Title: Mental Capacity (Amendment) Act (MC(A)A)
IA No:

RPC Reference No:

Lead department or agency:
Department of Health and Social Care

Other departments or agencies:

Impact Assessment (IA)

Date: March 2022

Stage: Consultation

Source of intervention: Domestic

Type of measure: Primary and Secondary Legislation

Contact for enquiries:
LPS.CoP@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option (in 2019 prices, 2020 present value)

Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target
£1,985m	-£21.0m	£2.4m	Non qualifying (<£5m)

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

The Deprivation of Liberty Safeguards (DoLS) provide a legal process to review and, where appropriate, authorise arrangements for a person's care or treatment which may amount to a deprivation of liberty, for people aged 18 and over in a care home or hospital. It provides key safeguards to protect the person's human rights. The system is monitored by CQC. All other cases are considered by the Court of Protection (CoP). However, it is complex and overly bureaucratic, and since DoLS was introduced, two court judgments (*Cheshire West* and *Re D*) have broadened the scope of the system, resulting in it being overwhelmed. Thousands of people are potentially unlawfully deprived of their liberty, resulting in non-compliance with the law, and associated breaches of human rights.

What are the policy objectives of the action and the intended effects?

1. To create a new simplified legal framework which is accessible and clear to all affected parties.
2. To deliver improved outcomes for persons deprived of their liberty and their families / unpaid carers.
3. To provide a simplified authorisation process capable of operating effectively in all settings.
4. To ensure that the Mental Capacity Act 2005 (MCA) works as intended, by placing the person at the heart of decision-making and that it is compliant with Article 5 and 8 of the European Convention on Human Rights.
5. To provide a comprehensive, proportionate and lawful mechanism by which deprivations of liberty for young people aged 16 and 17 can be authorised.

The intended effects are to ensure increased compliance with the law, improve care and treatment for people lacking capacity and to provide a system of authorisation and robust safeguards 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: Status quo – the system as it runs now. Thousands of people are unlawfully deprived of their liberty.
Option 1: The existing deprivation of liberty mechanisms fully operationalised to cope with the actual number of DoLS applications received post *Cheshire West* and the expected number of CoP applications post *Re D*.
Option 2: Implementation of new adjusted Liberty Protection Safeguards (LPS) model (preferred option).
Our preferred option is a variation of the Law Commission's LPS proposal. It is our preferred approach for implementation because it is proportionate, cost-effective and resolves the problems identified in the existing DoLS system in a timely way.

Will the policy be reviewed? *Yes.* ***If applicable, set review date:*** *Following consultation on the secondary legislation*

Is this measure likely to impact on international trade and investment?	No

Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** N/A	**Non-traded:** N/A	

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

Signed by the responsible Minister: ..... Date: .....

Summary: Analysis & Evidence

Policy Option 0

Description: Status quo (DoLS and CoP authorisations at present)

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2020/21	2022/23	10	**Low: £0**	**High: £0**	**Best Estimate: £0**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	N/A	£0	**£0**
High	N/A		£0	**£0**
Best Estimate	N/A		£0	**£0**

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

This is the base case which assumes the current system will continue without reform. Costs and benefits of other options are compared with this.

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

We do not consider option 0 to be viable. The current system cannot keep pace with the high demand for DoLS authorisations and not all deprivations of liberty in community settings are being authorised through the CoP, meaning there has been subsequent non-compliance with the law and potential breaches of human rights.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£0	**£0**
High	N/A		£0	**£0**
Best Estimate	N/A		£0	**£0**

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

This is the base case which assumes the current system will continue without reform. Costs and benefits of other options are compared with this.

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

N/A

Key assumptions/sensitivities/risks **Discount rate** 3.5

N/A

BUSINESS ASSESSMENT (Option 0)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	**Benefits:**	**Net:**	
N/A	**N/A**	**N/A**	N/A

Summary: Analysis & Evidence

Policy Option 1

Description: Existing deprivation of liberty mechanisms (DoLS and relevant CoP orders) fully operationalised FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2020/21	2022/23	10	**Low: -£16,820**	**High: -£26,548**	**Best Estimate: -£21,554**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual* (excl. Transition) (Constant Price)	Total Cost* (Present Value)
Low	£9.47m	1	£1,972m	**£16,820m**
High	£25.61m		£3,112m	**£26,548m**
Best Estimate	£17.25m		£2,527m	**£21,554m**

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

This option assumes the current system will continue without reform, but that it will be fully operationalised and funded. The expected costs of fully operationalising the system, including current expenditure, are (based on the number of DoLS applications and relevant CoP orders in 2019/20):

- One-off transitional training costs for NHS, local authorities and providers £17.25m
- Refresher training costs £0.94m per year.
- Costs to managing and supervisory bodies £438m per year.
- Cost of deprivations of liberty through CoP in domestic settings and for 16/17-year olds following *Re D* ruling £747m per year.
- Legal costs £1,255m per year (£358m legal system, £897m self-funded).
- Costs to regulatory bodies £11m per year

*To derive the *additional* annual and total costs, we subtract the estimated £527m per annum costs of the existing system as currently funded (DoLS and relevant CoP orders). Annual costs over 10 years are modelled to increase over time due to demand. Therefore, average annual costs do not represent the expected cost in any specific year.

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	Not quantified	N/A	Not quantified	**Not quantified**
High	Not quantified		Not quantified	**Not quantified**
Best Estimate	Not quantified		Not quantified	**Not quantified**

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

It has not been possible to monetise benefits.

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

England and Wales: greater compliance with international human rights obligations.
Reduced exposure to damages for unauthorised deprivations of liberty.
Significant but unquantifiable improved health, human rights, social and education outcomes as everyone who requires an authorisation receives one.

Key assumptions/sensitivities/risks **Discount rate** 3.5

Sensitivities and assumptions are detailed, where neccesary, within the evidence base.
Risks:

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

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	**Benefits:**	**Net:**	
N/A	**N/A**	**N/A**	Non qualifying provision (score <£5m)

Summary: Analysis & Evidence

Policy Option 2

Description: Adjusted Liberty Protection Safeguards (LPS)[1]

FULL ECONOMIC ASSESSMENT

This is a draft final stage assessment of the design of the LPS as set out in the Mental Capacity (Amendment) Act 2019 (MC(A)A), the relevant draft regulations, and Code of Practice. A final assessment will be published after consultation.

Price Base Year 2020/21	PV Base Year 2022/23	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £1,113m	High: £3,859m	Best Estimate: £2,250m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	£61m	2	£344m	**£2,939m**
High	£117m		£503m	**£4,286m**
Best Estimate	£86m		£418m	**£3,564m**

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

This option assumes the current system is replaced by the LPS. The main expected costs to various bodies to introduce and operationalise the new system are estimated as follows (based on 2019/20 levels of demand):

- One-off, transitional training costs (advocate training, Approved Mental Capacity Professional (AMCP) upfront training, Best Interest Assesor (BIA) to AMCP conversion, and general staff awareness and specialist training) £76.32m.
- Data and other implementation costs: £9.42m

Ongoing costs arising from the proposed system:

- Administration: £46.74m per year.
- New assessments: £52.43m per year.
- Advocacy: £141.30m per year.
- Approval by Approved Mental Capacity Professionals (AMCP): £27.45m per year.
- Legal system costs: £18.58m per year.
- Costs to Responsible Body from Court of Protection reviews: £17.10m per year.
- Regulatory bodies: £14.90m per year.

*Average Annual costs above are an average of the full annual system costs of the LPS in 2020/21 prices over a 10-year period, where costs are modelled to increase over time due to demand. They do not represent the expected cost in any specific year. Costs no longer incurred from the existing system are accounted as benefits (cost savings) below.

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

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	£0	1	£482m	**£4,111m**
High	£0		£969m	**£8,261m**
Best Estimate	£0		£692m	**£5,898m**

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

The monetised benefits are the costs no longer incurred from operating the existing deprivation of liberty mechanisms (DoLS and relevant CoP orders). We project discounted annual savings forward, adjusting for future demand.

[1] Our proposed model is adjusted from the Law Commission's proposed LPS model. https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related

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

People who lack capacity: greater empowerment, equality and improved care outcomes.
Families and carers: greater certainty and empowerment.
Care providers: removes uncertainty of waiting for assessments to be completed.
NHS and local authorities: greater compliance with the law.
United Kingdom: greater compliance with international human rights obligations.

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

Sensitivities and assumptions are detailed, where neccesary, within the evidence base. Direct impact on business (Equivalent Annual) is the estimated training cost to care providers in the transitional year. We estimate no additional costs to business after this. While there are benefits to business, such as the removal of uncertainty, we have not been able to monetise these.

Unit costs assumptions

1. We have used information from the Personal Social Services Research Unit (PSSRU) Unit Costs of Health and Social Care[2] published in December 2020 as this provides the most authoritative evidence in relation to unit labour input costs, which feeds into the overall training costs calculations where relevant.
2. We have also used information from the comprehensive work undertaken by the Law Commission on reforming the DoLS system over a three-year period (2014 – 2017)[3] as this continues to represent the best available evidence on other unit costs excluding training costs. As such, various unit costs are sourced from the Law Commission's Mental Capacity and Deprivation of Liberty Impact Assessment (IA) and uplifted to 2018/19 prices. Unit costs are detailed in the Annex pages.

Risks

1. That costs of the proposed preferred option could materially exceed our estimates which will reduce the quantified benefits. Note however the significant non-monetised benefits.
2. That data from different sources has been combined and broad assumptions applied in order to generate estimated costs. Changing these assumptions could alter the estimated scale of cost impacts.

Mitigation of these risks includes approaching the whole process conservatively in relation to costs/benefits and using best estimates from the best available evidence. This is the approach taken here.

Direct impact on business (Equivalent Annual) £m (in 2019 prices, 2020 present values)			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs:	**Benefits:**	**Net:**	
£2.4m	N/A	£-2.4m	Non qualifying provision (score <£5m)

[2] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2018/
[3] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related (pages 29 – 35)

Evidence Base

1. Summary of changes in this version of the Impact Assessment

1.1 This is the draft final stage UK Government Impact Assessment relating to the LPS introduced in the primary legislation, the Mental Capacity (Amendment) Act 2019 (MC(A)A). The Government has set out the overall policy for the LPS in the draft secondary legislation and Code of Practice, which is now published for consultation. This Impact Assessment covers the policy as set out in these additional products, as well as the primary legislation.

1.2 This assessment builds on previous Impact Assessments, which only considered the primary legislation. The following paragraphs summarise the changes, bringing the assessments into line with the draft regulations and Code, and following conversations with affected stakeholders about what changes the LPS will bring.

1.3 The implementation costs for the LPS have been updated to reflect the implementation plan, in line with the draft regulations and Code in the following ways:

- Assumptions regarding 'familiarisation' and 'full' training have been replaced by assumptions framed by the LPS 'workforce & training triangle' (see page 38). This sets out six competency groups for the LPS training, from awareness level training to AMCP training. Where appropriate, we have outlined both cost of the professional's time to do the training and the cost of the course.
- The estimated costs now include training for other key professionals – such as nurses and other professionals who may support or look after young people aged 16 & 17.
- AMCP training has also been brought into line with the requirements set out in regulations.
- The care home manager role, as set out in the Act, is no longer planned for implementation, therefore training costs for this group have been brought into line with the training for all staff groups.
- Overall, estimated training costs have increased from around £39m to £76m. This includes the cost of professional's time, and any cost of developing or attending a course where appropriate.
- Data implementation costs have been updated to include the development of a national system to support CQC and Ofsted's role (in England) in monitoring and reporting, and to enable an annual report from NHSD. Additionally, this assessment includes an estimation for implementation costs for Responsible Bodies to set up local data systems for the running of the LPS system.

1.4 More recent data has been released since the previous version of the Impact Assessment. DoLS application data has been updated to the latest year available (2019/20). This has impacted our assumptions and assessments throughout the document. Legal aid costs have also been amended in line with current costs, which have been provided by the Ministry of Justice.

1.5 Any prices have been updated to the latest year: 2020/21

1.6 The Impact Assessment is partly based on work by the Law Commission[1]. Previous versions of the Impact Assessments are available on the UK Parliament website[2] and the UK Government website.[3]

[1] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/
[2] https://services.parliament.uk/Bills/2017-19/mentalcapacityamendment/documents.html
[3] https://www.gov.uk/government/publications/impact-assessment-of-the-mental-capacity-amendment-act-2019

2. Introduction

2.1 This is a draft final stage Impact Assessment for the Act. It evaluates options for reforming the DoLS system as set out in primary legislation. Option two assesses the design of the LPS as set out in both the primary and draft secondary legislation ('the regulations'), as well as the draft Code of Practice ('the Code').

2.2 The preferred option is an adjusted version of the LPS proposed by the Law Commission in their 2017 report and associated Impact Assessment[4].

2.3 We use the Law Commission Impact Assessment (IA) as our basis as we have largely brought forward their proposed model. However, we have amended their Impact Assessment to reflect differences between the Law Commission's model and the adjusted the LPS model set out in the Act, the regulations, the Code, and feedback received from delivery partners and stakeholders.

2.4 This Impact Assessment provides a view on the ongoing cost of the LPS as outlined in the Act, the regulations, and the Code. It also calculates transitional costs associated with training and other change programmes.

2.5 This policy applies to both England and Wales. The Act, the Code, and some of the regulations will apply to both nations. However, the Welsh Government is setting out some of the specific policy design for Wales within its own regulations. The Welsh Government are consulting on the Welsh regulations and has also published a specific, Welsh Impact Assessment. The Welsh assessment follows the analysis set out in this assessment, and therefore takes approximately 5% of the overall costs in this assessment as the Welsh impact, in line with this document. This will be reviewed following consultation.

2.6 Even though some of the regulations are devolved policy, the Act and the Code apply to both England and Wales. Therefore, all costs and benefits apply to both England and Wales. As much of the data used applies to England only, we make adjustments to account for costs and benefits arising in Wales, as set out where relevant in the Annexes. Unless otherwise stated we have updated the figures with the latest NHS Digital data (2019/20) and inflated to 2020/21 prices.

3. Background

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

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

3.3 In March 2014, the House of Lords, in their post-legislative review into the MCA, found that DoLS 'were not fit for purpose' and recommended replacing DoLS with a simpler system.[6] Days later, the Supreme Court judgments, *P v Cheshire West and Chester Council* and *P v Surrey*

[4] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related
[5] (2005) 40 EHRR 32 (App No 45508/99).
[6] House of Lords Select Committee on the Mental Capacity Act: Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139.

County Council[7] (known as "Cheshire West") gave a significantly wider definition of a deprivation of liberty than that which had been previously understood. Prior to Cheshire West, the conditions to be met for a deprivation of liberty were more nuanced. For example, in some cases consideration could be given to the views of the cared for person and their family. In Cheshire West, the Court held that a person who lacks capacity to consent to their confinement is considered to be deprived of their liberty when they are under continuous supervision and control and are not free to leave. This is irrespective of whether or not they appear to object to that state of affairs (subject to the deprivation of liberty being the responsibility of the state).

3.4 Since these judgments, the DoLS regime has struggled to cope with the increased number of cases. According to the Law Commission, in 2013/14, prior to the Supreme Court ruling in Cheshire West, the total number of DoLS applications in England was 13,715. The most recent data from NHS Digital shows that the number of DoLS applications in England has increased to 263,940 in 2019-20.[8] Furthermore, these figures only apply to people aged 18 and over in care homes and hospitals. It therefore does not capture 16/17-year-olds or adults in any other setting, such as shared lives or private domestic settings, who are deprived of liberty. The only available mechanism to provide Article 5 safeguards for those who lack the relevant mental capacity in these cases at present, is via a Court Order from the Court of Protection, Family Court or High Court.[9]

3.5 The Law Commission estimated that there are 53,000 adults deprived of their liberty in settings other than care homes and hospitals.[10] This is higher than the official figures of the Court of Protection as it is widely recognised that many local authorities and NHS bodies are unable to manage demand, and there are therefore many unauthorised cases within the community.[11]

3.6 In September 2019 in *D (A Child) UKSC 42* the Supreme Court ruled that where a 16/17-year-old lacks capacity to consent to arrangements which constitute a deprivation of liberty themselves, parental consent will not stop that being a deprivation of liberty. This was the latest in a string of judgments on this individual which began with *Re D (A Child) (Deprivation of Liberty) [2015] EWHC 922 (Fam).* Following this judgment, it is believed that thousands of young people are currently unlawfully deprived of their liberty in England and Wales. The Department for Education estimates that an additional 6,600 16/17-year-olds may require authorisation for such arrangements. This number is an upper estimate and is in fact expected to be lower in practice. There is limited data available on children that may be affected by this legislation, and therefore this is the best estimate based on information from NHSE, the School Census, and Government statistics on young people with special educational need[12], looked after children[13], and young people with learning disabilities[14].

