

## EXPLANATORY MEMORANDUM TO

# THE MENTAL CAPACITY (DEPRIVATION OF LIBERTY: APPOINTMENT OF RELEVANT PERSON'S REPRESENTATIVE) REGULATIONS 2008

2008 No. 1315

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

## 2. Description

2.1 The Mental Health Act 2007 has amended the Mental Capacity Act 2005 (“the Act”) to introduce a scheme known as the deprivation of liberty safeguards. This scheme provides a framework for authorising the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty.

2.2 Schedule A1 to the Act (inserted by the Mental Health Act 2007) contains a number of powers to allow the detailed requirements about representatives to be set out in Regulations. This instrument sets out the process for the selection, appointment and termination of an appointment of the relevant person's representative. A representative must be appointed for every person (the relevant person) in respect of whom a standard authorisation for a deprivation of liberty has been granted.

## 3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 This instrument makes the first use of powers under paragraphs 138(1), 142-145, 148, 149 and 151 of Schedule A1 to the Act. These regulations are subject to the negative resolution procedure.

## 4. Legislative background

4.1 This instrument is part of the implementation of deprivation of liberty safeguards inserted into the Act.

4.2 The Act provides a statutory framework for people who lack the mental capacity to make their own decisions. It sets out who can take decisions, in which situations, and how they should go about this. It contains principles, procedures and safeguards to empower people to make as many decisions themselves as they can and to play as full a part as possible in the decision-making process when they lack the capacity to make a decision. The Act also enables people to make provision for a time in the future when they may lack the capacity to make some decisions.

4.3 The deprivation of liberty safeguards have been introduced into the Act by the Mental Health Act 2007 (which was identified as a suitable vehicle through which to introduce the safeguards) in response to the European Court of Human Rights (ECtHR) judgement in *H.L. v the United Kingdom* (2004)<sup>1</sup>. The Court found that an autistic man with a learning disability, who lacked the capacity to decide about his residence and medical treatment, and who had been admitted informally to hospital, was unlawfully deprived of his liberty in breach of Article 5 of the ECHR.

4.4 The deprivation of liberty safeguards legislation contains detailed requirements about when and how deprivation of liberty may be authorised. The legislation includes the appointment

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<sup>1</sup> (2004) 40 EHHR 761.

of a representative to maintain contact with the person who has been lawfully deprived of their liberty and to support and represent them in matters relating to the deprivation.

4.5 There is a further instrument that forms part of the implementation package for the deprivation of liberty safeguards – the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008. These regulations are subject to the affirmative procedure and it is intended that they will be laid at the same time. This instrument sets out further detailed requirements of the Act in relation to the selection of assessors, the assessment process and disputes about the ordinary residence of the relevant person following the agreement of the principles in primary legislation.

4.6 There is a supplement to the Mental Capacity Act 2005 Code of Practice - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice - that also forms part of the implementation package. This Code supplement provides guidance on the deprivation of liberty safeguards for England and Wales. It is intended that it will be laid by the Ministry of Justice under section 43 of the Mental Capacity Act 2005 at the same time as this instrument.

4.7 The deprivation of liberty safeguards legislation is due to come fully into force in April 2009.

## **5. Extent**

5.1 These Regulations extend to England only. There will be separate regulations prepared by the Welsh Ministers for Wales.

## **6. European Convention on Human Rights**

6.1 As this instrument is subject to the negative resolution procedure and does not amend primary legislation, no statement is required

## **7. Policy background**

7.1 The deprivation of liberty safeguards introduced into the Act are intended to prevent the unlawful detention of people who lack the capacity to consent to the arrangements made for their care or treatment and who need to be deprived of their liberty, in their own best interests and to prevent harm, in either hospitals or care homes. This instrument sets out further detailed requirements of the Act in relation to the selection, appointment and termination of the appointment of a representative, following the agreement of the principles in primary legislation.

7.2 Once a standard authorisation of deprivation of liberty has been granted, the supervisory body must appoint a relevant person's representative for the person who is deprived of liberty (the relevant person). The role of the representative is to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

7.3 The representative's role is crucial in the deprivation of liberty safeguards process, providing the relevant person with representation and support that is independent of the staff providing the services they are receiving. In most cases, the representative will be a friend, relative or informal carer but a paid appointment can be made where the relevant person has no one else to fulfil the role. The best interests principle of the Mental Capacity Act 2005 applies to the relevant person's representative in the same way that it applies to other people acting, or making decisions, under the Act for people who lack capacity.

7.4 The Department of Health has worked closely with stakeholders including representatives in Wales, Primary Care Trusts, local authorities, hospitals and care homes, voluntary organisations and interested individuals whilst drafting these regulations.

7.5 The deprivation of liberty safeguards were the subject of a formal consultation exercise for a period of 12 weeks between March and June 2005, inviting responses to outline proposals for addressing the legal shortcomings identified by the ECtHR in its October 2004 judgement. The consultation document identified three possible options. The deprivation of liberty safeguards have been developed from the option that received most support within the consultation responses. A report on the outcome of the consultation process was published on 29 June 2006<sup>2</sup>. At the same time, an announcement was made setting out the proposed deprivation of liberty policy.

7.6 The instrument to which this explanatory memorandum relates was the subject of a further formal 12-week consultation exercise between September 2007 and December 2007. The Code supplement and the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 were the subject of the same consultation<sup>3</sup>.

7.7 The consultation received 110 responses<sup>4</sup>. The version of the regulations that is laid before Parliament is one that has been revised in the light of the consultation responses and further consideration of relevant issues within Government (the Ministry of Justice and the Department of Health).

7.8 A number of amendments were made to the regulations in the light of the consultation responses including:

- to enable a donee of Lasting Power of Attorney or a deputy appointed by the court to select themselves as a relevant person's representative, if they are eligible
- to add 'in laws' to the list of relatives of a person who is financially interested in the managing authority who are barred from becoming a relevant person's representative
- to allow the termination of a representative's appointment when the representative is not maintaining sufficient contact with the relevant person in order to support and represent them
- to allow for the termination of a representative's appointment when the representative is not acting in the best interests of the relevant person.

7.9 The Code supplement will provide further guidance on the regulations.

## 8. Impact

8.1 A Regulatory Impact Assessment<sup>5</sup> was produced for the passage of the Mental Health Act 2007. This covered all aspects of the Mental Health Act 2007. A specific deprivation of liberty safeguards Impact Assessment was prepared for the formal consultation process that took place between September 2007 and December 2007. A further deprivation of liberty safeguards Impact Assessment has been prepared for the laying of these regulations, the Code supplement and the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 in Parliament<sup>6</sup> and has been attached to this memorandum.

