ADASS position statement: Reforming Deprivation of Liberty Safeguards

Date: June 2025 Review date: December 2025

Overall recommendations

1. That the DHSC consider a '3 stage' implementation process as set out in this document, to enable a smooth transition from DoLS to LPS, allowing for learning from early adopters to be shared by those later in the change journey.
2. That the DHSC adopt at least a 2-year implementation process for the LPS stage, thus allowing for early implementation and learning.
3. That the DHSC consider working intensively with the ADASS West Midlands Councils area to develop and trial the LPS processes in ways that are person centered and proportionate (with a view to this area being seen as 'early adopters' who then share learning with other ADASS areas.)
4. That the DHSC consider using the current Mental Health Bill to introduce some of the LPS flexibility (lengths of orders and flexibility around validity of equivalent assessments) into DoLS as part of its transition planning, given the savings this could provide if such changes were enacted immediately.
5. That the revised Code, Regulations and Impact Assessment be published urgently, along with a recommendation that all be reviewed after 5 years to ensure that LPS is being implemented in a person centered rather than process driven manner.
6. That LPS implementation be considered alongside other changes suggested in the Adult Social Care system by the Casey Commission.

See Annex 1 for Case Studies.

Stage one: Making the most of the current DoLS system

The current system applies only in registered Care Homes and Hospitals and involves 2 specialist assessors undertaking assessments to determine whether the qualifying requirements are met.

The main limitations are

1. That the scheme only covers registered care homes and hospitals and only applies from age 18.
2. The need to pay doctors and Best Interests Assessors to make repeated assessments, including of someone's mental disorder, even where there is no chance the person could regain capacity - for example where someone has advancing dementia or a significant learning disability.
3. That families find the language intimidating, the need to go to Court for some approvals and all appeals daunting, and repeated assessments burdensome & stressful.
4. The additional costs and waiting lists that have developed as a result of the widening of criteria.

DoLS has wandered away from the legislative framework and become more bureaucratic than necessary. We support a back-to-basics approach which delivers the requirements of Schedule A1 but in a more pragmatic and proportionate manner.

The advantages of the DoLS scheme are that the system is operating under such difficult circumstances and professionals such as Best Interests Assessors (BIAs) and DoLS leads have developed a significant level of expertise in the work that they do, ensuring that people's rights are protected.

What follows are examples of where organizations can adapt their processes to make them proportionate and more cost effective.

Case Example – costs and benefits: *The current legislation allows Councils to rely on any or all previous assessments on renewal providing they are less than 12 months old. This means a reduction in new assessments that need to be commissioned after 12 months. The following example comes from an authority in the London area who seek to maximise the use of equivalent assessments where it is appropriate and proportionate to do so.*

The Council had 2104 requests for authorisation in 2023/24, of these requests 1332 were granted. This means that a BIA and an MHA would have been involved in carrying out a minimum of 1332 assessments.

This Council use Independent BIAs at a cost of £250 per assessment and pay their doctors £173

This results in a cost for these granted authorisations of £560, 436

However, this does not distinguish a new referral from a repeat request. The Council has approximately 52% renewal requests, so, if only 48% had a full assessment and all six previous assessments were relied on as equivalent for the 52% of renewals this would be a saving of **£288,698**

However, it is important to consider these savings over time as the numbers of assessments where equivalent assessments could be used will vary. The following takes the example from London and expands it over a 5-year period:

Total	Total	Total	Total	Total
Year one	full assessment £250	Av £17	full assessment £173	£440
Year two	Review for changes, use previous BIA report unless situation indicates need for new assessment		Use previous assessment (unless changes indicates review)	No cost
Year three	Full BiA assessment £250		Dr completes remote assessment remotely at reduced cost £140	£390
Year four	Review for changes, use 2nd BIA report unless change indicates need for new assessment		Use previous assessment (unless changes indicates review)	No cost
Year five	Full BIA assessment		Full MH assessment	£440
Total			**£1270 or ave. £254 per assessment annually**	

Being able to use equivalent assessments does require effective administration (to keep track of current authorisations) and the capacity to allocate and review assessments before the current authorisations expire. Some authorities choose to prioritise new assessments and allow existing authorisations in uncontroversial cases to expire, to ensure everyone is assessed at least once. Policy guidance in this area would be welcome.