3.7 When the 6,600 16-and-17-year-olds are added to the Law Commission estimate for community cases, it gives 59,600 people not covered by DoLS.

3.8 In response to the House of Lords report, in 2014 the Government tasked the Law Commission with completing a report into Mental Capacity and DoLS. The Law Commission published their

[7] [2014] UKSC 19, [2014] AC 896.
[8] Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England), NHS-Digital (2020) https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2019-20
[9] At present, the DoLS only apply to hospitals and care homes. A deprivation of liberty in any other setting must be authorised by the Court of Protection. These settings could include care provided in the person's home, supported living (accommodation which has been adapted or intended for occupation of adults with needs for care and support) and shared lives accommodation (a service that normally involves placements of people in family homes where they receive care and support from a shared lives carer and have the opportunity to be part of the carer's family and support networks).
[10] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related (page 24)
[11] We have estimated this figure by using estimates from the Association of Directors of Social Services of the number of deprivation of liberty cases in private setting placements commissioned by local authorities (see http://www.communitycare.co.uk/2015/06/17/councils-failure-make-court-applications-leaving-widespread-unlawful-deprivations-liberty-year-cheshire-west-ruling/), the numbers of persons falling under NHS continuing healthcare and estimates of the number of self-funders who would fall within our system.
[12] https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018
[13] https://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-las-31-march-2018
[14] https://www.gov.uk/government/statistical-data-sets/fe-data-library-equality-and-diversity

report in March 2017 and recommended replacing the current DoLS system, as a matter of urgency, with the LPS.[15] The Government responded to the Law Commission in March 2018 and stated that they would legislate for this after considering the details of the proposals and ensuring a new system would fit with the conditions of the health and social care sector.[16]

3.9 The Bill was introduced into Parliament in September 2018 and received Royal Ascent in May 2019. Since then, the Government has been developing the regulations, and co-producing the Code with over 100 sector experts and people with experience of the Mental Capacity Act. This draft Impact Assessment accompanies the public consultation of the Code and regulations, along with other implementation products. A final stage assessment will be published with the final products and the consultation response, ahead of them entering Parliament.

3.10 The DoLS have a significant impact on various user groups. Overwhelmingly those subject to DoLS are older people, many of whom have dementia. However, younger adults with learning disabilities and people with mental illness may also be subject to DoLS. A full Equality Assessment has been published which considers the impact on these groups.

3.11 Public bodies, such as the NHS and local authorities are impacted by the new policy intentions for the LPS, as well as the health and social care workforce.

4. Problem under consideration

4.1 The table below provides a summary of the key features and the identified problems with the current DoLS system [option 0 – status quo].

Table 1: Current DoLS system (Option 0) – Key features and associated problems

Key features	Associated problems
Limited in scope and not cost effective	Increased stress for people not accessing vital safeguards and their families
Overly complex system	Unnecessary burden for people and their families
Ill-suited and outdated terminology	DoLS seen as stigmatising, meaning authorisations aren't always sought
Scale of the problem	Applications not completed and people are left without protections
Individuals left without protections	People may receive inappropriately restrictive care and treatment

Limited in scope and not cost effective

4.2 The DoLS only apply to people over the age of 18 in care homes and hospitals. This means the authorisation of deprivations of liberty outside these settings, such as in supported living and private and domestic settings, must be dealt with by the Court of Protection. A Court Order from the High Court or the Family Court is also the only route for lawfully authorising deprivations of liberty for 16/17-year-olds, who are not covered by DoLS, despite being covered by other provisions within the MCA. This is a more expensive process for local authorities and NHS bodies (compared to authorisations under the DoLS) and can result in delay and increased stress for the person concerned, and their family or unpaid carers. The Law Commission concluded that cases are frequently not taken to Court when they should be, meaning people are not accessing vital safeguards and are deprived of their liberty unlawfully.

Overly complex system

[15] Law Commission: Report into Mental Capacity and Deprivation of Liberty Safeguards (2017)
[16] http://qna.files.parliament.uk/ws-attachments/861932/original/180314%20Response%20to%20Law%20Commission%20on%20DoLS%20-%20final.pdf

4.3 The legislation which set up the DoLS has been described as "tortuous and complex".[17] The current DoLS system requires six separate assessments to be carried out for each application and every application needs to be approved by a Best Interests Assessor (BIA). An authorisation of an application can last up to one year in a single location. A new and separate application also needs to be completed for every location where the person receives care or treatment. This means people who receive respite care or have a planned hospital admission are likely to end up with multiple applications, which place an unnecessary burden on individuals and their families, as well as the DoLS system and budget. Mr Justice Charles, Vice President of the Court of Protection, described the experience of writing a judgment in a case involving the DoLS as feeling "as if you have been in a washing machine and spin dryer".[18]

Ill-suited and outdated terminology

4.4 The terminology used in the DoLS – including terms such as "standard authorisations"– has been criticised as cumbersome and failing to reflect modern health and social care functions. The Law Commission found in their engagement that the label "Deprivation of Liberty Safeguards" is also seen as stigmatising and may make care providers reluctant to seek authorisations.

Scale of the problem

4.5 The Government's original Impact Assessment, completed in 2008, 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. Their worst-case scenario 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.

4.6 Since the Cheshire West judgment there has been a significant increase in DoLS applications. In 2019/20 there were 263,940 applications in England, which is over ten times the number of applications the DoLS system was expected to need to process in the worst-case scenario. Approximately two million people are thought to lack the capacity to make certain decisions for themselves, so the number of people subject to DoLS could grow even further.[19]

4.7 The DoLS were designed with a relatively small number of cases in mind and were not intended to deal efficiently with the present levels of demand. Lack of workforce capacity means there is a building but ever-changing 'backlog' of pending applications not completed within the year they are received by local authorities.

Individuals left without safeguards

4.8 In 2019/20 the number of cases that were not completed as at year end was 129,780. Of these just under 40% (49,500) had a duration of over one year.[20] The volume of cases pending approval by local authorities means that individuals are often left without safeguards for an extended period of time. This means that individuals may be receiving inappropriate care and that local authorities are not meeting their statutory duties.

5. Rationale for Intervention

5.1 The current legal framework fails to protect the rights of people and establishes a compelling case for reform. It is clear from the above that more than 120,000 people are being left without the protections they need and around 50,000 have been waiting more than one year for an

[19] Social Care Institute for Excellence: Mental Capacity Act 2005 at a glance https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

[20] Mental Capacity Act (2005) Deprivation of Liberty Safeguards, (England) 2019/20, Official Statistics, Applications data, Table 9

authorisation. These figures only include individuals who have applications for DoLS and there could be many more in non-DoLS settings. This creates a situation where people are being deprived of their liberty without any oversight and can mean that overly restrictive practices are used which may interfere with their Article 5 human rights.

5.2 Furthermore, inefficiencies in the administration of the DoLS authorisation process create wastage. It is important to ensure that the system is operating as efficiently as possible, particularly given wider pressures on the health and care sector caused by an ageing population and other factors.

6. Policy Objectives

5.1 The policy objectives are as follows:

- To create a new simplified legal framework which is accessible and clear to all affected parties
- To deliver improved outcomes for persons deprived of their liberty and their families / unpaid carers
- To provide a simplified authorisation process capable of operating effectively in all settings
- To ensure that the MCA works as intended, by placing the person at the heart of decision-making, and that it is compliant with Articles 5 and 8 of the European Convention on Human Rights.

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

7. Current DoLS Procedure

7.1 The DoLS system is used to assess and authorise deprivations of liberty for over 18s which occur in care homes and hospital settings. Deprivations of liberty also occur outside DoLS settings, for example in supported living and private domestic settings. We describe both scenarios below.

<u>Deprivation of liberty in care homes and hospital settings</u>

7.2 The DoLS require managing authorities (the hospital or care home where the deprivation of liberty will occur) to apply to supervisory bodies (generally the local authority or, in the case of Wales, also a Local Health Board) when they propose to deprive a person of their liberty (referred to as a ‘DoLS application’). The supervisory body, on receiving a DoLS application, must arrange a series of six assessments (age, no refusals, mental capacity, mental health, eligibility, and best interests). At a minimum, these can be completed by two people; a Best Interests Assessor (BIA) and mental health assessor, who must be a s12 doctor. If all the assessments are “positive” the supervisory body must authorise the deprivation of liberty (referred to as a ‘standard authorisation’).

7.3 A standard authorisation must authorise a deprivation of liberty for up to one year. If it is proposed to deprive the person of liberty for a further period, a fresh DoLS application and authorisation are required. The standard authorisation may be subject to a review by the supervisory body at any time, at the request of a managing authority or an individual or their representative (referred to as an ‘internal review’).

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

7.5 To assist the person through the assessment process, an Independent Mental Capacity Advocate (IMCA) or a relevant person's representative (RPR) is appointed by the supervisory body. If an IMCA is appointed, in most cases this appointment ceases following authorisation and the supervisory body then appoints an RPR. The RPR's role is to maintain contact with the relevant person and support and represent the person. On request by the relevant person or the RPR, and in certain other circumstances, the supervisory body must appoint an IMCA after the authorisation. The role of the IMCA includes representing and supporting the relevant person and explaining the DoLS authorisation to the relevant person and RPR.

Deprivation of liberty outside care homes and hospital settings

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

7.7 Similarly, people aged 16 or 17, or people whose lack of mental capacity results from a disorder of the brain (as opposed to a disorder of the mind) are not eligible for the DoLS, although the rest of the MCA applies to 16-/17-year-olds. In such cases an authorisation from the Court would be needed. Following the *Re D* ruling that parental consent is not sufficient to deprive a 16/17-year-old of their liberty, it is estimated that 6,600 16/17-year-olds need an authorisation each year. However, it is expected that this is an over-estimate, see para 3.6.

8. Description of options considered

This impact assessment considers three options:

8.1 Option 0 - Business as usual (status quo) – do not amend the current system. This is the base case that the costs and benefits of other options are compared to. Under this option, the local authority 'backlog' of pending applications would remain and continue to increase, and individuals would be left without safeguards. We do not consider Option 0 to be a viable option. The DoLS are overly complex and are not well understood by both those subject to them and those applying them.

8.2 Option 1 – The existing deprivation of liberty mechanisms (DoLS and CoP authorisations) fully operationalised to cope with actual number of applications following *Cheshire West* and *Re D* judgments. Under this option, assessments would all take place within statutory time limits, cases would be taken to Court when they should be, and referrals would be made by managing authorities when they should be. Option 1 represents the true potential cost to the system without reform. We include this as a potential option as a useful comparison and to highlight the high cost of the current system if it were to continue and be fully adhered to. Option 1 would improve human rights outcomes, as fully funding DoLS would enable local authorities to process all cases within statutory time limits.

8.3 Option 2 – Implementation of new adjusted the LPS model (preferred option). This is a new system based on the Law Commission's proposal and set out in the MC(A)A and is designed to deal with the large increase in applications. It would offer the improved outcomes of Option 1 at a reduced cost, with potential further human rights benefits.

9. The proposed new system (Option 2) – Adjusted LPS

9.1 The Law Commission designed a new system, the LPS, as part of their report. The Government agreed in principle to the introduction of a new system and subsequently brought forward an adjusted version of the Law Commission's model after working with a range of stakeholders to consider the detail. A list of some of the stakeholders we have engaged with can be found in Annex 1. This model achieves the Government's objectives and will be compliant with Article 5 of the European Convention on Human Rights, namely that everyone has the right to liberty and security of person.

9.2 The LPS system significantly widen the scope of protection by extending safeguards to other settings, such as shared lives schemes and children's care settings, as well as to 16/17-year-olds in line with the wider MCA.

9.3 When it is identified that a person might need an LPS authorisation, a Responsible Body[21] will arrange the assessments needed, or use existing valid assessments where available and appropriate, and complete the relevant consultation.

9.4 A key change in the new model is that NHS organisations in England will also be Responsible Bodies in addition to local authorities. This means NHS organisations will no longer need to apply to a local authority to have arrangements authorised. This is in line with how the system works in Wales currently.

9.5 The arrangements should always be informed, as far as possible, by the person's wishes and feelings. The Responsible Body must carry out consultation with the person and certain other individuals to determine the person's wishes and feelings.

9.6 The Responsible Body must organise a necessary and proportionate assessment to ensure that depriving the person of their liberty is needed to keep them safe from harm and is a reasonable response to the probability of them suffering harm. This assessment must always consider less restrictive options. This must be a new assessment, although, where possible, this should be done alongside existing care planning to reduce duplication.

9.7 Additionally, the Responsible Body must also arrange for a capacity assessment and a medical assessment to take place. Where previous or equivalent assessments exist, these can be used for the purposes of the LPS, which should reduce the financial and administrative burden on Responsible Bodies.

9.8 The intention for the LPS is that, as far as possible, every person subject to the LPS will have ongoing representation and support from either an 'Appropriate Person' or an IMCA, unless this is not in their best interests or it is not possible to appoint one. The role of the Appropriate Person or IMCA is to represent and support the person throughout the LPS process, in some cases the Appropriate Person may also be supported by an IMCA. It is the duty of the Responsible Body to talk all reasonable steps to ensure that there is an Appropriate Person or IMCA provided as soon as an application is made.

9.9 Following assessments and consultation, a pre-authorisation review is completed by the Responsible Body. In cases where a person resides in an independent hospital, has raised an objection to the arrangements, or has particularly complex circumstances, the pre-authorisation review will be completed by an Approved Mental Capacity Professional (AMCP). This will mean that objections to the proposed arrangements can be considered by someone not involved directly in the person's care and treatment.

9.10 In the preferred model, the Responsible Body will arrange an independent pre-authorisation review for every referral. As reported by the Law Commission, most authorisations should be straightforward, so we do not expect this to be burdensome on local authorities, NHS Trusts and CCGs (in England), or local health boards (in Wales). In a small number of other cases (for

[21] Responsible body refers to a local authority, Hospital Trust, Clinical Commissioning Group (CCG) or Local Health Board

example, if the person does not wish to reside in the place where the arrangements are carried out), an AMCP will be brought in to ensure that the assessments have been done to the highest standard. This means that resources are used efficiently, and skills are focused where they are most needed. In many cases under the current system, the arrangements proposed for the person are reasonable and no changes are needed, but the BIA is required to approve every application. By redefining the role of BIAs into AMCPs we are able to make the system much more efficient by focusing skills in the right places.

9.11 Every person subject to the LPS has a right to information about their authorisation. This right reflects current rights to information under the European Convention on Human Rights, so this does not represent a policy change.

Wider amendments to the MCA

9.12 The Law Commission also proposed making some wider amendments to the MCA which the Government has decided not to legislate for at this point, as it believes that there are other effective levers to deliver improvement in these areas.

9.13 This includes their proposal to remove the statutory defence under section 5 of the MCA in certain cases if a decision-maker is making a best interest decision and fails to confirm in a written record that they have followed the relevant framework, as set out in sections 1 to 4 of the Act. The Law Commission also proposed to confirm in statute the right to bring civil proceedings against private care homes and independent hospitals for unauthorised deprivation of liberty. These points were not included in the Law Commission's Impact Assessment.

The Mental Health Act 1983 (MHA) Review

9.14 The independent Mental Health Act Review was recently consulted on, and a response to that consultation has now been published[22]. As set out in the response, the Government does not intend to take forward any changes to the interface between the MHA and the MCA, at this time.

10. Policy Objectives of Adjusted LPS

The LPS have the following objectives:

Simplification

10.1 **The LPS aim to be clear and accessible to all users.** Key changes are: unnecessary assessments will be removed from the process; authorisations will be able to apply in more than one location in certain circumstances; authorisations will be extended to 16/17-year olds and to individuals in settings which are not covered by DoLS; authorisations will be able to last for up to three years (after the first authorisation of up to 12 months and a renewal for up to 12 months) for those with stable conditions who will not recover; and the NHS will be able to have a greater role in the authorisation process. This streamlined system is designed to reduce delays and allow people to access protections more quickly.

10.2 **The LPS will be embedded in the care planning process.** Assessments used as part of the care planning process can form the basis of the application and, in some cases, the care home manager will work with the responsible body to arrange the assessments if a new assessment is needed. This could be applicable to everyone subject to an LPS authorisation.

