17
F. Costs to regulators	2.89	4.54	7.89
Total ongoing costs [B+C+D+E+F]	**1,700.02**	**2,154.56**	**2,617.72**

Present value over 10 years	14,145.43	17,932.66	21,791.70

Benefits

Transitional benefits

We do not foresee transitional benefits.

Ongoing benefits

A fully operationalised DoLS would bring quantifiable and non-quantifiable benefits.

Non-monetised benefits would include respect for the rights of those subject to the DoLS, along with improved care outcomes as a result of the independent scrutiny brought by best interests assessors. However these benefits would be secured in an inefficient manner.

1. *Benefits of fully operationalised DoLS: hospitals and care homes*

A core quantifiable benefit will be the reduction in the risk of damages awards for unlawful deprivations of liberty. Currently only about 55% of DoLS applications are being processed in the same year, leaving many people potentially deprived of liberty without proper legal process for an extended period of time.[54] We have assumed that if local authorities keep this backlog, then 45% of applications per year will involve an unauthorised, and therefore unlawful, deprivation of liberty.

Table 15: Benefits of fully operationalised DoLS [£ million]

	Low estimate (£)	Best estimate(£)	High estimate (£)
A. Avoided risk of damage awards	52.88	79.33	105.77
Total annual benefits [A]	**52.88**	**79.33**	**105.77**
Present value over 10 years	**439.82**	**659.72**	**879.63**

Assumptions:

- £1500 per month in damages avoided for each month an unauthorised deprivation of liberty continues. In estimating this cost we note that damages will be payable only where, had the law been complied with, the person's circumstances would have been altered.[55] We assume a range from £1000 to £2000 per month of liberty lost and base this range on a recent case law damage award for a substantive breach of article 5.[56]
- 6 months average time an unauthorised deprivation of liberty will continue. We assume for the purposes of our high estimate that, in a worst case scenario, a deprivation will continue for a year unauthorised and for our low estimate, in a best case, for only 3 months.
- 8,814 unauthorised cases of deprivation of liberty per year avoided. We assume that compensation will be payable and pursued in 10% of cases of unlawful deprivation of liberty being, currently, 45% of all DoLS applications made, as noted above.

2. *Benefits of fully operationalised DoLS: other settings*

---

[54] Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 3 Return 2014-15* (2015) p 8.

[55] *Essex County Council v RF* [2015] EWCOP 1.

[56] *A Local Authority v D* [2014] EWHC B34 (COP).

Again, we anticipate that the principal benefit of Option 1 in other settings will consist of a reduced risk of damages claims for unauthorised deprivations.

Table 16: Benefits in other settings [£ million]

	Low estimate (£)	**Best estimate(£)**	**High estimate (£)**
A. Avoided risk of damage awards	42.93	45.32	47.70
Total annual benefits [A]	**42.93**	**45.32**	**47.70**
Present value over 10 years	**357.03**	**376.87**	**396.70**

In calculating the avoided damages we have used the same assumptions regarding the numbers of people deprived of liberty in settings outside the DoLS (53,000 people), the average length of a deprivation of liberty, and the average damages award.

Assumptions:

- 95% of those who are deprived of liberty in settings outside the DoLS are deprived without court authorisation (with an upper estimate of 100% and a lower estimate of 90%). This is based on the number of cases going to the Court of Protection now as opposed to our estimate of 53,000 people deprived of liberty. However, we have assumed that only 10% will go on to make an actionable claim for a substantive breach, consistent with our assumptions above regarding such claims for people in care homes and hospitals.

3. *Improved health outcomes*

It is anticipated that the extension of DoLS safeguards to cover all of those properly within the present law would bring improved care outcomes for those who would not otherwise have been assessed. We do not anticipate benefits for those who *would* have been assessed under the current level of operation, as they will not be treated any differently.

For each person subject to the fully operationalised DoLS who would not otherwise have been assessed under the current regime (79,502 people), we assume that there may be a small improvement to the person's care across various dimensions (anxiety/depression, mobility, self-care, usual activities and pain/discomfort). However, as we are not in a position to estimate the different benefits that might accrue to different cohorts across different dimensions, we have instead taken a broader approach, and simply assumed that 30% of those who would not have been assessed under the present regime would enjoy a small benefit to the usual activities dimension (with a lower estimate of 20% of people and an upper estimate of 40% of people). Using the EQ-5D model we have estimated that on average there will be a 0.058 gain (an improvement from level 3 (major problems) to level 2 (some problems) across the usual activities dimension for these various cohorts. This improvement represents the second smallest improvement in the QALY dimension that yields the smallest gain. This approach serves to keep these estimates conservative.

Table 17: QALY benefits from a fully operationalised DoLS [£ million]

	Low estimate	**Best estimate**	**High estimate**
A. No. of people with delayed assessments	79,502	79,502	79,502
B. Percentage of A affected	20.0	30.0	40.0

C. Number of people affected	15,900	23,851	31,801
D. QALY coefficient value	0.058	0.058	0.058
E. Value per person under the scheme **[Cx£60,000]**	£3,480	£3,480	£3,480
F. Total QALY value [CxE]	**£55.33**	**£83.00**	**£110.67**
G. Present value over 10 years	**£460.19**	**£690.28**	**£920.37**

4. *Summary of benefits*

The various transitional and ongoing benefits are summarised in the table below.

Table 18: Summary of key benefits [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Avoided risk of damage awards: hospitals and care homes	52.88	79.33	105.77
B. Avoided risk of damage awards: other settings	42.93	45.32	47.70
C. QALY gain	55.33	83.00	110.67
Total annual benefits [A+B+C]	**£151.15**	**£207.65**	**£264.14**
Present value over 10 years	**£1,257.03**	**£1,726.87**	**£2,196.7**

Option 2: the Liberty Protection Safeguards and wider recommendations

Option 2 includes our recommended replacement scheme for the DoLS and wider reforms to sections 5 and 6 of the Mental Capacity Act 2005. This option is costed in three parts to highlight the cost of each aspect of our recommendations, setting out the associated transitional and ongoing costs and benefits in turn. The summary table at the end of this option then shows the total cost of the scheme.

