

<b>Title:</b> Mental Capacity and Detention <b>IA No:</b> LAWCOM0044 <b>Lead department or agency:</b> Law Commission <b>Other departments or agencies:</b> Department of Health	<b>Impact Assessment (IA)</b>
	<b>Date:</b> 6 August 2015
	<b>Stage:</b> Consultation Period
	<b>Source of intervention:</b> Domestic
	<b>Type of measure:</b> Primary legislation
	<b>Contact for enquiries:</b> Tim Spencer-Lane: 0203334 3758
<b>Summary: Intervention and Options</b>	

**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. This process is seen as complex and overly-bureaucratic. It is also limited in its scope as the DoLS do not apply to community settings, such as supported living. Recent case law has also widened the cohort of people considered to be deprived of liberty, leading to a sharp increase in the number of authorisations required. It is unlikely that the DoLS can cope with this extra demand. The result is likely to be widespread non-compliance with the law and breaches of human rights. Law reform is necessary to provide improved outcomes for people and to create a sustainable authorisation process.

**What are the policy objectives and the intended effects?**

The policy objectives include the creation of a new legislative framework which: is straightforward and accessible for people who lack capacity, their families and carers and professionals; complies with international human rights law; can be applied appropriately in different settings; responds proportionately to more intrusive interferences with human rights; and establishes a clearer interface with existing mental capacity, mental health and social care legislation. The intended effects are to improve care and treatment outcomes for people who lack capacity and their families or carers, and meet the demand for authorisations 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: Fully fund the Deprivation of Liberty Safeguards to meet present demand.  
Option 2 (preferred): A new system called protective care based in the Mental Capacity Act 2005. This is our preferred option because it would reduce bureaucracy through tailored schemes, and improve care outcomes by empowering individuals and implementing increasingly protective safeguards for more intrusive treatment and care.  
Option 3: The new protective care system as above, though without provision for automatic tribunal review of care and treatment.

**Will the policy be reviewed?** It will be reviewed.

# Summary: Analysis & Evidence

# Policy Option 1

## Description:

The Deprivation of Liberty Safeguards fully funded

Price Base Year 2014/15	PV Base Year 2014/15	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low -£8,905.24	High: -£14,254.62	Best Estimate -£11,852.76

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£1.70	£1,145.00	£9,522.55
High	£3.43	£2,059.92	£17,131.57
Best Estimate	£2.56	£1,584.97	£13,181.58

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

Transitional costs: training new health and social care professionals, best interest assessors, advocates and paid representatives [£2,564,274 per year to individuals, local authorities and the NHS – best estimate];  
On-going costs: authorisations under DoLS [£172,104,812 per year to local authorities – best estimate]; authorisations outside the DoLS [£341,589,000 per year to local authorities/NHS – best estimate]; legal costs to parties before court [£1,039,862,066 per year to families, official solicitor and legal aid – best estimate]; cost of regulation and inspection [£31,415,216 per year to CQC, CSSIW and HIW – best estimate].

### 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	£74.43	£619.01
High	0	£364.34	£2,880.39
Best Estimate	0	£160.09	£1,331.38

### 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 [£66,188,562 per year to NHS, local authorities and other providers – best estimate]; reduced exposure to damages in domestic settings [£27,900,000 per year to local authorities – best estimate]. Improved health outcomes as measured by the gain in quality adjusted life-years (QALYs) [£65,998,200 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.

# Summary: Analysis & Evidence

# Policy Option 2

## Description:

The new Protective Care Scheme based in the Mental Capacity Act

Price Base Year 2014/15	PV Base Year 2014/15	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -£547.96	High: -£3,175.61	Best Estimate: -£1,814.18

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£1.94	£184.70	£1,538.02
High	£5.83	£1,161.95	£9,669.34
Best Estimate	£3.89	£529.53	£4,403.93

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

Transitional costs: NHS/Local Authorities – training, advocates, doctors and carers, Approved Mental Capacity Professionals and paid representatives [£3,886,420 - best estimate]

On-going costs: Supportive care system [£8,168,159 per year to local authorities - best estimate]; Restrictive care and treatment scheme [£321,110,677 per year to local authorities - best estimate]; Hospital settings [£866,943 per year to NHS/local authorities - best estimate]; New assessment, advocacy and review costs in domestic settings [£46,719,322 per year to local authorities - best estimate]; Legal costs of parties before tribunal [£135,968,049 per year to legal aid, incapacitated people and official solicitor - best estimate]; Regulators - cost of regular inspections [£16,701,520 per year to regulators - best estimate].

### 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	£119.04	£990.07
High	0	£780.81	£6,493.73
Best Estimate	0	£311.39	£2,589.75

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

No transitional benefits identified

On-going benefits of reduced exposure to damages: for breach of article 8 of the European Convention [£9,192,856 per year to local authorities, care homes and supported living and shared lives providers - best estimate]; for unlawful deprivation of liberty in care homes, supported living and shared lives [£182,018,546 per year to local authorities, care homes and supported living and shared lives providers]; for unlawful deprivation of liberty in hospitals [£478,103 per year to the NHS]; and for unlawful deprivation of liberty in domestic settings [£45,892,980 per year to local authorities and private individuals]. Improved health outcomes as measured by the gain in quality adjusted life-years (QALYs) [£73,812,384 per year – best estimate].

### 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

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

Risks -

- A tribunal will not significantly reduce costs for parties as compared with court applications.
- Inadequate current compliance with the Mental Capacity Act will lead to substantial costs for supportive care.
- There will be difficulties in training up a sufficient cohort of Approved Mental Capacity Professionals (AMCP's), due to inadequate numbers of people willing and able to take up the role.

# Summary: Analysis & Evidence

# Policy Option 3

**Description:** The new Protective Care Scheme, without automatic tribunal review of care and treatment

Price Base Year 2014/15	PV Base Year 2014/15	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £342.21	High: £1,752.04	Best Estimate: £722.87

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£1.94	£63.48	£529.92
High	£5.83	£559.41	£4,658.23
Best Estimate	£3.89	£209.71	£1,744.10

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

Transitional costs: NHS/Local Authorities – training, advocates, doctors and carers, Approved Mental Capacity Professionals and paid representatives [£3,886,420 - best estimate]

On-going costs: Supportive care system [£8,168,159 per year to local authorities - best estimate]; Restrictive care and treatment scheme [£136,226,575 per year to local authorities - best estimate]; Hospital settings [£728,192 per year to NHS/local authorities - best estimate]; New assessment, advocacy and review costs in domestic settings [£20,695,265 per year to local authorities - best estimate]; Legal costs of parties before tribunal [£27,193,610 per year to legal aid, incapacitated people and official solicitor - best estimate]; Regulators - cost of regular inspections [£16,701,520 per year to regulators - best estimate].

### 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	£104.87	£872.13
High	0	£770.78	£6,410.27
Best Estimate	0	£293.63	£2,466.97

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

No transitional benefits identified.

On going benefits of reduced exposure to damages: for breach of article 8 of the European Convention [£9,192,856 per year to local authorities, care homes and supported living and shared lives providers - best estimate]; for unlawful deprivation of liberty in care homes, supported living and shared lives [£182,018,546 per year to local authorities, care homes and supported living and shared lives providers]; for unlawful deprivation of liberty in hospitals [£478,103 per year to the NHS]; and for unlawful deprivation of liberty in domestic settings [£45,892,980 per year to local authorities and private individuals]. Improved health outcomes as measured by the gain in quality adjusted life-years (QALYs) [£59,049,907 per year – best estimate].

### 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

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

Risks -

- Inadequate current compliance with the Mental Capacity Act will lead to substantial costs for supportive care.
- There will be difficulties in training up a sufficient cohort of AMCP's, due to inadequate numbers of people willing and able to take up the role.

# Evidence Base

## 1. Introduction

### Background

The Deprivation of Liberty Safeguards (DoLS) govern the circumstances in which a person who lacks mental capacity to consent to care or treatment might lawfully be deprived of liberty. The DoLS ensure that a professional assessment takes place regarding whether the person lacks capacity, and whether it is in their best interests to be deprived of liberty for the relevant treatment and care.

The DoLS were introduced as amendments to the Mental Capacity Act 2005 by the Mental Health Act 2007 in response to the judgment of the European Court of Human Rights in *HL v UK*.<sup>1</sup> That case had found that the common law process to allow for care and treatment of those lacking mental capacity, including by depriving them of liberty, was not compliant with article 5 of the European Convention on Human Rights.<sup>2</sup> This was because article 5 demanded more stringent legal safeguards than those provided by the common law. The DoLS were introduced to provide these necessary safeguards to those accommodated in care homes and hospitals. However they did not extend to other settings, such as supported living and community settings.

The DoLS apply where a care home or hospital proposes to provide treatment and care to a person who lacks mental capacity which deprives them of their liberty. It was initially assumed that if a person did not object to the care and treatment offered, then the person would not be considered as deprived of liberty, and did not fall to be dealt with under the DoLS. However, the United Kingdom Supreme Court held in *Cheshire West* that someone will be deprived of liberty where they are under continuous supervision and control and are not allowed to leave, irrespective of whether or not they appear to object to that state of affairs.<sup>3</sup> This decision therefore meant that a far greater number of people fell to be dealt with under the DoLS system than was previously thought, as far more people were likely being deprived of liberty.

As a result of this decision, research by the Association of Directors of Adult Social Services estimates that DoLS cases in hospitals and care homes will increase from 13,719 in 2013/14 to projected figures of over 138,000 in 2014/15 and nearly 176,000 in 2015/16. Furthermore, these figures do not capture people who are deprived of liberty in settings not covered by the DoLS, including supported living and community settings where the only available mechanism to provide safeguards is the Court of Protection and High Court. Cases involving deprivations of liberty in these settings are expected to rise from 212 in 2013/14 to over 28,500 in 2014/2015 and over 31,000 in 2015/2016.<sup>4</sup> Governmental bodies and care providers report that they are presently unable to cope with this additional demand without significant additional resources.

Separately to these quantitative developments, the underlying structure of the DoLS has been subject to criticism. For instance, 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”.<sup>5</sup> 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.<sup>6</sup>

In response to this report and the *Cheshire West* decision, the Department of Health referred the question of how the DoLS should be reformed, and whether it should be extended to community settings, to the Law Commission. The terms of this reference assumed that any potential reform would be based in the Mental Capacity Act. This project is part of our 12th programme of law reform.

---

<sup>1</sup> *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99).

<sup>2</sup> Common law is that law made through decisions of courts. Statutory law is law enacted by Parliament.

<sup>3</sup> *P v Cheshire West and Chester Council and P v Surrey County Council* [2014] UKSC 19, [2014] AC 896.

<sup>4</sup> Association of Directors of Adult Social Services, *Emerging Headline Findings from the ADASS Deprivation of Liberty Survey* (2014).

<sup>5</sup> House of Lords Select Committee on the Mental Capacity Act, *Mental Capacity Act 2005: Post Legislative Scrutiny* (2014) HL Paper 139, para 257.

<sup>6</sup> House of Lords Select Committee on the Mental Capacity Act, *Mental Capacity Act 2005: Post Legislative Scrutiny* (2014) HL Paper 139, paras 273 to 274.