Compliance with human rights law

10.3 **The LPS will provide an authorisation process and review scheme that is Article 5 compliant.** It also gives effect to rights under Article 8 of the ECHR, a right to respect for a

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1002920/reforming-mental-health-act-consultation-response-web-accessible.pdf

person's private and family life, and other relevant international human rights law, such as the United Nations Convention on the Rights of People with Disabilities. This will be complimented by a comprehensive monitoring system, which will ensure that no one is unfairly treated while deprived of their liberty, in line with the requirements of the Optional Protocol to the Convention of against Torture.

Improved outcomes

10.4 **The LPS aim to ensure that people are only deprived of their liberty if this is necessary and proportionate.** The Act will also improve outcomes for families and carers, as there will be a duty to consult with them and they will be brought into the process. A greater focus is also given to the person's wishes and feelings about their care or treatment.

Comprehensiveness

10.5 **The LPS extend beyond hospitals and care homes, to include authorisations in a wide range of settings including supported living, shared lives schemes, education settings, children's residential homes and domestic settings.** Rather than relying on the court system, the new scheme provides a more cost-effective way of ensuring authorisations can occur and allows individuals to access robust safeguards in an easier and less cumbersome way. An authorisation will also apply to all settings a person is planned to receive care or treatment in, reducing the burden of processing multiple authorisations on the provider, Responsible Body, and crucially the person.

Increased access to safeguards for vulnerable people

10.6 A more streamlined and less complex system will enable authorisations to be **processed more efficiently, which means vulnerable people will be able to access safeguards more quickly and human rights outcomes will be improved.**

11. Differences between DoLS and LPS

Current DoLS System	**Proposed LPS System**
Local authorities act as Supervisory Bodies in England. Local authorities and Local Health Board act as Supervisory Bodies in Wales.	Local authorities, CCGs and NHS hospitals act as responsible bodies, in England, reducing delays and allowing individuals to access protections more quickly. No change in Wales.
Supervisory body organises six assessments which must all be new.	Responsible body organises three assessments. Recent assessments can be reused if applicable and may be arranged by the care home manager, including assessments completed in the care planning process. This streamlines the system and reduces cost.
A different DoLS authorisation with new assessments is required for different locations.	LPS authorisations are not setting specific. This means one LPS authorisation can cover a range of settings so can be used, for instance, to cover residential care and day centre visits.
BIA required to approve every authorisation.	AMCP only required to approve authorisation in specific cases where the relevant skills are most

	needed. By focussing skills, the system will be more efficient.
DoLS authorisations only apply to care homes and hospital settings. A Court of Protection authorisation must be sought for other locations, which is a complex and expensive process.	LPS authorisations cover all settings, including transport and domestic settings. This improves human rights outcomes.
DoLS authorisations apply to individuals aged 18 and over.	LPS authorisations apply to 16 / 17-year olds in line with the MCA. This improves protection and human rights outcomes.
DoLS authorisations last up to 12 months.	LPS authorisations for stable conditions can last for up to three years (after the initial authorisation of 12 months and renewal of 12 months).
The duty under the MCA to consult with appropriate persons with an interest in the person's welfare only applies to care home residents.	There is an explicit duty in the MC(A)A to consult with those interested in the person's welfare. There is therefore greater involvement for families within the LPS.
An IMCA is appointed if there is no independent person to consult about the individual's best interests, or when an individual wishes to challenge the authorisation.	Access to advocacy for both the individual and the Appropriate Person supporting them will be widened and brought closer to the Law Commission's proposed opt out system.

12. Cost benefit analyses

12.1 The focus of the following sections is to calculate the full system costs of each option under consideration, including the status quo, then compare these to identify the additional relative impacts. All costs and benefits apply to both England and Wales. Although the cost analysis section evaluates costs in monetary terms, some important benefits of the proposed reforms cannot be monetised. These include impact on care outcomes, equity and fairness, and public confidence. The overall Net Present Value (net benefit) of the policy is therefore likely larger than we have quantified.

12.2 The analysis follows the same method as the Law Commission's publication in 2017. The approach in this analysis is to use publicly available data to come to a reasonable understanding of the likely impact of the considered reforms as they are outlined in the 2019 Act. In some cases, this entails providing estimates where reliable data is not available or using assumptions as part of the methodology. **Full methodology is offered in Annex 2.**

12.3 High, low and best estimates are provided where possible to reflect uncertainty, based on ranges of assumptions provided by stakeholders or in other data sources, with best estimates being the mid-point. These estimates will be further refined for the final stage impact assessment using information gathered during the public consultation period.

12.4 **Unless otherwise stated, all costs have been uplifted to 2020/21 prices. Costs in the text (apart from Table 7) and in Annex 2 are at 2019/20 levels of demand, but the 10-year costs in Table 7 and in the summary pages at the front of this IA reflect an annual increase in Adult Social Care demand as estimated by the Personal Social Services Research Unit**

(PSSRU). Where possible, the latest published NHS Digital data is used. Unit costs are rounded to the nearest pound.

13. Baseline costs: Option 0 (DoLS and CoP authorisations at present)

13.1 We first estimate the full costs of maintaining the current scheme, to outline the benefit of moving to the preferred model. The same method has been used to evaluate the status quo as in the Law Commission Impact Assessment but updated data has been used in some cases. These costs are not included in the front pages for Option 0 (which as the status quo option are, by definition, zero). They are instead deducted from the gross costs of Option 1 to identify the net cost of the policy and are presented as the monetised benefits (savings) of Option 2.

13.2 The following section presents the estimated cost of DoLS as it operates currently (i.e. using current authorisation volumes) in England and Wales using the same methodology as the Law Commission. In the main body of this IA we only present best estimate figures (BE). Low estimate (LE) and high estimate (HE) figures can be found in Annex 2 (sensitivity analysis). The annual costs break down as follows:

- **Costs of authorising DoLS** which fall on supervisory bodies: **£395.27m**.
- **Costs of authorisations for deprivations of liberty outside of DoLS settings: £42.96m.**
- **Legal costs**: This includes the cost to the courts, legal aid, Official Solicitor (i.e., the system) and people who lack the relevant mental capacity and their families or carers (self-funded costs): **£79.10m**.
- **Costs to regulatory bodies**: The Care Quality Commission, Care Inspectorate Wales and Healthcare Inspectorate Wales currently incur costs in monitoring and reporting on the DoLS: **£9.40m**
- **Recurrent training costs of BIAs: £0.45m**

13.3 Total per annum system costs of the status quo are estimated to be **£527.18m**. We have included a spreadsheet and further explanation of methodology as an Annex to show clearly how the costs in Table 1 are calculated. The Annex and the below table also include low (LE) and high estimates (HE).

Table 2: Summary of costs of status quo (DoLS at present) per annum

At 2020/21 prices and 2019/20 levels of demand:

Total costs (per annum)	**Low estimate**	**Best estimate**	**High estimate**
Costs of authorising DoLS	£265.72 m	£395.27 m	£571.89 m
Costs of DoL outside of DoLS settings	£40.09 m	£42.96 m	£46.54 m
Total legal system costs	£19.96 m	£27.55 m	£35.90 m
Total self-funded legal costs	£35.17 m	£51.55 m	£67.66 m
Costs to regulatory bodies	£6.27 m	£9.40 m	£15.67 m
Ongoing training costs	£0.22 m	£0.45 m	£0.67 m
Total costs (per annum)	**£367.44 m**	**£527.18 m**	**£738.34 m**

**Costs shown in this table have not been subject to demand increases, whereas those used to estimate total net present value costs over 10 years are scaled using social care demand projections.*

14. Option 1- Existing deprivation of liberty mechanisms fully operationalised

14.1 This section estimates what the DoLS model and CoP authorisations would cost if they were to operate as intended following increased eligibility caused by *Cheshire West* and *Re D* judgments. Much of the analysis is taken directly from the Law Commission IA. To cost Option 1, first we have calculated the cost of the status quo (Table 2 above). We then estimate the cost to the health, care and court systems of fully funding it.

Costs (monetised)

14.2 The modelling for Option 1 is identical to that of the status quo other than the following changes, which are explained in more detail in the Annex:

- All applications received assumed to be processed each year, so 280,000 applications received during a year (in England and Wales) will be processed, rather than the 260,000 currently completed. This in turn increases the number of appeals and reviews, leading to an increase in costs to managing and supervisory bodies of £43m.
- All deprivations of liberty in community settings and for 16/17-year-olds assumed to be processed through the Court of Protection (increased to 59,600 cases from around 3,400. This means there would be an increase of £704m on the Court of Protection.
- The increase in S.21 appeals and Court of Protection cases results in an increase in legal aid and Official Solicitor time required (meaning legal system costs increase by £330m) and an increase in self-funded legal costs (by about £845m)
- Increased inspection and training costs in response to the increased volume of authorisations and inspections

14.3 Total per annum full system costs of Option 1, excluding transitional costs, are estimated to be around **£2.45 billion.** A summary of these costs is presented in the table below. Detailed calculations along with low and high estimates are contained within Annex 2.

14.4 The annual costs of the status quo system (existing DoLS) are presented as a cost-saving in the table below and can be subtracted from the costs of Option 1 to estimate the additional costs that would be incurred to fully resource the current DoLS model: **£1.92 billion per annum**.

Table 3: Summary of full system costs under existing deprivation of liberty mechanisms fully operationalised

At 2020/21 prices and 2019/20 levels of demand:

Total transitional costs	**Low estimate**	**Best estimate**	**High estimate**
Upfront training costs	£9.47m	£17.25m	£25.61m
Total transitional costs	**£9.47m**	**£17.25m**	**£25.61m**

Total ongoing costs (per annum)	**Low estimate**	**Best estimate**	**High estimate**
Cost to managing and supervisory bodies	£293.74m	£438.47m	£635.71m
Costs of DoL outside of DOLS settings	£697.30m	£747.11m	£809.37m
Total legal system costs	£259.82m	£358.19m	£466.82m
Total self-funded legal costs	£611.69m	£896.53m	£1176.69m
Costs to regulatory bodies	£6.90m	£10.81m	£18.80m
Ongoing training costs	£0.47m	£0.94m	£1.41m
Total ongoing costs (per annum)	**£1869.93m**	**£2452.06m**	**£3108.81m**
Total ongoing savings (per annum)			
Annual costs of current DoLS system	£367.44 m	£527.18 m	£738.34 m

**Costs shown in this table have not been subject to demand increases, whereas those used to estimate total net present value costs over 10 years are scaled using social care demand projections.*

Costs (non-monetised)

14.5 We do not identify any non-monetised costs.

Benefits (non-monetised)

14.6 This policy option would result in greater compliance with international human rights obligations in England and Wales, reduced exposure to damages for unauthorised deprivations of liberty, and significant but unquantifiable improved health, human rights, social and education outcomes as everyone who requires an authorisation receives one. A fully funded DoLS system would enable Supervisory Bodies and the Court of Protection to process all applications they receive in a timely manner, therefore reducing the chances of people being unlawfully deprived of their liberty.

14.7 Reducing the 'backlog' means respecting the rights of those subject to DoLS and improving outcomes for these people. There would also be a reduction in the risk of damages awards for unlawful deprivations of liberty.

15. Option 2: Adjusted LPS – our preferred model

Summary of option

15.1 This section summarises the expected costs our preferred LPS model (Option 2), described in detail in Sections 9 to 11. As with previous costings, most of the methodology and figures are taken from the Law Commission IA. The main changes from the MC(A)A impact assessment completed in December 2020 relate to implementation costs (primarily relating to training and data implementation). These are based on updates to policy, set out in secondary legislation, and consultations with affected stakeholders. The basis and calculations for these estimates are detailed in Annex 2.

Costs (monetised)

15.2 The following section will calculate the cost of Option 2. Narrative will only use best estimate figures (BE). Low (LE) and high estimate (HE) figures can be found in Annex 2. The costs breakdown is as follows:

Transitional (one-off)

- Transitional training costs (including advocate training, AMCP upfront training, BIA to AMCP conversion, and general staff awareness and specialist training): £76.32m.
- Data and other implementation costs: £9.42m

Ongoing (recurring annual)

- Cost of administration: £46.74m
- Cost of new assessments: £52.43m
- Total cost of advocacy: £141.30m
- Cost of approval by Approved Mental Capacity Professionals (AMCP): £27.45m
- Legal system costs: £18.58m
- Costs to supervisory body from Court of Protection reviews: £17.46m

- Regulatory bodies: £14.90m

15.3 Total per annum costs of Option 2 (Adjusted LPS) are estimated to be **£319m**. Set against these are the cost savings of **£527m** per year from no longer running the existing DoLS system. This suggests that the LPS system could generate **annual savings of around £208m** compared with the existing DoLS system, consistent with engagement with care providers which indicated a general view that the current DoLS assessment process duplicates a lot of work.

15.4 We have included a spreadsheet and further methodology as an Annex to show clearly how the Option 2 costs in the below table are calculated. Table 5 below also includes low (LE) and high estimates (HE).

Table 4: Summary of full system costs for Option 2, Adjusted LPS

15.5 At 2020/21 prices and 2019/20 levels of demand:

Total costs	**Low estimate**	**Best estimate**	**High estimate**
Transitional			
Training costs	£51.34 m	£76.32 m	£108.03 m
Data implementation costs	£6.57 m	£6.57 m	£6.57 m
Other implementation costs	£2.85 m	£2.85 m	£2.85 m
Total transitional costs	**£60.76 m**	**£85.74 m**	**£117.45 m**
Ongoing			
Cost of admin (desktop reviews)	£46.74 m	£46.74 m	£46.74 m
Cost of reviews and new 'necessary and proportionate' assessments	£46.48 m	£52.43 m	£58.36 m
Total cost of advocacy	£116.62 m	£141.30 m	£173.39 m
Total AMCP costs	£11.33 m	£27.45 m	£44.35 m
Total legal system costs	£14.00 m	£18.58 m	£23.30 m
Costs to supervisory body from CoP reviews	£15.96 m	£17.10 m	£18.67 m
Regulation costs	£11.52 m	£14.90 m	£18.28 m
Total ongoing costs (per annum)	**£262.65 m**	**£318.50 m**	**£383.08 m**
Total ongoing cost-savings			
Annual costs of current DoLS system	£367.44 m	£527.18 m	£738.34 m

**Costs shown in this table have not been subject to demand increases, whereas those used to estimate total net present value costs over 10 years are scaled using social care demand projections.*

Costs (non-monetised)

15.6 We do not identify any non-monetised costs.

Benefits (non-monetised)

15.7 With the adjusted LPS model the main unquantified benefit is the improvement in quality of life for users achieving the optimal outcome from this process. This policy offers the same improvements to human rights as Option 1, but also offers a simpler process that is less difficult for professionals to navigate, resulting in greater compliance with the law and, ultimately, improved human rights outcomes for individuals.

15.8 As the LPS model is designed to ensure that all cases can be processed within a timely manner, and therefore removed the backlogs that have grown under DoLS, the main benefit will be that people will not be left in unlawful situations unable to access safeguards. Streamlining the system into the care and treatment planning will also reduce the number of burdensome processes individuals, and their families have to go through. Overall, the policy will have a positive having on people who may need to be deprived of their liberty.

15.9 It has not been possible to quantify these benefits due to a lack of available data required to estimate the quality of life gains (e.g. in quality-adjusted life years) under the proposed system. Doing so would be complex and resource intensive. This Impact Assessment demonstrates that the LPS system should generate considerable cost savings and therefore is expected to have large net gains to society even in the absence of these quantified benefits. Therefore, it is proportionate not to attempt to estimate these further.

16. Present values

16.1 This section summarises the present value costs of Option 1 and Option 2 models over the 10-year period 2022/23 to 2031/32. Transition costs are included in Year 1. Monetised costs are discounted at a rate of 3.5% per annum, as per the HMT Green Book. The annual costs used to calculate these values have been adjusted to account for increases in social care demand using a demand index taken from adult social care user demand projections up to 2031/32.[23] See Annex 2 for further detail.

16.2 These do not include potentially significant non-monetised benefits of Options 1 and 2, which have not been possible to estimate due to complexity and data limitations.