Part 1: the Liberty Protection Safeguards

Costs

Transitional costs

1. Training costs

The Liberty Protection Safeguards will require several professionals to be retrained, to ensure they can adequately implement the reforms. This includes health and social care professionals, advocates and new Approved Mental Capacity Professionals.

Table 19: Training costs under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Training of health and social care professionals	0.37	0.74	1.12
B. Training Approved Mental Capacity Professionals	0.02	0.10	0.27

C. Training advocates	4.72	10.50	17.31
Total annual costs	**5.11**	**11.34**	**18.70**

Assumptions:

- 228,000 people will require an authorisation under the new scheme during one year. This is estimated on the basis of existing figures re the number of DoLS applications, estimates of the number of 16 and 17 year olds who will fall under our scheme and the number of deprivation of liberty applications we would expect to occur in other settings.
- £22 per health and social care professional trained. This assumption is consistent with that made regarding training under the fully operationalised DoLS and reflects the costs of existing awareness training courses on the DoLS.[57]
- 33,856 doctors and social workers will require training. We estimate this figure as there are presently 238,498 registered doctors and 100,062 social care workers (93,962 in England and 6,100 in Wales).[58] We have assumed that a range of these professionals within England and Wales will require training regarding the Liberty Protection Safeguards (10% as a best estimate, and 5% as a lower and 15% as an upper estimate).
- 684 Approved Mental Capacity Professionals will be required to meet demand (see table 22), with a high estimate of 1806 and a low estimate of 123.
- £1,200 to train each new Approved Mental Capacity Professional.[59] 68 new Approved Mental Capacity Professionals will require training. This represents 10% of total Approved Mental Capacity Professionals. It is presumed that 90% of all Approved Mental Capacity Professionals will be recruited from existing best interests assessors. We have assumed that the content of Approved Mental Capacity Professional courses will have significant overlaps with current best interests assessor training. Therefore, existing best interests assessors will not require the standard training and instead will attend a “conversion course”.
- £250 per Approved Mental Capacity Professional conversion course. This would be for existing best interests assessors who wanted to undertake this new role and would resemble best interests assessor’s refresher courses. Refresher courses cost on average £150 but we have presumed, as this will be introducing new legislation, this will likely cover a wider range of content than refresher courses at present and therefore have increased the cost accordingly.
- £1500 to train each new advocate.[60] It is assumed that the training cost under the new scheme will be equivalent to the cost of training a person as a DoLS advocate.[61]
- 6,995 new advocates will require training, with a high estimate of 11,541 and a low estimate of 3,148. This figure is obtained from the numbers of advocates required both to support the person when there is no appropriate person, and to support the appropriate person (see below). As a high and low estimate, we have assumed that the total number of applications will be +/- 10%.
- We have assumed, in line with the demand reported in an academic study authored by Shah and others, that 25% of people eligible for the new scheme have a right to an advocate (where there is no appropriate person).[62] We have assumed that advocacy referrals will take 27.5 hours on average. Assuming that there are 1,800 working hours a year, we have calculated that 3,483

57 EDGE Training, http://www.edgetraining.org.uk/half-day-courses.php and http://www.edgetraining.org.uk/deprivation-liberty-safeguard.php.

58 General Medical Council, *List of Registered Medical Practitioners*, http://www.gmc-uk.org/doctors/register/search_stats.asp; Health and Care Professionals Council, *Statistics* http://www.hpc-uk.org/aboutregistration/theregister/stats/; and Care Council for Wales, *Facts and Figures of the registered workforce* http://www.ccwales.org.uk/profiles-of-the-registered-workforce/.

59 This is calculated on the basis of current best interests assessor training, which lasts approximately five days and costs between £600 and £1500.

60 http://www.seap.org.uk/training/cg-qualification-in-advocacy-qia/.

61 This figure is to train a person with no experience to the level of a current DoLS advocate, so includes the cost of the four core units 301 – 304 and the specialist unit 310 (providing Independent Mental Capacity Advocacy – Deprivation of Liberty Safeguards). It may be that current advocates trained in other specialisms could sit a further specialist module to qualify as an advocate under the new scheme, which would be significantly cheaper. It is assumed, however, that there is no capacity among advocates to train in other areas, and thus that advocates will need to be trained from scratch. This assumption is made as a result of feedback at consultation, where it was explained that there is a shortage of advocate across all areas of specialist advocacy.

62 A Shah and others, ‘Deprivation of Liberty Safeguards in England: Implementation Costs’ (2011) 199 *The British Journal of Psychiatry* 232.

advocates will be required to support the person (a high estimate of 5748 and a low estimate of 1568).

- In addition, under the new scheme appropriate persons (who is appointed to represent and support the person and, where appointed, means the person does not require an advocate) will have the right to an independent advocate to support them. 75% of people will have an appropriate person (or will refuse an advocate). Of this cohort, it is likely that a significant number will have an independent advocate supporting the appropriate person. We have assumed that two thirds of appropriate persons will receive an advocate to support them. The time taken for this type of advocate will be much less than for the independent advocate supporting the detained person – much of the work can be undertaken by the appropriate person, once their rights have been explained. It is assumed that the time taken for this type of advocacy will be half of that required for advocacy supporting the person when there is no appropriate person: 14 hours. Assuming that there are 1,800 working hours a year, we have calculated that 3,511 advocates will be required to support the appropriate person (a high estimate of 5,793 and a low estimate of 1,580).

2. Costs of recruitment

Costs will be incurred as Lead Approved Mental Capacity Professionals (the person responsible for a team of Approved Mental Capacity Professionals in each local authority) are recruited.

Table 20: Recruitment costs under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Recruitment of Lead Approved Mental Capacity Professionals	0.01	0.02	0.05
Total annual costs	**0.01**	**0.02**	**0.05**

- £22,620 to recruit Lead Approved Mental Capacity Professionals in 10% of local authorities. We have assumed that 90% of local authorities will have sufficient management structures in place to accommodate the new role, adapting either a DoLS Lead role or other safeguarding management equivalent. We have assumed it would cost on average £1,300 per recruitment process. There are 174 local authorities in England and Wales, so 10% would be 17.
- As an upper and lower estimate, we have assumed 20% and 5% of local authorities will need to recruit a Lead Approved Mental Capacity Professional.