## **The problem under consideration**

### **The narrow focus on article 5 of the ECHR**

As noted, the DoLS were designed as a response to the *HL v UK* case which found that the previous common law process breached article 5 of the European Convention of Human Rights. As a result, the DoLS focus on the presence of a deprivation of liberty as a trigger. However, the concept of deprivation of liberty may be unclear for the person and their family or carers, and difficult for practitioners to ascertain. Most significantly, it may lead to other rights of the person and their family or carers being overlooked such as article 8, which provides rights to home and family life.

### **Difficult interface with other legislation**

At present, several different legal regimes with differing purposes may also apply to a person who lacks capacity and requires treatment and care which will deprive them of liberty. For instance, the Mental Health Act 1983 provides a mechanism for compulsory treatment of people with mental disorders. The Mental Capacity Act governs the making of decisions on behalf of people who lack mental capacity. The Care Act and the Social Services and Well-being (Wales) Act deal with the provision of social care to adults. Finally, various provisions of NHS law govern the provision of adult health care.

The interface between these regimes and the DoLS is often unclear and confusing and has, at times, attracted adverse judicial comment, particularly regarding the interface between the DoLS and the Mental Health Act. In addition, the intersection of these regimes results, in some cases, in duplicated functions, particularly in the area of advocacy.

### **Application only to care homes and hospitals**

The DoLS presently apply only in care homes and hospitals, requiring the authorisation of deprivations of liberty outside these settings to be dealt with by the Court of Protection or the High Court. This can lead to increased costs for care providers, NHS bodies and local authorities (as compared to applications under the DoLS), and increased stress for the relevant person and their family or carers.

### **A one size fits all approach**

The present DoLS adopt the same approach to authorisation of a deprivation of liberty, irrespective of the circumstances in which the person is to be deprived of their liberty. For instance, the same process is applicable for long stays in a hospital or care homes as is applicable to a short stay in an intensive care ward or in a palliative care facility. This results in a system that is disproportionate to the benefits to be gained in some circumstances.

### **Lack of oversight**

The DoLS have been criticised for lacking an effective oversight system in various respects. For instance, the regulators which monitor the DoLS do not have an express oversight role regarding supported living, despite deprivations of liberty being possible in these settings. Further, the DoLS lack an effective system to monitor compliance with authorisations made, and with any conditions which may accompany those authorisations. Finally, the person subject to the DoLS may face practical obstacles to challenge decisions made, and is often reliant on others to do so.

### **Complexity**

As already noted, the legislation which sets up the DoLS is extremely complex. This has meant that it has not been widely understood by both those administering the scheme, and those subject to it.

## Unsustainable

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.<sup>7</sup> 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.<sup>8</sup>

However, since the *Cheshire West* judgment there has been a significant increase in DoLS applications. Between April 2014 and April 2015 there were 110,800 DoLS applications, pointing to a 10 fold increase on 2012-13 figures.<sup>9</sup> These figures tend to indicate that the DoLS were designed with a relatively small number of cases in mind, and were not intended to efficiently deal with the present demands being placed upon them.

## 2. Rationale for intervention

The current system is not workable due to the high number of DoLS cases and the unsuitability of the system to cope with this demand. In order to avoid potential non-compliance with the requirements of article 5 of the European Convention of Human Rights, significant increases in resources are likely to be needed. Additionally, the present law is overly complex, leading to a lack of understanding by those applying the law and those subject to it. The DoLS also do not apply to all settings where a deprivation of liberty is possible. The law needs to be simplified, and reformed to provide sustainable and practical safeguards for people who lack capacity.

The problems identified above result from the present legislative framework. The only manner in which these matters can be rectified is through reform of primary legislation.

## 3. Policy objectives

### Simplification

The reformed system should be clear and accessible for all, including users and the professionals who have to apply it.

### Compliance with human rights

The system should provide safeguards which comply with articles 5 and 8 of the European Convention of Human Rights, and other relevant international human rights law.

### Appropriate adaption to different settings

The system should not be limited to hospitals and care homes, but should recognise that people who lack mental capacity often receive care and treatment in a wide range of settings. The system should recognise differences in these settings and provide safeguards in a manner tailored to them.

### Proportionality

The system should respond proportionately to greater or lesser interferences with human rights.

---

<sup>7</sup> Department of Health and Ministry of Justice, *Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to Accompany The Code of Practice and Regulations* (2008) paras 30 and 32.

<sup>8</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Assessments (England): Annual report 2012/13* (2013) p 9.

<sup>9</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Assessments (England): Annual report 2012/13* (2013) p 8 and Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 4 Return 2014-15* (2015).

## Effective interface with existing legislative regimes

The system should establish an effective interface with existing mental capacity, mental health, social care and NHS legislation. It should also seek to remove duplicated functions where these regimes overlap.

## Intended effects

The intended effects of reform are to provide a system to cope with the present numbers of people who require deprivation of their liberty for treatment and care in a manner that protects their article 5 and article 8 rights under the European Convention of Human Rights. Crucially, the system should also improve care and treatment outcomes for these people.

## 4. 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 disorders. The main stakeholders affected by changes to the DoLS include these groups, along with their relatives and carers, doctors and nurses, social workers, local and national government and other providers of health and social care.

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

First, we have estimated the cost to 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. In this regard, the DoLS require managing authorities to apply to supervisory bodies 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 provide a professional assessment on matters including whether the person lacks capacity, and whether it is in their best interests to be deprived of liberty. The supervisory body may then permit the deprivation of liberty (referred to as a DoLS authorisation). DoLS authorisations may permit 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 must be made. Those under a DoLS authorisation may then be subject to a review by the supervisory body at any time (referred to as an internal review). To assist the person through this process, various provisions make allowance for the appointment of an advocate or a paid representative, involving further cost.

Second, people who are deprived of their liberty in community settings (for instance, supported living and shared lives accommodation) are not eligible for the DoLS. This means that, where necessary, care providers must apply to the Court of Protection for authorisation to deprive them of their liberty. Similarly, 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, or for authorisation by the Court of Protection.<sup>10</sup> This means that care providers must apply to the High Court for authorisation to deprive such people of their liberty, incurring costs.

Third, the Court of Protection and High Court incur costs in hearing reviews of cases under the DoLS and hearing applications for authorisation for people who fall outside the DoLS.

Fourth, cases which proceed to the courts involve costs to the various parties who then become involved. These include the Official Solicitor, and incapacitated people and their families or carers, whether self-funded or funded by legal aid.

Finally, the regulators with responsibility to monitor and report on the DoLS (the Care Quality Commission, Care and Social Services Inspectorate Wales, and Healthcare Inspectorate Wales) currently incur costs in inspecting settings where deprivations of liberty occur and generating reports.

It should be noted that our analysis here represents what we have estimated the DoLS *actually* cost to administer each year. However, this analysis must be seen in a context in which the existing demand for the DoLS is significantly outstripping supply and that, as a result, a large number of requests for

---

<sup>10</sup> For further information on this distinction see chapter 6 of the Consultation Paper.



authorisation of deprivations of liberty under the DoLS are not being processed. For instance, the Health and Social Care Information Centre reports that between April and December in 2014, only 46 per cent of DoLS authorisation requests had been dealt with by the supervisory body.<sup>11</sup> This tends to show that the DoLS will require significant additional funding.<sup>12</sup>

Further, the quantifiable aspects of this under-utilisation are not presently represented in the cost of the DoLS because its effects are not being realised, for instance, through litigation leading to damages claims for breached rights, as few people are taking such legal action. It again follows that the true costs of the DoLS, if people were relying upon their existing legal rights, would be very significantly higher than here represented.

In arriving at the figures presented below, we have relied upon publically available data published by Government and other bodies. In addition, where necessary, we have provided realistic estimates for data that is not available. For instance, where figures are available either only for England or for Wales we have estimated a total by inflating with respect to the population 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 over-burdening the document with detailed breakdowns. We welcome feedback and suggestions from consultees on the various figures used throughout this impact assessment.

An itemisation of the various present costs of the DoLS follows.

### 1. *Costs to managing 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 and managing authorities.<sup>13</sup>

**Table 1: Costs for deprivations of liberty under DoLS**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Authorisation, advocacy and representative costs – under DoLS	51,537,119	74,155,290	105,282,202
B. Internal review of authorisations under DoLS	1,295,429	2,645,788	4,499,670
C. Cost to supervisory bodies of Court of Protection review of authorisations under DoLS costs	3,069,079	3,341,524	3,613,662
<b>Total [A+B+C]</b>	<b>55,901,627</b>	<b>80,142,602</b>	<b>113,395,534</b>

Assumptions:

- 53,853 DoLS applications processed per year. We derive this figure from the numbers of DoLS applications reported by the Health and Social Care Information Centre in England (110,800 applications), increased them to reflect the Welsh population (117,071 applications), and discounted them by 46 per cent to account for the significant number of applications currently not being processed.<sup>14</sup>

<sup>11</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 4 Return 2014-15* (2015).

<sup>12</sup> We estimate this funding increase below under option 1.

<sup>13</sup> We note that our estimate of roughly £80m per year incurred by managing and supervisory bodies appears out of line with the £35m in funding actually provided for both DoLS and Mental Capacity Act responsibilities. However, we consider our figures to more realistically represent what DoLS is actually costing. Others have noted a similar discrepancy: <http://www.theguardian.com/society/2015/mar/24/councils-bill-deprivation-of-liverty> (last visited 25 June 2015).

<sup>14</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 4 Return 2014-15* (2015).

- £1,377 per DoLS application, along with associated advocacy and representative costs. We derive this figure from an academic study produced by Shah and others.<sup>15</sup> However, as this study makes no provision for the costs of a paid representative, we have factored in a component to represent this. In doing so, we have assumed that the cost of a paid representative will be equivalent to that of an advocate as determined by Shah, and we have assumed that 25 per cent of people subject to the DoLS will receive a paid representative. In arriving at our upper and lower estimates for the total figure we have used the upper (£1,955) and lower (£957) average costs of a DoLS authorisation reported by Shah, with our additional component for paid representatives factored in.<sup>16</sup>
- 8.5 per cent of DoLS authorisations lead to an internal review (4,578 reviews). We derive this figure from the internal review rate reported by the Welsh regulators.<sup>17</sup>
- £578 per internal review application. 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 (£578), as we assume that this will be the sole focus of almost all internal reviews.<sup>18</sup> In arriving at our upper and lower estimates we have used the upper (£983) and lower (£283) average costs of the best interests component of a DoLS authorisation reported by Shah.<sup>19</sup>
- 570 further reviews to the Court of Protection for review of a DoLS authorisation. We derive this figure from an academic study produced by Series and others.<sup>20</sup>
- £10,879 incurred by supervisory bodies per Court of Protection review. We have taken this figure from those reported in a similar study by Series, along with our lower (£9,992) and upper (£11,765) estimates.<sup>21</sup>

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.

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

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

**Table 2: Costs for deprivations of liberty outside DoLS settings**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. CoP authorisation costs for settings outside DoLS	987,702	1,067,741	1,147,781
<b>Total [A]</b>	<b>987,702</b>	<b>1,067,741</b>	<b>1,147,781</b>

### Assumptions:

<sup>15</sup> 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.

<sup>16</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232. Again, we have deducted the costs associated with Court of Protection from these figures as they are costed separately.