Table 5: Present Values

Over a 10-year period (2022/23 to 2031/32) at 2020/21 prices with rising demand:

10-year present values	Low estimate	Best estimate	High estimate
Total full system costs of options			
Option 0 (baseline - existing DoLS system)	£4,111m	£5,898m	£8,261m
Option 1 (DoLS fully operationalised)	£20,932m	£27,453m	£34,809m
Option 2 (Preferred LPS model)	£2,999m	£3,648m	£4402m
Total additional costs of options vs existing DoLS system			
Option 1 (DoLS fully operationalised)	£16,820m	£21,554m	£26,548m
Option 2 (Preferred LPS model)	-£1,113m	-£2,250m	-£3,859m

16.3 Table 7 summarises the present value costs associated with each option. The full system costs of each option are presented, including the baseline Option 0, so that each can be readily compared. The second part of the table shows the *additional* costs of Options 1 and 2 with baseline costs subtracted.

16.4 This clearly shows that the preferred LPS model (Option 2) is expected to generate considerable *cost-savings* relative to the current DoLS system (Option 0), even with the exclusion of important non-monetised benefits, and is vastly less costly than fully operationalising the DoLS system (Option 1).

17. Summary

17.1 In summary, keeping the DoLS system as it is at present is not a viable option as people frequently are not granted safeguards and may continue to be unlawfully deprived of their liberty. The preferred option is to move to the adjusted LPS model. This makes the system more efficient and reduces the number of people who will potentially be unlawfully deprived of their

[23] https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf Interpolated to single years using compound average growth rates.

liberty. At the same time, it could generate in the region of **£2 billion** in cost savings over a 10-year period, in addition to important non-monetised benefits.

18. Further considerations

Statutory equality duty

18.1 Whilst there are some impacts on the protected characteristics, we do not assess that our proposals will have any adverse equality impact on any social group as defined by their race, age, religion or belief, sex, sexual orientation, disability, or gender reassignment.

18.2 All people who lack capacity and need to be deprived of their liberty for their care or treatment will have the same access to the same protections, regardless of protected characteristic. Due to the scope of the LPS and demographic data showing who is most likely to receive a DoLS authorisation, we anticipate that people with disabilities aged over 16 and older people will be particularly impacted by the new system. Therefore, older people and people with disabilities aged 16 and above will disproportionately benefit from the protections provided by the LPS. 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. This Act will also move England and Wales closer towards compliance with the demanding requirements of the United Nations Convention on the Rights of Persons with Disabilities. An equalities impact assessment of the primary legislation was published when the Mental Capacity (Amendment) Bill was going through Parliament.[24] A revised equalities impact assessment, which includes further assessments of the impact on people with protected characteristics, has been published during consultation. A final version will be published with the final LPS products and the consultation response, ahead of them entering Parliament.

Competition

18.3 We do not anticipate that there will be any particular effect, whether positive or negative, on competition. The requirements will apply to all providers in scope of the regulations equally and without derogation or exemption and therefore no adverse impact on competition is expected.

Small business

18.4 There are a substantial number of small firms in the care home industry, with CQC data for June 2019[25] showing that 25% of all care home beds in England are operated by providers that run fewer than 50 beds (likely 1 or 2 homes) in total. However, we do not anticipate that there will be any specific effect, whether positive or negative, on small firms beyond training requirements for staff, who will need to be aware of the LPS. Whether the care home is large or small, if it is looking after people, the care home is expected to conduct good care planning. The training costs per care home will be relatively low, given that they already have requirements on training, and we do not therefore envisage small businesses being disproportionately affected by these costs.

Environmental impact and wider environmental issues

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

International trade

18.6 The services in scope of this change are not traded internationally, so we do not expect there to be any impacts on international trade.

[24] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765385/equality-impact-assessment.pdf
[25] Care Quality Commission (June 2019), Care Directory With Filters, http://www.cqc.org.uk/about-us/transparency/using-cqc-data

Health and well-being

18.7 We expect our provisional proposals to have a positive effect on health and well-being. Our proposals are directed towards improving care and treatment outcomes for vulnerable groups of people. At present, many people whose arrangements ought to be assessed under the present framework are simply not receiving these assessments or the associated safeguards. Our rationalised system should make it possible for these groups to receive the attention they deserve.

Human rights

18.8 We expect our preferred model to have a significant positive effect on human rights. Our provisional proposals are directed towards guaranteeing compliance with Article 5 (right to liberty) of the European Convention on Humans Rights. This is not presently the case under the current system, as there are a number of people whose arrangements are pending authorisation. Our model is also directed towards ensuring compliance with other rights, such as Article 8 (family, correspondence, privacy and home) and the United Nations Convention on the Rights of the Child which are not adequately protected under the present system.

Justice system

18.9 The impact on the justice system has been considered throughout this Impact Assessment. A further Justice Impact Assessment will be completed to determine the direct impact on the justice system.

19. Direct costs and benefits to business calculations

19.1 Impacts to private businesses and voluntary and community bodies have been determined following RPC guidance[26] and ONS Interdepartmental Business Register (IDBR) data.

19.2 The following types of organisations are included in the Equivalent Annual Net Direct Costs to Business (EANDCB) calculations:

- Private residential and nursing care homes
- General Practitioners
- Independent special schools

19.3 Monetised costs to these organisations relate only to one-off, transitional training for staff to understand the new system.

19.4 We do not expect any significant additional ongoing costs or savings to care and nursing homes, as DoLS are already applicable in these settings, and therefore their role under the LPS will not change.

19.5 For independent special schools, whilst this is a new role, we do not envisage a significant amount of demand being placed upon them once the LPS is up and running. This is because the role for providers is mainly cooperating with the Responsible Body and correctly storing paperwork, a role that these organisations will already undertake for other responsibilities. Additionally, as the LPS is designed to integrate with other legislation, such as Education Health and Care Plans, this should reduce the burden in these organisations.

19.6 General Practitioners may see an increase in the number of requests for assessments and files. However, many GPs are already carrying out assessments under DoLS, and recover this cost from the relevant Supervisory Body. We would expect that to be the case under the LPS as well.

26 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/858862/Issues_around_defining_a_business.pdf

Additionally, under the LPS, previous and equivalent assessments can be used, which should mitigate any additional burden on GP time.

19.7 Table 6 below summarises the estimated one-off costs to these businesses.

Table 6: one-off costs to businesses

Business type	
General Practitioners	£8.63m
Residential and nursing care homes	£12.83m
Independent special schools	£1.46m

19.8 Using the BEIS impact assessment calculator, these represent an EANDCB of £2.4m in 2019 prices discounted to the year 2020.

Fees

19.9 CQC currently recovers inspection costs under DoLS through registration and other fees charged to hospitals and care homes. We expect these fees to continue under the LPS; however, CQC will determine these via a subsequent consultation exercise. Therefore, the cost of these fees is unknown at this stage. They are not direct costs to business in this Impact Assessment, as they will be subject to a subsequent decision-making process.

19.10 To illustrate the potential magnitude of these costs, we provide some indicative estimates below.

19.11 Based on data provided by CQC, current CQC costs under the existing DoLS system are around £9.4m per year, compared with an expected £13.5m under the LPS. This suggests an additional £4.1m costs to CQC could be in scope for cost recovery via fees under the LPS. The CQC data broadly indicates that around half of inspection costs relate to hospitals, with the rest to adult social care providers (just over £2m per annum). Therefore, this could generate an additional £2m per annum in costs to business, if CQC decided to fully recover these costs and assuming for simplicity that all adult social care providers incurring fees would be private businesses. However, any increase to fees is subject to consultation with providers by CQC.

20. Monitoring and Evaluation

20.1 The MC(A)A 2019 requires the Code to be reviewed three years after implementation, and then every five years subsequently. This will ensure that the Code can remain up to date with practice development and will also allow for improvements to be made.

20.2 The LPS is a system of state oversight in itself and international law requires government to put in place a mechanism to provide further oversight of the arrangements where they apply. We have therefore set out in regulations how this scheme will be monitored to ensure its effective operation, on an ongoing basis. In the Monitoring and Reporting regulations, CQC and Ofsted will have a statutory role to ‘monitor and report’ on an annual basis on the operation of the LPS for adults (CQC) and 16-17 year olds (Ofsted) deprived of their liberty in any setting. The information collected by CQC and Ofsted should provide a picture of how effectively the LPS is operating and inform priorities for improvement in its implementation.

20.3 Responsible Bodies will have a duty to notify CQC and Ofsted about LPS authorisations they oversee on a regular basis. This data will allow them to identify local trends about the operation of the LPS. This will inform targeted monitoring activity to assure themselves that the LPS arrangements are being followed. They will have powers granted in regulations to visit settings where authorisations apply (with permission, as there is no power of entry), meet with the person the authorisation applies to (with their consent), meet any individual caring for them or interested in their welfare, and request records about the deprivation from the Responsible Body or the setting it applies in.

20.4 A reliable flow of data from Responsible Bodies to CQC and Ofsted will be crucial to the success of their monitoring, in order to inform their monitoring activities and enable them to identify trends in the operation of the LPS to investigate further.

20.5 This process will also enable national evaluation of the new system. The Government is setting out a national minimum data set, which will provide a comprehensive data set. This will provide a clear picture of how the system is working and allow Government to monitor the progress of implementation.

Annex 1

Key Stakeholders

- Individuals who lack capacity
- The families and carers of those who lack capacity
- Health and Social Care Professionals
- The Welsh Government
- Local authorities
- NHS Trusts and Clinical Commissioning Groups (CCGs) in England
- Health Boards in Wales
- Private Care Providers
- Advocacy Organisations
- The Care Quality Commission (CQC) in England
- Healthcare Inspectorate Wales (HIW)
- Care Inspectorate Wales (CIW)
- Ofsted in England
- Estyn in Wales

Annex 2

All estimates in the following tables are based on 2020/21 prices and 2019/20 levels of demand.

The front pages of the IA show costs adjusted upwards in line with 10-year social care demand projections published by the Care Policy and Evaluation Centre.[27]

Table 7: Unit cost summary table (for Options 0 and 1 only)

	Low estimate	Best estimate	High estimate
Unit cost per internal review application	£313	£648	£1,097
Unit cost per granted DoLS application	£1,039	£1,536	£2,173
Unit cost per completed but refused DoLS application	£888	£1,358	£2,037
Unit cost incurred by supervisory bodies per S.21 Court of Protection review	£11,700	£12,535	£13,684
Unit costs per Court of Protection review (non S.21)	£11,700	£12,535	£13,580
Unit cost of legal aid per case hearing	£7,340	£10,470	£13,684
Legal aid unit costs for paper Re X authorisations	£452	£655	£853
Unit cost for Official Solicitor	£11,700	£12,535	£13,580
Self-funded legal costs by the person or carers per case	£13,684	£20,057	£26,324
Unit Cost per CQC inspection	£0	£7,505	£0
Unit cost of annual refresher training for Best Interest Assessor	£0	£165	£0

21. Option 0 – Status quo

Costs of authorising DoLS which falls on both supervisory bodies and local authorities

21.1 Calculated as the sum of: **total cost of authorisations, advocacy and relevant person's representative (RPR) costs per application; total cost of internal reviews, and cost to supervisory body of Court of Protection review.**

21.2 **Total cost of authorisations, advocacy and RPR costs per application:** calculated as (i) cost per granted DoLS application (£1,536)[28] multiplied by the 2019/20 number of granted applications (126,731), plus (ii), the cost per completed but refused DoLS application (£1,358) multiplied by the 2019/20 number of non-granted applications (132,142), giving £374m.

21.3 **Total cost of internal reviews**: calculated as cost per internal review application (£648), from the Shah study, multiplied by the number of DoLS applications leading to internal review (10,772). The number of DoLS applications leading to internal review is calculated by assuming 8.5% of granted DoLS authorisations lead to an internal review, which the Law Commission derived from the internal review rate reported by the Welsh regulators.[29] Multiplying gives a cost of £6.98m.

21.4 **Cost to supervisory body of Court of Protection (CoP) challenge:** we take the number of applications to CoP for s.21A challenge in 2019/20 (1,136)[30] and multiply by the cost incurred by supervisory bodies per s.21A Court of Protection challenge (£12,535) to give £14.24m.

[27] https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf Interpolated to single years using compound average growth rates.

[28] Unit costs are based on A Shah and others, 'Deprivation of Liberty Safeguards in England: Implementation Costs' (2011) 199 The British Journal of Psychiatry 232. They estimate the cost of professionals (including travelling time and distance) in conducting the six DoLS assessments, cost of secretarial time for processing DoLS, and cost of independent mental capacity advocates (including travelling time and distance) in conducting their assessments and apportioned across all those assessed. We assume these costs are comprehensive estimates of employment costs.

[29] Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales, Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2013-14 (2015) p 11.

[30] https://www.gov.uk/government/collections/family-court-statistics-quarterly

21.5 Summing the above three costs gives a total cost of **£395.27m**.

Costs of authorisations for deprivations of liberty outside of DoLS settings

21.6 The CoP recovers its costs by charging the applicant, for example, the relevant public body. Costs are normally incurred by local authorities and NHS bodies where authorisations for deprivations of liberty are sought in settings that fall outside the DoLS, for instance, supported living, private and domestic settings and settings for 16/17-year-olds. This cost is calculated as **(unit cost per CoP authorisation** multiplied by **number of authorisation cases).** S.16 cases allow a person to challenge a deprivation of liberty that occurs in a non-DoLS setting in the CoP. S.16 cases include Re X cases, which is the procedure that applies in non-contentious cases.

21.7 The unit cost of CoP authorisation of each case is given as £12,535. The number of CoP authorisation cases are given as the number of Re X applications (3,104) plus the number of s.16 applications (323), giving 3,427 cases in total in 2019/20. A Re X case is where a case goes to the CoP without objection and a decision is made of the paperwork alone, meaning a Re X case has a shorter process.

21.8 Multiplying gives a total cost of **£42.96m.**

Legal costs

21.9 Calculated as: **Total legal aid costs** plus **total self-funded and Official Solicitor costs.** These costs ultimately fall on public authorities such as LAs and self-funded applicants due to the high cost recovery of the Court of Protection. There will be a cost to Her Majesty's Courts and Tribunals Service (HMCTS).

21.10 **Total legal aid costs** are given as the sum of legal aid hearing costs plus legal aid paper costs for Re X applications. Legal aid for pre-proceedings work is assumed to have negligible costs based on conversations with MoJ.

21.11 Legal aid hearing costs are given as the cost of legal aid per case hearing (£10,470) multiplied by the total number of legal aid hearings (1,217). The total number of legal aid hearings is the sum of total s.16 and s.21A cases requiring legal aid. Under s.21A, a person who is subject to DoLS can challenge their deprivation of liberty in the Court of Protection. We assume, in line with the Law Commission, that 100% of s.21A cases (1,136) require legal aid, and that 25% of s.16 cases require legal aid (0.25*323 = 81). They give a legal aid hearing cost of £12.74m per annum.

21.12 Legal aid paper costs for Re X applications are given as the legal aid unit cost for paper Re X authorisations (£655[31]) multiplied by the number of legal aid paper cases (assumed to be 25% of Re X cases = 776). This gives a cost of £0.51m.

21.13 Adding gives the total legal aid cost as £13.25m.

21.14 **Total self-funded and Official Solicitor costs** are calculated as the sum of self-funded legal costs and Official Solicitor costs. Self-funded legal costs are calculated as the number of self-funded litigants (2,570) multiplied by estimated self-funded legal costs by the person or carers per case £20,100), giving a cost of £51.55m. Total Official Solicitor costs are given as the number of cases involving the Official Solicitors (total cases going to CoP multiplied by assumed % of cases going to the Official Solicitors). This gives 4,563*25% = 1,141 cases. Multiplying gives the Official Solicitor cost of £14.30m. Summing gives a total self-funded and the Official Solicitor cost of £65.85m.

21.15 Summing gives a total legal cost of **£79.10m**.

21.16 We follow the Law Commission Impact Assessment by not providing any costs associated with damages claimed by those deprived of liberty without authorisation because, at present, there do

[31] This figure was provided to us by the Legal Aid Agency as an indicative unit cost based on similar claims made over the past three years.

not appear to be significant numbers of cases brought on this basis. However, if the 'backlog' continues to grow we expect the number of these claims to increase. We also follow the Law Commission Impact Assessment by not making any allowance for cases proceeding to the High Court rather than the CoP, as we do not have figures regarding the number of such cases. As a result, the figures here should be regarded as an underestimate.

21.17 The CoP incurs costs in hearing applications to authorise deprivations of liberty in settings falling outside the DoLS and for 16/17-year-olds, and in hearing reviews of authorisations in settings within the DoLS. We assume, as the Law Commission did, that the fees charged by the Court of Protection broadly achieve cost recovery in cases involving deprivation of liberty.[32] These costs are charged to the local authority and self-funders who lack capacity and are costed above.