Ongoing costs

1. Costs of the authorisation process

The authorisation process will involve initial and ongoing assessment, advocacy and internal review costs. Authorisation costs can be broken down into the cost of conducting assessments (i.e. the assessments of mental health and mental capacity, and whether the detention is necessary and proportionate) and administrative costs.

Table 21: Costs associated with the authorisation process under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Cost of assessments	52.94	58.82	64.71
B. Cost of administration	28.73	31.92	35.11

B. Cost of review	1.11	1.23	1.35
C. Cost of advocacy	29.55	32.83	36.12
Total annual costs	**112.33**	**124.80**	**137.29**
Present value over 10 years	**934.18**	**1,037.97**	**1,141.77**

Assumptions:

- 228,000 people will require an authorisation under the new scheme during one year. As a high and low estimate we have presumed that +/- 10% people will require an authorisation under our scheme.
- £258 per person for the average cost of conducting assessments. We have assumed that the cost of conducting assessments under the new scheme will be significantly lower than the current cost under the DoLS.
- £15 is the average cost of a mental health assessment under the new scheme. The cost of a mental health assessment under the DoLS is £102. The Shah study estimates that the cost of the mental health assessor under the DoLS is £336 per assessment, but this includes the mental health assessor also undertaking the mental capacity assessment, as well as the mental health assessment.[63] We have assumed that the mental capacity assessment takes three times longer than the mental health assessment, and have calculated the cost of the mental health assessment alone on this basis. The cost of the mental health assessment under the new scheme needs to be reduced to take into account reliance on equivalent assessments. We have estimated that 85% of people will have previous mental health assessments which can be relied upon. The estimate is based on informal soundings taken from a small number of best interests assessors and evidence from consultation responses. The cost of a mental health assessment under the DoLS has been reduced accordingly.
- £135 is the average cost of the assessment of whether the detention is necessary and proportionate. The cost of a best interests assessment under the DoLS is £406. The Shah study estimates that the cost of the best interests assessor under the DoLS is £550 per assessment, but this includes the best interests assessor also undertaking the mental capacity assessment, as well as the best interests assessment. We have assumed that the best interests assessment takes three times longer than the mental capacity assessment, and have calculated the cost of the best interests assessment alone on this basis.
- £108 is the average cost of the mental capacity assessment under the new scheme. The cost of the mental capacity assessment under the DoLS has been estimated in the same way as the best interests assessment, and is the other part of the cost of a best interests assessor (£144). The cost of the mental capacity assessment under the new scheme needs to be reduced to take into account reliance on equivalent assessments. We have estimated that 25% of people will have previous mental capacity assessments which can be relied upon. The estimate is based on informal sounding from a number of practitioners and evidence from consultation. The cost of a mental capacity assessment under the DoLS has been reduced accordingly.
- £140 is the cost of administrative time per authorisation. The Shah study estimated the cost in secretarial terms in a DoLS authorisation to be £280.[64] The new scheme will integrate assessments and reviews into existing care planning processes or treatment care plans (as far as possible), which should improve the efficiency in dealing with assessments. This should be a less intrusive assessment. We have, therefore, decreased the secretarial costs per assessment under the new scheme by 50%.
- £5.40 is the average cost of review per authorisation. We have estimated the cost of a review to be £90, and that 6% of authorisations will lead to a review. We assume that the review will generally consider whether the detention is necessary and proportionate which costs £135. The review

[63] A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

[64] A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

process under the new scheme will be integrated where possible with existing care planning processes, for example those under the Care Act, and will be less bureaucratic. This will lead to cost savings. We think that the figure above should be reduced by one third to reflect this. The cost of review will therefore be £90. In Wales, 8% of DoLS authorisations led to a review in 2013 to 2014.[65] In 2014 to 2015, the number of DoLS authorisations leading to a review dropped to 1%.[66] In England, 4% of DoLS authorisations led to at least one review in 2014 to 2015.[67] We have estimated the percentage of review somewhere between these numbers at 6%.

- £144 is the average cost of advocacy per authorisation. The Shah study estimated the average cost of advocacy to be £72 per authorisation (this did not include an estimate of the cost of paid relevant person's representatives which would make the average cost £144; we have assumed that the paid relevant representative costs the same as an Independent Mental Capacity Advocate and is appointed in 25% of cases).[68] This is an average over assessments, so takes into account the fact that an independent advocate is not appointed in every situation. It was estimated that 25% of cases are referred to an Independent Mental Capacity Advocate. The cost per Independent Mental Capacity Advocate is therefore £288. Under the new scheme, it is likely that referral to independent advocates (when there is no appropriate person) will remain the same at 25%. The cost of an independent advocate (when there is no appropriate person) will be equivalent to the cost estimated in the Shah study: £72. In addition, under the new scheme appropriate persons will have the right to an independent advocate to support them. 75% of people will have an appropriate person (or will refuse an advocate). Of this cohort, it is likely that a significant number will have an independent advocate supporting the appropriate person. We have assumed that two thirds of appropriate persons will receive an advocate to support them. This is equivalent to 50% of the total cohort of people deprived of liberty. The cost of this type of advocate will be much less than the independent advocate supporting the detained person – much of the work can be undertaken by the appropriate person, once their rights have been explained. It is assumed that the cost of this type of advocate will be half the cost of the IMCA: £144. Averaged over all authorisations, the cost is £72. The total average cost of advocacy will be the two figures for the different types of advocate added together: £144.

2. Costs of approval by an Approved Mental Capacity Professional

The costs of approval by an Approved Mental Capacity Professional will comprise the cost of employing an Approved Mental Capacity Professional, the cost of employing a Lead Approved Mental Capacity Professional in each local authority, and the cost of providing refresher training for Approved Mental Capacity Professionals.