<sup>17</sup> 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.

<sup>18</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

<sup>19</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232. Again, we have deducted the costs associated with Court of Protection from these figures as they are costed separately.

<sup>20</sup> 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.

<sup>21</sup> L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

- 97 cases per year for authorisation in the Court of Protection. We take this figure from an academic study produced by Series and others.<sup>22</sup>
- £11,019 per case brought. Again, we take this figure from an academic study.<sup>23</sup> In calculating our upper and lower estimates we have varied the average cost of cases to reflect the upper (£11,845) and lower (£10,193) estimates reported in that study.

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 conservative.

### 3. 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. However, unlike managing authorities and supervisory bodies, the courts charge 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 these matters.<sup>24</sup> Of course, those who pay these fees incur costs, and these are reflected later in this impact assessment.

Of the cases brought to the Court of Protection, 15 per cent are subject to further appeal in the Court of Appeal, however this court does not fully recoup its costs from court fees.<sup>25</sup> 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 extremely conservative.

### 4. 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 3: Cost to incapacitated people, their families, the official solicitor and legal aid**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Legal aid	1,550,303	2,214,843	2,879,287
B. Incapacitated people and their families or carers	3,488,400	5,087,250	6,686,100
C. Official solicitor	1,580,323	2,135,482	2,754,673
<b>Total [A+B+C]</b>	<b>6,619,026</b>	<b>9,437,576</b>	<b>12,320,060</b>

Assumptions:

- 388 cases proceed to the court for authorisation or review per year. We have taken this figure from an academic study authored by Series and others.<sup>26</sup>

<sup>22</sup> 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> (last visited 25 June 2015).

<sup>23</sup> 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> (last visited 25 June 2015).

<sup>24</sup> 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> (last visited 25 June 2015)

<sup>25</sup> 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> (last visited 25 June 2015)

<sup>26</sup> L Series and others, *Use of the Court of Protection's Welfare Jurisdiction by Supervisory Bodies in England and Wales* (2015) p 12.

- £22,857 incurred in legal costs by legal aid per case. We have taken this figure from a similar academic study by Series.<sup>27</sup> We have then increased and decreased these costs by 30 percent to reach an upper (£29,714) and lower (£15,999) estimate.<sup>28</sup>
- 25 per cent of cases which proceed to the Court of Protection require legal aid funding (72 cases per year). We have taken this figure from the original impact assessment accompanying the DoLS.<sup>29</sup>
- £17,500 in legal costs by the person or their carers per case. We take these figures from an academic study authored by Series which reports the average costs charged by private solicitors for Court of Protection matters.<sup>30</sup>
- 75 per cent of cases which proceed to the Court of Protection will involve self-funded litigants. Again, this assumption is in line with the original impact assessment accompanying the DoLS.<sup>31</sup> To obtain a range we have taken the upper (£23,000) and lower (£12,000) average legal costs reported in the same academic study.<sup>32</sup>
- 50 per cent of cases involve the official solicitor. The official solicitor will usually become involved where the person lacks capacity to litigate and there is no other suitable person able to intervene. However, figures representing the costs to the official solicitor are not published. As a result we use an upper estimate of 60 per cent and a lower estimate of 40 per cent.
- £11,019 in legal costs by the official solicitor per case. We estimate their costs as equal to those incurred by local authorities when seeking authorisation from the Court of Protection (with an upper estimate of £11,845, and a lower estimate of £10,193).<sup>33</sup>

#### 5. Costs to regulators

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

**Table 4: Costs to regulators**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Conducting inspections and preparing reports	11,175,373	27,317,579	43,459,785
<b>Total [A]</b>	<b>11,175,373</b>	<b>27,317,579</b>	<b>43,459,785</b>

#### Assumptions:

- 12,412 DoLS related inspections per year. We derive this figure by decreasing the total number of regulatory inspections reported by the Care Quality Commission in England (30,334) to reflect the percentage (39 per cent) which occurred in hospitals and care homes (11,752) and then further decreasing by 50 per cent to account for non-DoLS related inspections in these settings.<sup>34</sup>

<sup>27</sup> L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

<sup>28</sup> This inflationary figure is roughly based on the range of legal costs reported as incurred by private parties. See: L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

<sup>29</sup> Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008).

<sup>30</sup> L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

<sup>31</sup> Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008).

<sup>32</sup> L Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

<sup>33</sup> 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> (last visited 25 June 2015).

<sup>34</sup> Care Quality Commission, *Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13* (2014) pp 39 to 40.

We have then adjusted these figures to include inspections and reporting in Wales (a multiplier of 1.0566).

- £4,400 cost per inspected facility. We derive this figure from Care Quality Commission's estimates, and have used £1,800 as a low estimate and £7,000 as a high estimate.<sup>35</sup>

## 5. The options considered

We have considered four options for reform:

- Option 0 – Do nothing;
- Option 1 – The Deprivation of Liberty Safeguards fully funded;
- Option 2 – New Protective Care Scheme based in the Mental Capacity Act; and
- Option 3 – New Protective Care Scheme without provision for automatic tribunal review.

### Option 0: Do nothing

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

Key features	Associated problems
A focus on deprivation of liberty	Other relevant rights are omitted
A separate scheme from the Mental Health Act	This interface is overly complex
Application to care homes and hospitals	Cases outside these settings are dealt with by courts
Uniform administrative approval scheme	Fails to recognise that different cases warrant different treatment

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. Of course, this latter problem could be addressed through significant increases in resources.

### Option 1: The Deprivation of Liberty Safeguards fully funded

We have therefore given consideration, through option 1, to the possibility of retaining the same legal framework as exists under the DoLS but providing this legal system with adequate resources to allow it to keep pace with present demand for authorisations. In estimating this demand we use predicted application figures provided by the Association of the Directors of Adult Social Services, rather than figures reporting present numbers of applications. There is a significant difference in these figures because the demand for authorisations (although it is not presently being met) fails to reflect the true numbers of people who ought properly to be being referred for authorisation through the DoLS and the Court of Protection, as they are presently being deprived of liberty.

Option 1 would therefore involve funding further 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 funding 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 disproportionate amount. For this reason, it is not our preferred option.

<sup>35</sup> Care Quality Commission, *Changes in the Way We Regulate and Inspect Adult Social Care: Final Regulatory Impact Assessment* (2014) p 29.

## Option 2: New Protective Care Scheme based in the Mental Capacity Act

Instead, option 2, which recommends the replacement of the DoLS with our new protective care scheme, is the preferred option.<sup>36</sup> This is because it would provide cheaper and more efficient compliance with human rights law, whilst reinforcing and complementing existing entitlements under care law. It would also improve care outcomes for patients by ensuring that care needs are considered at an early stage, potentially allowing a plan to be put in place to delay or avoid the need for future deprivations of liberty in some cases. Earlier intervention would also allow greater provision for advanced decision making and supported decision making, which may ultimately remove the need for some deprivations of liberty. The safeguards would also be more straightforward and easy to understand as they would be triggered where a person's care arrangements reach a certain threshold of intrusiveness, rather than where the potentially unclear legal concept of "deprivation of liberty" occurs, assisting understanding by those who will be responsible for administering it, and those subject to it.

The new protective care scheme will apply to those aged 16 years and over accommodated in hospitals, care homes, supported living, shared lives and domestic accommodation. Whether someone falls within the protective care scheme will be determined by an assessment. However, the nature of the assessment, and the safeguards provided, will vary according to the particular setting.

First, people who lack capacity and are living in care homes, supported living and shared lives accommodation will be provided with a set of safeguards called "supportive care". These safeguards are intended to ensure a person's accommodation and care and treatment are appropriate for them, and that their existing legal rights are being given effect to (for instance, advocacy rights under other legislation).

Second, additional safeguards would then apply if a person accommodated in these settings requires more restrictive forms of care or treatment. We have provisionally called these safeguards the "restrictive care and treatment scheme". This scheme will include individuals deprived of liberty, but also those whose care arrangements fall short of this.

Third, a separate scheme will apply to hospital settings and palliative care to recognise that these settings, in contrast to long-term care, ordinarily involve shorter stays and an assumption that the person will return home as soon as possible. This is a more streamlined scheme and the trigger for its application is based around the concept of deprivation of liberty.

Fourth, our proposed protective care scheme will not be capable of being used to authorise the detention in hospital of incapacitated people who require treatment for a disorder of the mind. Instead, the Mental Health Act will be amended to establish a formal process and safeguards for such people.

Fifth, the new scheme will allow for the authorisation of a deprivation of liberty of a person living in family homes or other domestic settings. This will be an administrative form of authorisation, avoiding the present need to seek court authorisation.

Finally, the review jurisdiction of the Court of Protection will be replaced with a system of automatic review before the First-tier Tribunal.

In summary then, the protective care scheme would consist of:

- supportive care: this will apply to people in care home, supported living and shared lives accommodation;
- a restrictive care and treatment scheme: this will apply to people receiving restrictive care and treatment in care home, supported living and shared lives accommodation (and to deprivations of liberty involving people living in family and other domestic settings); and
- a hospital and palliative care scheme;
- a scheme based in the Mental Health Act 1983 for people who lack capacity and need mental health treatment in their best interests and are not objecting; and<sup>37</sup>
- automatic review to the First-tier Tribunal for those under the restrictive care and treatment scheme and under a deprivation of liberty in domestic settings.

---

<sup>36</sup> A summary is provided here. For further detail, see the Consultation Paper.

<sup>37</sup> We have not costed this aspect of the scheme separately, as we do not have data indicating the proportions of people who require a deprivation of liberty for mental health treatment and those who require a deprivation of liberty for physical treatment. Instead we have costed all of those who require either mental or physical treatment in a hospital under the hospitals scheme.

### **Option 3: New Protective Care Scheme without automatic tribunal review**

We have also prepared a costing of the new protective care scheme with the provision for automatic tribunal review omitted. Although this option is not preferred, we have included it because we recognise that the costs associated with automatic review form a substantial proportion of the overall costs of the new scheme. This alternative scheme would require the person, their family, advocate, or AMCP to seek a tribunal review. This would result in lower uptake of review, and so reduce the cost implications of the scheme. It would, of course, also reduce the benefits of the scheme in terms of care outcomes, as it would weaken the safeguards provided.

## **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 positive or negative impacts on care outcomes, equity and 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 publically available data published by Government and other bodies to inform our assessment. In addition, where necessary, we have provided what we hope are 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 under-estimate benefits and over-estimate costs. When making estimations of this kind, we have sought to include the key figures and assumptions that we have relied upon, without over-burdening the document with detailed breakdowns. We again welcome feedback and suggestions from consultees on the various figures used.

When calculating the net present values for the impact assessment we have used a time frame of ten years, with 2014-15 being year 0.<sup>38</sup> 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 per cent has been used in all cases in accordance with Treasury guidance.<sup>39</sup> Unless stated, all figures are in 2014/15 prices, and have been uprated using the GDP deflator.

## **Option 0: Do nothing**

Option 0 is the base case against which our other options are measured.

### **Costs**

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

### **Benefits**

Retaining the DoLS 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.

---

<sup>38</sup> 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.

<sup>39</sup> HM Treasury, *The Green Book: Appraisal and Evaluation in Central Government* (July 2011).