21.18 Of the cases brought to the Court of Protection, 15% are subject to further appeal in the Court of Appeal; note that the Court of Appeal does not fully recoup its costs from Court fees.[33] 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 incomplete.

Costs to regulatory bodies

21.19 Calculated as the **number of inspections in England and Wales where DoLS assessments did take place** multiplied by the **cost of the DoLS component of inspection.**

21.20 **The number of inspections in England and Wales where DoLS assessments did take place** is calculated by using the Law Commission's estimate of 15,810 CQC inspections taking place in 2015/16. Assuming only 50% include a DoLS inspection[34] gives 7,905 DoLS inspections in England. Accounting for inspections in Wales by multiplying by a Wales population factor of 1.0566 gives the total number of inspections in England and Wales as 8,352.

21.21 **The cost of the DoLS component of inspection** is calculated by first taking the £87.22m 2017/18 total of CQC's Adult Social Care costs[35] for inspection, registration, monitoring/ analysis and their Independent Voice function, dividing by 12,141 ASC inspections in 2017/18 (ASC) inspection costs, and multiplying by the estimated % of the duration of each inspection that is devoted to DoLS assessment (15%). This gives a cost of £1,126, inflated to 2020/21 prices.

21.22 Multiplying gives a total cost to regulatory bodies of (8,352 * £1,126 =) **£9.40m**.

Training costs

21.23 The only training costs which we have costed for DoLS at present are recurrent annual training costs. The only recurrent annual training cost is the annual BIA refresher training course, which is calculated by multiplying the number of BIAs (2,720) by the refresher training cost per user (£165) to give **£0.49m**. The number of BIAs is estimated using the same methodology as the Law Commission.

21.24 There are also upfront training costs for local authorities for new BIAs, advocates and RPRs. However, we have no estimates for how many new BIAs, advocates and RPRs are trained each year. Therefore, we have not included this cost in our figures for this model. In DoLS fully funded and in the preferred model we include these costs as upfront transitional costs.

[32] 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
[33] 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
[34] https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/lc372_mental_capacity_impact.pdf page 16
[35] Care Quality Commission, Annual Report and Accounts 2017/18, https://www.cqc.org.uk/sites/default/files/20180711_annualreport201718.pdf

The following table is at 2020/21 prices and 2019/20 levels of demand:

Table 8: Detailed costings for Option 0[36]

	Low estimate	Best estimate	High estimate
APPLICATION VOLUMES			
Number of granted applications		126,731	
Number of non-granted applications		132,142	
ALL COSTS ARE ONGOING COSTS			
Unit cost per granted DoLS application	£1,039	£1,536	£2,173
Unit cost per completed but refused DoLS application	£888	£1,358	£2,037
Authorisations advocacy and RPR costs per application	**£249,054,517**	**£374,054,031**	**£544,532,907**
Number of granted applications (from above)		126,731	
% of DoLS applications leading to internal review		8.5%	
Number of DoLS applications leading to internal review		10,772	
Unit cost per internal review application	£313	£648	£1,097
Total cost of internal reviews	**£3,375,820**	**£6,976,696**	**£11,815,372**
Applications to Court of Protection for S.21 review		1,136	
Unit cost incurred by supervisory bodies per S.21 Court of Protection review	£11,700	£12,535	£13,684
Cost to supervisory body of CoP review	**£13,290,830**	**£14,240,175**	**£15,545,524**
Total cost to managing and supervisory bodies	**£265,721,167**	**£395,270,902**	**£571,893,803**
reX applications to Court of Protection (paper cases)		3,104	
S.16 applications to Court of Protection		323	
Unit costs per Court of Protection review (non S.21)	£11,700	£12,535	£13,580
Total costs outside of DOLS settings	**£40,094,783**	**£42,958,696**	**£46,538,588**
Applications to Court of Protection for S.21 review (from above)		1,136	
% of S.21 cases requiring legal aid		100%	
Number of S.21 cases requiring legal aid		1,136	

[36] Note that to reduce complexity the table does not present the complete calculations. Please refer to the text in Section 21 above.

	Low estimate	Best estimate	High estimate
S.16 applications to Court of Protection (from above)		323	
% of other Court of Protection cases needing legal aid		25%	
Number of S.16 cases requiring legal aid		81	
Total number of legal aid hearings (S.21 plus S.16)		1,217	
Unit cost of legal aid per case hearing	£7,340	£10,470	£13,684
Legal aid hearing costs	£8,930,711	£12,739,726	£16,650,479
reX applications to Court of Protection (paper cases) (from above)		3,104	
Number of Legal Aid Cases paper (25% of re.X Cases)		776	
Legal aid unit costs for paper reX authorisations	£452	£655	£853
Legal aid paper costs for re.X applications	£350,382	£508,007	£661,833
Total legal aid costs	**£9,281,094**	**£13,247,732**	**£17,312,312**
Total applications to Court of Protection		4,563	
% of cases involving Official Solicitor	20%	25%	30%
Number of cases involving Official Solicitor	913	1141	1369
Unit cost for Official Solicitor	£11,700	£12,535	£13,580
Total Official Solicitor costs	**£10,677,123**	**£14,299,718**	**£18,589,633**
Total legal system costs	**£19,958,216**	**£27,547,450**	**£35,901,945**
Number of S.21 cases not attracting Legal Aid		-	
Number of S.16 cases not attracting Legal Aid		242	
Number of Re X applications to Court of Protection (paper cases) not attracting Legal Aid		2,328	
Total number of self-funded litigants		2,570	
Self-funded legal costs by the person or carers per case	£13,684	£20,057	£26,324
Total self-funded legal costs	**£35,172,433**	**£51,550,436**	**£67,659,947**
No cost for damages claims from those deprived of liberty without authorisation - but no change proposed.			
No costs for court of appeal hearings - but no change proposed.			
Number of CQC inspections in 2015/16		15,810	
% of inspections where DOLS assessments take place		50%	
Number of inspections in England where DOLS assessments did take place		7,905	
Wales population factor		1.0566	
Number of inspections in England and Wales where DOLS assessments did take place		8,352	

	Low estimate	Best estimate	High estimate
% of inspection devoted to DOLS assessment	10%	15%	25%
Unit cost per CQC inspection		£7,505	
Hence cost of DOLS component of inspection	£750	£1,126	£1,876
Total inspection costs	**£6,268,325**	**£9,402,487**	**£15,670,812**
Number of Best Interest Assessors needed	1,360	2,720	4,080
Unit cost of annual refresher training for Best Interest Assessor		£165	
Ongoing annual training cost	**£224,467**	**£448,933**	**£673,400**

22. Option 1 – Existing deprivation of liberty mechanisms fully operationalised

22.1 Identical methodology is used as in Option 0 but with the following assumptions:

- All 280,828 applications are assumed to be processed each year (263,940 for England and 16,888 for Wales), based on total DoLS applications received in 2019/20. This means that there will be an increase in applications processed (leading to more reviews), Court of Protection cases, BIAs and advocates.
- We follow the Law Commission and DfE by assuming that all 59,600 community DoLS and cases concerning 16/17-year-olds are covered by authorisations of deprivations of liberty by the Court of Protection. This figure is calculated based on an Association of Directors of Adult Social Services (ADASS) study and Department for Education (DfE) estimates. The ADASS study estimated 53,000[37] people in domestic settings are potentially deprived of their liberty, and DfE estimates increased numbers of 16/17 year olds being deprived of their liberty. Following the *Re D* judgment, which ruled that parents could not consent to the arrangements for care and treatment which amount to a deprivation of liberty on behalf of their children, a further 6,600 16/17-year olds are estimated to be subject to authorisations by the Court of Protection, based on DfE data.
- In England and Wales, there are 57,358 GPs[38], 139,510 NHS doctors[39] and 22,108 adult social workers employed by local authorities[40]. We assume that 20% of doctors and social workers will require training if DoLS were fully operationalised. This gives 11,472 GPs and 27,902 hospital doctors in England and Wales needing training, along with 4,422 social workers. We also assume a two-hour training course for health and social care professionals costs £24[41] per person. Added on the costs of the professionals' time, this gives a total course cost of £101 for social workers, £194 for GPs and £150 for non-GP doctors.
- We follow the Law Commission by assuming 15% greater regulatory costs will be incurred under a fully operationalised DoLS as compared to the present estimated costs, with 20% and 10% for upper and lower estimates respectively.
- Training costs can be split into both transitional and ongoing. Transitional costs such as training health and social care professionals are upfront, and only incurred in year 1 and not shown in the per annum costs. They are however represented in the NPV (Net Present Value) calculations. Ongoing costs are only comprised of the BIA refresher course.

22.2 We use the same methodology as the status quo to calculate the additional number of BIAs, advocates and RPRs needed under a fully operationalised system. The upfront training costs of these staff are considered in the cost to transition to a fully operationalised system. We estimate that 2,988 additional BIAs will be required to meet the additional number of applications under fully operationalised DoLS. We use the same £165 BIA refresher training costs as the status quo, but this is applied to the higher number of BIAs (5,708 in total).

22.3 We also use the same methodology as the status quo to estimate legal costs. We follow the Law Commission Impact Assessment in assuming that 1% of all granted applications will lead to a challenge at the Court of Protection. Approximately 49% of completed applications were granted

[37] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related (page 24)

[38] GP Workforce, March 2020 (England)

[39] NHS Workforce statistics, Dec 2020 (Doctors by Grade and Specialty, Jan 2021 figures), and Wales Medical and Dental Staff Headcount (excluding dental), Dec 2020

[40] Personal Social Services Staff, England 2020 (Reference Tables, tab T3), and Social Care Wales Registration data, snapshot taken 15/11/18

[41] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related page 22

in 2019/20. Therefore, if all applications were completed, we expect that 137,479 would be granted. Applying the assumed 1% challenge rate leads to 1,375 s.21A cases.

Table 9: Detailed costings for Option 1 (2020/21 prices and 2019/20 levels of demand)[42]

	Low estimate	Best estimate	High estimate
APPLICATION VOLUMES			
Number of DoLS applications		280,828	
Percentage of applications granted		49%	
Percentage of applications not granted		51%	
Number of granted applications		137,479	
Number of non-granted applications		143,349	
TRANSITION COSTS			
Number of additional Best Interest Assessors needed	1,494	2,988	4,482
Unit cost of training for new Best Interest Assessor	£0	£1,581	£0
Upfront Best Interest Assessor training cost	**£2,361,790**	**£4,723,580**	**£7,085,370**
Number of additional advocates needed	856	1,712	2,568
Unit cost of training for new advocate	£0	£1,651	£0
Upfront advocate training cost	**£1,413,579**	**£2,827,159**	**£4,240,738**
Number of additional representatives needing training	856	1712	2568
Unit cost of training for new paid relevant persons representative	£0	£1,651	£0
Cost of training representatives	**£1,413,579**	**£2,827,159**	**£4,240,738**
Numbers of GPs		57,358	
Numbers of non-GP doctors		139,510	
Numbers of adult social workers		22,108	
% of doctors and social workers needing training	15%	20%	25%
Number of GPs needing training	8,604	11,472	14,340
Number of non-GP doctors needing training	20,927	27,902	34,878
Number of adult social workers needing training	3,316	4,422	5,527
Unit cost of 1 hour of GP's time		£68	
Unit cost of 1 hour of non-GP doctor's time		£51	
Unit cost of 1 hour of adult social worker's time		£31	

[42] Note that to reduce complexity the table does not present the complete calculations. Please refer to the text in Section 21 above.

	Low estimate	Best estimate	High estimate
Length of training course	2	2.5	3
Unit cost of training course		£24	
Unit cost of GP training	£160	£194	£228
Unit cost of non-GP doctor training	£125	£150	£176
Unit cost of adult social worker training	£85	£101	£116
Total cost of GP training	£1,378,540	£2,228,663	£3,274,089
Total cost of non-GP doctor training	£2,618,892	£4,197,226	£6,128,245
Total cost of adult social worker training	£282,804	£444,782	£640,614
Cost of training health and social care professionals	**£4,280,237**	**£6,870,671**	**£10,042,949**
Total upfront training cost	**£9,469,185**	**£17,248,568**	**£25,609,794**
ONGOING COSTS			
Number of DoLS applications (from above)		280,828	
% of DoLS applications leading to internal review		8.50%	
Number of DoLS applications leading to internal review		23,870	
Unit cost per internal review application	£313	£648	£1,097
Total cost of internal reviews	**£7,480,598**	**£15,459,903**	**£26,182,094**
Number of granted applications (from above)		137,479	
Number of non-granted applications (from above)		143,349	
Unit cost per granted DoLS application	£1,039	£1,536	£2,173
Unit cost per completed but refused DoLS application	£888	£1,358	£2,037
Authorisations advocacy and RPR costs per application	**£270,177,140**	**£405,778,019**	**£590,715,421**
Unit cost incurred by supervisory bodies per S.21 Court of Protection review	£11,700	£12,535	£13,684
Cost to supervisory body of Court of Protection review	**£16,084,641**	**£17,233,544**	**£18,813,285**
Total cost to managing and supervisory bodies	**£293,742,379**	**£438,471,466**	**£635,710,800**
Court of Protection Appeal rate		1%	
Applications to Court of Protection for S.21 review		1,375	
Re X applications to Court of Protection (paper cases)		0	
S.16 applications to Court of Protection		59,600	
Total applications to Court of Protection		60,975	

	Low estimate	Best estimate	High estimate
Unit costs per Court of Protection review (non S.21)	£11,700	£12,535	£13,580
Total costs outside of DOLS settings	**£697,300,580**	**£747,107,765**	**£809,366,745**
Unit legal costs by legal aid per case hearing	£7,198	£10,268	£13,420
% of S.21 cases requiring legal aid		100%	
% of other Court of Protection cases needing legal aid		25%	
Number of S.21 cases requiring legal aid		1,375	
Number of S.16 cases requiring legal aid		14,900	
Total number of legal aid hearings		16,275	
Legal aid hearing costs	£117,145,967	£167,109,584	£218,407,734
Legal aid unit costs for paper Re X authorisations	£463	£671	£874
Legal aid paper costs for Re X applications	£0	£0	£0
Total legal aid costs	**£117,145,967**	**£167,109,584**	**£218,407,734**
Number of self-funded litigants		44,700	
% of cases involving Official Solicitor	20%	25%	30%
Number of cases involving Official Solicitor	12195	15244	18292
Unit cost for Official Solicitor	£11,700	£12,535	£13,580
Total self-funded and Official Solicitor costs	**£142,677,044**	**£191,085,327**	**£248,410,925**
Total legal system costs	**£259,823,011**	**£358,194,911**	**£466,818,659**
Unit self-funded legal costs by the person or carers per case	£13,684	£20,057	£26,324
Total self-funded legal costs	**£611,694,482**	**£896,529,318**	**£1,176,694,729**
Number of CQC inspections in 2015/16		15,810	
% of inspections where DoLS assessments take place		50%	
Number of inspections in England where DoLS assessments did take place		7,905	
Wales population factor		1.0566	
Number of inspections in England and Wales where DoLS assessments did take place		8,352	
Unit cost per CQC inspection	£0	£7,505	£0
% of inspection devoted to DoLS assessment	10%	15%	25%
Hence cost of DoLS component of inspection	£750	£1,126	£1,876
Uplift	10%	15%	20%
Total inspection costs	**£6,895,157**	**£10,812,860**	**£18,804,974**
Total number of Best Interest Assessors	2,854	5,707	8,561

	Low estimate	Best estimate	High estimate
Unit cost of annual refresher training for Best Interest Assessor	£0	£165	£0
Annual Best Interest Assessor refresher training cost	**£471,050**	**£941,934**	**£1,412,984**
SUMMARY TABLE			
Total transitional costs			
Upfront training costs	£9.47m	£17.25m	£25.61m
Total transitional costs	**£9.47m**	**£17.25m**	**£25.61m**
Total ongoing costs (per annum)			
Cost to managing and supervisory bodies	£293.74m	£438.47m	£635.71m
Costs of DoL outside of DoLS settings	£697.30m	£747.11m	£809.37m
Total legal system costs	£259.82m	£358.19m	£466.82m
Total self-funded legal costs	£611.69m	£896.53m	£1176.69m
Costs to regulatory bodies	£6.90m	£10.81m	£18.80m
Ongoing training costs	£0.47m	£0.94m	£1.41m
Total ongoing costs (per annum)	**£1869.93m**	**£2452.06m**	**£3108.81m**

23. Option 2 – Adjusted LPS System

Total applications under LPS

23.1 The analysis assumes that around 279,000 new applications will be received and completed per year in Option 2 at 2019/20 demand levels, which is then scaled through the 10-year appraisal period by the projected increases in social care demand up to 2031/32.[43]

23.2 This estimate is based on the following:

- There were 263,940 English[44] and 16,888 Welsh[45] DoLS applications in 2019/20, giving a total of 280,828.
- This is then adjusted by the proportion of new applications under DoLS that would instead be renewals under LPS, since under LPS authorisations can be renewed for up to 3 years vs 12 months for DoLS. Discussions with NHS Digital suggest that around 22% of DoLS applications indicated that there was a previously-granted authorisation for the individual, with no gap between the previous authorisation and the current application. These applications are therefore likely to be renewals under LPS, leaving 78% as new applications i.e. non-renewals. This gives around 219.000 new applications.
- We then add extra applications for 16/17-year-olds and domestic settings. Applications in domestic settings was estimated by the Law Commission to be 53,000[46] and there are an estimated 6,600 applications for 16/17-year-olds, based on data provided by the Department for Education.