Table 22: Costs of approval by an Approved Mental Capacity Professional under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of approval by an Approved Mental Capacity Professional assessments	2.44	6.78	11.93
B. Cost of Lead Approved Mental Capacity Professional	0.35	0.59	0.84
B. Cost of repeat assessments	0.05	0.14	0.24

65 Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2013-14* (2015) p 1.
66 Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales, *Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2014-15* (2016) p 12.
67 Health and Social Care Information Centre, *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England) Annual Report 2014-15* (September 2015) p 28.
68 A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

C. Cost of refresher courses	0.02	0.10	0.27
Total annual costs	**2.86**	**7.61**	**13.28**
Present value over 10 years	**23.79**	**63.29**	**110.44**

Assumptions:

- 57,000 applications will require approval by an Approved Mental Capacity Professional. We assumed that 25% of the total authorisations under the Liberty Protection Safeguards will require such approval. We were informed by the Association of Directors of Adult Social Services that referrals would be required in 30% of existing DoLS assessments. However, this would only apply to hospitals and care homes. We think 25% of all cases (including in other settings as well as care homes and hospitals) would require a referral, once you take these settings into account, as we assume individuals are less likely to want to leave or move from the setting if it is their own home.
- As a high and low estimate, we have assumed that between 10% and 40% of total authorisations will require approval by an Approved Mental Capacity Professional, with total authorisations adjusted as above to be +/- 10% for high and low estimates.
- 5.4 hours per case. This is estimated from the Cornwall Council best interests assessor time study.[69] This includes a breakdown of the time it takes a best interests assessor to complete particular parts of a DoLS assessment. We have selected the relevant parts of the study for the Approved Mental Capacity Professional's role; 66 minutes travelling, 90 minutes prior to the visit gathering information or consulting with others, 126 minutes with the person and gathering information and 42 minutes giving feedback to the relevant body (in this case, the commissioning body).
- 684 Approved Mental Capacity Professionals will be required to meet demand, with a high estimate of 1,806 and a low estimate of 123. We estimate that there are 1,800 working hours in a year and each assessment takes 5.4 hours. We also assume that the Approved Mental Capacity Professional role to be similar to the best interests assessors role, and therefore it is unlikely this will be filled by full time staff. Instead professionals would work on a rota basis, perhaps one or two days a week. Therefore we have multiplied this by four to reflect this decreased capacity, by six for a high estimate and by two for a low estimate.
- We have assumed that Approved Mental Capacity Professionals will be recruited from existing staff in the commissioning body (i.e. social workers or other professions) so there are no associated recruitment costs or costs to the employer.
- £119 per approval by an Approved Mental Capacity Professional. Estimated from the average salary of best interests assessors (£22 per hour) multiplied by 5.4 hours. We have estimated average salary by using figures received at consultation, which informed us that best interests assessors are currently AFC band 6 within the NHS. AFC band 6, as of 1 April 2016, is a wage of between £26,302 and £35,225. This matches the salary of best interests assessors jobs advertised online. As a best estimate (an average of these costs) an Approved Mental Capacity Professional could earn £30,764. If we presume that there are 1,800 working hours in a year, then a full time Approved Mental Capacity Professional would be earning £17 an hour, uplifted by 30% to reflect the whole employment cost to a total of £22 per hour.
- 5% of cases will be "repeat assessments". This is where the Approved Mental Capacity Professional considers that an authorisation cannot be given, on the basis that one or more of the assessments is incorrect or unlawful. In these cases, the responsible body may have to go back and complete the relevant assessment. The Approved Mental Capacity Professional will then decide whether or not to approve the arrangements once more. We estimate that this would only occur in a small number of cases, as in most instances we would expect the responsible body and Approved Mental Capacity Professional to liaise beforehand informally on such matters. Furthermore, this rate may be higher in the short term, as responsible bodies become experienced in undertaking their function and

[69] The Deprivation of Liberty Safeguards: A Best Interest Assessor Time Study, Emma Goodall and Paul Wilkins at Cornwall Council (Nov 2015).

arranging proper assessments. We expect that in the long term, this rate will drop considerably. We estimate the cost will be 50% that of current assessments (see above): £48.50.

- £150 per refresher course.[70] All Approved Mental Capacity Professionals will be required to complete refresher courses each year. We assume that this will be similar to existing courses and therefore cost the same.
- £2615 per annum per Lead Approved Mental Capacity Professional. This reflects the average 8.5% salary bonus likely to be granted on promotion. This is assumed as currently Lead Approved Mental Health Professionals earn the same as Approved Mental Health Professionals (an average of £36,378; an upper limit of £41,373 and a lower limit of £31,383) plus a bonus. This varies from 5 to 12%. If the average salary of an Approved Mental Capacity Professional is therefore £30,764, a Lead Approved Mental Capacity Professional would earn a £2615 bonus for the role. As a high estimate, we have assumed the salary bonus will be 12% (£3,692) and as a low estimate, 5% (£1,538). Uplifted to include the whole employment cost, this is a best estimate of £3,400, a low estimate of £2,000 and a high estimate of £4,800.

3. Costs to the Court of Protection and other courts under the Liberty Protection Safeguards

As above, we have assumed that the fees charged by the Court of Protection broadly achieve cost recovery in these matters, meaning no additional cost would be incurred under the Liberty Protection Safeguards.

4. *Legal costs to incapacitated people and their families, the official solicitor and legal aid under the Liberty Protection Safeguards*

Table 23: Cost to incapacitated people, their families, the official solicitor and legal aid under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost to supervisory body for Court of Protection reviews	24.2	26.2	28.5
B. Legal aid	37.8	54.3	70.5
C. Official solicitor	4.8	6.6	8.4
Total annual cost [A+B+C]	**66.8**	**87.1**	**107.4**
Present value over 10 years	**555.96**	**723.87**	**892.91**

In estimating the cost under the Liberty Protection Safeguards, several assumptions would change. Otherwise we have used the same assumptions outlined above in the DoLS at present and the DoLS fully operationalised.