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<sup>2</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4136789](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136789)

<sup>3</sup> The consultation papers can be accessed at: [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_078052](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078052)

<sup>4</sup> A report of the public consultation can be accessed at:

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

<sup>5</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/DH\\_063423](http://www.dh.gov.uk/en/Publicationsandstatistics/DH_063423)

<sup>6</sup> The deprivation of liberty safeguards Impact Assessment can be accessed at:

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

## **9. Contact**

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## Summary: Intervention & Options

<b>Department /Agency:</b> Ministry of Justice and Department of Health	<b>Title:</b> Impact Assessment of the Mental Capacity Act 2005 deprivation of liberty safeguards to accompany the Code of Practice and regulations	
<b>Stage: Implementation IA</b>	<b>Version: 1</b>	<b>Date: 2 May 2008</b>
<b>Related Publications: Mental Capacity Act 2005 Code of Practice</b>		

Available to view or download at:

Contact for enquiries: Mike Preston

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

European Convention on Human Rights incompatibility regarding the protection of people who lack capacity to consent to arrangements made for their care or treatment from arbitrary deprivation of liberty.

This was identified by the October 2004 European Court of Human Rights judgment in H.L. v the United Kingdom (the Bournemouth judgment), which requires that people may only be deprived of their liberty through a process set out in law, with safeguards to prevent arbitrary detention and speedy access to a Court to review the detention.

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

To provide safeguards for people who are cared for in hospitals or registered care homes in circumstances that deprive them of their liberty, in their best interests, and who are unable to consent (but who are not detained under the Mental Health Act 1983). The policy objective is to ensure that people are only deprived of their liberty when there is no lesser restrictive way of providing them with the treatment or care that is needed to prevent them from harm.

### What policy options have been considered? Please justify any preferred option.

Option 1: The introduction of a new system of deprivation of liberty safeguards into the Mental Capacity Act 2005. This is the preferred Option - see the Evidence Base below for the reasons for preferring this Option.

Option 2: Extending the use of detention under the Mental Health Act 1983.

Option 3: Extending the use of guardianship under the Mental Health Act 1983.

### When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

The operation of the safeguards will be monitored by the Care Quality Commission, and will be formally reviewed by the Department of Health after the first year of implementation.

### Ministerial Sign-off For Impact Assessments:

*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 option.*

Signed by the responsible Minister:

**Ivan Lewis**.....Date: **8th May 2008**

## Summary: Analysis & Evidence

**Policy Option: Option 1**

**Description: The introduction of a new system of deprivation of liberty safeguards into the Mental Capacity Act 2005**

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups' <b>Annual costs (in Evidence Base) which will primarily fall upon NHS and local authorities are estimated by calculating the costs of conducting the assessments each year.</b>
	<b>One-off (Transition)</b>	<b>Yrs</b>	
	<b>£ 5.835m</b>	1	
	<b>Average Annual Cost (excluding one-off)</b>		
	<b>First year costs of £13.9M falling to £4.3m (steady state)</b>	2-7	<b>Total Cost (PV)</b> <b>£ 66m (over 10yrs)</b>
Other <b>key non-monetised costs</b> by 'main affected groups' <b>The costs to individual hospitals or care homes where the nature of care regimes may need to change are non-monetised. This is due to uncertainty about the extent and nature of any changes that may be required.</b>			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups' <b>These could not be monetised. However the provisions are designed to provide protection to vulnerable people, as per paragraph 13 of the evidence base</b>
	<b>One-off</b>	<b>Yrs</b>	
	<b>£</b>		
	<b>Average Annual Benefit (excluding one-off)</b>		
	<b>£</b>		<b>Total Benefit (PV)</b> <b>£</b>
Other <b>key non-monetised benefits</b> by 'main affected groups' <b>There had to be a legislative solution to the issues highlighted by the Bournemouth judgment – these changes to the Mental Capacity Act 2005 will resolve the infringement of the European Convention on Human Rights. This represents a considerable benefit.</b>			

**Key Assumptions/Sensitivities/Risks See Evidence Base**

<b>Price Base</b> Year	<b>Time Period</b> Years	<b>Net Benefit Range (NPV)</b> £ n/a	<b>NET BENEFIT (NPV Best estimate)</b> £ n/a
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What is the geographic coverage of the policy/option?	England and Wales			
On what date will the policy be implemented?	April 2009			
Which organisation(s) will enforce the policy?	LAs/PCTs			
What is the total annual cost of enforcement for these organisations?	n/a			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	No			
What is the value of the proposed offsetting measure per year?	£ 0			
What is the value of changes in greenhouse gas emissions?	£ 0			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	n/a	n/a

<b>Impact on Admin Burdens Baseline (2005 Prices)</b>					(Increase - Decrease)	
Increase of	£	n/a	Decrease of	£	n/a	<b>Net Impact</b> £ n/a

Key: Annual costs and benefits: Constant Prices (Net) Present Value

## Evidence Base (for summary sheets)

### Brief summary of policy options (as consulted on from March to June 2005)

The Department of Health identified three potential solutions in our policy consultation for solving the legal shortcomings identified by the Bournemouth judgment.

The first was for the introduction of a new system of deprivation of liberty safeguards, referred to as "Protective Care", into the Mental Capacity Act 2005. The new safeguards were to govern the circumstances in which a person who lacks capacity to consent to the arrangements made for their care or treatment might lawfully be deprived of liberty in their best interests. They were also to cover the arrangements for review of, and challenges in relation to, deprivation of liberty, including the right of access to a court to determine the lawfulness of the deprivation of liberty.

The second option was to extend the use of detention under the Mental Health Act 1983. This would have involved extending the criteria for detention under the Mental Health Act 1983 to cover the wider group of people affected by the Bournemouth judgment, including the need to bring registered care homes within the ambit of the Mental Health Act 1983.

The third option was to extend the use of guardianship under the Mental Health Act 1983. The aim would have been to amend the guardianship provisions to provide European Convention on Human Rights compliant safeguards, whilst avoiding the need for people to be formally detained under the Mental Health Act 1983.