Case example: triaging hospital referrals **–** *Acute hospital referrals present a significant challenge for Councils. Whilst hospitals must make referrals to protect themselves and their patients in many cases it is simply not possible to assess the patients before they leave.*

Case Example: Community DoLS *– In order to support councils to manage demand and the impact of Community DoLS applications on themselves and the courts, ADASS developed a tool to help services triage community DoLS cases, to target resources and assessments on those in the greatest need of the protections offered. This does however mean councils carry a level of legal risk, as not all cases will be seen by the courts in a timely way.*

Case Example: Back to basics approach to DoLS processes & reports *– Many Councils have had to look at their paperwork and systems. Introduction of online referrals systems or systems which link directly with Adult Social Care systems produce great improvements and mean applications are more likely to be right first time. This in turn saves admin time and money.*

Summary

During this stage of the proposals, efficiencies can be made by Councils having the confidence to use equivalent assessments, by taking a proportionate approach to assessments both new and renewals and by triaging referrals for both DoLS and Community DoLS.

This could be supported by the development of national policy guidance to encourage all councils to adopt a similar approach. Further support could provide for digital referrals rather than manual systems. However, it is important to note that savings are not financial savings but rather they serve to reduce or remove waiting lists. Additionally, pressure on the Court of Protection is likely to grow over time as numbers of community DoLS are identified & put forward. In the meantime, councils will continue to hold a level of legal risk due to unauthorised deprivation of liberty cases.

Stage two: an amended version of DoLS

The second stage of these proposals could be accomplished by accepting the amendments proposed by ADASS & BASW to the current Mental Health bill.

Suggested amendments are as follows:

- Removing the limit of time on reusing previous assessments, which is particularly relevant for repeated Mental Health assessments in cases where the person's diagnosis and capacity are unlikely to change. This will align DoLS with LPS in relation to renewals which do not require further assessments and the time limit is removed.

- Extending the maximum authorisation time that can be recommended from 1 to 3 years. Aligning with LPS.
- Amending regulations which currently require the DoLS mental capacity assessment to be carried out by a BIA or MHA. The pool could be widened to the same professionals proposed in LPS. This will both align with LPS and allow some of the LPS Policy intentions to be tested.
- If LPS is delayed for a much longer period of time then consideration could be given to wider amendments to DoLS 1) to include all settings and 2) to reduce the age to 16 aligning with LPS

Example of potential savings:

Based on the London example the following savings could be expected:

Total number of DoLS applications processed	2104	**Numbers granted**	1332	**Numbers not granted**	609	**Numbers not completed/ signed off**	163

Table 3: Potential Savings area		Current costs per assessment	Potential savings
Removing requirement for repeated Mental Health /Capacity assessments for 3 yrs	Assume that 20% of renewals would still require an MH / Capacity [1]assessment annually (estimate) so 266 cases	£173 per assessment only payable for initial assessment (if it is not already available elsewhere)	Total assessments = 1332 52% of these assessments are renewals = 693 of which 80% (554) will not need a new MH assessment. @£173 per assessment the annual **saving is £95,861**
Extending validity of BIA assessments in suitable cases to 3yrs	Reduces number of repeat assessments annually by up to 1/3	£250 per assessment, but that assessment would be valid for up to 3yrs	Total assessments = 1332 52% of these assessments are renewals = 693 of which 80% (554) will not need a new BIA assessment. **Savings of £138,500**

Based on the above calculations, the average cost per case needing attention in the London example would be as follows:

- £440 full DoLS assessment without any adjustments (stage 1)
- £254 when using a proportionate approach (stage 1 with adjustments)
- £175 if amendments to the MH act introduced further flexibilities to the use of Mental Health and BIA assessments. (stage 2 so legislative change needed)

It is important to note that any savings would enable more assessments to be completed, thus ensuring people have the protections they are entitled to.

[1] Please note annual reviews would still happen, and if this indicates that capacity may have been regained this would trigger a new Capacity assessment.