# Option 1: The Deprivation of Liberty Safeguards fully funded

## Costs

### Transitional costs

#### 1. Training costs

A fully funded 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 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 5: Training costs**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Training health and social care professionals	759,937	1,519,874	2,279,812
B. Training Best Interests Assessors	921,060	1,023,400	1,125,740
C. Training advocates	9,450	10,500	11,550
D. Training paid representatives	9,450	10,500	11,550
<b>Total [A+B+C+D]</b>	<b>1,699,897</b>	<b>2,564,274</b>	<b>3,428,652</b>

#### Assumptions:

- £22 per person to train general health and social care professionals. This reflects the costs of existing awareness training courses on the DoLS.<sup>40</sup>
- 69,085 doctors and social workers will require training. 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).<sup>41</sup> We have assumed that 20 per cent of these professionals within England and Wales would require training on the DoLS if it were fully funded (with 10 per cent as a lower and 30 per cent as an upper estimate).
- £850 to train a new Best Interests Assessor.<sup>42</sup>
- 1,204 additional Best Interests Assessors will be required to meet the additional number of people under a fully funded DoLS (63,234). Because statistics are not published on the numbers of qualified Best Interests Assessors at present, we have sought to estimate this number. In so doing, we have assumed, in line with the original impact assessment on the DoLS, that each assessment will take, on average, 8 hours.<sup>43</sup> We have also assumed that there are 1680 working hours in a year and that 63,234 more people will receive assessments under the DoLS who would not otherwise if it were not fully funded (this figure represents the present reported numbers of people who have been referred for a DoLS authorisation though not yet processed, as explained above). On the basis of these figures, we estimate that 301 new full-time Best

<sup>40</sup> EDGE Training, <http://www.edgetraining.org.uk/half-day-courses.php> and <http://www.edgetraining.org.uk/deprivation-liberty-safeguard.php> (last visited 25 June 2015).

<sup>41</sup> General Medical Council, *List of Registered Medical Practitioners*, [http://www.gmc-uk.org/doctors/register/search\\_stats.asp](http://www.gmc-uk.org/doctors/register/search_stats.asp) (last visited 25 June 2015) and Health and Care Professionals Council, *Statistics* <http://www.hpc-uk.org/aboutregistration/theregister/stats/> (last visited 25 June 2015).

<sup>42</sup> 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> (last visited 25 June 2015).

<sup>43</sup> Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008) p 17.



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 (1,204), with a low and high estimate ranging from 10 per cent less to 10 per cent more individuals.

- £350 to train each new advocate.
- 30 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 funded DoLS. We have assumed, in line with the demand reported in an academic study authored by Shah and others, that 25 per cent of people eligible for the DoLS have a right to an advocate.<sup>44</sup> We assume that 63,234 additional people will require an assessment under a fully funded DoLS. This leads to a figure of 15,809 additional people having a right to an advocate. We then assume that only 10 per cent of this group will take up this right to advocacy (1,581), with a range of 50 per cent higher and lower. Using the same figures regarding the number of working hours in a year (1680), we therefore assume that 8 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 (300).
- £350 to train each new representative.
- 30 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 funded DoLS

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

**Table 6: Costs for deprivations of liberty under the fully funded DoLS**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Authorisation, advocacy and representative costs – under DoLS	112,037,215	161,207,153	228,874,352
B. Internal review of authorisations under DoLS	2,816,150	5,751,712	9,781,891
C. Cost to supervisory bodies of Court of Protection review of authorisations under DoLS costs	4,726,382	5,145,947	5,565,040
<b>Total annual cost [A+B+C]</b>	<b>119,579,746</b>	<b>172,104,812</b>	<b>244,221,283</b>
<b>Present value over 10 years</b>	<b>994,497,552</b>	<b>1,431,327,796</b>	<b>2,031,092,022</b>

Assumptions:

- 117,071 people will fall within the DoLS each year. In estimating this larger cohort we have used the undiscounted figures for the number of DoLS applications reported by the Health and Social Care Information Centre in England (110,800) and inflated for Wales (117,071).

<sup>44</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232.

- In estimating the increased costs associated with authorisation, internal review, and review by the courts we have used exactly the same reasoning as above, albeit using this increased figure.
2. *Costs for deprivations of liberty outside DoLS settings to local authorities and the NHS under the fully funded DoLS*

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

**Table 7: Costs for deprivations of liberty outside DoLS settings under the fully funded DoLS**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. CoP authorisation costs for settings outside DoLS	284,384,700	341,589,000	403,914,500
<b>Total annual cost [A]</b>	<b>284,384,700</b>	<b>341,589,000</b>	<b>403,914,500</b>
<b>Present value over 10 years</b>	<b>2,365,115,309</b>	<b>2,840,860,895</b>	<b>3,359,197,480</b>

Assumptions:

- 31,000 people require authorisation in settings outside the DoLS. In calculating this cohort, we have taken the estimated number of people who are deprived of liberty in settings outside of the DoLS from a study published by the Association of Directors of Adult Social Services (31,000 in 2015/2016) and assumed a range of 10 per cent higher and lower for the high and low estimates.<sup>45</sup>
- 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 funded 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 funded DoLS.

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

**Table 8: Cost to incapacitated people, their families, the official solicitor and legal aid under the fully funded DoLS**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Legal aid	170,817,323	244,038,475	317,248,950
B. Incapacitated people and their families or carers	384,363,000	560,529,375	736,695,750
C. Official solicitor	174,124,980	235,294,217	303,518,649
<b>Total annual cost [A+B+C]</b>	<b>729,305,304</b>	<b>1,039,862,066</b>	<b>1,357,463,349</b>

<sup>45</sup>

Association of Directors of Adult Social Services, *Emerging Headline Findings from the ADASS Deprivation of Liberty Survey* (2014).

<b>Present value over 10 years</b>	<b>6,065,344,373</b>	<b>8,648,122,393</b>	<b>11,289,486,914</b>
------------------------------------	----------------------	----------------------	-----------------------

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

Assumptions:

- 11,707 cases per year will proceed to the court for review of a DoLS authorisation. In estimating this figure we have assumed that the number of people proceeding to a review of a DoLS authorisation in the Court of Protection would increase in line with the greater number of authorisations required. In estimating that number we have based our assumptions on undiscounted figures for the number of DoLS applications reported by the Health and Social Care Information Centre in England (110,800) and inflated for Wales (117,071). We have assumed that 10 per cent of these cases will be reviewed by the Court of Protection (11,707).
- 31,000 cases will proceed to the court for an authorisation outside of the settings under the DoLS. This figure represents the estimated number of people requiring such authorisations as reported by the Association of Directors of Adult Social Services for 2015/2016.

#### 5. Costs to regulators under the fully funded 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 9: Costs to regulators under the fully funded DoLS**

	<b>Low estimate (£)</b>	<b>Best estimate (£)</b>	<b>High estimate (£)</b>
A. Conducting inspections and preparing reports	11,734,142	31,415,216	54,324,731
<b>Total annual cost [A]</b>	<b>11,734,142</b>	<b>31,415,216</b>	<b>54,324,731</b>
<b>Present value over 10 years</b>	<b>97,588,228</b>	<b>261,267,953</b>	<b>451,797,347</b>

Assumptions:

- 15 per cent greater regulatory costs will be expended under a fully funded DoLS as compared to the present estimated costs above (with an upper and lower estimate of 25 per cent and 5 per cent respectively).

#### 6. Summary of costs

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

**Table 10: Summary of key costs for a fully funded DoLS**

	<b>Low estimate (£)</b>	<b>Best estimate (£)</b>	<b>High estimate (£)</b>
<i>Transitional</i>			
A. Training costs	1,699,897	2,564,274	3,428,652
<b>Total transitional [A]</b>	<b>1,699,897</b>	<b>2,564,274</b>	<b>3,428,652</b>
<i>Ongoing</i>			

B. Costs for deprivations of liberty	119,579,746	172,104,812	244,221,283
C. Costs for deprivations of liberty outside DoLS settings to local authorities and the NHS	284,384,700	341,589,000	403,914,500
D. Costs to the Court of Protection and other courts	0	0	0
E. Legal costs to incapacitated people and their families, the official solicitor and legal aid	729,305,304	1,039,862,066	1,357,463,349
F. Costs to regulators	11,734,142	31,415,216	54,324,731
<b>Total ongoing costs [B+C+D+E+F]</b>	<b>1,145,003,892</b>	<b>1,584,971,094</b>	<b>2,059,923,863</b>
<b>Present value over 10 years</b>	<b>9,522,545,462</b>	<b>13,181,579,036</b>	<b>17,131,573,763</b>

## Benefits

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

Non-quantifiable 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.

The core quantifiable benefit of the fully funded DoLS will flow from the avoided risk of damages claims for unlawful deprivations of liberty. We set out these benefits, as they accrue, in each of these settings.

### 1. Benefits of fully funded DoLS: hospitals and care homes

A fully funded DoLS would bring significant quantifiable benefits. A core quantifiable benefit will be the reduction in the risk of damages awards for unlawful deprivations of liberty. This is so because currently only 46 per cent of DoLS applications are being processed, leaving many people potentially deprived of liberty without proper legal process.<sup>46</sup>

**Table 11: Benefits of fully funded DoLS**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damage awards	22,062,854	66,188,562	176,502,832
<b>Total annual benefits [A]</b>	<b>22,062,854</b>	<b>66,188,562</b>	<b>176,502,832</b>
<b>Present value over 10 years</b>	<b>183,488,049</b>	<b>550,464,147</b>	<b>1,467,904,392</b>

<sup>46</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 3 Return 2014-15 (2015)* p 8.

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.<sup>47</sup> 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.<sup>48</sup>
- 6 months average time an authorised 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.
- 7,354 unauthorised cases of deprivation of liberty per year avoided. We assume that compensation will be payable and pursued in 10 per cent of cases of unlawful deprivation of liberty being, currently, 54 per cent of all DoLS applications made, as noted above.

## 2. Benefits of fully funded DoLS: other settings

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

**Table 12: Benefits in domestic settings**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damage awards	8,370,000	27,900,000	81,840,000
<b>Total annual benefits [A]</b>	<b>8,370,000</b>	<b>27,900,000</b>	<b>81,840,000</b>
<b>Present value over 10 years</b>	<b>69,609,986</b>	<b>232,033,288</b>	<b>680,630,979</b>

In calculating the avoided damages we have used the same assumptions regarding the numbers of people deprived of liberty in settings outside of the DoLS (31,470 people), the average length of a deprivation of liberty, and the average damages pay out.

Assumptions:

- 95 per cent of those who are deprived of liberty in settings outside the DoLS are deprived without court authorisation (with an upper estimate of 100 per cent and a lower estimate of 90 per cent). However, we have assumed that only 10 per cent 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 regime, as they will not be treated any differently.

We have sought to measure the health improvements brought about by DoLS using the notion of a quality adjusted life year (known as a QALY). 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. Using the EQ-5D

<sup>47</sup> *Essex County Council v RF* [2015] EWCOP 1.  
<sup>48</sup> *A Local Authority v D* [2014] EWHC B34 (COP).

scale<sup>49</sup> health outcomes are measured across five dimensions (anxiety/depression, mobility, self care, ability to perform usual activities and pain/discomfort). Each of the dimensions has three levels, representing greater or lesser improvements, and to which coefficients are assigned to arrive at the total QALY change. The Department of Health assigns a value of £60,000 to 1 QALY.