Policy has subsequently been developed in the light of the outcome of the 2005 consultation exercise. The policy is broadly based on the "Protective Care" option that was favoured by the majority of respondents to the consultation. Most people felt that the vulnerable groups of people for whom the new safeguards were required were more appropriately linked with the Mental Capacity Act 2005, with the principles of that Act applying, rather than being brought within the ambit of the Mental Health Act 1983. In particular, the Mental Capacity Act 2005 includes the requirement that any act done, or decision made, on behalf of a person who lacks capacity must be done, or made, in the person's best interests.

A report on the outcome of the consultation was published in June 2006. At the same time, the Government announced its decision to proceed with the Protective Care option favoured by the majority of respondents to the consultation, with a view to new deprivation of liberty safeguards being introduced into the Mental Capacity Act 2005. The Mental Health Bill was identified as a suitable vehicle through which to amend the Mental Capacity Act 2005 for this purpose. The deprivation of liberty safeguards continued to be developed in the lead up to the introduction of the Mental Health Bill into Parliament in November 2006. The safeguards were subsequently the subject of Parliamentary scrutiny, and some amendment, during the passage of the Mental Health Bill, which was completed on 4 July 2007. What is now the Mental Health Act 2007 received Royal Assent on 19 July 2007.

Between September 2007 and December 2007 a consultation exercise was undertaken in respect of draft deprivation of liberty safeguards Code of Practice guidance for England and Wales and two sets of draft deprivation of liberty safeguards regulations for England. An Impact Assessment was prepared as part of that consultation exercise. The Code of Practice

guidance and regulations have been revised in the light of the responses to the consultation exercise<sup>7</sup>.

Consultation on the draft deprivation of liberty safeguard regulations for Wales was undertaken by the Welsh Assembly Government, on behalf of the Welsh Ministers, between October 2007 and January 2008. These regulations are being revised in the light of the responses received.

A revised Impact Assessment follows below.

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<sup>7</sup> The deprivation of liberty safeguards Code of Practice guidance, and the regulations for England, as laid before Parliament, can be accessed at:  
<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

# Mental Capacity Act 2005: Deprivation of Liberty Safeguards Impact Assessment

## Background

1. The Mental Health Act 2007, which received Royal Assent on 19 July 2007, amended the Mental Capacity Act 2005 in order to introduce deprivation of liberty safeguards into that Act. The safeguards are a response to the European Court of Human Rights (ECtHR) judgment in October 2004 in the case of H.L. v UK (commonly referred to as the Bournemouth judgment). This case concerned a man, lacking the capacity to consent to arrangements being made for his care and treatment, who was admitted to hospital into a care regime that the ECtHR considered deprived him of his liberty without appropriate safeguards against arbitrary detention being in place.
2. The Government undertook a 12 week consultation exercise between March and June 2005 inviting responses to outline proposals for addressing the legal shortcomings identified within the Bournemouth judgment. One hundred and eight (108) replies were received. Those responding made helpful and supportive comments.
3. The consultation document identified three options for addressing the Bournemouth judgment. The first was a system of safeguards, referred to as "Protective Care", that would be introduced into the Mental Capacity Act 2005 and would provide the protection necessary to meet those requirements of the European Convention on Human Rights (ECHR) that had been infringed in the Bournemouth case. The other two options concerned extending either the detention or guardianship provisions in the Mental Health Act 1983 to cover the wider group of people who would fall within the scope of the Bournemouth judgment. This again would have provided the safeguards needed to meet the requirements of the ECHR.
4. Overall, there was good support for the "Protective Care" option outlined in the consultation document. Respondents generally thought that, since the Bournemouth judgment was about a person who lacked capacity, it was most appropriate to put the necessary safeguards into the Mental Capacity Act 2005. All the principles of the Mental Capacity Act 2005 would then apply, for example about how capacity should be assessed, and the requirement to act in the best interests of a person lacking capacity. Wider use of the Mental Health Act 1983, including extending its coverage to embrace registered care homes (hereafter referred to as care homes), received relatively minor support. There were concerns about extending the "stigma" of detention under the Mental Health Act 1983 and it was also seen as a disproportionate response running counter to the principle of seeking to identify approaches that are less restrictive of a person's rights and freedom of action.
5. Detailed policy proposals were subsequently developed, building on the Protective Care option, in the light of the consultation responses and further consideration of the issues involved. A report on the outcome of the consultation process was published on 29 June 2006. At the same time, an announcement was made setting out the proposed deprivation of liberty safeguards policy.
6. The amendments inserted into the Mental Capacity Act 2005 by the Mental Health Act 2007 provide ECHR compliant safeguards in respect of the initiation and review of care and treatment arrangements for people with a mental disorder who lack capacity to consent to the arrangements made for their care or treatment, who are being deprived of their liberty within the meaning of Article 5 of the ECHR and who are not detained under the Mental Health Act 1983. The safeguards apply to people in care homes as well as

people in hospitals whether they are placed there under public or private arrangements. It is planned that the safeguards will be brought into effect from April 2009.

7. A draft deprivation of liberty safeguards Code of Practice (hereafter referred to as the Code) supplementary to the Mental Capacity Act 2005 Code of Practice, and two sets of draft deprivation of liberty safeguards regulations for England, were consulted on over a 12 week period between September 2007 and December 2007. A similar consultation exercise was undertaken by the Welsh Assembly Government on the regulations for Wales. The consultation paperwork relating to the Code and the regulations for England can be accessed at:-

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

8. 110 responses were received to the consultation. The responses were helpful and constructive. The Code and regulations have been revised in the light of the responses.
9. An Impact Assessment was included within the consultation paperwork, and comments invited on its validity. The comments received in response to the consultation exercise have been considered in producing this revised Impact Assessment. The main point raised was that the estimates of the numbers of people who would need to be the subject of the deprivation of liberty safeguards assessment process were well below the actual numbers that would arise in practice. This point is addressed later in this revised Impact Assessment.