23.3 NHS Digital indicates that the data drawn upon to derive the proportion of renewals (22%) is likely to lead to an underestimate, as the backlog in processing cases by LAs in many cases has created a gap between previous authorisations and subsequent applications for the same individual. This would lead to the number of new cases and associated costs herein being overestimated.

23.4 At the same time, the analysis does not currently estimate the costs of the 22% (approximately 62,000) of applications that are assumed to be renewals. Estimating the costs of renewals is complex. In many cases, renewals could just be a simple paperwork activity where it agreed that nothing in the person's circumstances has changed and therefore no further assessments are needed, giving rise to minimal costs. In some cases, further assessments may be needed, generating higher costs. Potential costs of renewals would also depend on whether an individual has a pre-existing health and care plan. Further evidence to estimate the potential costs of renewals will be sought during the consultation period.

23.5 The proposed definition for a deprivation of liberty, as set out in the Code, is also likely to impact the number of applications per year. The exact impact is difficult to quantify at present, however, we will aim to provide an estimation for the final assessment.

Transitional costs

Training costs

23.6 A range of staff across the health and care sectors, including children's services and local authorities, will require training on the new LPS system.

[43] https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-7.pdf Interpolated to single years using compound average growth rates.

[44] https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments

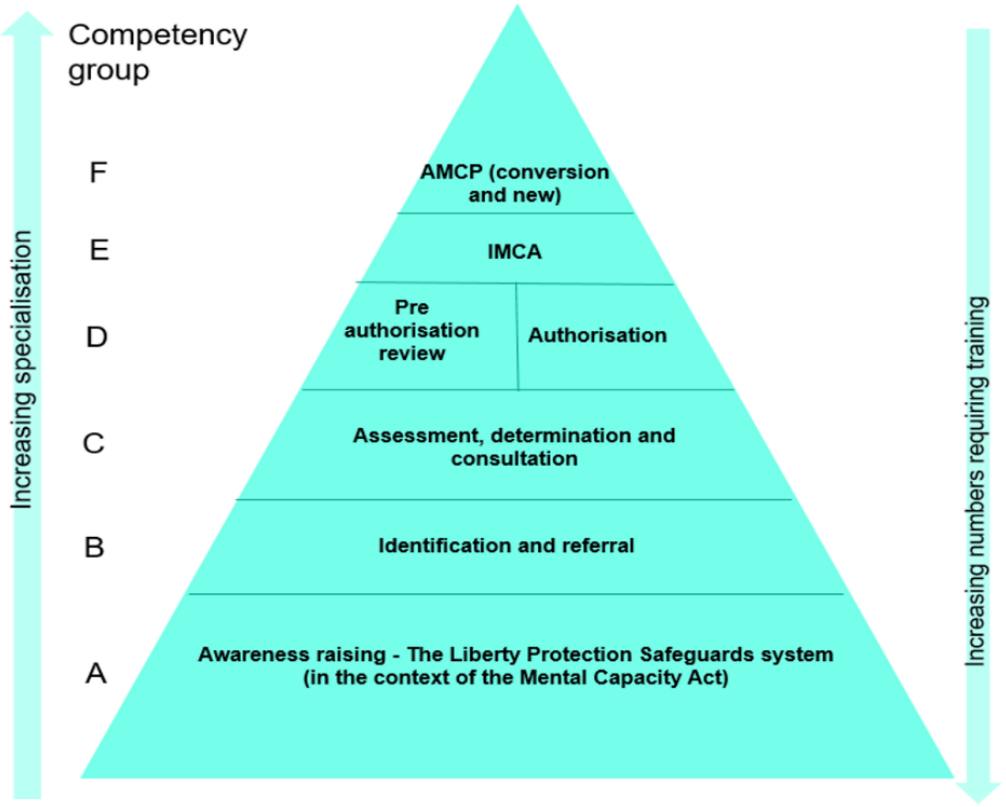
[45] https://careinspectorate.wales/sites/default/files/2021-03/210324-dols-2019-20-en.pdf

[46] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related (page 24)

23.7 The previous iteration of the Impact Assessment focused solely on the key roles requiring significant levels of training – doctors, social workers, AMCPs and advocates. We have expanded our analysis to include other core health and social care staff (such as nurses) and other staffing groups who may support or look after young people aged 16 and 17 (e.g. special education staff). This is by no means an exhaustive list, and we expect that some staff in NHS Trusts and Responsible Bodies, for example, will have to undertake training in order to carry out their responsibilities as part of the LPS process. However, it is difficult to identify these individuals and to quantify the impact.

23.8 The LPS 'Workforce and Training Triangle', below, sets out the six 'workforce competency groups' for training on LPS, which includes: awareness raising training on the LPS (competency group A); identification and referral (competency group B); assessment, determination and consultation (competency group C); pre-authorisation and authorisation (competency group D); Independent Mental Capacity Advocate (competency group E) training; and Approved Mental Capacity Professional (competency group F) training. These have been identified with a group of expert stakeholders. The details of each competency group are set out in the LPS workforce and training strategy and the LPS training framework.

Liberty Protection Safeguards (LPS) Workforce and Training Triangle



23.9 Our ambition is for all health and care staff that may care for, look after or regularly come into contact with someone who lacks mental capacity, to receive awareness training (competency group A) under the new system. This impact assessment covers all health and care staff whose roles are most relevant to the LPS that will need training ahead of implementation. Other members of staff may choose to carry out the training either prior to or after implementation, however, we have only included staffing groups required to enable the system to work in this Impact Assessment.

23.10 All costs for training are presented within the document. As is the convention in social cost benefit analysis, we have costed staff training at the full cost of staff time per hour (salary plus

employer national insurance and pensions contributions), which serves as a proxy for the opportunity cost of time. Furthermore, we have divided staff training costs into two distinct groups, based in turn on relevant 'competency groups' set out in the LPS National Workforce and Training Strategy, which we have published for consultation in England (see training triangle above).

23.11 This strategy, and the estimates of the types and proportions of staff requiring training, have been developed through engagement with relevant professional bodies, including NHS Partners, ADASS, some local authorities, the Nursing and Midwifery Council (NMC), and training providers including Health Education England and others.

23.12 The first type of training is **'general awareness training'.** This classification aligns with 'competency group A: awareness raising.' The second type of training is '**specialised training**'. **Specialised training** includes training on identification and referral (competency group B), assessment, determination and consultation (competency group C), and pre-authorisation and authorisation (competency group D).

23.13 For the purposes of the analysis, we have grouped together specialised competency groups B, C and D, since the numbers undertaking each will be smaller than those undertaking competency group A (general awareness raising); it is unclear how many staff will require training within these groups; and we will not know this until the system is implemented. However, it is likely that most social workers and care home managers will need training in identification and referral (competency group B) given their role and responsibility under DoLS and proposed under the LPS.

23.14 Given the lack of data, the analysis also assumes that most staff will only undertake specialised training in one of the competency groups. Although some professionals may undertake training across two or more areas, this has not been costed since who these professionals are, and what number, is difficult to quantify. We will update this assumption with any information received during the consultation period.

23.15 Where relevant, costs arising from general awareness training, and costs arising from specialised training are presented separately in the analysis below.

23.16 DHSC will work with national providers across local government, social care and health to develop and commission national training materials covering the workforce competency groups A to D[47]. This learning will be available for use by employers and training providers, across a variety of settings, to deliver training on the during the implementation period.[48] Given this, we have assumed that organisations will not incur training fees (except for IMCA and AMCP training), meaning the only training cost to organisations across local government, social care and health in this assessment is time spent by staff on training.

23.17 We estimate that general awareness training will take 2-3 hours, so we use an average of 2.5 hours. This is based on the cost of existing DoLS awareness training courses running for two hours[49], and the Law Commission Impact Assessment assumption that social workers would on average require two hours of awareness training. Similarly, specialised training on the LPS will take an additional 2-3 hours, so we use an average of 2.5 hours. This is based on the expectation that specialised training (i.e. competency groups B to D) on the LPS will take a similar length of time. These do not change for different types of staff.

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47 https://www.gov.uk/government/publications/liberty-protection-safeguards-implementation-support. The costs to DHSC related to this are already committed (sunk) and so are not included in this impact assessment.

48 In practice, training providers may develop and charge for training products beyond this core package but these should not be required to comply with the regulations and so are not costed here'

49 https://www.highspeedtraining.co.uk/safeguarding-people/dols-training.aspx

23.18 Note that time estimated for specialised training is in addition to time for awareness training, and that all staff requiring specialised training will also have awareness training – i.e. 5 hours of training in total. We first estimate costs for England and then apply an uplift based on relative population to account for additional costs in Wales.

23.19 Training for IMCAs (competency group E) and AMCPs (group F) are costed separately. As these are based on the expected number of LPS applications, which already includes applications in Wales, no further population adjustment is applied to cost estimates for groups E and F.

Doctors

23.20 There are 131,825 NHS doctors[50] and 47,005[51] GPs in England, as of January 2021. However, our expectation is that only doctors who may care for or treat patients lacking the relevant mental capacity will need to receive the LPS training for the proposed system to function.

23.21 The types of hospital doctors that we consider need to be aware of the LPS are Emergency, Psychiatry, Intensive Care, Geriatrics, and 20% of Paediatrics (totalling 28,225[52]). We assume all of these hospital doctors will need general awareness training. In addition, we assume that all GPs will require the LPS awareness training. This gives 75,230 doctors in total requiring 2.5 hours awareness training.

23.22 Some doctors will also require specialised training. The Law Commission's Impact Assessment estimated that between 5-15% of all doctors will require training on the LPS. Based on further consideration of the roles, we consider that this represents a plausible proportion of the estimated 75,230 relevant doctors assessed in the previous paragraph (i.e. those requiring general awareness raising) that will also need specialised training. Using 10% as a best estimate gives 7,523 doctors needing specialised training.

23.23 To work out the unit cost of a hospital doctor's time we have weighted the average of the unit costs[53] of employing hospital doctors of different grades per hour. Unit costs of doctors come from the latest Unit Costs of Health and Social Care.[54] The cost per hour for hospital-based doctors in 2019/20 range from £16.58 for a foundation doctor in their first year (FY1) to £67.36 for a consultant psychiatrist. Using the proportions in the workforce in January 2021[55], we have estimated a weighted unit cost for a doctor at £48.63 per hour.[56] This is then uplifted to 20/21 prices, leading to a cost of £49.58 per hour. These figures include salary and 'on costs' (national insurance and pensions contributions) to the employer.

23.24 The equivalent hourly cost for a GP is calculated by dividing the net renumeration figure by the estimated hours worked, resulting in a unit cost for a GP of £65.49 per hour[57]. This is then uplifted to 20/21 prices, leading to a cost of £66.78 per hour.

23.25 The training time cost per hospital doctor is therefore £124, for both awareness training and specialist training. The training time cost per GP is £167, for both awareness training and specialist training.

23.26 Based on these assumptions, the initial costs of time for doctors across both awareness and specialised training is £12.5m. This includes £11.3m on general awareness training, and £1.1m on specialised training.

[50] NHS Workforce Statistics, January 2021
[51] NHS Digital Publication on General and Personal Medical Services. Data from 31st March 2021
[52] Based on FTE proportions from January 2018 (See "Doctors by Grade and Specialty" worksheet), applied to the Jan 2021 Headcount
[53] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/
[54] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/
[55] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2021
[56] Further details available from the Department of Health and Social Care
[57] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/

Social Workers

23.27 The hourly costs of time are £30.04 for an adult social worker and £30.75 for a children's social worker (after uplifting to 2020/21 prices). Applying the estimated 2.5 hours for awareness training and 2.5 hours for specialised training, the cost for social workers to carry out each training session (awareness or specialised) averages at £75 per adult social worker and £77 per children's social worker.

23.28 There are 15,900 adult social workers employed in local authorities in England[58]. We assume that 100% of adult social workers who are employed by local authorities in adult social care will need both awareness and specialised training. Note that we have not included adult social workers not employed by local authorities. Therefore, this is likely to be an underestimate, as some social workers may instead be employed by private contractors engaged by local authorities.

23.29 There are 33,966[59] children's and family social workers employed in England. We expect that all children's social workers will need awareness training, and 20% will need specialised training on the LPS. This figure is in line with the Law Commission's estimate and is considerate of the fact that the number of authorisations that may be required will only be for young people aged 16 & 17.

23.30 Based on these assumptions, the initial awareness and specialised training costs for social workers across both adult and children's services is £5.5m. Of this, £3.8m is for general awareness, and £1.7m on specialised training.

Nurses

23.31 These costs are a best estimate based on the number of nurses currently working across various specialities and settings, the cost of training these nurses, and are based on assumptions relating to the number of DoLS cases. These estimates do not consider the number of nurses who may be joining or leaving the profession or moving between settings, though we are aware that there are a number who will require refresher training if moving speciality or setting. We are also aware that there some settings have not been included in this assessment. Nonetheless, this estimate covers the majority of nurses that we think will need training either ahead of implementation or as part of continuing professional development across all settings.

23.32 As of March 2021, there were approximately 558,000 nurses working in England[60] – excluding midwives and half of the nurses that are also midwives. Of this number:

- 428,966 are adult nurses
- 44,291 are children's nurses
- 13,381 are Learning Disability (LD) nurses
- 71,385 are Mental Health nurses

23.33 Our assumption is that 50% (214,483) of all adult nurses, 20% (8,858) of children's nurses, all LD nurses (13,381) and all Mental Health nurses (71,385) will need awareness training on the LPS given the settings they work in and likelihood of coming into contact with the LPS process. These assumptions are a reflection on the number of applications being made across the various settings – acute hospitals, nursing led care homes, community settings – and consideration of the likelihood of nurses being involved.

23.34 Our calculation is that around 11% of all nurses will require specialised training on the LPS, by which we mean competency groups B to D. This has been estimated as follows:

[58] NHS Digital: Personal Social Services: Staff of Social Services Departments, England 2020, Tab T4
[59] https://explore-education-statistics.service.gov.uk/find-statistics/children-s-social-work-workforce
[60] Registration data reports - The Nursing and Midwifery Council (nmc.org.uk)

- *Adult nurses:* We assume enough nurses will need to be trained so that nurse can expect to only need to be involved in 5 cases per year each. Given that we expect around 65,900 LPS applications will happen in acute settings and 89,500 in nursing homes (applying the proportions of existing applications in these settings to expected application numbers under LPS) [61], this suggests that approximately 13,200 nurses in acute settings and 17,900 in nursing homes will require specialist training, giving 31,100 adult nurses in total.
- *Mental health nurses:* We expect all mental health nurses of band 7 and above will need specialised training. Approximately 22%[62] of the 71,385 mental health nurses are band 7 and above, giving an estimated 15,753 nurses requiring specialist training.
- *Learning disability nurses:* We estimate that all 13,381 learning disability nurses will require some form of specialised training, since they work on very specialised and LPS-relevant cases.
- *Children's nurses*: We estimate that 5% of 44,291 children's nurses will require training on LPS, on the basis that the estimated number of LPS cases for 16/17-year-olds is 6,600 out of approximately 279,000 total applications (less than 5%; proportion requiring training increased to 5% as an allowance for uncertainty). This comes to 2,215 nurses.

23.35 Summing the above gives a total estimated number of all nurses needing specialised the LPS training of about 62,400.

23.36 The cost of an hour of a nurse's time is estimated using the same method as doctors above. PSSRU estimates the time cost for each nursing pay band from 4 to 9[63]. We calculate the proportion of nurses at each band[64] and apply these time costs to estimate a weighted unit cost per hour of £27.55.