For each person subject to the fully funded DoLS who would not otherwise have been assessed under the current regime (63,218 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 per cent 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 per cent of people and an upper estimate of 40 per cent of people). Using the EQ-5D model we have estimated that on average there will be a 0.036 gain (a change from level 2 to level 1) across the usual activities dimension for these various cohorts. This improvement represents the smallest improvement in the QALY dimension that yields the smallest gain. This approach serves to keep these estimates conservative.

**Table 13: QALY benefits from a fully funded DoLS**

	Low estimate	Best estimate	High estimate
A. Number of people affected	12,643	18,965	25,287
B. QALY coefficient value	0.036	0.036	0.036
C. Value per person under the scheme <b>[Bx£60,000]</b>	£3,480	£3,480	£3,480
<b>Total QALY value [AxC]</b>	<b>43,997,640</b>	<b>65,998,200</b>	<b>87,998,760</b>
<b>Present value over 10 years</b>	<b>365,911,007</b>	<b>548,880,981</b>	<b>731,850,956</b>

#### 4. Summary of benefits

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

**Table 14: Summary of key benefits**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damage awards: hospitals and care homes	22,062,854	66,188,562	176,502,832
B. Avoided risk of damage awards: other settings	3,623,130	28,682,685	136,020,000
C. QALY gain	43,997,640	65,998,200	87,998,760
<b>Total annual benefits [A+B+C]</b>	<b>69,683,624</b>	<b>160,869,447</b>	<b>400,521,592</b>
<b>Present value over 10 years</b>	<b>619,009,042</b>	<b>1,331,378,416</b>	<b>2,880,386,327</b>

<sup>49</sup> EQ-5D is widely used and has been validated in many different patient populations. Scores are generated from 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.

## Option 2: A new protective care scheme

### Costs

The following is an analysis of the costs that we anticipate will be incurred under our new protective care scheme.

We anticipate two categories of transitional costs.

First, the transition to the new regime will require some re-training. We anticipate that these training costs will consist predominantly in training existing health and social care professionals to become familiar with the new regime, and in training a new cohort of Approved Mental Capacity Professionals to administer it. However, we anticipate that the costs of the latter will be minimised, as many of those required can be drawn from presently existing Best Interests Assessors, who will already possess many of the relevant skills.

Second, the creation of a tribunal jurisdiction to review cases may be expected to require set up costs. Although we have anticipated this potential expense, we do not include any figures for this cost, as we assume it to be minimal, given that the key administrative architecture necessary will already be in place in the First-tier Tribunal. Instead this architecture will simply require expansion, and we assume this expansion to be reflected in the on-going costs of the tribunal, which are dealt with below.

We also anticipate seven categories of on-going cost.

First, the supportive care scheme will apply to those lacking mental capacity who are living in or moving into care homes, supported living and shared lives accommodation, and provide rights to an assessment, advocacy, and ongoing review. By extending to these settings, the new scheme will impose various new authorisation and review costs where these existing entitlements under the Care Act and Mental Capacity Act are not presently being exercised.

Second, the restrictive care and treatment scheme will apply where restrictive care or treatment is provided to a person lacking mental capacity who lives in a care home, supported living or shared lives accommodation. Where this sort of care or treatment is to be provided, an Approved Mental Capacity Professional (a new class of professional created by the scheme) must assess its suitability and, if it is judged necessary and in the person's best interests, authorise it. There will also be rights to advocacy and on-going review. Each of these processes will generate costs in some cases.

Third, the supportive care scheme envisages a separate regime to authorise deprivations of liberty in hospitals. Deprivations for 28 days or less can be authorised by a registered medical practitioner within the hospital. Thereafter, deprivations must be approved by an Approved Mental Capacity Professional and a responsible clinician, similar to the process required under restrictive care and treatment. In either case, there is a right to on-going review. Within the first 28 days, the right to review is to a responsible clinician and, for deprivations after this period, the review is conducted by an Approved Mental Capacity Professional. These various processes represent a cost that is not presently realised, as the DoLS is under-utilised in hospitals.

Fourth, at present, those within supported living, shared lives accommodation and domestic settings should be proceeding to the Court of Protection where care and treatment amounting to a deprivation of liberty is occurring. However, applications to the Court of Protection are not being made as they should, and so our system will impose costs. There will also be costs in some cases associated with rights to advocacy and ongoing review accorded to this group of people under the supportive care scheme.

Fifth, under the protective care scheme, the First-tier Tribunal will take over jurisdiction for reviewing authorisations for deprivations of liberty from the Court of Protection. In addition, there will be an automatic referral to the tribunal after a certain period under the restrictive care and treatment scheme and for those under the hospitals scheme, in addition to rights to apply at any time. This will generate new costs.

Sixth, where cases proceed to the tribunal, costs will then be incurred by the various parties involved. These include people who lack capacity and their families or carers, whether self-funded, or funded by legal aid.

Finally, there will be a small flow on cost for the regulators (Care Quality Commission, Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales) as a result of the greater numbers of

people under the new scheme, and its expansion to a greater number of settings. The regulators will be required to inspect and oversee the scheme with respect to the people in these settings.

These various costs are itemised below.

## Transitional costs

### 1. Training costs

Training costs will be incurred as health and social care professionals and new Approved Mental Capacity Professionals require training.

**Table 15: Training costs**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Training health and social care professionals	379,969	759,937	1,139,906
B. Training Approved Mental Capacity Professionals	1,531,700	3,063,400	4,595,100
C. Training advocates	15,771	31,541	47,312
D. Training paid representatives	15,771	31,541	47,312
<b>Total annual costs [A+B+C+D]</b>	<b>1,943,210</b>	<b>3,886,420</b>	<b>5,829,630</b>

#### Assumptions:

- £22 per health and social care professional trained. This assumption is consistent with that made regarding training under the fully funded DoLS and reflects the costs of existing awareness training courses on the DoLS.<sup>50</sup>
- 34,542 doctors and social workers will require training. 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).<sup>51</sup> We have assumed that a range of these professionals within England and Wales will require training regarding our new scheme (10 per cent as a best estimate, and 5 per cent as a lower and 15 per cent as an upper estimate).
- 3,604 new Approved Mental Capacity Professionals will require training. In arriving at this figure we assume that all of the current pool of existing Best Interests Assessors will be automatically recognised as Approved Mental Capacity Professionals, requiring no additional training.<sup>52</sup> Therefore training costs will only be incurred training Approved Mental Capacity Professionals to cater for the larger cohort of people who fall within Protective Care. Because there are not figures stating the present numbers of Best Interests Assessors, we have sought to calculate the additional number of Approved Mental Capacity Professionals that will be required. In doing so we have assumed, in line with the original impact assessment on the DoLS, that each assessment will take, on average, 8 hours.<sup>53</sup> We have also assumed that there are 1680 working hours in a year and that 189,248 additional people will require an assessment (who would not otherwise be catered for under the DoLS). Using these various figures, we estimate that a total of

<sup>50</sup> EDGE Training, <http://www.edgetraining.org.uk/half-day-courses.php> and <http://www.edgetraining.org.uk/deprivation-liberty-safeguard.php> (last visited 25 June 2015).

<sup>51</sup> General Medical Council, *List of Registered Medical Practitioners*, [http://www.gmc-uk.org/doctors/register/search\\_stats.asp](http://www.gmc-uk.org/doctors/register/search_stats.asp) (last visited 25 June 2015) and Health and Care Professionals Council, *Statistics* <http://www.hpc-uk.org/aboutregistration/theregister/stats/> (last visited 25 June 2015).

<sup>52</sup> The finer details of how a person might transition from the role as a BIA to an AMCP are yet to be determined. We are presently assuming that BIAs will be able to transition immediately, given the similarities of the roles. We welcome consultees' views on this assumption.

<sup>53</sup> Ministry of Justice and Department of Health, *Impact Assessment of the Mental Capacity Act 2005* (2008) p 17.



901 full-time Approved Mental Capacity Professionals will be required to meet the numbers of assessments under the protective care scheme. However we assume that not every Approved Mental Capacity Professional will work full-time and so assume four times as many individuals will require training (3,604), with a range of 10 per cent higher and lower.

- £850 to train each new Approved Mental Capacity Professional. This is equal to the present cost of training a best interest assessor.<sup>54</sup>
- New advocates and representatives will also be need to be trained to meet the increased demand for existing advocacy rights. Our reasoning regarding the cost is the same as under the transitional cost of option 1, save that we have used the figure of the additional people who will require an assessment under protective care (189,248).

## Ongoing costs

### 1. Costs of the supportive care scheme

Our supportive care scheme will apply to a broader cohort of people and in a number of new settings. Although the scheme may appear to involve new costs associated with assessment, internal review, advocacy and paid representation, we anticipate that the financial impact of the scheme will be minimal. This is because the various rights conferred by the supportive care scheme already exist under the Mental Capacity Act and the Care Act. However, imperfect present uptake of these rights mean that the new protective care scheme will result in some additional costs, as those entitled to these rights increasingly avail themselves of them.<sup>55</sup>

**Table 16: Costs associated with the supportive care scheme**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of assessment, advocacy and paid representative	586,504	6,751,233	29,953,389
B. Cost of on-going review	88,558	1,416,926	8,855,784
<b>Total annual costs [A+B]</b>	<b>675,062</b>	<b>8,168,159</b>	<b>38,809,173</b>
<b>Present value over 10 years</b>	<b>5,614,224</b>	<b>67,931,355</b>	<b>322,760,575</b>

### Assumptions:

- 122,570 people will fall within supportive care. In determining this total we have first increased the total projected number of people who will require a DoLS authorisation in England (128,895 people) to additionally represent the population of Wales (136,190 people). We have then taken this figure and further increased it by 100 per cent to reflect the broader cohort who will fall within supportive care (272,380) (we assume 50 per cent more as a low estimate and 150 per cent more as a high estimate).<sup>56</sup> We have then subtracted from this cohort our estimate for the number of people who will fall within restrictive care and treatment (149,810 people), as this cohort is costed separately below.<sup>57</sup> When calculating the number of people falling within restrictive care and treatment, we have again increased the number of people who are projected to require a DoLS authorisation, though by a smaller amount (10 per cent more, with an upper

<sup>54</sup> 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> (last visited 25 June 2015).

<sup>55</sup> For more, see the consultation paper at paras 6.34 to 6.51.

<sup>56</sup> Association of Directors of Adult Social Services, *Emerging Headline Findings from the ADASS Deprivation of Liberty Survey* (2014). The protective care scheme will also include children aged 16 to 18 years old. We do not separately cost the expansion of this cohort as we do not consider this change to be significant, given the wide margin of error we have built into the range of those included within supportive care.

<sup>57</sup> Association of Directors of Adult Social Services, *Emerging Headline Findings from the ADASS Deprivation of Liberty Survey* (2014).

estimate of 20 per cent more and a lower estimate of zero per cent more), to reflect the greater similarity between the DoLS threshold and that of restrictive care and treatment.