The West Midlands region has attempted to introduce an amended fee structure for payments to DoLS Mental Health assessors. See Annex for more details * Savings can be realised from adopting these rates but are dependent on an adequate number of MHAs in each Council area.

Further efficiencies might be made were the scheme expanded to include other settings such as group homes & supported living environments, enabling funds currently incurred in Court applications to be redirected to ensuring more people in community settings are covered by the legal protections of DoLS. This would also save Court of Protection time, as 're X' cases would now be covered by the DoLS system, leaving the court to focus on s21A and other appeals. This could speed up processes in the Court for DoLS challenges.

During this stage we would also suggest further scoping be undertaken from a representative number of councils to understand the actual costs of DoLS as well as the potential impact of LPS especially in relation to self-funders.

Summary

In stage two an amended DoLS scheme would have the advantage of familiarity, and savings could still be realised without detriment to those the scheme is intended to protect. It could also provide more capacity (especially if the legal amendments to DoLS were agreed) that would help to tackle waiting lists and prepare the sector for the implementation of LPS. These changes would not negate the need to consider further legal changes as more people are community based, and the system for challenges may need review. This stage two option will carry risks especially if the scheme was amended to all settings and covered appropriate 16-17 yr olds. Additional funding would be required to facilitate the increased numbers of assessments. This paper has not explored many of the additional costs relating to 16/17-year-olds if these options were to be implemented and further work would be required.

Stage 3. Introducing the Liberty Protection Safeguards

Introducing the Mental Capacity Amendment Act (MCAA) would require a significant systems change across both the local authority and NHS. Consultation carried out in 2022 on both the draft Code of Practice and the Impact Assessment (not yet published) raised a large number of challenges to the successful implementation of LPS. As the DoLS scheme has grown to become overly bureaucratic and burdensome, LPS will pose the same challenges if the concerns raised by the consultation are not addressed. However, if addressed, the system has significant advantages.

Implementation of LPS will provide efficiencies by allowing

1. Three-year authorisations
2. Simpler renewal processes
3. Specialist roles to be better targeted i.e. the AMCP role
4. Aligning generic practice with LPS

The policy intention of LPS was the integration of LPS decision making into Care Act decision making, in a way that avoided double burdens and 'hand offs' between professionals. Much of the concern around the Draft code of practice & regulations focused on its failure to live up to these expectations. Publication of the results of the 2022 consultation and a revised code of practice would help understanding as to whether these concerns have been addressed.

Case example – specialist input. *The main difference between DoLS and LPS is the targeting of specialist resources. In DoLS every authorisation granted has an assessment which has been completed by a BIA. LPS moves these assessments to the wider workforce and replaces the current BIA role with an Approved Mental Capacity Professional (AMCP). This professional will provide reviews of cases where the person indicates an objection to care or accommodation. The Impact assessment assumes this will be in 26% of cases.*

Case example – acute hospital referrals. *The LPS scheme will remove NHS hospitals from the remit of the local authorities, thus saving time & money in the triage processes and assessments, but more importantly will ensure hospitals conduct the process which should increase the numbers of people who have their rights protected. Currently Councils are often unable to proritise acute hospital applications in time to assess them before people are discharged.*

The LPS scheme includes all settings and also includes 16/17-year-olds. Currently all applications for 16/17-year-olds require a Court hearing regardless of location.

Case example 16–17-year-olds. *The impact assessment in relation to LPS and this age group was developed before Judge Hilder's decision [2]that all cases involving 16 and 17yr olds had to have a Court Hearing. This raised the costs of these cases significantly. Additionally, not all DoLO (Deprivation of Liberty Order) cases involve young people who lack capacity, and whose ongoing care would be supported by the DoLS scheme. More scoping is therefore needed of this cohort to understand how many young people will have been known to the courts using the DoL**O** scheme, and how many will be eligible for the LPS scheme. For those 16 and 17yr olds who do fall within the remit of the LPS scheme, there will be financial benefits to local authorities as this will significantly reduce court pressures, and local authority legal costs.*

Additional Areas of concern that need focus

Despite identifying potential benefits from introducing LPS we remain very concerned that the consultation has not yet been published. We urge caution in proceeding with the version of LPS which was emerging from the Code and recommend a radical revision. In this paper we have attempted to provide a direction for travel but this is not exhaustive and many of the workforce implications have not been highlighted here and need to be further tested.