### **Coverage of this Impact Assessment**

10. This Impact Assessment has been prepared to accompany the laying in Parliament of the Code and two sets of deprivation of liberty safeguards regulations for England. However, it looks at the overall costs of implementation of the deprivation of liberty safeguards in England and Wales. This is because the changes to the main Mental Capacity Act 2005, the use of the regulation-making powers and the contents of the Code are so inter-linked as to make it impractical to seek to break the costs down between the three elements.
11. The Code covers England and Wales. It has been developed jointly between the Ministry of Justice (MoJ), which has responsibility for the Mental Capacity Act 2005, the Department of Health and the Welsh Assembly Government. The regulations currently being laid in Parliament relate to England only. The development of the regulations for Wales has been led by the Welsh Assembly Government on behalf of the Welsh Ministers, and in due course the regulations will be laid before the National Assembly for Wales. The costings in this Impact Assessment cover both England and Wales and, as mentioned in paragraph 10 above, relate to the overall costs of implementation of the deprivation of liberty safeguards

### **Benefits**

12. There had to be a legislative solution to the issues highlighted by the Bournemouth judgment. Following the public consultation between March and June 2005, it was decided that the introduction of the deprivation of liberty safeguards into the Mental Capacity Act 2005 was the most appropriate way in which to respond to the Bournemouth judgment.
13. The main benefits of the deprivation of liberty safeguards are that they provide protection for a very vulnerable group of people and bring the legislation for England and Wales into compliance with the ECHR. Other benefits are mentioned elsewhere in this Impact Assessment. The safeguards are most appropriately placed in the Mental Capacity Act 2005 since the Bournemouth judgment raised what were primarily mental capacity rather

than mental health issues. This means that the principles of the Mental Capacity Act 2005, for example the requirement to act in the best interests of a person who lacks capacity, will apply in the context of the deprivation of liberty safeguards. The incorporation of the safeguards into the Mental Capacity Act 2005 avoids the need to extend detention under mental health legislation to cover the people to whom the safeguards will apply. The extension of detention was one of the alternative options contained in the March to June 2005 policy consultation document. The majority of respondents to that consultation opposed the extension of the Mental Health Act 1983 in this way.

## **Risks**

14. It is difficult to estimate with confidence the numbers of people who might need to be covered by the deprivation of liberty safeguards, and thus the extent of the additional workload that will be generated for the field, and for the Court of Protection. (The Court of Protection being the legal route through which the giving of deprivation of liberty authorisations may be challenged.)
15. Several respondents expressed doubts about the validity of the figures contained in the Impact Assessment that was published as part of the Code and regulations consultation exercise. In particular, they challenged the estimates of the number of people who would need to be assessed for deprivation of liberty safeguards purposes.
16. The Government remains of the view, on the basis of the legal advice it has received, that the number of people who lack capacity to consent to the arrangements made for their care or treatment, and who need to be deprived of their liberty in their best interests in hospitals (excluding people who are detained under the Mental Health Act 1983) or care homes, should be relatively small. In particular, the Government does not accept the view expressed by some respondents to the consultation that every person who lacks capacity to consent to the arrangements made for their care or treatment, and who is in a care home from which they are not allowed complete freedom of egress, are inevitably deprived of their liberty within the meaning of Article 5 of the ECHR.
17. The Government maintains the view that the court judgments to date indicate that a particular factor, or combination of factors, do not inevitably constitute deprivation of liberty in every case. When assessing whether a person is, or may be, deprived of their liberty, it is necessary to consider all the relevant circumstances, including the combined impact of all restrictions placed upon the person. Chapter 2 of the Code sets out more fully the Government's view of how decisions about whether or not a person is being deprived of liberty should be taken.
18. The Government will keep the matter under review in the light of future court judgments, and has revised the Impact Assessment on the basis of consultation responses and further sensitivity analysis.
19. Through communication and training, hospitals and care homes will be encouraged to make every effort to avoid instituting deprivation of liberty care regimes wherever possible and, consequently, the numbers of people who genuinely need to become subject to the safeguards are expected to be relatively small.

## **Costs**

20. For current planning purposes, the core estimate is that an assessment would cost approximately £600. This would cover the costs of all necessary associated procedures and paperwork. Costs would be higher (in the region of £1000) where an authorisation is given because of the extra work involved (eg appointment of a representative), and lower

(in the region of £500) where an authorisation is not given. The figure of £600 represents an average across both categories. Given the number of procedures expected each year, the total cost of implementing the policy would be in the region of £4.3m per year from 2015/16<sup>8</sup>, falling from a peak of £13.6m in 2009/10.

21. We have assumed that, once understanding has developed about deprivation of liberty and how to avoid it, 10% of the relevant population will be subject to assessment for authorisation, of whom no more than 25% at any one time are likely to be justifiably deprived of liberty. We have also assumed, based on the MoJ forecasts of use of the Court of Protection, that of those for whom a deprivation of liberty authorisation is issued, 2.5% (1 in 40) might result in a Court of Protection hearing. The costs of oral hearings of the Court of Protection are each estimated to be £9,000, including legal aid. Legal advice will be available to people subject to a deprivation of liberty authorisation and their representative. We have assumed this will be taken up in 25% of cases. We now discuss the relevant population.
22. It is estimated that there are roughly 500,000 people in England and Wales who have a mental disorder and who lack capacity, including over 190,000 people with severe learning disabilities and about 230,000 older people with dementia living in institutions. This estimated number also includes people who lack capacity for other reasons, such as acquired brain injury or mental health difficulties. A study undertaken by the Department of Health's analysts in 2000 concluded that around 1 in 10 of that number - about 50,000 people - would require additional restrictions for their protection, including restrictions that would prevent them from leaving the facility, which in some cases may amount to a deprivation of liberty.
23. As indicated in paragraph 16 above, the Department of Health takes the view that hospitals or care homes that operate a "locked door" policy are not necessarily depriving of liberty those people who reside in the facility. In the Bournemouth judgment, the ECtHR itself stated that whether a person was deprived of liberty under the ECHR depended on the specific facts of each individual case. In the Bournemouth case, the ECtHR observed that "as a result of the lack of procedural regulation and limits, the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit."
24. This was an extreme set of circumstances and indicates that an individual is more likely to be deprived of liberty in ECHR terms the greater the degree of control exerted over their circumstances (eg excessive limitations on freedom of movement within the facility, unreasonable controls over timing of visits from family or friends, barring family and friends from taking the person out for social purposes or refusing a request from carers for the person to be discharged to their care) without taking on board the views of other interested parties.
25. In the past, the assessment of such people has concentrated on whether they were able to live independently, or in sheltered accommodation or a care home, or needed to be in hospital for treatment. Decisions rarely, if ever, considered whether the nature of the regime that should be applied to such people within the care home or hospital setting needed to amount to a deprivation of liberty. It is expected that the introduction of the deprivation of liberty safeguards will focus attention on the potential for deprivation of liberty to arise and that, while the nature of the regimes operated by individual hospitals or care homes will vary, few if any are likely to choose to deprive people of liberty unless it is essential to do so.