Assumptions:

- 1% of total authorisations under our scheme will result in an appeal (2,280 appeals per annum).[71]
- All these cases will be entitled to non-means-tested legal aid and the Official Solicitor will continue to be involved in 25% of cases.
- Unlike under the DoLS (at present or fully operationalised), there will be no costs to the supervisory

[70] This figure is derived from publically available information online of refresher training courses. See for example http://www.sanctuarytraining.com/collections/courses/products/bia-refresher.

[71] This reflects the Lucy Series study which estimates 1.3% of DoLS cases would be appealed to the Court of Protection and the existing uptake for s21A appeals (far less than 1% at present but uplifted on the assumption that our scheme will encourage more cases to go to the court).

body to take deprivation of liberty cases outside DoLS settings to the Court of Protection, as our scheme is not setting-specific.

There will also be no cost to incapacitated persons / carers / families as they would be entitled to non-means-tested legal aid under our new scheme.

5. Costs to regulators

The regulators will incur costs through the expansion of their regulatory remit, as a result of our scheme applying to a wider range of settings and to 16 and 17 year olds. In many cases it may that these settings are already regulated by the DoLS regulators and / or Ofsted / Estyn. In other cases, these settings will not be covered by the existing regulatory remit of these bodies. In both, there will be new requirements to monitor deprivation of liberty applications under our scheme, which will result in associated costs.

Table 24: Costs to regulators under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Conducting inspections and preparing reports in care homes and hospitals	4.63	6.94	11.57
Total annual cost	**4.63**	**6.94**	**11.57**
Present value over 10 years	**38.51**	**57.70**	**96.21**

Assumptions:

- There were 15,809 inspections in adult social care provider and hospital settings in England, increased to reflect Welsh population to 16,704. We assume that, as our scheme will apply to all settings, there will be a greater proportion of inspections occurring in settings with DoLS authorisations in place. Therefore, rather than reducing by 50% we have only reduced by 20% (a total 12,647).
- £472 per inspection in a care home or hospital. This relies on data from the CQC, reduced to reflect the time spent inspecting DoLS (with upper and lower estimates of £315 and £787).
- In the remainder of settings, we anticipate regulation will be "light touch" and not necessarily require inspections. Instead, we have assumed regulation may involve merely monitoring DoLS applications and reporting on these annually. Therefore, we have assumed that this will increase the total cost of regulating the DoLS by no more than 10%.

6. Summary of costs

The various transitional and ongoing costs are summarised in the table below.

Table 25: Summary of costs under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
Transitional			
1. Training costs	5.11	11.34	18.70
2.Recruitment costs	0.01	0.02	0.05
Total transitional	**5.12**	**11.36**	**18.75**
Ongoing			

1. Authorisation process	112.33	124.80	137.29
2. Approval by an Approved Mental Capacity Professional	2.86	7.61	13.28
3. FTT / COP	66.8	87.1	107.4
4. Regulation	4.63	6.94	11.57
Total ongoing costs	**186.62**	**226.45**	**269.54**
Present value over 10 years	**1,552.43**	**1,882.85**	**2,241.34**

Benefits

Transitional benefits

We do not foresee transitional benefits.

Ongoing benefits

We envisage the Liberty Protection Safeguards will bring both ongoing quantifiable and non-quantifiable benefits.

We anticipate a number of unquantifiable benefits. Firstly, we anticipate that because the scheme will be simpler to understand and apply, and will be viewed as conferring practical benefits to those subject to it, it will enjoy more consistent compliance. In turn, this should lead to benefits for public confidence in the social and health care system and the rule of law generally.

Secondly, we assume that there will be a number of unquantifiable benefits arising from the freeing up of various state and other resources by the more efficient authorisation scheme. For instance, expanding the Liberty Protection Safeguards to cover a wider range of settings than just hospitals and care homes will remove many cases from the Court of Protection, freeing up time and resources for other cases and allowing more a more efficient judicial system. Similar flow on benefits can be expected regarding freed up local authority resources, by allowing responsible bodies to be both local authorities and NHS bodies.

We also anticipate a number of quantifiable benefits. First, a quantifiable benefit will flow from the avoided risk of damages claims for unlawful deprivations of liberty in the various settings to which the scheme applies. We set out these benefits, as they accrue, in each of these settings.

Second, and most importantly, we consider that the scheme's proactive approach to monitoring and authorising care and treatment, and its strengthening of the role of the person in making decisions regarding their own care, will lead to improved care outcomes and will ultimately serve to reduce the need for restrictive care and treatment and for deprivations of liberty. We seek to quantify these improved care outcomes using the QALY methodology.

1. Benefits of the Liberty Protection Safeguards

The Liberty Protection Safeguards will bring significant quantifiable and non-quantifiable benefits to a range of people. The streamlining of the role of commissioning authorities will free resources up to be used elsewhere. By requiring Approved Mental Capacity Professionals to approve arrangements that give rise to a deprivation of liberty only in certain key cases, the system will considerably free up resources. Currently, a similar role is undertaken by best interests assessors who are required to carry out an assessment in all cases, even when an assessment is not necessary or appropriate. Similarly, enabling front line professionals to complete assessments, as well as utilising existing and previous assessments, and allowing authorisations to apply across multiple settings, will cut out a significant portion of duplicated work in the present system, again freeing up resources.

There will also be the reduction in the risk of damages awards for unlawful deprivation of liberty. This is so

because currently only 46% of DoLS applications are being processed, leaving many people potentially deprived of liberty without proper legal process.[72] Also, we have heard that in settings outside the DoLS there are presently potential deprivations of liberty not being authorised, potentially as a result of backlogs in the Court of Protection. As above, damages will be payable only where, had the law been complied with, the person's circumstances would have been altered.[73]

Table 26: Avoided risk of damages under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Avoided risk of damages	192.30	288.45	384.60
Total annual benefit [A]	**192.30**	**288.45**	**384.60**
Present value over 10 years	**1,599.28**	**2,398.92**	**3,198.57**

Assumptions:

- 228,000 people will be subject to the Liberty Protection Safeguards, of which 128,200 will have otherwise been unlawfully deprived of liberty.
- 45% of people under the new scheme who fell under the DoLS would otherwise have been unlawfully deprived of liberty (77,850).
- 95% of people under the new scheme who fell outside DoLS settings would otherwise have been unlawfully deprived of liberty (50,350).
- 25% of those who are unlawfully deprived of liberty will have actionable claims and will pursue those claims (32,050).
- £1500 per month of liberty lost avoided in damages. We assume a range from £1000 to £2000 per month of liberty lost.
- 6 months average deprivation of liberty avoided.