Below is a selection of our ongoing concerns.

1. **Private & independent hospitals**: These will continue to be the responsibility of Councils. The Draft code was unclear about the relationship and the responsibilities between the location of the hospital and the Council where the person is ordinarily resident. As this could significantly impact time spent on assessments this is another area where clarity is required by the Code of Practice.

   There are potential benefits of one local authority having an overarching responsibility for LPS in the private and independent hospital in its area in respect of its safeguarding responsibilities.

[2] https://www.bailii.org/ew/cases/EWCOP/2022/24.html

A number of the Serious Case Reviews (Whorlton Hall, Winterbourne View) involving people with a learning disability, autism and/or behaviors which challenged people noted the problems that existed because so many of those placed were either from outside of the area and/or paid for under either continuing health or mental health act budgets. Providers and their residents were often 'invisible' to local services and safeguarding partnerships. If one local authority had a leadership role in LPS for a private/independent hospital, but the ability to charge the authority of ordinary residence for assessments where appropriate, there would be greater safeguarding oversight and an improved ability to identify and challenge poor practice/closed cultures that developed.

2. **Mental Health Bill changes**: Changes proposed by the reform of the Mental (Health Act also need to be considered alongside LPS, in particular the removal of people with only a learning disability or autism from long term hospital detention.[3] Moving these people onto LPS would have the advantage of mandating greater local authority involvement and scrutiny (as suggested above) LPS would provide a more flexible legal framework and process to support people to move on from current inpatient stays.

> *NHS digital identified in February/ March 2025 there were **851** people with a learning disability or autistic people detained under the Mental Health Act by Independent (non-NHS) providers. Of these, an estimate of 168 would no longer be detained after the MH bill changes are implemented.*

3. **Self -Funders**: The DoLS scheme makes no distinction between funded and self-funded care, the entry point is exactly the same. This is because DoLS is deliberately separated from care management. However, the LPS scheme is intended to combine functions thereby potentially bringing many more self-funders into Council waiting lists for Care Act assessments in order for their liberty to be protected. Concerns amongst some DoLS Leads about the potential impact of needing to undertake Care Act assessments on people not previously known to local authority systems helps to explain why some have suggested LPS assessments taking up to 31hrs. How proportionate such Care Act assessments can be needs to be properly explored as does how AI could be used to manage the LPS system more effectively**.** The referral system for self-funders was not identified with any clarity in the Draft Code and needs to be clear to prevent the kind of bureaucratic entanglement that has occurred in DoLS.

4. **Further scoping of numbers**: It is unclear how many older people currently living in supported or sheltered accommodation, or their own homes may fall within the scheme and need assessment. Given their status they are less likely to have been previously known to the local authority, and the need for Care Act as well as LPS assessments will make the process more extensive & costly per person, should they have to access a Care Act assessment in order to benefit from the LPS.

5. **The costs of LPS implementation**: This remains largely unknown and the impact of self-funders on the current Care Act assessment waiting lists is not recognised in the Impact assessment nor the Code of Practice. Having a 'staged' implementation period, with a plan to

[3] Data Source:https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-march-2025-mhsds-february-2025/datasets---at

review the Code & regulations after 5yrs to ensure they are meeting the policy requirements would be helpful and could help meet other government imperatives such as needing to report back to Parliament on the implementation of the Mental Health Act changes.

6. **The Casey Review**: Any changes also need to take account of any recommendations coming out of this work. For example, were the review to make recommendations around funding flows for care it would be helpful to see these alongside the implementation of LPS. This would not necessarily be unhelpful but needs planning in a system that is facing significant changes and challenges already.