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<sup>8</sup> Costs are assumed to be higher in the first 6 years after implementation, as we envisage more assessments being undertaken in the first year, with progressively fewer in subsequent years as all parties become familiar with the circumstances.

26. The interim guidance issued by the Department of Health in December 2004<sup>9</sup> and the Welsh Assembly Government in January 2005<sup>10</sup> following publication of the ECtHR's judgment drew to the attention of hospital and care home managers the importance of avoiding the deprivation of individuals' liberty, and it is expected that action to implement the guidance will already have been taken. The deprivation of liberty procedures cannot be used in situations where a person should more appropriately be detained under the Mental Health Act 1983.
27. The Government believe that the circumstances of the Bournemouth case were so extreme that only a relatively small number of individuals might be detained in a manner equivalent to taking full control over the individual's liberty. We would expect too, following the issue of the interim guidance referred to in paragraph 26, that hospital and care home managers will have taken steps to ensure compliance with the law.
28. For these reasons, the Government considers that there are likely to be very few people of unsound mind, who lack capacity, and need to be deprived of liberty in ECHR terms. A precise estimate could not be obtained without an exercise to examine the circumstances of all individuals judged to be in the at-risk group. So, in costing the implementation of the deprivation of liberty safeguards, we have taken advice from professionals with experience of such cases.
29. Inevitably, these estimates are highly tentative, and must be so unless a comprehensive survey of the potential population deprived of liberty were to be undertaken. The possibility remains, however unrealistic, that assessments will be requested in respect of the entire at-risk population, i.e. 50,000 people, at a cost of £32m in 2009/10. We consider this unrealistic because it is clear that not all of the at-risk population are, or need to be, deprived of their liberty. The actual cost in the first year will depend on how clearly hospital and care home managers and assessors understand the distinction between deprivation and restriction of liberty, and therefore how well they can identify those to whom the deprivation of liberty safeguards apply.
30. We do have an estimate of numbers from one local authority, which gives us a basis on which to estimate a realistic "worst-case" scenario for the number of assessments requested in the first year. On this basis, a total of 17,000 people in residential care might be subject to a deprivation of liberty assessment. A further 25% might be in hospitals, which would make a total potential population, in England and Wales, of 21,000.
31. Applying the same cost estimates as before, including the same proportion of Court of Protection hearings and uptake of legal advice, total costs would be £13.6m.
32. We envisage more assessments being undertaken in the first year, with progressively fewer in subsequent years as all parties become familiar with the safeguards. The proportion of deprivation of liberty authorisations would remain fairly constant, with numbers of authorisations ranging from around 5,000 in the first year, to approximately 1,700 each year after 2015/16. The costs of 21,000 assessments in the first year are estimated to be £13.6M and of approximately 7,000 assessments in 2015/16 to be £4.3M.
33. In the period before the deprivation of liberty provisions come into force, the Department of Health and the Welsh Assembly Government will commission communication and training for hospitals, care homes, supervisory bodies and assessors, which will include a focus on the meaning of deprivation of liberty in ECHR terms. The cost of these extra provisions is

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<sup>9</sup>Available at

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4097992.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4097992.pdf)

<sup>10</sup> Available at <http://www.wales.nhs.uk/sites3/Documents/438/WHC%202005%205F005The%20BournemouthCase%20Epdf>

estimated at £2.435m for England; £100,000 for the MoJ and £100,000 for Wales. The policy priority is that authorisation for such an extreme and restrictive regime is only given where it is necessary in the best interests of the person concerned. Working in partnership with local authorities, Primary Care Trusts (PCTs), Local Health Boards, Trusts and other key stakeholder organisations will reduce the numbers referred unnecessarily for assessment.

34. For that reason, we suggest that the government costs in the year 2008-09 would reach a total of £2.635m pre implementation, assuming commencement in April 2009. In the first year of implementation, 2009/10, costs to local authorities, the NHS and the MoJ are estimated at £13.6m, and to the Department of Health £0.25M. This is on the basis of the set of assumptions discussed in paragraph 20, conservatively based on a population of 21,000 people requiring assessments in the first year. Costs are assumed to fall to a steady state £4.3m by 2015-16, based on around 7,000 assessments required that year. From this year, costs are assumed to change only in line with demographic change in the relevant population. After allowing for the central provision of the extra communication and training materials, and the costs arising in respect of the Court of Protection, and the commissioning of IMCA services via local authorities, we have assumed that around 80% of the remaining costs would fall to local authorities, and around 20% to the NHS. Local authorities and PCTs will bear the costs of carrying out each assessment irrespective of whether the person being assessed is state funded or privately funded in either a care home or a hospital.
35. Table 1 summarises the costs, showing the breakdown by organisation, both in the first year of implementation, and in the years following on until 2015/16. All costs and activity figures use 2004/05 prices.

**Table 1: summary of Mental Capacity Act 2005 deprivation of liberty safeguards costs by organisation, assuming commencement in April 2009**

It is assumed that steady state will be reached in 2015/16. In 2008-09, there will be costs as follows:

- Department of Health £2.435m
- Welsh Assembly Government £0.1m
- MoJ £0.1m
- LA and NHS £3.2m
- Total £5.835m

(Note: the LA and NHS pre-implementation costs are included in the Area Based Grant (LASSL 2/2007.)

England and Wales	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	Steady State
LA	10.0	8.9	7.7	6.6	5.4	4.3	3.2
NHS	2.2	2.0	1.7	1.5	1.2	1.0	0.7
MoJ (OPG)	1.4	1.2	1.1	0.9	0.7	0.6	0.4
DH	0.25						
<b>Total</b>	<b>13.9</b>	<b>12.1</b>	<b>10.5</b>	<b>9.0</b>	<b>7.4</b>	<b>5.9</b>	<b>4.3</b>

*Costs in millions of pounds to the nearest hundred thousand.*

A brief discussion of how these costs were calculated can be found at Annex 1. A short sensitivity analysis, which looks at how overall costs change if our assumptions change, can be found at Annex 2.

36. It is expected that the introduction of deprivation of liberty safeguards into the Mental Capacity Act 2005 will have a relatively small impact on workforce numbers.

### **Competition Assessment**

37. The Code and draft regulations are not expected to have a significant effect on competition. The resource implications of the introduction of the deprivation of liberty safeguards as a whole are expected to impact largely on the NHS and local authorities. It is possible that the implementation of the safeguards could have different effects on different independent hospitals and care homes, and thus affect their charges differently, depending on the extent to which they have “deprivation of liberty type” regimes, but the draft Code and draft regulations do not change that situation.
38. The impact on individual care homes is likely, for example, to vary depending on the nature of the client groups that they care for. Homes that specialise in caring for the Elderly Mentally Ill are more likely to be affected, but all such homes will be affected in the same way. Some other care homes may only be minimally affected, but will need to be aware of the safeguards.