- 10 per cent of people under supportive care are not taking up their existing entitlements (with an upper estimate of 15 per cent and a lower estimate of 5 per cent). Therefore we estimate that 12,257 people within supportive care will generate new costs (with an upper estimate of 18,386 and a lower estimate of 6,129), this being a proportion of the total number of people who will fall under the supportive care scheme (122,570 people).
- Because some people will move from supportive care to restrictive care and treatment, we include this cohort within our calculation for those falling into supportive care. The costs of their moving to restrictive care and treatment are included in the costs of on-going review.
- We have assumed that the cost of the assessment and associated advocacy and representative rights will be significantly cheaper under supportive care than under the DoLS, as a result of the AMCP's ability to delegate functions and to use assessments already carried out, as well as the removal of the requirement to carry out a mental health assessment in every case. We have therefore discounted the present range of costs by 60 per cent (with an upper and lower estimate of 50 and 70 per cent respectively) estimate of a full DoLS assessment and associated advocacy and paid representative to arrive at this cost.<sup>58</sup>
- £231 per case for on-going review. In calculating this cost, we have used the present cost of a best interests assessment and authorisation under the current DoLS (£578), however we have discounted this figure for the removal of duplication of work as between the managing authorities and supervisory bodies (we estimate 30 per cent of original cost as a low estimate and 50 per cent as a high estimate).<sup>59</sup>

## 2. Costs of the restrictive care and treatment scheme

The restrictive care and treatment scheme will involve ongoing assessment, advocacy, and internal review costs.

**Table 17: Costs associated with restrictive care and treatment**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of assessment, advocacy and paid representative	39,100,280	82,515,074	159,751,406
B. Cost of on-going review	1,702,381	7,490,475	24,514,282
C. Costs of tribunal review to local authorities	83,291,360	231,105,127	464,594,677
<b>Total annual costs [A+B+C]</b>	<b>124,094,021</b>	<b>321,110,677</b>	<b>648,860,366</b>
<b>Present value over 10 years</b>	<b>1,032,040,996</b>	<b>2,670,550,766</b>	<b>5,396,315,574</b>

Assumptions:

- 149,810 people will be subject to the restrictive care and treatment scheme. In order to avoid double counting of costs, we do not include within this figure those who are within supportive

<sup>58</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

<sup>59</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

care, despite the fact that many in restrictive care and treatment will have transitioned through supportive care. This movement is costed above in relation to supportive care.

- £551 per person for assessment and advocacy costs. As with supportive care, we have assumed this cost to be significantly cheaper than a full DoLS assessment and associated advocacy and paid representative rights (£1377), as a result of existing entitlements and the removal of duplication of functions (we assume an upper estimate of £978 and a lower estimate of £287).<sup>60</sup> Also, under restrictive care and treatment, evidence from a medical practitioner will only be required where necessary and the Approved Mental Capacity Professional has discretion to delegate responsibilities to health and social care professionals, further reducing costs.
- £100 per person per year for ongoing review. We have assumed that this cost will be comparable to the costs of a best interests assessment under the current DoLS (£578), but heavily discounted given that this review can be delegated to existing care and support staff who already have obligations to review the person's status (we assume an upper estimate of £200 and a lower estimate of £50).<sup>61</sup>
- £2,204 per person who seeks a tribunal review of their care and treatment. In calculating this figure we have assumed a cost of 20 per cent of those that would be incurred before the Court of Protection (£11,019) due to the simplified evidential requirements and hearing procedure, leading to shorter average hearings (we assume an upper estimate of £2,883 and a lower estimate of £962 representing 30 and 10 per cent of the costs of a court procedure respectively).<sup>62</sup>
- 70 per cent of people subject to the scheme will require a tribunal review. Although restrictive care and treatment provides for automatic review, we have assumed this figure (with an upper and lower range of 80 per cent and 60 per cent) given that there will be a cohort who will only receive restrictive care or treatment for a short period of time (for instance those requiring specific treatment rather an ongoing care), and so not trigger the review provisions.

### 3. Costs in hospital settings

The separate regime applicable in hospitals will involve costs as registered medical practitioners or Approved Mental Capacity Professionals are required to authorise deprivations of liberty. There will also be costs associated with reviews.

**Table 18: Costs associated with the hospitals scheme**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of assessment by registered medical practitioner	30,126	433,480	2,769,453
B. Cost of assessment by Approved Mental Capacity Professional	45,190	216,740	769,293
C. Cost of on-going review by Approved Mental Capacity Professional	6,493	43,285	216,425
D. Costs of Tribunal review to local authorities and NHS	32,088	173,439	559,321

<sup>60</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

<sup>61</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

<sup>62</sup> 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> (last visited 25 June 2015).

<b>Total annual cost [A+B+C+D]</b>	<b>113,896</b>	<b>866,943</b>	<b>4,314,491</b>
<b>Present value over 10 years</b>	<b>947,228</b>	<b>7,210,022</b>	<b>35,881,918</b>

Assumptions:

- 7,870 people will require authorisation in the hospitals scheme. In calculating this figure we have taken figures for present DoLS authorisations in hospitals from a Health and Social Care Information Centre report (1490 applications) and increased this figure to account for the Welsh population (1,574).<sup>63</sup> As these figures are prior to the *Cheshire West* case we have also increased them by 400 per cent to reflect both the additional cases of deprivation of liberty and the under use of the DoLS in hospitals at present (7,870). We have used a range of 200 per cent and 900 per cent respectively for our low and high estimates.
- 100 per cent of people deprived of liberty in hospitals (7,870) will require authorisation a clinician.
- 5 per cent of people deprived of liberty in hospitals (394) will require deprivation of liberty for longer than 28 days and will receive an additional authorisation from an AMCP. This is on the basis that the average stay in hospital is presently around 5 days.<sup>64</sup>
- 80 per cent of the required capacity assessments will be undertaken as a result of existing obligations (with a range of 70 and 90 per cent).
- £275 per capacity assessment carried out by a registered medical practitioner for deprivations of liberty under 28 days in length. We have assumed that this cost will be 20 per cent of the present cost of a DoLS authorisation and associated advocacy (£1,377) (with an upper estimate of £587 and a lower estimate of £96).<sup>65</sup> This discount is greater than that assumed in relation to supportive care and restrictive care and treatment assessments on the basis that it is performed simply by a medical practitioner and is significantly simplified. We have assumed that there are no costs associated with on-going review by a responsible clinician, as we assume that the patient will be checked and reviewed at present in any event.
- £524 per assessment carried out for authorisation by an Approved Mental Capacity Professional for a deprivation for greater than 28 days and for advocacy. For this figure we assume the same costs as those used above in relation to restrictive care and treatment.
- £220 per patient requiring ongoing review. We have assumed that this cost will be the same as that used above regarding restrictive care and treatment above.
- 50 per cent of the 5 per cent of people who are deprived of their liberty for longer than 28 days, will remain in hospital for a sufficient amount of time to require an internal review (with an upper estimate of 100 per cent and a lower estimate of 25 per cent).
- £2,204 per patient who challenges their deprivation before the tribunal. This figure is the same as that assumed above in relation to restrictive care and treatment.
- 1 per cent of those under the hospital scheme will seek a tribunal review. This represents 20 per cent of those that we are assuming will require an authorisation for longer than 28 days.

4. *Costs in domestic settings*

The administrative authorisation of deprivations of liberty in domestic settings will generate ongoing assessment, advocacy and review costs.

**Table 19: Costs associated with domestic settings scheme**

<sup>63</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 3 Return 2014-15* (2015) p 25.

<sup>64</sup> Nuffield Trust, *Length of Stay in Hospital in England*, see: <http://www.nuffieldtrust.org.uk/data-and-charts/length-stay-hospital-england> (last visited 25 June 2015).

<sup>65</sup> A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 *The British Journal of Psychiatry* 232, 236.

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Cost of assessment and advocacy	4,109,435	11,086,778	25,184,779
B. Cost of ongoing review	930,742	3,102,473	9,307,418
C. Cost of tribunal review to local authorities	8,753,911	32,530,071	82,398,672
<b>Total annual cost [A+B+C]</b>	<b>13,794,088</b>	<b>46,719,322</b>	<b>116,890,869</b>
<b>Present value over 10 years</b>	<b>114,719,985</b>	<b>388,546,162</b>	<b>972,135,223</b>

#### Assumptions:

- 26,838 people will fall within the domestic settings scheme (with an upper and lower estimate varying by 20 per cent). At present there is no systematic processing of those deprived of liberty in their own homes and, as a result, it is difficult to find robust figures estimating the numbers of people involved. As a result, we have taken two approaches to estimate this figure. Our primary approach has been to use figures representing the number of people who presently receive intensive home care in England (127,000) and to increase this to account for Wales (134,188).<sup>66</sup> We have then assumed that 20 per cent of this cohort (26,838) will lack mental capacity and are being deprived of liberty, and so will fall within our domestic settings scheme (with an upper estimate of 30 per cent, being 40,256, and a lower estimate of 10 per cent, being 13,419). To check these figures we have taken figures from the Association of the Directors of Adult Social Care, who estimate that there are 31,470 people within all domestic settings (including supported living and shared lives).<sup>67</sup> Because we cost people in supported living and shared lives elsewhere, this figure should be considered to overestimate the numbers involved. It does serve though to show that the primary estimate is realistic and conservative.
- Our assumptions regarding the costs of assessment, advocacy and for on-going review are the same as those above in relation to restrictive care and treatment, save that we assume a lesser reduction in the cost of assessments as compared to the DoLS. We also adopt the same assumptions regarding the numbers of reviews that will be required.
- In calculating the costs of tribunal review, we make the same assumptions regarding cost as above with regards to restrictive care and treatment. However we assume that a smaller proportion of people (50 per cent, with an upper and lower range of 60 per cent and 40 per cent) will require tribunal review, on the basis that those with a longer term need for restrictive care and treatment are more likely to be dealt with in a care home or supported living placement, rather than in a domestic setting.

#### 5. Costs of First-tier Tribunal and Court of Protection

The new tribunal jurisdiction will generate ongoing costs to administer. However, after making inquiries, we have been unable to locate the data necessary to estimate the present costs of the Mental Health Review Tribunal. As a result, we are unable to realistically estimate the administrative costs of operating the new tribunal. As a result, we have assumed, like the Court of Protection, that the new tribunal jurisdiction will broadly achieve cost recovery from fees charged.<sup>68</sup> This may render our estimates in this regard relatively optimistic.

<sup>66</sup> Health and Social Care Information Centre, *Community Care Statistics: Social Services Activity, England 2013-14, Final Release* (2014) p 53 <http://www.hscic.gov.uk/catalogue/PUB16133/comm-care-stat-act-eng-2013-14-fin-rep.pdf> (last visited 25 June 2015).

<sup>67</sup> Intensive care denotes those receiving more than 10 hours of care with overnight, live-in or 24 hour services.

<sup>67</sup> Association of Directors of Adult Social Services, *Emerging Headline Findings from the ADASS Deprivation of Liberty Survey* (2014).

<sup>68</sup> Government policy is for the tribunal service to aim for cost recovery across all claims: Her Majesty's Courts and Tribunals Service, *Annual Report and Accounts 2013-14* (2014) HC 154, pp 19 to 20.

Consistently with the above, we have assumed that, of the cases brought to the tribunal, 15 per cent are subject to further appeal in the Upper Tribunal. Again, however, we have not included these costs as we lack the relevant data, and so assume cost recovery by the tribunal.