7. **The current costs and suitability of the appeals process**: The Law Society paper on LPS reform[4] recommended that consideration be given to whether the current process is fit for purpose and affordable, given the increased numbers in the system, its costs, and concerns about whether individuals and families are able to make best use of the system

8. **More clarity is needed on professional standards:** for those who will operate the LPS system, more clarity about the standards of practice, the qualifications, and who can do what assessments would be useful. The specific and bespoke training requirements of those who support 16/17-year-olds need to be considered.

9. **Links with progression to adulthood work:** ongoing work towards successful LPS implementation should not continue in isolation but should link with developing work around progression to adulthood[5]. This paper predominantly presents an Adult Services perspective and further collaboration is required with ADCS and wider stakeholders.

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[4] Recommendation 34: "*In tandem with the "Transforming our Justice System" programme, the Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals should review the question of the appropriate judicial body for determining challenges to authorisations of deprivation of liberty under the Liberty Protection Safeguards. This review should be undertaken with a view to promoting the accessibility of the judicial body, the participation in the proceedings of the person concerned, the speedy and efficient determination of cases and to the desirability of including medical expertise within the panel deciding the case*"[4]

[5] Preparing for Adulthood Report ADASS – IMPOWER

Annex 1 – Case Studies

Case example: costs and benefits.

The current legislation allows Councils to rely on any or all previous assessments on renewal providing they are less than 12 months old. This means a reduction in new assessments that need to be commissioned after 12 months. The following example comes from an authority in the London area who seek to maximise the use of equivalent assessments where it is appropriate and proportionate to do so.

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This Council use Independent BIAs at a cost of £250 per assessment and pay their doctors £173

This results in a cost for these granted authorisations of £560, 436

However, this does not distinguish a new referral from a repeat request. The Council has approximately 52% renewal requests, so, if only 48% had a full assessment and all six previous assessments were relied on as equivalent for the 52% of renewals this would be a saving of ***£288,698***

Case example: triaging hospital referrals.

Acute hospital referrals present a significant challenge for Councils. Whilst hospitals must make referrals to protect themselves and their patients in many cases it is simply not possible to assess the patients before they leave.

Another Council reports using a triage approach for hospital and hospice referrals to ensure that assessments were conducted in a proportionate and appropriate manner. (evidence suggests many of these referrals were resolved either because the person was discharged from hospital or died prior to assessments being undertaken). By triaging cases, early intervention in situations where the person needed the protection of DoLS was possible. The DoLS lead in this authority estimated an annual saving of over £100k annually by taking this approach.

Case example: community DoLS

In order to support councils to manage demand and the impact of Community DoLS applications on themselves and the courts, ADASS developed a tool to help services triage community DoLS cases, to target resources and assessments on those in the greatest need of the protections offered. This does however mean councils carry a level of legal risk, as not all cases will be seen by the courts in a timely way.

For one London authority illustrated here, 261 people were identified who potentially fitted the criteria for a community DoL Order but only 45 (16%) were seen as fitting the 'priority one' criteria for application to the Court of Protection. Costs for re X Community Cases where there are no objections or disputes is about £2,000. Cases involving disputes cost upwards of £12,000 per case. (based on 2019 Impact assessment estimates which will need revision)

Case example: back to basics approach to DoLS processes & reports.

Many Councils have had to look at their paperwork and systems. Introduction of online referrals systems or systems which link directly with Adult Social Care systems produce great improvements and mean applications are more likely to be right first time. This in turn saves admin time and money.

Example from the West Midlands region.

WMADASS have funded support for its Councils to develop proportionate and pragmatic approaches to DoLS. This includes

- *Greater use of equivalent assessments*
- *A new approach to Best Interests Assessments which are written in a report style format and are more person centred and can be tailored to each individual situation, often taking less time*
- *The use of a shorter renewal assessment form for both BIAs and MHAs when the circumstances have not changed at all*
- *Encouraging online systems*

The use of these measures makes efficiencies which in turn result in more assessments being completed and the waiting lists reducing over time.

Case example of potential savings: West Midlands

The West Midlands region has attempted to introduce an amended fee structure for payments to DoLS Mental Health assessors. Savings can be realised from adopting these rates but are dependent on an adequate number of MHAs in each Council area.