### **Small Firms Impact Test**

39. The Mental Capacity Act 2005 deprivation of liberty safeguards will require care homes to seek authorisation if a person in their care is, or is to be, deprived of liberty. It is estimated that the application will take approximately two hours of management time on average. Authorisation will not be required for the majority of care home residents. In the first year of operation of the safeguards, it is anticipated that there will be some 16,800 (80% of the total estimate of 21,000) applications for authorisation relating to care home residents. This is in the context of approximately 440,000 care home residents in England in 2006, of whom approximately 338,000 were in independent care homes<sup>11</sup>. The latest estimates indicate that there are also some 24,000 care home residents in Wales.
40. It will be necessary for care home managers to consider, for residents who are not able to consent, whether an authorisation needs to be sought. However, the need to consider the lawful basis of care provided and the risk of deprivation of liberty is not new as it was addressed in the interim guidance on the matter published by the Department of Health in December 2004 and the Welsh Assembly Government in January 2005. This should form part of the existing arrangements for care review and there is no requirement to carry out a separate care review for the purpose of the safeguards.
41. Care homes currently face difficult judgements about the point where restrictions needed for a person’s protection fall short of, or constitute, a deprivation of liberty. They will benefit from the clarity provided by a duly completed authorisation about the lawfulness of care to be provided.

### **Legal Aid Impact Assessment**

42. The Legal Aid rules will be the same for anybody who becomes subject to a standard or urgent deprivation of liberty authorisation. In particular, non-means tested Legal Aid will be

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<sup>11</sup> Commission for Social Care Inspection “The state of Social Care in England” December 2006

available to enable the person to challenge the giving of either a standard or urgent deprivation of liberty authorisation through the Court of Protection.

43. There is a merits test for all categories of legal aid application, though it operates differently for certain areas. We are considering how best the merits test should work in deprivation of liberty safeguards cases. The principle will be that those who need legal aid in the Court of Protection for these cases will be able to get it.
44. Each person subject to a standard deprivation of liberty authorisation will have available the support of an IMCA and/or relevant person's representative to help them make application to the Court of Protection, so the opportunity for challenge will be the same regardless of the extent of the lack of capacity of the person who is subject to the deprivation of liberty safeguards. Legal Aid costs are included in the estimates for the Court of Protection contained in Table 1 above.

### **Age Impact Assessment**

45. The deprivation of liberty safeguards apply only to people aged 18 and over. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. In these circumstances, the existing powers of the court, particularly those under Section 25 of the Children Act 1989, provide safeguards that meet the requirements of Article 5 of the ECHR. Use of the Mental Health Act 1983 may also be possible if the relevant criteria are satisfied. Applying the deprivation of liberty safeguards from the Mental Capacity Act 2005 to people under the age of 18 is not therefore necessary.
46. The safeguards will apply in the same way to people aged 18 and over who meet the criteria for deprivation of liberty, regardless of their actual age. However, a major cause of lack of capacity is dementia, which is more prevalent in older age groups. For this reason, it is likely that the nature of the criteria (lacking capacity to consent to the arrangements made for their care or treatment and needing to be deprived of liberty for their own safety and in their best interests) is more likely to embrace elderly people, particularly those with dementia. This is considered to be a positive aspect of the safeguards in that it is giving this group of disadvantaged people protections that have previously been lacking.

### **Health Impact Assessment**

47. The introduction of the deprivation of liberty safeguards is expected to make a positive contribution to health improvement. A very vulnerable group of people will receive safeguards that are currently lacking, and which will place a new focus on their human rights and the lawfulness of the arrangements made for their care. We believe this will introduce a pressure to encourage excellent planning of care regimes, taking account of the whole needs of each individual. We expect this benefit to extend beyond people who are actually deprived of liberty in that hospitals and care homes will look for ways, where safety considerations permit, of increasing the freedoms and autonomy of people in their care such that they do not cross the deprivation of liberty threshold.

### **Race Equality Impact Assessment**

48. The deprivation of liberty safeguards are not expected to impact in any different way on different racial or ethnic groups. Attention is, however, drawn in the Code to the need to take care to ensure that the provisions are not operated in a manner that discriminates against particular racial or ethnic groups.
49. It is also stated in the Code:

- That managing authorities and supervisory bodies should ensure that their staff are aware of their responsibilities to different racial or ethnic groups and of the need to ensure that the safeguards are operated fairly and equitably.
  - That assessors, when carrying out deprivation of liberty assessments, must take account of cultural issues, and will need to have an understanding of how to take account of the cultural background of the individual concerned.
  - That interpreters should be available, where necessary, to help assessors to communicate not only with the relevant person but also with people with an interest in their care and treatment.
  - That information should be made available in other languages where relevant.
  - That any decision about the instruction of IMCAs or appointment of relevant person's representatives in accordance with the deprivation of liberty safeguards should take account of the cultural, national, racial and ethnic background of the relevant person.
50. In addition, the assessor regulations state that a person is only eligible to carry out a deprivation of liberty assessment if the supervisory body is satisfied that they have the skills and experience appropriate to the assessment. This would be expected to include an understanding and respect for people's qualities, abilities and diverse backgrounds.
51. It is intended that information will be collected about the ethnicity of people coming within the scope of the deprivation of liberty safeguards. In their local populations, PCTs (in Wales, the National Assembly for Wales) and local authorities will be expected to monitor whether there are any indications that the safeguards are being applied differently in relation to different racial or ethnic groups.