2. Improved health outcomes

We consider that the Liberty Protection Safeguards will result in improved care outcomes across three distinct groups.

- Those who would not have been assessed under the current regime;
- Tangible benefits for those who would have nevertheless been assessed under the old regime, as a result of the expansion of the authorisation and associated safeguards to a wider range of settings. For this cohort we expect that, even where similar care would be offered to that under the current regime, the greater involvement of the person and simpler process should, we think, produce care outcome gains; and
- Those who would have received treatment under the previous scheme but will also benefit from approval from an Approved Mental Capacity Professional.

We anticipate that for those who would not have been otherwise assessed under the current regime, but will be assessed under the Liberty Protection Safeguards (55,500 people) there will be a moderate increase across one of the various QALY dimensions resulting from the improved care coming from the various assessments. This is consistent with our modelling for the fully operationalised DoLS scheme. Because we are unable to model the different cohorts likely to receive improved outcomes across the different dimensions, we have again taken a broad approach and included an uplift to the proportional benefit received under option 1 and assumed that 50% [best estimate, +/- 10% for high/low estimates] of all of those who would not have been assessed under the old regime will enjoy 0.058 gain (a change from level 3 (major problems) to level 2 (some problems) using the EQ-5D scale) across the usual activities dimension. The usual activities dimension has been chosen as it yields the second smallest gains for a change in level as compared to the other dimensions, keeping the overall estimate conservative.

In addition, we assume that all of those subject to the new scheme who *would* have been assessed under

---

72 Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Annual Report 2014-15* (2015).

73 *Essex County Council v RF* [2015] EWCOP 1.

the present regime (115,463 people), will enjoy some improvement in their care as a result of the improved process under our proposed new scheme. There are two issues of relevance here – the group with delayed access who now benefit from timely intervention, and improved systems and procedures from which the entire cohort benefits. We have assumed a marginal improvement of 40% as a best estimate [relative to 30% under option 1], and +/- 10% for high/low estimates.

Those receiving approval from an Approved Mental Capacity Professional (57,000 people) experience the greatest gain from more rigorous assessment and follow-up care. Based on comprehensive consultation responses we believe a very high proportion of this group (80% - best estimate, +/- 10% for high/low estimates) will experience a wider range of health outcomes. For this reason, the QALY gain in the usual activities dimension is the midpoint between a one level improvement from L3 to L2 and a two level improvement from L3 to L1.

Table 27: Annual QALY benefits under the Liberty Protection Safeguards [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. QALY benefit for those receiving a new assessment	77.26	96.57	115.88
B. QALY benefit for those who would have received a DoLS assessment	120.54	160.72	200.91
C. QALY benefit to enhanced group	138.85	214.09	289.33
Total QALY value [A+B+C]	**336.65**	**471.39**	**606.12**
Present value over 10 years	**2,799.80**	**3,920.33**	**5,040.87**

The summary of key monetised benefits is listed in table 28 below.

Table 28: The Liberty Protection Safeguards - Summary of annual key benefits [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Avoided risk of damages	192.30	288.45	384.60
B. QALY gain	336.65	471.39	606.12
Total annual benefit	**528.95**	**759.84**	**990.72**
Present value over 10 years	**4,399.07**	**6,319.29**	**8,239.43**

Part 2: Reforms to sections 5 and 6 of the Mental Capacity Act 2005

Costs

Transitional costs

We consider that there may be some transitional training costs associated with these reforms for health and social care professionals. However, as these reforms involve applying existing Mental Capacity Act principles, we have assumed that this should be absorbed into training on the existing Mental Capacity Act and the reforms introduced by the draft Bill will be taken up by front line staff, as costed under the new scheme's authorisation process' ongoing costs.

Ongoing costs

1. Costs of safeguards

The section 5 reforms will involve administrative, assessment, care planning and advocacy costs.

Table 29: Costs associated with amended section 5 safeguards [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of capacity assessments	5.40	8.10	10.80
C. Cost of care planning	0.67	1.34	2.00
Total annual costs	**6.07**	**9.44**	**12.8**
Present value over 10 years	**50.48**	**78.51**	**106.45**

Assumptions:

- 267,295 people will be entitled to section 5 safeguards. We estimated this using our figures in the consultation paper impact assessment for supportive care and restrictive care and treatment. There were 206,010 individuals with active DoLS applications in 2015/16 and 122,570 in supportive care. In order to reflect the overlap highlighted to us by consultees (i.e. the number of people who we assumed would fall into supportive care, but it was argued would in fact be deprived of their liberty and therefore fall into restrictive care and treatment), we have reduced the number of people in supportive care by 50%.
- Of these, we have assumed that the 206,010 individuals who have had their arrangements authorised under the Liberty Protection Safeguards will already have received supported decision making, a capacity assessment and a best interests determination. Costs for these elements have been calculated on the basis of the remaining 61,285 individuals. As a high estimate, we have assumed this will be 75,000 people, at a low estimate 50,000 people.
- We have assumed that the cost of ensuring, as far as possible, supported decision making and proper best interests determinations should be minimal as this is what is required of professionals to ensure Mental Capacity Act compliance.
- Training in the Mental Capacity Act should cover the need for decisions to be made in the person's best interests (and for particular weight to be given to wishes and feelings). Therefore we have assumed that there will be minimal additional costs as a result of this requirement.
- 75,000 persons will need a capacity assessment. We have inflated the total number of individuals to reflect the fact that capacity assessments are decision specific. However, in the vast majority we anticipate that the assessment will consider capacity to consent to care and treatment on the whole (covered by DoLS capacity assessments). We costed a capacity assessment under the new authorisation scheme at £108. This totals £8,475,000. At a high estimate 100,000 people will need a capacity assessment, at a low estimate 50,000.
- As advocacy is only required under these reforms if the individual is already entitled to an advocate under another statutory provision, we consider that the cost of advocacy should not be attributed to our reforms.
- We have estimated that the percentage of cases which will require a care plan will be similar to the percentage of deprivation of liberty cases we estimated are currently not referred to local authorities / Local Health Boards. This was 10%. We have estimated the costs of care planning as the standard hourly rate of social workers (£17) multiplied by 3 hours: a total of £51. For the sake of the impact assessment, we have rounded this to £50. A high estimate is 15% and a low estimate is 5%.
- We consider that there will be a slight increase in administrative costs as a result of our proposals. We do not anticipate this to be significant however and anticipate that in many cases this can be absorbed under existing practice. We have been unable to calculate an estimate, but not that the total cost of this option will therefore we higher than as estimated above.