If Councils do not utilise a sliding scale, they will set their own flat rate per assessment and adopt the shortened 4B fee of £75	
Single urgent assessment including Mental Health, Eligibility and (and if required mental capacity) with a return within 24 hours	*£175*
Single assessment in a setting mental Health, Eligibility (and if required mental capacity)	*£165*
Two assessments in the same setting mental Health and Eligibility (and if required mental capacity)	*£155*
Three or more assessments in the same setting mental Health and Eligibility (and if required mental capacity)	*£140*
One or more shortened, proportionate renewals 4B	*£75*

Case example: specialist input.

The main difference between DoLS and LPS is the targeting of specialist resources. In DoLS every authorisation granted has an assessment which has been completed by a BIA. LPS moves these assessments to the wider workforce and replaces the current BIA role with an Approved Mental Capacity Professional (AMCP). This professional will provide reviews of cases where the person

indicates an objection to care or accommodation. The Impact assessment assumes this will be in 26% of cases.

323,870 applications for DoLS were completed in 2023-4 of these 145,945 were fully assessed.

Of the authorisations which were fully assessed and not granted only 915 failed the criteria for DoLS in 2023-4. We could therefore expect that a fully funded system working at full capacity receiving in approximately 300,000 might expect to grant a significant portion of them. If we assume 299,000 only 26% of these will need the oversight of a specialist professional i.e. 77,740 whereas in a fully operationalised DoLS scheme with 299,000 applications being assessed all of them would have the specialist input of a BIA.

Independent BIA costs average £250 (74,750,000) and the Impact Assessment assumes an AMCP cost would be £125 (9,717,500) a saving in a fully funded, fully operationalised scheme of ***£65,032,500.*** *These financial efficiencies could be redeployed to meet the additional workforce costs of generic Pre Authorisation reviews and front-line social workers.*

Case example: acute hospital referrals

The LPS scheme will remove NHS hospitals from the remit of the local authorities, thus saving time & money in the triage processes and assessments, but more importantly will ensure hospitals conduct the process which should increase the numbers of people who have their rights protected. Currently Councils are often unable to proritise acute hospital applications in time to assess them before people are discharged.

In 2023-24 100,550 applications for DoLS authorisations were received from acute hospitals. 96,265 of these were completed but only 4645 were assessed. This means that 95 % were not able to be assessed in time. Councils have still received these applications, added them to their systems, completed them as applications not able to be granted and included them in the annual return. All of which takes admin time. Assuming a time of 1 hour spent (@15ph) in total this is a potential cost of £1,374,300 currently spent without achieving any assessments. In LPS these tasks will be carried out in hospitals by staff already working directly with patients and should result in the protection of LPS. Saved admin time in councils could be redirected to supporting the new processes.

Case example 16–17-year-olds

The impact assessment in relation to LPS and this age group was developed before Judge Hilder's decision [6]that all cases involving 16 and 17yr olds had to have a Court Hearing. This raised the costs of these cases significantly. Additionally, not all DoLO (Deprivation of Liberty Order) cases involve young people who lack capacity, and whose ongoing care would be supported by the DoLS scheme. More scoping is therefore needed of this cohort to understand how many young people will have been known to the courts using the DoL**O** scheme, and how many will be eligible for the LPS scheme. For

[6] https://www.bailii.org/ew/cases/EWCOP/2022/24.html

those 16 and 17yr olds who do fall within the remit of the LPS scheme, there will be financial benefits to local authorities as this will significantly reduce court pressures, and local authority legal costs.

The Impact Assessment estimated a total saving of £1.36m per annum for the 16-17yr old whose cases needed to be heard by the High Court using its inherent jurisdiction. However, the IA happened before Judge Hilder's judgement that all cases involving under 18yr olds needed to have a full hearing, which has raised the numbers of cases being heard via the Children's DoLS Court.

The Nuffield Family Justice Observatory Research (published September 2023) suggested approximately 1400 cases were being referred annually, of which 33% involved 16 and 17yr olds (462). Using the IA estimate of heard case costs of £12k, the estimated costs for this age group is £5.544 million. Even if only half of these young people would qualify for LPS, legal costs for local authorities are significantly higher than the IA estimates.