### **Disability Equality Impact Assessment**

52. The deprivation of liberty safeguards legislation will have a positive impact on disability equality. It provides important safeguards for people who lack capacity to consent to the arrangements made for their care or treatment and who need to be deprived of their liberty for their own safety.
53. The people concerned will be largely those with significant learning disabilities, or older people suffering from dementia or some similar disability, but will also include other causes such as neurological conditions (for example, if someone has a brain injury).
54. Any action taken under the deprivation of liberty safeguards must be in line with the principles of the Mental Capacity Act 2005:
- A person must be assumed to have capacity unless it is established that they lack capacity.
  - A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
  - A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
  - An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
55. The deprivation of liberty safeguards Code is based on these principles and reinforces the need to protect the rights of this very disadvantaged group of people. One role of the best interests assessor is to support a person in respect of whom they are undertaking an assessment to communicate their views.
  56. The regulations also embrace these principles. For example, some people being assessed for deprivation of liberty with a view to their receiving mental health treatment in hospital will, for whatever reason, have difficulty expressing an objection. The best interests assessor, supporting them to communicate and taking account of those with an interest in their care, is likely to identify information about their objection (or not) which might not otherwise be taken into account, and this must be sought by the eligibility assessor in establishing whether or not the person objects to receiving the mental health treatment.
  57. Other regulations state the type of person who is eligible to carry out each kind of assessment, the qualifications, training, skills and experience they will need to have, the training they will need to have undertaken and the need to ensure that the work of the assessors is covered by liability insurance.
  58. These regulations will have a positive impact on disability equality. In order to carry out a proper assessment it is vital that the assessor is able to communicate with the person being assessed and with others whose views must be taken into account. The regulations will require that all assessors have:
    - the ability to act independently; and
    - the ability to take account of diverse views and weigh them appropriately in decision making.
  59. The supervisory body should also consider choosing assessors who are appropriate for the person's individual case and the Code identifies the following as factors to consider:
    - the reason for the proposed deprivation of liberty
    - whether the potential assessor has experience of working with the service user group from which the person being assessed comes.

### **Gender Equality Impact Assessment**

60. The Code and regulations, like the deprivation of liberty legislation itself, do not discriminate between men and women. A principle on which the safeguards are based is that everybody should be treated as an individual, and their care regimes determined by reference to their specific needs. In some cases those needs may relate to gender.
61. It is anticipated that a large proportion of those who will become subject to the deprivation of liberty safeguards will be older people with dementia. This may well mean that more women than men become subject to the deprivation of liberty safeguards because women tend to live longer than men do and, at higher ages (75+), the prevalence of dementia in women tends to be higher than in men. But the deprivation of liberty safeguard provisions themselves will operate in an identical way regardless of gender.

## **Human Rights Impact Assessment**

62. The purpose of the deprivation of liberty safeguards is to bring the law for England and Wales into line with the ECHR with regard to the circumstances in which a person who lacks capacity to consent to the arrangements made for their care and treatment, and who is not detained under the Mental Health Act 1983, may be deprived of their liberty within the meaning of Article 5 of the ECHR.
63. The safeguards have been introduced in specific response to the October 2004 ECtHR judgment in the case of H.L. v the United Kingdom. This judgment found that:-
  - the manner in which H.L. was deprived of liberty was not in accordance with “a procedure prescribed by law” and was, therefore, in breach of Article 5(1) of the ECHR, and
  - there had been a contravention of Article 5(4) of the ECHR because H.L. was not able to apply to a court quickly to see if the deprivation of liberty was lawful.
64. The safeguards value human rights and give protection to a very vulnerable group of people. They make clear that a person’s human rights cannot be infringed simply because they are profoundly disabled, or very old, and lack the capacity to consent to arrangements made for their care and treatment.
65. The Government believe that the deprivation of liberty safeguards bring the legislation into compliance with the ECHR.

## **Rural Proofing Impact Assessment**

66. There is no reason to believe that there will be proportionately more or less people subject to the deprivation of liberty safeguards in rural areas than there are elsewhere, and thus no reason to suppose that the Code and draft regulations will impact on rural areas any differently to the way in which they impact on other areas.

## Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

**Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.**

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No

# Annexes

## Annex 1: Key assumptions and logic behind calculations

We model the costs of the processes involved in carrying out assessments and authorisations by making three assumptions about each part of the process: first, which professional will be responsible for carrying out the task; second, how long each task will take; and, third, the cost of each hour of work by the relevant professional. This annex describes each of the main assumptions.

### A1.1 Number of assessments

It is assumed that there will be

- 21,000 assessments in 2009/10 (assumption as discussed at paragraphs 30-31 in main evidence section)
- 6,600 assessments in 2015/16 (as above, uprated for demographic change)

The number of assessments is assumed to diminish at a constant rate in years between.

### A1.2 Assessment process

It is assumed that 20% of people are assessed in the care of the NHS and 80% in the care of Local Authorities. This leads to an assumption that **20% of the costs of the assessments will be paid by the NHS and 80% by Local Authorities**. PCTs and local authorities will bear the costs of carrying out each assessment irrespective of whether the person being assessed is state funded or privately funded in either a care home or a hospital.

The assessment process is assumed to require the following, in every case:

- **2 hours of a consultant psychiatrist's time**, to carry out a mental health assessment, mental capacity assessment and no refusals assessment and write a report
- **8 hours of an approved social worker's time**, to carry out a best interests assessment, have discussions with family, and write a report
- **3 hours of time from a senior manager from the supervisory body** (that is, the PCT or Local Authority) to arrange assessments, determine the representative, keep records and make notifications of decisions
- **2 hours of time from a senior manager from the managing body** (e.g. care home) to identify the person and process associated paperwork

### A1.3 Number of assessments

It is assumed that 25% of people assessed will be authorised each year. This means that, in the first year, there will be around 5,000 authorisations, steadily declining to around 1,700 authorisations at steady state.

### A1.4 Authorisation process

25% of people who are authorised seek legal advice. This incurs a cost to the Court of Protection, assumed to be £141 per person who seeks legal advice.

In addition, 20% of people who are authorised are assumed to need a representative appointed for them. This person is required for 26 hours a year.

Of those people who are authorised but do not have a representative appointed for them, 90% are assumed to request an IMCA. The IMCA is assumed to use 8 hours during the authorisation process.

### **A1.5 Total costs**

Total costs are calculated simply by

- i) adding up the costs of the assessment process described, and multiplying them by the number of people assumed to have an assessment
- ii) adding up the costs of the authorisation process described, and multiplying them by the number of people authorised
- iii) adding these two costs together.

## Annex 2: Sensitivity Analysis

The figures here reflect how overall costs change if our assumptions change. We have considered a few factors of interest:

- a. how total costs change if the number of assessments change
- b. how total costs change if the proportion of people authorised changes
- c. how total costs change if the time it takes to do different tasks changes
- d. how total costs change if consultants are paid a fee of £173, rather than the current salary-based assumption

We also look at how total costs change if the first three of these factors change at once. It can clearly be seen that the costs are very sensitive to the assumptions.