Benefits

Transitional benefits

None identified.

Ongoing benefits

1. Benefits of section 5 MCA reforms

At present, because section 5 of the Mental Capacity Act does not require any specific safeguards or processes before it can be relied upon, the defence is potentially available in cases which breach the person's Article 8 rights. Therefore, our reforms to section 5 will bring significant quantifiable benefits as local authorities will avoid the risk of damages claims resulting from existing potential breaches of Article 8 rights (such as where a person is moved from their home or has their contact with another person restricted in their best interests without adequate safeguarding), provided that they comply with the new requirements.

Table 30: Benefits of section 5 MCA reforms [£ million]

	Low estimate (£)	**Best estimate(£)**	**High estimate (£)**
A. Avoidance of damage awards (article 8)	80.19	120.29	160.38
Total annual benefit [A]	**80.19**	**120.29**	**160.38**
Present value over 10 years	**666.91**	**1,000.36**	**1,333.82**

Assumptions:

- 267,295 people will be entitled to section 5 safeguards.
- 5% (13,365) of people would have made an actionable claim for damages for breach of article 8.
- £1,500 in damages avoided per month for an average of 6 months (with an upper estimate of £2,000 and a lower estimate of £1,000).[74]

2. *Improved health outcomes*

Table 31: QALY benefits of section 5 MCA reforms [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Number of people receiving new safeguards	61,285	61,285	61,285
B. Percentage likely to have an improved health outcome from more rigorous assessment	40.00	50.00	60.00
C. Total QALY gain	**85.31**	**106.64**	**127.96**
Present value over 10 years	**709.49**	**886.88**	**1,064.19**

We consider that the section 5 reforms will result in improved care outcomes for those who would have not received safeguards under the current regime. For example, it will ensure that when a person is moved into a care home the professional must confirm that the move represents the best choice between available options and that existing rights to advocacy have been complied with. This should help to ensure that the best outcome for the person concerned is achieved.

[74] A Local Authority v D [2014] EWHC B34 (COP), Health and Social Care Information Centre, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 3 Return 2014-15 (2015) p 8.

We anticipate that for those who would not have been otherwise assessed under the current regime, but will be under our scheme, 61,285 people, there will be an improved health outcome. Because we are unable to model the different cohorts likely to receive improved outcomes across the different dimensions, we have again taken a broad approach and included an uplift to the proportional benefit received under option 1 and assumed that 50% [best estimate, +/- 10% for high/low estimates] of all of those who would not have been assessed under the old regime will enjoy 0.058 gain (a change from level 3 (major problems) to level 2 (some problems) using the EQ-5D scale) across the usual activities dimension.

The summary of key monetised benefits is listed in table 32 below.

Table 32: Section 5 MCA reforms - Summary of annual key benefits [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damages	80.19	120.29	160.38
B. QALY gain	85.31	106.64	127.96
Total annual benefit	**164.49**	**226.93**	**288.34**
Present value over 10 years	**1,376.40**	**1,887.29**	**2,398.01**

Part 4: Totals

Total Costs

Table 33: Total costs under Option 2 [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
Transitional			
1. Training costs	5.11	11.34	18.70
2.Recruitment costs	0.01	0.02	0.05
Total transitional	**5.12**	**11.36**	**18.75**
Ongoing			
1. Authorisation process	112.33	124.80	137.29
2. Approval by an Approved Mental Capacity Professional	2.86	7.61	13.28
3. FTT / COP	66.8	87.1	107.4
4. Regulation	4.63	6.94	11.57
5. Cost of capacity assessments	5.40	8.10	10.80
7. Cost of care planning	0.67	1.34	2.00
Total ongoing costs	**192.69**	**235.89**	**282.34**
Present value	**1,602.91**	**1,961.36**	**2,347.79**

over 10 years			

Total Benefits

Table 34: Total benefits under Option 2 [£ million]

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided damages	272.49	408.74	544.98
B. QALYs	421.96	578.03	734.08
Total	**694.45**	**986.77**	**1,279.06**
Present value over 10 years	**5,775.47**	**8,206.58**	**10,637.44**

Option 3: the Liberty Protection Safeguards without the AMCP role

Option 3 mirrors option 2, except that authorisations would not be approved by an Approved Mental Capacity Professional. This is not our preferred option for reform as it removes the significant benefits this role would otherwise provide. See revised QALY gain in table 36 below.

Costs

Table 35: Summary of costs of Option 3

	Low estimate(£)	Best estimate (£)	High estimate (£)
Transitional			
1. Training costs	5.09	11.24	18.43
Total transitional	**5.09**	**11.24**	**18.43**
Ongoing			
1. Authorisation process	112.33	124.80	137.29
2. FTT / COP	66.8	87.1	107.4
3. Regulation	4.63	6.94	11.57
5. Cost of capacity assessments	5.40	8.10	10.80
7. Cost of care planning	0.67	1.34	2.00
Total ongoing cost	**189.83**	**228.28**	**269.06**
Present value over 10 years	**1,584.22**	**1,909.67**	**2,255.78**

Benefits

The avoided risk of damages is the same as Option 2, both under the Liberty Protection Safeguards and our wider recommendations to reform sections 5 and 6 of the Mental Capacity Act. Equally the estimated QALY benefits provided by our wider recommendations to reform sections 5 and 6 of the Mental Capacity Act are the same. However, we assume that the removal of approval by an Approved Mental Capacity Professional from the Liberty Protection Safeguards will significantly affect the QALY benefits provided by the safeguards. This is set out below.