Of course, those who use the tribunal incur these fees, and these are reflected below.

#### 6. *Legal costs to the parties before the tribunal*

There will be costs incurred in some cases by the parties to tribunal proceedings, including people who lack capacity and their families or carers, whether self-funded, or funded by legal aid. The costs incurred by local authorities and the NHS have already been costed above.

**Table 20: Cost to the parties**

	<b>Low estimate (£)</b>	<b>Best estimate (£)</b>	<b>High estimate (£)</b>
A. Legal aid in First-tier Tribunal	14,685,540	32,976,369	61,431,621
B. Legal aid on appeal	1,979,532	5,124,337	9,652,127
C. Incapacitated people and their families or carers in First-tier Tribunal	22,699,922	85,626,571	211,836,290
D. Incapacitated people and their families or carers on appeal	3,242,476	12,240,772	30,302,883
<b>Total annual cost [A+B+C]</b>	<b>42,607,469</b>	<b>135,968,049</b>	<b>313,222,920</b>
<b>Present value over 10 years</b>	<b>354,349,503</b>	<b>1,130,792,600</b>	<b>2,604,951,403</b>

#### Assumptions:

- 70 per cent of people under restrictive care and treatment in care homes and supported living arrangements will proceed to the automatic tribunal review (with an upper and lower estimate of 60 per cent and 80 per cent). We have made the same assumptions regarding the numbers of people in this cohort as above.
- 70 per cent all of those deprived of liberty in domestic settings will proceed to the tribunal (with an upper and lower estimate of 60 per cent and 80 per cent). We have made the same assumptions regarding the numbers of people in this cohort as above.
- 1 per cent of those under the hospitals scheme will proceed to the tribunal, due to the very short average stay in hospitals. We have made the same assumptions regarding the numbers of people in this cohort as above.
- 15 per cent of all of those that proceed to the tribunal will then pursue an appeal to the Upper Tribunal.
- 25 per cent of people will be legally represented before the First-tier and the Upper Tribunals, due to the expertise and procedures of these tribunals.
- 25 per cent of those who will be represented before the tribunal will be provided with legal aid, we have assumed, in line with the original impact assessment accompanying the DoLS.<sup>69</sup>

- We have decreased the costs to legal aid and of private legal representation assumed above in relation to the Court of Protection to reflect the simplified tribunal process, both before the First-tier Tribunal, and on appeal to the Upper Tribunal.<sup>70</sup> We assume that costs will be 20 per cent of those before the court, with an upper and lower estimate of 30 and 10 per cent.

#### 7. Costs of regulation

The regulators of the new scheme will incur costs in inspecting the settings to which it is applicable, in generating reports and in taking regulatory action where appropriate.

**Table 21: Costs of regulation**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Conducting inspections and preparing reports	3,416,220	16,701,520	39,855,900
<b>Total [A+B]</b>	<b>3,416,220</b>	<b>16,701,520</b>	<b>39,855,900</b>
<b>Present value over 10 years</b>	<b>28,411,353</b>	<b>138,899,950</b>	<b>331,465,790</b>

Assumptions:

- The various regulators already inspect the settings in which our scheme will apply (aside from domestic settings). In some instances, these inspections are for DoLS compliance (in hospitals and care homes for instance), in others it is only for broader regulatory compliance (in supported living for instance). Because our scheme does not contemplate inspections in domestic settings, we have assumed that no further inspections will be required, albeit that the cost of each inspection will increase, and that there will be a cost associated with the preparation of additional reports.
- 18,979 will be required under the protective care scheme. In calculating this figure we have taken the present numbers of inspections in England (17,962) and increased them to reflect Wales.<sup>71</sup>
- £4,400 per facility inspected. This figure is derived using Care Quality Commission figures, and we have assumed a range £1,800 and £7,000 per facility.<sup>72</sup>
- We have assumed that the additional work attributable to our scheme will represent 20 per cent of these current costs (with 10 per cent change as a low estimate and 30 per cent change as a high estimate).

#### 8. Summary of costs

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

**Table 22: Summary of key costs**

	Low estimate (£)	Best estimate (£)	High estimate (£)
<i>Transitional</i>			
A. Training costs	1,943,210	3,886,420	5,829,630

<sup>70</sup> Lucy Series, *Costing the Deprivation of Liberty Safeguards* (2012), see: <http://thesmallplaces.blogspot.co.uk/2012/01/costing-deprivation-of-liberty.html> (last visited 25 June 2015).

<sup>71</sup> Care Quality Commission, *Annual Report and Accounts 2013-14* (2014) pp 9 to 10.

<sup>72</sup> Care Quality Commission, *Changes in the Way We Regulate and Inspect Adult Social Care: Final Regulatory Impact Assessment* (2014) p 29.

<b>Total transitional [A]</b>	<b>1,943,210</b>	<b>3,886,420</b>	<b>5,829,630</b>
<i>Ongoing</i>			
B. Supportive care costs	675,062	8,168,159	38,809,173
C. Restrictive care and treatment costs	122,094,021	321,110,677	648,860,366
D. Hospital setting costs	113,896	866,943	4,314,491
E. Domestic settings costs	13,794,088	46,719,322	116,890,869
F. Legal costs to incapacitated people, families and Legal Aid	42,607,469	135,968,049	313,222,920
G. Regulatory costs	3,416,220	16,701,520	39,855,900
<b>Total ongoing costs [B+C+D+E+F+G]</b>	<b>184,700,756</b>	<b>529,534,670</b>	<b>1,161,953,720</b>
<b>Present value over 10 years</b>	<b>1,538,026,500</b>	<b>4,403,930,855</b>	<b>9,669,340,114</b>

## Benefits

### Transitional benefits

We do not foresee transitional benefits.

### Ongoing benefits

We envisage that the protective care scheme will bring both on-going quantifiable and non-quantifiable benefits.

We anticipate a number of unquantifiable benefits. First, 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 health care system and the rule of law generally.

Second, 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, once a tribunal system is implemented for review of authorisations, and the administrative authorisation procedure is extended, it is expected that the number of applications to the Court of Protection will undergo a drop to lower levels. This will free up judicial resources, with flow on benefits to other court users and the Court of Protection itself, allowing these resources to be deployed elsewhere. Similar flow on benefits can be expected regarding freed up local authority resources.

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 quality-adjusted life years methodology (QALYs).

#### 1. Benefits of supportive care

Supportive care will bring significant quantifiable benefits as local authorities avoid the risk of damages claims resulting from existing potential breaches of article 8 rights where a person is moved away from



their family or home into a care home, supported living or shared lives accommodation, without being subject to restrictive care. At present, because the DoLS does not explicitly deal with article 8 rights, there is a risk of unlawful infringement.

**Table 23: Benefits of supportive care**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoidance of damage awards (article 8)	2,042,857	9,192,856	20,428,569
<b>Total annual benefit [A]</b>	<b>2,042,857</b>	<b>9,192,856</b>	<b>20,428,569</b>
<b>Present value over 10 years</b>	<b>16,989,635</b>	<b>76,453,355</b>	<b>169,896,346</b>

Assumptions:

- 122,657 people will fall within supportive care. We use the same figures derived above here.
- 5 per cent of people will bring an actionable claim for damages for breach of article 8.
- £1500 in damages avoided per award (with an upper estimate of £2000 and a lower estimate of £1000).<sup>73</sup>

## 2. Benefits of restrictive care and treatment

Restrictive care and treatment will bring significant quantifiable and non-quantifiable benefits to a range of people. The streamlining of the role of managing authorities will free resources up to be used elsewhere. By allowing Approved Mental Capacity Professionals (currently the Best Interests Assessor) to authorise a deprivation of liberty, the system will remove the processing burden presently upon supervisory bodies and reduce their role to one of oversight only. This will cut out a significant portion of duplicated work in the present system, again freeing up resources.

The core quantifiable benefit will be the reduction in the risk of damages awards for unlawful deprivations of liberty. This is so because currently only 46 per cent of DoLS applications are being processed, leaving many people potentially deprived of liberty without proper legal process.<sup>74</sup> 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.<sup>75</sup>

**Table 24: Benefits of restrictive care and treatment**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damages	55,157,135	182,018,546	529,508,497
<b>Total annual benefit [A]</b>	<b>55,157,135</b>	<b>182,018,546</b>	<b>529,508,497</b>
<b>Present value over 10 years</b>	<b>458,720,123</b>	<b>1,513,776,409</b>	<b>4,403,713,185</b>

<sup>73</sup> *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.

<sup>74</sup> Health and Social Care Information Centre, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards (England) Quarter 4 Return 2014-15* (2015).

<sup>75</sup> *Essex County Council v RF* [2015] EWCOP 1.

Assumptions:

- 149,810 people will be subject to the restrictive care and treatment scheme. This is the same number as assumed above.
- 54 per cent of people under the restrictive care and treatment scheme would otherwise have been unlawfully deprived of liberty.
- £1500 per month of liberty lost avoided in damages. We assume a range from £1000 to £2000 per month of liberty lost.<sup>76</sup>
- 6 months average deprivation of liberty avoided. We assume that, in a worst case scenario, a deprivation will continue for a year unauthorised and, in a best case, for only 3 months.
- 25 per cent of those who are unlawfully deprived of liberty will have actionable claims and will pursue those claims.

### 3. *Benefits in hospital settings*

We anticipate that the new hospital authorisation scheme will also mitigate the risk of damages claims for unauthorised deprivations of liberty, as we have heard that, at present, a proportion of deprivations in hospital settings are not being subject to the DoLS.

**Table 25: Benefits to hospitals**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damage awards	84,996	478,103	1,699,920
<b>Total annual benefit [A]</b>	<b>84,996</b>	<b>478,103</b>	<b>1,699,920</b>
<b>Present value over 10 years</b>	<b>706,878</b>	<b>3,976,194</b>	<b>14,137,564</b>

Assumptions:

- 7,870 people will fall within the hospitals scheme. This is the same number as that used above.
- 54 per cent of cases of deprivation of liberty in hospitals are not presently being authorised and so are unlawful.
- 5 per cent of those unlawfully deprived of liberty in hospitals would go on to claim.
- 45 days on average deprivation of liberty avoided. This figure is significantly lower than those under restrictive care and treatment, due to significantly shorter average stays in hospitals, as compared with restrictive care and treatment settings.<sup>77</sup> In arriving at upper and lower avoided damages estimates we have assumed a period of deprivation of between 30 and 60 days.

### 4. *Benefits in domestic settings*

We anticipate that the benefits of supportive care in domestic settings will consist of improved safeguards and care outcomes for those deprived of liberty in their family home, and a reduced risk of damage claims for unauthorised deprivations.

<sup>76</sup> *Essex County Council v RF* [2015] EWCOP 1.

<sup>77</sup> Nuffield Trust, *Length of Stay in Hospital in England*, see: <http://www.nuffieldtrust.org.uk/data-and-charts/length-stay-hospital-england> (last visited 25 June 2015).