### 3.3.a How costs change if the number of assessments change

As total costs are calculated on a “per assessment” basis, they rise in proportion with the number of assessments – that is, if assessments are 15% higher (or lower) than the core estimate, then total costs will also be 15% higher (or lower). This is illustrated in the tables below.

<i>Costs if 15% more assessments than core assumption are received:</i>							
England and Wales	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	Steady State
LA	11.5	10.2	8.9	7.6	6.3	4.9	3.6
NHS	2.6	2.3	2.0	1.7	1.4	1.1	0.8
MoJ (OPG)	1.6	1.4	1.2	1.0	0.9	0.7	0.5
<b>Total</b>	<b>15.7</b>	<b>13.9</b>	<b>12.1</b>	<b>10.3</b>	<b>8.5</b>	<b>6.7</b>	<b>5.0</b>

*Costs in millions of pounds, to the nearest hundred thousand*

<i>Costs if 30% more assessments than core assumption are received:</i>							
England and Wales	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	Steady State
LA	13.0	11.5	10.0	8.6	7.1	5.6	4.1
NHS	2.9	2.6	2.3	1.9	1.6	1.3	0.9
MoJ (OPG)	1.8	1.6	1.4	1.2	1.0	0.8	0.6
<b>Total</b>	<b>17.7</b>	<b>15.7</b>	<b>13.7</b>	<b>11.6</b>	<b>9.6</b>	<b>7.6</b>	<b>5.6</b>

*Costs in millions of pounds, to the nearest hundred thousand*

### 3.3.b How costs change if the proportion of assessed persons who are authorised changes

This table show how total costs change if the proportion of assessed persons authorised is 35%, rather than 25% as in the core assumption. This additional 10% of assessed persons who are authorised leads to total costs that are around 8% higher.

<b>Costs if 35% of assessed persons are authorised:</b>							
<b>England and Wales</b>	<b>2009/2010</b>	<b>2010/2011</b>	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>	<b>Steady State</b>
<b>LA</b>	10.5	9.3	8.1	6.9	5.7	4.5	3.3
<b>NHS</b>	2.3	2.1	1.8	1.5	1.3	1.0	0.7
<b>MoJ (OPG)</b>	1.9	1.7	1.5	1.3	1.0	0.8	0.6
<b>Total</b>	<b>14.7</b>	<b>13.1</b>	<b>11.4</b>	<b>9.7</b>	<b>8.0</b>	<b>6.3</b>	<b>4.7</b>

*Costs in millions of pounds, to the nearest hundred thousand*

The next table illustrates the impact on costs if **both assessments and authorisations are higher** than the core assumptions.

<b>Costs if assessments are 15% higher than core assumption, and 35% are authorised:</b>							
<b>England and Wales</b>	<b>2009/2010</b>	<b>2010/2011</b>	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>	<b>Steady State</b>
<b>LA</b>	12.1	10.7	9.3	7.9	6.6	5.2	3.8
<b>NHS</b>	2.7	2.4	2.1	1.8	1.5	1.1	0.8
<b>MoJ (OPG)</b>	2.2	1.9	1.7	1.4	1.2	0.9	0.7
<b>Total</b>	<b>16.9</b>	<b>15.0</b>	<b>13.1</b>	<b>11.2</b>	<b>9.2</b>	<b>7.3</b>	<b>5.4</b>

*Costs in millions of pounds, to the nearest hundred thousand*

### 3.3.c How costs change if the time it takes to do different tasks changes

This table show how total costs change if every task takes an extra hour to complete, excluding the tasks done by IMCA, which are assumed still to take 8 hours<sup>12</sup>. (This could be due to, for example, travel time taking longer than anticipated.)

<b>Costs if most tasks take one extra hour:</b>							
<b>England and Wales</b>	<b>2009/2010</b>	<b>2010/2011</b>	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>	<b>Steady State</b>
<b>LA</b>	12.6	11.2	9.8	8.3	6.9	5.4	4.0
<b>NHS</b>	2.9	2.6	2.2	1.9	1.6	1.3	0.9
<b>MoJ (OPG)</b>	1.4	1.2	1.1	0.9	0.7	0.6	0.4
<b>Total</b>	<b>16.9</b>	<b>15.0</b>	<b>13.1</b>	<b>11.1</b>	<b>9.2</b>	<b>7.3</b>	<b>5.4</b>

*Costs in millions of pounds, to the nearest hundred thousand*

The next table show the impact on total costs if every task takes 25% longer than assumed in the core case, again excluding the tasks done by IMCA, which are assumed still to take 8 hours. (This would be the case if all tasks took longer than anticipated due to, for example, unforeseen complexity, or for example if factors such as sick leave and additional ad hoc tasks were not fully factored into estimates of task duration.)

<b>Costs if most tasks take 25% longer than assumed in core case:</b>							
<b>England and Wales</b>	<b>2009/2010</b>	<b>2010/2011</b>	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>	<b>Steady State</b>
<b>LA</b>	12.0	10.7	9.3	7.9	6.6	5.2	3.8
<b>NHS</b>	2.8	2.4	2.1	1.8	1.5	1.2	0.9
<b>MoJ (OPG)</b>	1.4	1.2	1.1	0.9	0.7	0.6	0.4
<b>Total</b>	<b>16.2</b>	<b>14.3</b>	<b>12.5</b>	<b>10.6</b>	<b>8.8</b>	<b>7.0</b>	<b>5.1</b>

*Costs in millions of pounds, to the nearest hundred thousand*

<sup>12</sup> IMCA tasks are excluded as there is a high level of confidence that the core assumption is correct.

The next table illustrates the impact on costs if **assessments and authorisations are higher than the core assumptions, and most tasks take an additional hour**. This is the most costly example considered here.

<b>Costs if assessments are 15% higher than core assumption, and 35% are authorised and most tasks take one extra hour:</b>							
<b>England and Wales</b>	<b>2009/2010</b>	<b>2010/2011</b>	<b>2011/2012</b>	<b>2012/2013</b>	<b>2013/2014</b>	<b>2014/2015</b>	<b>Steady State</b>
<b>LA</b>	15.1	13.4	11.7	10.0	8.2	6.5	4.8
<b>NHS</b>	3.4	3.0	2.6	2.3	1.9	1.5	1.1
<b>MoJ (OPG)</b>	2.2	1.9	1.7	1.4	1.2	0.9	0.7
<b>Total</b>	<b>20.8</b>	<b>18.4</b>	<b>16.0</b>	<b>13.7</b>	<b>11.3</b>	<b>8.9</b>	<b>6.6</b>