Table 36: Amended QALY benefits under the Liberty Protection Safeguards without approval by an Approved Mental Capacity Professional

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. QALY benefit for those receiving a new assessment	77.26	96.57	115.88
B. QALY benefit for those who would have received a DoLS assessment	120.54	160.72	200.91
Total QALY value [A+B]	**197.8**	**257.29**	**316.79**
Present value over 10 years	**1,645.02**	**2,139.78**	**2,634.62**

As a result the total benefits of Option 3 are as follows:

Table 37: Summary of key benefits of Option 3

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
A. Avoided risk of damages	272.49	408.74	544.98
B. QALY gain	283.11	363.93	444.75
Total annual benefit	**555.60**	**772.67**	**989.73**
Present value over 10 years	**4,620.71**	**6,425.99**	**8,231.19**

Summary of cost benefit analysis[75]

This section provides a summary of the various options presented in this impact assessment.

Table 38: Summary of cost benefit analysis [£ million]

	Low estimate (£)	**Best estimate (£)**	**High estimate (£)**
Option 0			
A. Ongoing cost	166.48	244.59	329.53
Option 1			
A. Transitional cost	7.03	14.06	21.09
B. Ongoing cost	1,700.03	2,154.56	2,617.73
C. Present value over 10 years [Cost]	**14,143.00**	**17,927.81**	**21,784.43**
D. Transitional benefit	0	0	0
E. Ongoing benefit	151.14	207.65	264.14
Present value over 10 years [Benefit]	**1,257.03**	**1,726.87**	**2,196.7**
Net Present value	**-12,885.97**	**-16,200.94**	**-19,587.72**

[75] Rounding means that some totals may not be an exact match.

Option 2			
F. Transitional cost	5.12	11.36	18.75
G. Ongoing cost	192.69	235.89	282.34
H. Present value over 10 years [Cost]	**1,602.91**	**1,961.36**	**2,347.79**
I. Transitional benefit	0	0	0
J. Ongoing benefit	**694.45**	**986.77**	**1,279.06**
Present value over 10 years [Benefit]	**5,775.47**	**8,206.58**	**10,637.44**
Net Present value	**4,165.77**	**6,233.85**	**8,270.90**
Option 3			
K. Transitional cost	5.09	11.24	18.43
L. Ongoing cost	189.83	228.28	269.06
M. Present value over 10 years [Cost]	**1,584.22**	**1,909.67**	**2,255.78**
N. Transitional benefit	0	0	0
O. Ongoing benefit	555.6	772.67	989.73
Present value over 10 years [Benefit]	**4,620.71**	**6,425.99**	**8,231.19**
Net Present value	**3,036.49**	**4,516.58**	**5,975.42**

7. Specific impact tests

Statutory equality duty

We think that our proposals will not have any adverse equality impact on any social group as defined by their race, age, religion or belief, sexual orientation, disability, or gender.

We anticipate that the new system will have beneficial impacts for older and disabled people. These benefits will include greater advocacy rights for these groups, better protection of their human rights, and greater empowerment for these groups relating to issues of treatment and care. Our provisional proposals will also move the United Kingdom closer towards compliance with the United Nations Convention on the Rights of Persons with Disabilities.

Competition

We do not anticipate that there will be any particular effect, whether positive or negative, on competition.

Although the authorisation obligations will apply equally to the various settings within the scheme, it is possible that, in practice, the resourcing consequences may differ as between different providers, resulting in distortions to the prices charged for services. For instance, some care homes may house greater numbers of people who require restrictive care as compared to others. However, we anticipate that these differences are likely to be minimal. In addition, these differences already exist under the present DoLS regime, and so the new scheme will not alter this situation.

Small firms

We do not anticipate that there will be any particular effect, whether positive or negative, on small firms. The costs associated with the new scheme will fall equally upon both large and small care providers.

Environmental impact and wider environmental issues

We do not anticipate that there will be any particular effect, whether positive or negative, on the environment.

Health and well-being

We expect our provisional proposals to have a significant positive effect on health and well-being. Our provisional proposals are directed towards improving care and treatment outcomes for vulnerable groups of people. At present, many people who ought to be assessed under the present framework are simply not receiving these assessments. Our rationalised system should make it possible for these groups to receive the attention they deserve. Additionally, the tiered system should improve decision making which should, in turn, improve patient outcomes.

Human rights

We expect our provisional proposals to have a significant positive effect on human rights. Our provisional proposals are directed towards guaranteeing compliance with Article 5 of the European Convention on Humans Rights. This is not presently the case. Our provisional proposals are also directed towards ensuring compliance with other rights, such as Article 8 (family, correspondence, privacy and home) which are not adequately protected under the present system.

Justice system

The impact on the justice system has been considered throughout this impact assessment. Our provisional proposals recognise the stresses that are currently being felt by the Court of Protection as a result of increased caseloads under the present system. By extending the ability to provide administrative authorisations for deprivations of liberty occurring outside hospitals and care homes, our provisional proposals should significantly reduce the numbers of cases that previously were dealt with by courts.

Our provisional proposals also recommend that a new tribunal jurisdiction be created to take over responsibility for some cases which would otherwise remain with the Court of Protection. This will lead to an impact on the tribunal system. However, as measured against the justice system as a whole, we expect significant efficiency savings to flow from the transfer of these matters from a formal court process to a more informal tribunal setting. Overall, we anticipate a positive effect on the justice system.

Rural proofing

We do not foresee any differential impact on rural areas.

Sustainable development

We do not foresee any implications for sustainable development.