23.37 Based on these assumptions, our best estimate on the total cost for the initial awareness and specialised training costs for nurses is £26m. Of this, £21.6m is for general awareness, and £4.4m on specialised training.

Special School Staff

23.38 Unlike DoLS, the LPS extends to 16-17 year olds. As the LPS also applies to all settings where the person is receiving care or treatment, this means certain staff at special schools who are likely to come across the LPS issues will need training, as they care for young people who lack mental capacity. The two considered groups are classroom teachers (estimated 36,004 individuals in England) and senior staff (7,859). Teachers will only be required to get awareness training, estimated to take 2.5 hours. Senior staff will need awareness training and specialised training (5 hours in total).

23.39 The unit costs of school staff time are assumed to be the same regardless of the school type. We add 22% to salary to bring these time costs into line with those used for other professions, which include pension and employer national insurance contributions.[65] Thus we take the median salary for classroom teachers (£37,832) and senior school staff (£56,600) in November 2019 [66], divide by the number of working days (230) and the hours in a day (8), multiply by

[61] DoLS Application Data, Table 1

[62] HSCS staff by secondary AoW, level, area and grade, Jan 2010 to 2018

[63] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/

[64] https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/staff-numbers/hchs-staff-by-secondary-aow-level-area-and-grade-jan-2010-to-2018

[65] RPC Guidance Note

[66] DfE 2021 Pay Award Evidence, paragraphs A7 & A13

122%, and uplift to 2020/21 prices to get £25.58 per hour for classroom teachers, and £38.27 per hour for senior staff.

23.40 This leads to an estimated for the total cost of special school staff training of £3.8m. Of this, £3.0m is for general awareness, and £0.8m on specialised training.

Care home managers

23.41 In the previous impact assessment, training costs for care home managers were estimated by calculating the total number of care homes, a care home managers salary per working day and the working days taken for training, on the assumption that they will have a specific role in the LPS process and that it would take one day for them to take on board the new policy. The new specific function under the LPS for care home managers is no longer being implemented, but care home managers will still need awareness training, and some will need specialised training. This brings the calculation in line with other professions.

23.42 The total number of adult care homes in England in June 2019 is 15,692[67]. Each of these will require a care home manager with both awareness training and specialised training. The LPS will introduce a new system for education, voluntary and community settings serving 16/17-year-olds. We know that there were 2,460 children's homes as of 31 March 2020 registered with Ofsted. Each of these would have a registered manager and if interacting with 16/17-year-olds should receive both awareness and specialised training on the LPS. Assuming that all children's care home managers require this training, this gives an estimated 18,152 care home managers requiring training across children and adult care homes.

23.43 Applying the time estimates for awareness training and specialised training (2.5 hours each) and the unit cost of an hour of a care home manager's time (£26.86 in 2020/21 prices)[68], gives a £67.14 cost of time per training course for each manager.

23.44 The new best estimate for the cost of training care home managers is therefore £2.4m. Of this, £1.2m is for general awareness, and £1.2m on specialised training.

Total training Groups costs, with adjustment for Wales

23.45 Added together, general awareness training for all staff is estimated at £41.1m, while specialised training is estimated to cost £9.2m. Since only English staff are accounted for above, we apply an uplift of 5.66% for Wales, based on the relative population size for England and Wales. This results in a total of £53.1m for both England and Wales.

Independent Mental Capacity Advocates (IMCAs) – Group E

23.46 We estimate that training is needed for 11,451 new IMCAs, based on the expected number of the LPS applications. This figure is comprised of 7,451 IMCAs to provide direct support and 4,000 IMCAs to support Appropriate Persons. The calculations assume, drawing on estimates provided by Voicability, that:

- IMCAs work 1,350 hours full time equivalent per year
- each direct support case requires 38 hours IMCA support
- each Appropriate Support case requires 17 hours support

[67] Latest CQC directory of registered care providers can be found at: *https://www.cqc.org.uk/file/148450*

[68] PSSRU Unit costs 2020

- assumptions relating to the proportions of LPS applications and appropriate persons requesting an advocate and an adjustment for the fact that advocates are part time, as detailed in Table 10.

23.47 The training cost for each new IMCA is £1,933. This is based on City and Guild course prices and uplifted to 2020/21 prices. It is assumed that the training cost under the new scheme will be equivalent to the cost of training a person as a DoLS advocate.

23.48 **The total advocate training cost** is calculated by multiplying the number of advocates needed (11,451) by the advocate training cost (£1,933), giving £22.1m.

Approved Mental Capacity Professionals (AMCPs)

23.49 It is presumed, in line with the Law Commission Impact Assessment that 90% of all AMCPs will be recruited from existing Best Interests Assessors (BIAs). Therefore, only 10% (116) of AMCPs will require full training ahead of implementation.

23.50 The training cost for each new AMCP comprises a course fee and the cost of time. The unit cost of an AMCP trainee's time is estimated to be £30[69] per hour - we have used the social worker hourly cost for estimation purposes since social workers are the largest group that perform the BIA role under DoLS. The course will be worth 60 credits and will be longer than the 30 credit, 48 hour course BIAs currently undertake. On the basis that the course is worth twice the credits, we assume it will be twice as long, i.e. 96 hours, giving a total time cost of £2,883. We also assume it will cost twice as much as the £1,581 estimated by the Law Commission, giving £3,162. **The total cost of AMCP upfront training** is calculated by multiplying the number of AMCPs who need training (116) by the combined unit cost of the AMCP upfront training course (£6,045), giving a cost of £0.7m.

23.51 **The cost of conversion** is the cost of converting BIAs to AMCPs. BIAs already perform a similar role to AMCPs, so the cost of conversion is lower than training a new AMCP. Furthermore, since DHSC is supporting the cost of the development of the training materials, the cost of each course will include only the time taken to undertake this training which we expect will be between 8-16 hours. We will take the centre of this range, 12 hours. Using the £30 per hour unit cost of an AMCP trainee's time, this gives a total time cost of £360.

23.52 The Law Commission estimated that 90% of AMCPs would be existing BIAs. We have therefore multiplied the number of AMCPs converted from BIAs (90%, giving 1,043), by the unit cost of a BIA to AMCP conversion course (£360), and added the one-time course materials price. This gives a cost of £0.38m.

Other Training Groups

23.53 We recognise there will be other roles requiring training, which includes some staff in Responsible Bodies, NHS Trusts and other settings who may be involved in parts of the LPS process (such as assessments, determinations and consultation tasks) and those who will have new responsibilities for authorising arrangements. These costings have not been included, as it is not clear exactly how many groups will be affected, and the number within each group is difficult to quantify at this time.

Data and monitoring bodies

[69] PSSRU Unit costs 2020

23.54 It is important that there is a reliable and detailed data set regarding the LPS to enable appropriate monitoring of the effectiveness of the system, and to spot any trends that may need to be addressed. The monitoring bodies (CQC and Ofsted in England) also have a vital role in ensuring that the system is being delivered fairly and the rights of people impacted by it are protected. Responsible Bodies will be required to notify the monitoring bodies of every authorisation, in line with a national minimum data set, to allow the bodies to plan inspections and report appropriately on the data.

23.55 In order for this to work, data systems at a national and local level need to be in place. The national level data system will collect data from Responsible Bodies and feed it into the monitoring bodies. DHSC is currently budgeting £1.5m for the development of this system.

23.56 At a local level, local authorities will already have systems in place from their role under DoLS. These systems will need updating to align with the LPS process and to work with the national system. However, NHS bodies (Clinical Commissioning Groups and NHS Trusts in England, Health Boards and NHS Trusts in Wales) have a new role that they did not have under DoLS. They do not currently have systems in place and will therefore need to develop entirely new systems. DHSC currently has limited information about these potential costs so, for the purposes of this Impact Assessment, we estimate that each Responsible Body will need to spend on average around £10k on data implementation, across LAs and NHS bodies. This means that data systems for responsible bodies would cost around £5.1m.

23.57 The monitoring bodies themselves also have implementation costs in order to prepare for their roles within the LPS. We currently estimate CQC's implementation costs to be £2.25m, and Ofsted's to be £0.6m.

Ongoing costs

Assessment Costs

23.58 The cost of new assessments is expected to be met by the Responsible Body. There are three assessments required under the LPS: necessary and proportionate, mental capacity and medical assessments.

23.59 If appropriate, previous or equivalent assessments can be used. This is the case at initial authorisation stage and where an authorisation is being considered for a renewal. In appropriate scenarios, such as if the person's medical condition, capacity or arrangements have not changed, further assessments are not required for a renewal. This applies to all assessments.

Medical and capacity assessments

23.60 In many cases, capacity and medical assessments will already be available for the purposes of an LPS authorisation. For example, if someone has a diagnosis of dementia that is still valid, this can be used for the purposes of an assessment for mental disorder. Similarly, if a capacity assessment is carried out for another purpose, such as hospital discharge, and it is still valid, this capacity assessment might be used.

23.61 The Law Commission estimated that a medical assessment will already have been completed in 85% of cases. This means a new medical assessment will be required in 15% of cases. Using this as a basis and uplifting slightly to consider applications concerning 16/17-year-olds which are likely to be first time authorisations, we estimate that new medical assessments will need to be completed in 20% of cases. The medical assessment under the LPS system will not need to cover the level of detail of those completed in the current DoLS by Section 12 doctors. It is therefore difficult to establish the cost of a medical assessment, so we have used £121 per medical assessment as a best estimate, inflated from the 2011/12 Law Commission cost of £102.

23.62 There is limited information available to establish how many capacity assessments will be required. However, stakeholders have indicated that a new capacity assessment will be needed more often than a new medical assessment. Using this as a basis and allowing for 16/17-year-olds as above, a new capacity assessment will be needed in 40% of cases at a cost of £170 per capacity assessment (inflated from the Law Commission estimate).

Necessary and proportionate assessments

23.63 New necessary and proportionate assessments will be needed in every new case. However, for those who have a care plan under the Care Act 2014, Continuing Healthcare arrangements, or other statutory health or care planning, the necessary and proportionate assessment can be completed alongside the care planning for this. Approximately 50% of those subject to the LPS will have such a plan. For these people we estimate that the cost of completing the necessary and proportionate assessment alongside this care planning will be 20% of the standard cost of completing a new standalone necessary and proportionate assessment. The cost for these individuals is therefore equal to 139,300 assessments (50% of all expected applications under the LPS) at a cost of £32 per assessment (20% of the full standalone 'necessary and proportionate' assessment cost of £160 each).

23.64 The remaining 50% (139,300) will not have such a care plan and they will all require standalone 'necessary and proportionate' assessments, at a cost of £160 each.

23.65 Multiplying and summing gives a total annual cost of **£52.43m** for the assessments required for the LPS.

Advocacy

23.66 Under the LPS most people will receive representation and support from either an Independent Mental Capacity Advocate (IMCA) or from an Appropriate Person. Local authorities will be responsible for ensuring there are enough advocates available in their local area and therefore have commissioning and financial responsibilities for the IMCA service.

23.67 For the purposes of this Impact Assessment, we have calculated this cost by summing the **cost of direct IMCA support to persons subject to an LPS authorisation** and the **cost of IMCA support to Appropriate Persons**. Our calculations consider the different advocacy needs of a person subject to an LPS authorisation and an Appropriate Person. Voiceability (an advocacy provider) estimates that 95% of first-time applicants require some form of representation and support. Applying this to the **number of (first time) applications (278,646)** gives an estimate of **264,714 applications per year** requiring some form of representation and support**.**

23.68 We have calculated the **cost of direct IMCA support to persons subject to an LPS authorisation** by assuming that, of individuals requiring some form of representation and support, **25% have direct IMCA support** (**66,178**) and that an IMCA provides **38 hours of direct support per client**. The cost of IMCA support is roughly **£37 per hour.** These figures are devised by Voiceability and are used as a best estimate. There is a great deal of variation in the number of hours per client; PohWER Advocacy have indicated that this can range between 9 and 81 hours in an individual case. Multiplying together gives a cost of **£91.94m.**

23.69 **Cost of IMCA support for appropriate persons** is calculated by assuming that **75%** of people requiring some form of representation and support have an Appropriate Person, and **40%** of appropriate persons have an IMCA. Therefore, **79,414 Appropriate Persons require IMCA support.** An IMCA provides **17 hours of support** to an Appropriate Person at a cost of **£37 per hour**. Multiplying gives a cost of **£49.36m.**

23.70 Adding gives a total annual cost of advocacy of **£141.30m**.

Cost of administration and pre-authorisation review – not requiring AMCP approval

23.71 Once all the assessments have been carried out, Responsible Bodies have a duty to arrange a pre-authorisation review to determine whether the authorisation conditions are met. In most cases, this will be a desktop review of the evidence and will not need to be carried out by a specific professional. In some cases, this will be carried out by an Approved Mental Capacity Professional, see 'Cost of approval by AMCP' below.

23.72 Following the pre-authorisation review, the Responsible Body must decide whether to authorise the arrangements. The person and their Appropriate Person or IMCA must be provided with a copy of the authorisation record, and those providing care and treatment to the person should also be informed.

23.73 The cost for pre-authorisation review and authorisation, is calculated as the **number of applications per year under the preferred model 278,646**, less the **72,500 applications approved by AMCP** (see 'Cost of approval by AMCP section below)**,** multiplied by the **cost of administration and pre-authorisation review (£227).** This gives a total cost of **£46.74m.**

23.74 The cost represented here is the cost to Responsible Bodies of undertaking pre-authorisation reviews (when this is not done by an AMCP) and other administrative tasks such as providing the person with information, managing ongoing reviews and arranging for an advocate to be appointed. To cost this we have taken the cost of administration under DoLS at present from the Law Commission Impact Assessment (£324 in 2020/21 prices) and reduced it by 30% to £227. This is to account for the fact that the new process will be less cumbersome and will work better alongside existing care planning.

23.75 The previous version of the Impact Assessment also covered the impact of authorisations in care homes, where care home managers provided a statement to the Responsible Body for pre-authorisation review. This formal role for care home managers is no longer planned for implementation along with the other provisions of the MC(A)A. This is subject to public consultation and, if accepted, will be kept under review as the LPS is implemented. Care home managers may still have an informal role in some cases, for example, being consulted on the person's wishes and feelings to carrying out some reviews.

Cost of approval by AMCP

23.76 Comprised of the sum of: **AMCP cost for all cases requiring their approval, cost of repeat assessments,** and **cost of refresher courses**.

23.77 **AMCP cost for all cases requiring their approval** is calculated by multiplying the number of cases requiring an AMCP (between 11% and 41% of the 278,646 applications per annum, with a central estimate of 26%, giving 72,500 cases) by the AMCP cost per approval (£131 more than the £227 standard cost of administration and pre-authorisation review, giving £358), taken from the Law Commission. This gives a cost of £25.91m.[70]

23.78 If the AMCP is not satisfied with existing assessments, they can choose to do their own. **Cost of repeat assessments** is calculated by using the Law Commission assumptions and multiplying the number of cases subject to AMCP approval above, the cost per repeat assessment (£53) and an assumption on the repeat assessment rate (5%). This gives a cost of £0.19m.

23.79 AMCPS must also complete 18 hours of refresher training each year to maintain their approval. **The unit cost of refresher training** is assumed to be £1,159 per AMCP per year, accounting for course and time costs. This includes the Law Commission's estimate of a conversion course (£263)[71] uplifted to 2020/21 prices and multiplied by 18/8 to reflect a longer expected course

[70] The presentation of costs between 'Costs of administration and pre-authorisation review – not requiring AMCP approval' and 'Costs of approval by AMCP' have been revised since the last published impact assessment to ensure that the costs of AMCP approval are correctly accounted for. This revision does not affect the total combined costs in these two sections.

[71] https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/#related (pages 29 – 35)

length of 18 hours (versus 8 hours in previous version of the IA), giving a course fee of £618. The unit cost of an AMCP time is assumed to be similar to that of existing Best Interests Assessors (who can be a social worker, nurse, occupational therapist or registered psychologist by law) and is estimated to be £30[72] per hour (uplifted to 2020/21 prices) - we have used the social worker hourly cost as a proxy for estimation purposes as it falls in the middle. This gives a time cost per course of £541. Multiplying the number of AMCPs (1,159) by the total cost of per refresher training (£1,159), gives a cost per annum of £1.34m.