**Table 26: Benefits in domestic settings**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Avoided risk of damage awards	14,492,520	45,892,980	128,822,400
<b>Total annual benefit [A]</b>	<b>14,492,520</b>	<b>45,892,980</b>	<b>128,822,400</b>
<b>Present value over 10 years</b>	<b>120,528,569</b>	<b>381,673,801</b>	<b>1,071,365,057</b>

Assumptions:

- Again, in calculating the avoided damages we have relied upon similar assumptions to those used above regarding the numbers of people with the domestic setting scheme, the average length of a deprivation of liberty, and the average damages pay out.
- 95 per cent of those who would fall within the domestic settings scheme are presently being deprived of their liberty unlawfully (with an upper estimate of 100 per cent and a lower estimate of 90 per cent).
- 25 per cent of those unlawfully deprived of liberty will go on to make an actionable claim for a substantive breach, consistent with our assumptions above regarding such claims under the restrictive care and treatment scheme.

#### 5. Improved health outcomes

We consider that the protective care scheme will result in improved care outcomes for those who would not have been assessed under the current regime. However, in addition (and by way of comparison with our reasoning above regarding a fully-funded DoLS) we also anticipate tangible benefits for those who would have nevertheless been assessed under the old regime, as a result of the proactive approach to the provision of care, the greater involvement of the person built into the protective care scheme, and the provision for automatic tribunal review. 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.

We anticipate that for those who would not have been otherwise assessed under the current regime, but will be assessed under the restrictive care and treatment scheme<sup>78</sup> (95,957 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 funded 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 broader approach and simply assumed that 30 per cent of all of those who would not have been assessed under the old regime will enjoy 0.036 gain (a change from level 2 to level 1 using the EQ-5D scale) across the usual activities dimension. We assume that 20 per cent and 40 per cent of this cohort will receive this benefit to arrive at lower and upper estimates. The usual activities dimension has again been chosen as it yields the smallest gains for a change in level as compared to the other dimensions, keeping the overall estimate conservative.

As noted, in addition, we assume that all of those subject to the restrictive care and treatment scheme who *would* have been assessed under the present regime, (53,853 people) will also enjoy a small improvement in their care as a result of the improved process under our proposed new scheme. Because this cohort would have received a DoLS assessment under the current regime, we have assumed that only 10 per cent of those within the cohort will enjoy the gain. Again we have estimated the gain as an improvement from level 2 to level 1 across the usual activities dimension, yielding the smallest coefficient increase recognised.

<sup>78</sup> To ensure that our estimates remain conservative we only include those within the restrictive care and treatment scheme here, and omit those in supportive care, the hospitals scheme, and in domestic settings.

**Table 27: QALY benefits**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. QALY benefit for those receiving a new assessment	41,453,424	62,180,136	82,906,848
B. QALY benefit for those who would have received a DoLS assessment	5,816,124	11,632,248	17,448,372
<b>Total QALY value [A+B]</b>	<b>47,269,548</b>	<b>73,812,384</b>	<b>100,355,220</b>
<b>Present value over 10 years</b>	<b>393,122,175</b>	<b>613,868,466</b>	<b>834,614,757</b>

### 6. Summary of benefits

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

**Table 28: Summary of key annual benefits**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Supportive care benefits	2,042,857	9,192,856	20,428,569
B. Restrictive care and treatment benefits	55,157,135	182,018,546	529,508,497
C. Hospital setting benefits	84,996	478,103	1,699,920
D. Domestic setting benefits	14,492,520	45,892,980	128,822,400
E. QALY gain	47,269,548	73,812,384	100,355,220
<b>Total [A+B+C+D+E]</b>	<b>119,047,056</b>	<b>311,394,868</b>	<b>780,814,605</b>
<b>Present value over 10 years</b>	<b>990,067,379</b>	<b>2,589,748,224</b>	<b>6,493,726,908</b>

## Option 3: A new protective care scheme without automatic tribunal review

Option 3 mirrors option 2, save that tribunal review would not be automatically triggered. This scheme does not represent our preferred option for reform, although it does bring significant cost savings.

### 1. Summary of benefits

In assessing the benefits of option 3, we have been unable to rigorously disaggregate the extent of the QALY benefits flowing from tribunal review under option 2. This is because we have not yet settled upon what the trigger for review if the automatic trigger were removed, and because it is difficult to estimate the size of the cohort that would be denied a review under this option and would benefit from such a review. As a result, we have simply assumed that the QALY benefits associated with option 2 would be

decreased by 20 per cent as a best estimate to reflect the risk the smaller cohort of people who would receive a review (with a reduction of 10 per cent as a high estimate and 30 per cent as a low estimate).

**Table 29: Summary of key benefits without automatic review**

	Low estimate (£)	Best estimate (£)	High estimate (£)
A. Supportive care benefits	2,042,857	9,192,856	20,428,569
B. Restrictive care and treatment benefits	55,157,135	182,018,546	529,508,497
C. Hospital setting benefits	84,996	478,103	1,699,920
D. Domestic setting benefits	14,492,520	45,892,980	128,822,400
E. QALY benefits	33,088,684	59,049,907	90,319,698
<b>Total [A+B+C+D+E]</b>	<b>104,866,192</b>	<b>296,632,392</b>	<b>770,779,084</b>
<b>Present value over 10 years</b>	<b>872,130,730</b>	<b>2,466,974,530</b>	<b>6,410,265,432</b>

## 2. Summary of costs

In assessing the costs of option 3, we have again made the same assumptions as listed in option 2, save that we have assumed that tribunal review will be initiated in only 20 per cent of those cases in which it is enlivened under option 2 (being, regarding option 2, 70 per cent of people in restrictive care and treatment, 1 per cent in hospitals, and 50 per cent of people in domestic settings) as a best estimate, with reviews instituted in 10 and 30 per cent of cases as a low and high estimate respectively.

**Table 30: Summary of key costs without automatic review**

	Low estimate (£)	Best estimate (£)	High estimate (£)
<i>Transitional</i>			
A. Training costs	1,943,210	3,886,420	5,829,630
<b>Total transitional [A]</b>	<b>1,943,210</b>	<b>3,886,420</b>	<b>5,829,630</b>
<i>Ongoing</i>			
B. Supportive care costs	675,062	8,168,159	38,809,173
C. Restrictive care and treatment costs	49,131,797	136,226,575	323,644,092
D. Hospital setting costs	85,017	728,192	3,922,967
E. Domestic settings costs	5,915,568	20,695,265	59,211,799
F. Legal costs to incapacitated people, families and Legal Aid	4,260,747	27,193,610	93,966,876

G. Regulatory costs	3,416,220	16,701,520	39,855,900
<b>Total ongoing costs [B+C+D+E+F+G]</b>	<b>63,484,411</b>	<b>209,713,321</b>	<b>559,410,807</b>
<b>Present value over 10 years</b>	<b>£529,918,000</b>	<b>1,744,102,921</b>	<b>4,658,228,525</b>

## Summary of cost benefit analysis

*Table 31: Summary of cost benefit analysis*

	Low estimate	Best estimate	High estimate
<b>Option 1</b>			
A. Transitional cost	1,699,897	2,564,274	3,428,652
B. On-going cost	1,145,003,892	1,584,971,094	2,059,923,863
<b>C. Present value over 10 years [Cost]</b>	<b>9,522,545,462</b>	<b>13,181,579,036</b>	<b>17,131,573,763</b>
D. Transitional benefit	0	0	0
E. On-going benefit	74,430,494	160,086,762	346,341,592
<b>Present value over 10 years [Benefit]</b>	<b>619,009,042</b>	<b>1,331,378,416</b>	<b>£2,880,386,327</b>
<b>Net Present value</b>	<b>-8,905,236,299</b>	<b>-11,852,764,893</b>	<b>-14,254,616,087</b>
<b>Option 2</b>			
F. Transitional cost	1,943,210	3,886,420	5,829,630
G. On-going cost	184,700,756	529,534,670	1,161,953,720
<b>H. Present value over 10 years [Cost]</b>	<b>1,538,026,500</b>	<b>4,403,930,855</b>	<b>9,669,340,114</b>
I. Transitional benefit	0	0	0
J. On-going benefit	119,047,056	311,394,868	780,814,605
<b>Present value over 10 years [Benefit]</b>	<b>990,067,379</b>	<b>2,589,748,224</b>	<b>6,493,726,908</b>

<b>Net Present value</b>	<b>-547,959,120</b>	<b>-1,814,182,630</b>	<b>-3,175,613,205</b>
<b>Option 3</b>			
K. Transitional cost	1,943,210	3,886,420	5,829,630
L. On-going cost	63,484,411	209,713,321	559,410,807
<b>M. Present value over 10 years [Cost]</b>	<b>529,918,000</b>	<b>1,744,102,921</b>	<b>4,658,228,525</b>
N. Transitional benefit	0	0	0
O. On-going benefit	104,866,192	296,632,392	770,779,084
<b>Present value over 10 years [Benefit]</b>	<b>872,130,730</b>	<b>2,466,974,530</b>	<b>6,410,265,432</b>
<b>Net Present value</b>	<b>342,212,730</b>	<b>722,871,608</b>	<b>1,752,036,907</b>

In summary, option 1 will involve costs to local authorities and the NHS who will continue to incur costs under the fully funded DoLS; legal costs to incapacitated people, families and legal aid; and regulatory costs to the regulators. We estimate the total ongoing annual cost of option 1 to be £1,584,971,094 (best estimate), with a present value over ten years of £13,181,579,036 (best estimate) and transitional costs of £2,564,274. The main benefits of option 1 are a reduced risk of damage claims for breaches of human rights and the QALY benefits which flow to those now receiving an assessment. We estimate the annual ongoing benefit of option 1 to be £160,086,762 (best estimate), with a net present value over ten years of -£11,852,764,893 (best estimate). The negative net present value signals that the scheme will cost more than it will save.

Option 2 will also involve costs to local authorities and the NHS who will generally be responsible for administering the scheme; legal costs to incapacitated people, families and legal aid; and regulatory costs to the regulators. We estimate the total ongoing annual cost of option 2 to be £529,534,670 (best estimate), with a present value over ten years of £4,403,930,855 (best estimate) and transitional costs of £3,886,420. The main benefits of option 2 are improved safeguards and care outcomes for those deprived of liberty in their family home, and a reduced risk of damage claims for breaches of human rights. We estimate the annual ongoing benefit of option 2 to be £311,394,868 (best estimate), with a net present value over ten years of -£1,814,182,630 (best estimate). Again the negative figure shows that there will be significant costs.

Option 3 will involve costs to local authorities and the NHS who will generally be responsible for administering the scheme; legal costs to incapacitated people, families and legal aid; and regulatory costs to the regulators. We estimate the total ongoing annual cost of option 3 to be £209,713,321 (best estimate), with a present value over ten years of £1,744,102,921 (best estimate) and transitional costs of £3,886,420. The main benefits of option 3, as compared with option 0, are improved safeguards and care outcomes for those deprived of liberty, and a reduced risk of damage claims for breaches of human rights. However, as compared to option 2, option 3 offers potentially weakened safeguards as automatic tribunal review is replaced with a system to filter those cases worthy of review. This of course brings significantly reduced costs. We estimate the annual ongoing benefit of option 3 to be £296,632,392 (best estimate), with a net present value over ten years of £722,871,608 (best estimate). The positive figure here represents that the gains will outstrip the costs.

## 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 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 protective care 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 protective care 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 Human Rights (liberty). 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 case loads 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.