23.80 Summing these gives a total cost per annum of **£27.45m.**

Legal costs – Court of Protection

23.81 Having the right to make an application to the Court of Protection is a key safeguard of the LPS process. Anyone can make an application to the Court of Protection under section 21ZA of the MCA, and in respect of the use of section 4B. The person or their Appropriate Person, where relevant, are entitled to non-means tested legal aid.

23.82 Legal costs are comprised of **total legal aid costs, total costs to Responsible Body for CoP reviews,** and **total Official Solicitor costs.**

23.83 **Total legal aid costs** are calculated as the number of Court of Protection challenges multiplied by the cost of non-means tested legal aid.

23.84 Under the preferred LPS model more applications are processed per annum, therefore we expect there to be more challenges to the Court of Protection. However, in the LPS model, AMCPs will be considering cases where objections are raised prior to an authorisation being given, which may mean fewer authorisations are subsequently challenged in the Court of Protection. The Law Commission estimated that 1% of DoLS applications end up being challenged in the Court of Protection.

23.85 The LPS model is intended to ensure that the person at the centre of decision-making process, meaning their care or treatment arrangements should better mirror their wishes and feelings. Additionally, the AMCP role has been introduced to ensure that, as far as possible, where the person has concerns about the care or treatment arrangements that these can be addressed before an authorisation is given. However, the impact of this is difficult to quantify prior to implementation, and we have therefore kept the appeal rate consistent at 1% of authorisations given.

23.86 Therefore, legal aid cost is calculated by multiplying the number of appeals per annum (1,364, 1% of granted applications) by the legal aid cost (£10,489) provided by Ministry of Justice (MoJ). This gives a cost per annum of £14.30m.

23.87 This shows that Option 2 is expected to have a very similar legal aid cost to DoLS at present (£13.25m). It is also important to emphasise that by bringing 16/17-year-olds and community deprivations of liberty into the system, the preferred model stops the large cost pressure on legal aid of option 1, DoLS fully operationalised, being realised.

23.88 **Costs to responsible body of CoP challenges** is calculated by taking the cost of a CoP challenge (£12,535) provided by MoJ and multiplying by the number of challenges per annum (1,364). This gives a cost of £17.10m.

23.89 Unlike under the DoLS (at present or fully operationalised), under the LPS there will be no cost to the Responsible Body to take deprivation of liberty cases outside current DoLS settings to the Court of Protection, as the LPS scheme is not setting-specific. Cases outside DoLS settings are now covered by the LPS and included in the volume of these applications. Under DoLS at present (Option 0, presented in paragraphs 21.6 to 21.8) this cost is estimated at £42.96m per

[72] https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2020/

annum. Doing this also removes the legal costs of authorisations to people who lack capacity and their families / carers. As stated above these costs are not incurred in the new system.

23.90 **Total Official Solicitor costs** are calculated by multiplying the number of challenges per annum (1,393), the Official Solicitor cost per case (£12,535) inflated from the Law Commission Impact Assessment, and an assumption that 25% of cases involve an Official Solicitor. Multiplying gives a cost of £4.27m.

23.91 Summing total legal aid costs, costs to supervisory bodies for CoP challenges and Official Solicitor costs gives a **total legal cost per annum of £35.68m**.

Regulatory bodies (CQC and Ofsted)

23.92 The UK is a member of the Optional Protocol to the Convention against Torture, which is a UN protocol to protect anyone detained by the state. It is vital that anyone detained by the state is not treated unfairly during their detention. This includes anyone deprived of their liberty under the LPS.

23.93 Therefore, the LPS will be monitored by CQC and Ofsted, in England. In Wales, it will be monitored by Health Inspectorate Wales, Care Inspectorate Wales, and Estyn. The costs in this Impact Assessment are calculated as **cost of CQC regulation and Ofsted monitoring.**

23.94 **The cost of CQC regulation for LPS has been estimated at £13.5m per annum once DoLS is no longer in operation.** These figures are based on initial analysis done by the CQC team. The working assumption is that the majority of this will be recoverable through fees, except for the inspection of unregulated settings. This is subject to separate consultation with providers by CQC and so is not a direct impact of this regulatory change for the purposes of this Impact Assessment.

23.95 **Initial analysis by Ofsted suggests a cost of around £600,000 per annum.**

23.96 We do not have estimations of specific costs for the Welsh monitoring bodies, so have added an additional 5.66% to cover these costs. **This gives a total combined regulation cost of £14.90m per annum.**

The following table is at 2020/21 prices and 2019/20 levels of demand:

Table 10: detailed costings for Option 2[73]

	Low estimate	**Best estimate**	**High estimate**
APPLICATION VOLUMES (England and Wales)			
Number of DoLS applications received 2019/20		280,828	
% of assessments that are first (not repeat) assessments		78%	

[73] Note that to reduce complexity the table does not present the complete calculations. Please refer to the text above for a full description of calculations and assumptions. Where only 'best estimate' values are provided, these are also used for the 'low estimate' and 'high estimate' columns in subsequent calculations

in Section 23 above.

Number of 16-17 year olds and community DoLS assessments that fall under the new scheme		59,600	
Number of applications per year under preferred model		278,646	
TRANSITION COSTS			
Data Implementation (England and Wales)			
Master data system		£1,500,000	
Cost per Responsible Body (CCGs, NHS Trusts and UTLAs)		£10,000	
Number of Responsible Bodies (CCGs, England)		106	
Number of Responsible Bodies (NHS Trusts)		217	
Number of Responsible Bodies (UTLAs, England)		152	
Number of Responsible Bodies (Health Boards, Wales)		7	
Number of Responsible Bodies (NHS Trusts, Wales)		3	
Number of Responsible Bodies (UTLAs, Wales)		22	
Total Responsible Bodies (England & Wales)		507	
Total Costs for Responsible Bodies (CCGs, NHS Trusts and UTLAs)		£5,070,000	
Total Data Implementation Costs (England and Wales)	**£6,570,000**	**£6,570,000**	**£6,570,000**
Of which NHS	£3,330,000	£3,330,000	£3,330,000
Of which LA	£1,740,000	£1,740,000	£1,740,000
Of which DHSC	£1,500,000	£1,500,000	£1,500,000
Other Implementation Costs for external bodies			
CQC		£2,250,000	
Ofsted		£600,000	
Total Other Implementation Costs	**£2,850,000**	**£2,850,000**	**£2,850,000**
Of which Regulators	£2,850,000	£2,850,000	£2,850,000
Transition Training Costs			
Awareness Raising (Category A) – England only	**£32,849,133**	**£41,061,416**	**£49,273,699**
Of which NHS	£13,472,131	£16,840,164	£20,208,196
Of which LA	£3,972,606	£4,965,758	£5,958,909
Of which Private	£14,825,796	£18,532,245	£22,238,694
Of which DfE	£578,600	£723,250	£867,900
Specialised (Category B - D) – England only	**£6,910,056**	**£9,204,910**	**£11,726,699**
Of which NHS	£1,966,441	£2,632,991	£3,369,517

Of which LA	£1,594,986	£1,993,733	£2,392,479
Of which Private	£3,199,696	£4,392,021	£5,741,305
Of which DfE	£148,932	£186,165	£223,398
		4,812,889	
Uplift factor to account for Wales		5.6%	
Total cost of transition training for general staff (England and Wales)	**£42,009,558**	**£53,111,399**	**£64,453,021**
Of which NHS	£16,312,395	£20,575,335	£24,912,212
Of which LA	£5,882,718	£7,353,397	£8,824,077
Of which Private	£19,045,735	£24,221,779	£29,563,667
Of which DfE	£768,710	£960,887	£1,153,065
AMCP training costs – England and Wales			
AMCP hours per assessment		5.4	
AMCP working hours per year		1,350	
Hence assessments per full time AMCP per annum		250	
% of cases requiring an AMCP	11%	26%	41%
Number of applications per year under preferred model (from above)		278,646	
Hence number of cases requiring an AMCP	30,651	72,448	114,245
Hence number of full time AMCPs needed	123	290	457
Multiplier to adjust for fact that AMCPs are part time	2	4	6
Number of AMCPs	245	1,159	2,742
Of which converted from BIAs (90%)	221	1,043	2,468
Unit cost of BIA to AMCP conversion training		£0	
BIA to AMCP conversion training duration (hrs)	8	12	16
Unit cost of 1 hour of adult social worker's time		£30	
Unit cost of BIA to AMCP conversion training (price + time costs)	£240	£360	£481
Cost of BIA to AMCP conversion	**£53,027**	**£376,008**	**£1,185,872**
Of which LA	£53,027	£376,008	£1,185,872
Unit cost of AMCP upfront training		£3,162	
AMCP upfront training duration (hrs)		96	
Unit cost of 1 hour of adult social worker's time		£30.04	
Unit cost of AMCP upfront training (price + time costs)		£6,045	
Percentage of AMCPs requring upfront training		10%	
Number of AMCPs (from above)	245	1,159	2,742

Cost of AMCP upfront training course	**£148,237**	**£700,758**	**£1,657,563**
Of which LA	£148,237	£700,758	£1,657,563
Advocate training costs (England and Wales)			
Advocate full time working hours per year		1,350	
IMCA hours per client for direct support		38	
IMCA hours per client to support an appropriate person		17	
Hence direct support cases per full time advocate per annum		36	
Hence appropriate person support cases per full time advocate per annum		79.41	
% of cases requesting an advocate or appropriate person		95%	
of those, % of cases requiring an advocate		25%	
of those, remaining % use an appropriate person		75%	
% of those using an appropriate person who have an advocate to support them	20%	40%	66%
Number of applications per year under preferred model (from above)		278,646	
Hence number of cases requiring an advocate		66,178	
Number of advocates to provide direct support		1,863	
Multiplier to adjust for fact that advocates are part time	2	4	6
Number of advocates to provide direct support (after multiplier)	3,726	7,451	11,177
Number of cases requiring an appropriate person	39,707	79,414	131,033
Number of advocates to support appropriate persons	500	1,000	1,650
Multiplier to adjust for fact that advocates are part time	2	4	6
Number of advocates to support appropriate persons (after multiplier)	1,000	4,000	9,900
Total number of advocates needed (after multipliers)	4,726	11,451	21,077
Unit cost of advocate training		£1,933	
Total advocate training cost	**£9,132,442**	**£22,130,067**	**£40,732,206**
Of which LA	£9,132,442	£22,130,067	£40,732,206
Total upfront training cost (England and Wales)	**£51,343,264**	**£76,318,232**	**£108,028,662**
Of which NHS	£16,312,395	£20,575,335	£24,912,212
Of which LA	£15,216,424	£30,560,231	£52,399,718
Of which Private	£19,045,735	£24,221,779	£29,563,667
Of which DfE	£768,710	£960,887	£1,153,065
Of which DHSC	£0	£0	£0

Total Implementation costs (England and Wales)	**£60,763,264**	**£85,738,232**	**£117,448,662**
Of which NHS	£19,642,395	£23,905,335	£28,242,212
Of which LA	£16,956,424	£32,300,231	£54,139,718
Of which Private	£19,045,735	£24,221,779	£29,563,667
Of which DfE	£768,710	£960,887	£1,153,065
Of which DHSC	£1,500,000	£1,500,000	£1,500,000
Of which Regulators	£2,850,000	£2,850,000	£2,850,000
ONGOING COSTS (all England and Wales unless otherwise stated)			
Unit cost of administration under DoLS at present		£324	
Unit cost of administration under preferred Model (assuming 30% reduction)		£227	
Number of applications per year under preferred model (from above)		278,646	
Less applications requiring AMCP approval		206,198	
Total cost of administration (excluding applications approved by AMCP)		**£46,741,190**	
Number of applications per year under preferred model (from above)		278,646	
% of authorisations leading to a review		0%	
% of authorisations needing new necessary and proportionate (N&P) assessments	33%	50%	67%
% of authorisations with existing care plan for N&P assessments	67%	50%	33%
Hence number of new necessary and proportionate assessments	92,789	139,323	185,764
Hence number of N&P assessments with existing care plan	185,857	139,323	92,882
Unit cost of a new necessary and proportionate assessment		£160	
% of N&P cost for those with existing care plan		20%	
Unit cost of N&P assessment for those with existing care plan		£32	
Total costs of N&P assessments	£20,760,441	£26,707,256	£32,642,202
% of authorisations needing a medical assessment		20%	
Unit cost of medical assessment		£121	
Total costs of medical assessments		£6,726,272	
% of authorisations needing a capacity assessment		40%	
Unit cost of a capacity assessment		£170	

Total costs of mental capacity assessments		£18,991,827	
Total cost of reviews and necessary and proportionate assessments per annum	**£46,478,539**	**£52,425,355**	**£58,360,301**
Number of applications per year under preferred model (from above)		278,646	
% of first applications requiring advocacy support		95%	
Hence number of applications per year needing advocacy support		264,714	
IMCA hours per client for direct support		38	
IMCA hours per client to support an appropriate person		17	
Unit cost of IMCA support per hour		£37	
% of advocacy need met with direct IMCA support		25%	
Number of applications per year receiving direct IMCA support		66,178	
Cost of direct IMCA support	**£91,944,036**	**£91,944,036**	**£91,944,036**
% of advocacy need met by an appropriate person		75%	
% of appropriate persons requiring IMCA support	20%	40%	66%
Number of appropriate persons requiring IMCA support	39,707	79,414	131,033
Cost of IMCA support for appropriate persons	**£24,679,715**	**£49,359,430**	**£81,443,059**
Total annual cost of advocacy	**£116,623,751**	**£141,303,466**	**£173,387,095**
Unit cost of AMCP approval (additional to standard administration cost)		£131	
Total unit cost for AMCP approval		£358	
Number of cases requiring an AMCP (from above)	30,651	72,448	114,245
AMCP cost for all cases requiring their approval	**£10,963,455**	**£25,913,621**	**£40,863,786**
Unit cost per repeat assessment		£53	
Repeat assessment rate		5.0%	
Number of cases requiring an AMCP (from above)	30,651	72,448	114,245
Cost of repeat assessments	**£81,830**	**£193,416**	**£305,003**
Unit cost of AMCP refresher training		£618	
Hours of course		18	

Unit cost of 1 hour of adult social worker's time		£30	
Unit cost of AMCP refresher training (price + time costs)		£1,159	
Number of AMCPs (from above)	245	1,159	2,742
Cost of refresher training	**£284,143**	**£1,343,220**	**£3,177,231**
Total annual AMCP costs	**£11,329,427**	**£27,450,257**	**£44,346,020**
Assessment appeal rate (of granted applications)		1%	
Number of granted applications per year under preferred model (from above)		136,411	
Number of appeals per annum		1,364	
Unit cost of legal aid	£7,340	£10,489	£13,684
% of cases involving Official Solicitor	£10,012,314	£14,307,677	£18,667,026
Unit cost of Official Solicitor		25%	
Total Legal Aid costs	£11,700	£12,535	£13,580
Total Official Solicitor costs	£3,989,914	£4,274,908	£4,631,150
Total legal system costs	**£14,002,228**	**£18,582,585**	**£23,298,176**
Unit cost to supervisory body per Court of Protection review		1,364	
Number of appeals per annum (from above)	£11,700	£12,535	£13,684
Costs to supervisory body from CoP reviews	**£15,959,656**	**£17,099,631**	**£18,667,097**
Annual cost to CQC of LPS - England	£10,300,000	£13,500,000	£16,700,000
Annual additional cost to Ofsted - England		£600,000	
Population uplift factor to account for Wales		5.6%	
Annual cost to CQC of LPS		£14,264,100	
Annual total additional cost to Ofsted		£633,960	
Total cost of inspections	**£11,516,940**	**£14,898,060**	**£18,279,180**
SUMMARY TABLE			
Total costs	**Low estimate**	**Best estimate**	**High estimate**
Transitional			
Training costs	£51.34m	£76.32m	£108.03m
Data implementation costs	£6.57m	£6.57m	£6.57m
Other implementation costs	£2.85m	£2.85m	£2.85m
Total transitional costs	**£60.76m**	**£85.74m**	**£117.45m**
Ongoing			
Cost of admin (desktop reviews)	£46.74m	£46.74m	£46.74m

Cost of reviews and new 'necessary and proportionate' assessments	£46.48m	£52.43m	£58.36m
Total cost of advocacy	£116.62m	£141.30m	£173.39m
Total legal system costs	£14.00m	£18.58m	£23.30m
Costs to supervisory body from CoP reviews	£15.96m	£17.10m	£18.67m
Regulation costs	£11.52m	£14.90m	£18.28m
Total ongoing costs (per annum)	**£262.65m**	**£318.50m**	**£383.08m**