



# HOUSE OF LORDS

Unrevised transcript of evidence taken before

## **The Select Committee on the Mental Capacity Act 2005**

Inquiry on

### **THE MENTAL CAPACITY ACT 2005**

*Evidence Session No.1*

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*Questions 1 - 24*

TUESDAY 18 JUNE 2013

10.55 am

Witnesses: John Hall, Nick Goodwin, Anne-Marie Hamilton and Claire Crawley

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### Members present

Lord Hardie (Chairman)  
Lord Alderdice  
Baroness Andrews  
Baroness Barker  
Baroness Browning  
Lord Faulks  
Baroness Hollins  
Baroness McIntosh of Hudnall  
Lord Patel of Bradford  
Lord Swinfen  
Lord Turnberg

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### Witnesses

**John Hall**, Deputy Director of Family Justice, Ministry of Justice, **Nick Goodwin**, Deputy Director of Court Tribunal Fees, MoJ, **Anne-Marie Hamilton**, Director of the Social Care Quality and Safety Branch, Department of Health, and **Claire Crawley**, Senior Policy Manager, Adult Safeguarding, DoH

**Q1 The Chairman:** Good morning. I am sorry to have kept you waiting; we had some preliminary business to attend to. Mr Goodwin, if you have any difficulty understanding or hearing what we are saying, please indicate, and we will try to accommodate you as best we can. The evidence session that we are about to begin will be webcast live as well as transcribed. The transcripts will be published on the Committee's website and witnesses will have the opportunity to make minor corrections and clarifications to the text. I understand that there is no opening statement, but can I just have confirmation of that? In that case, we will simply go to the first question, which is to be put by Baroness Andrews.

**Baroness Andrews:** Thank you, Lord Chair. I am afraid that I have the blockbuster question on this hugely important Act, which is: to what extent to you think the Act has been a success? Is there a consensus about what is success? Is there a consensus, indeed,

about where there has been failure? Can you say something about the nature of the evidence and the criteria that you use as departmental officials to reflect that?

**Nick Goodwin:** Thank you. I shall start and pass you over to colleagues at some point. Overall, our view is that the Act has been a success. When it came in, it was certainly widely welcomed as a progressive piece of legislation that balanced protections with empowerment, and that is still largely the case in terms of the core principle of the Act and so forth. We engage with stakeholders, and that is their view. That is the day-to-day dialogue that we have. We have consulted over a few minor changes to the legislation, rules, regulations and so forth to implement the Act. The sense that we have had back from those consultations is that the legislation as a whole is still highly regarded.

How one gauges its success is a bit more difficult. We do not have any hard criteria or measures at the moment, so far as I am aware. The key things you would be looking for are whether the Act is used and understood and whether the accompanying objective of securing culture change has been achieved. In terms of use, yes, the Act is being widely used. Certainly, there is enthusiastic take-up of the lasting power of attorney. There have been about three-quarters of a million since the Act came in, and there is an increase in demand year on year for Public Guardian services generally. We acknowledge that there is probably further demand out there, and at the moment we are trying to put in place measures that allow that demand to be met or captured.

I know that colleagues in Health have done a lot of work on understanding, and I will leave them to explain a little more about that. We believe that the code of practice is still well regarded. It has been purchased by almost 60,000 people as well as being obtained free, so it is out there, and we think it is being used, but again we all acknowledge that understanding is not something that happens overnight, ditto culture change. There are some good examples of where we are now vis-à-vis 2005 or 2007. I know that the Office of the Public

Guardian has been talking to the financial industry recently, and banks are now putting into practice means whereby they allow small cash sums to be available to those with questionable capacity whereas larger, more strategic decisions still rest with attorneys and so forth. It is one of the examples in the code of practice, but life is being given to that now, and I think that shows that there is greater comprehension about what the Act means and what the principles mean in some respect. My assessment would be yes, overall, but there is still some progress to be made on understanding and culture change.

**Anne-Marie Hamilton:** We would say broadly, yes, it has been a success, but as legislation that requires significant cultural change across the health and care sectors, it takes time to embed and to truly see that.

The criteria we use are not formal criteria as such, but we ask whether the Act is understood, whether it is being used, and whether it is having an impact on people. In terms of the hard evidence we have, from data, we can see that referrals to independent mental capacity advocates have doubled in the five years since the Act was introduced. Referrals for deprivation of liberty safeguards have also increased over that time. We would expect best interests and capacity assessments to be taken on a daily basis, but obviously we do not collect data around that.

In terms of the informal evidence we have, we know that most hospitals and local authorities have Mental Capacity Act and deprivation of liberty safeguard leads in their organisations who are responsible for training staff, auditing practice and challenging practice. We know that local networks continue to meet to share innovative practice and discuss emerging case law. We know that the independent mental capacity advocate service is playing a valuable role in representing people's best interests. We have significant informal evidence and some data, but broadly speaking, to echo what Nick said, we think we have made considerable

progress so far but there remains a lot to be done truly to implement and embed this across the system.

**Q2 Baroness Andrews:** Thank you. What you said about that part of it is significant because when you look at the five statutory principles, they are all about culture change, essentially. The statutory principles—“A person must be assumed to have capacity unless it is established that he lacks capacity ... is not to be treated as unable to make a decision ... because he makes an unwise decision ... 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”—are very, very difficult. I know this is a difficult question, but do you think those statutory principles are being embedded in practice in culture?

**Claire Crawley:** I think they are in some places. Certainly we have seen evidence of individuals who previously would have had decisions made on their behalf. I shall give you an example. A woman in her very late 90s was diagnosed with vascular dementia. She was very frail and had no hearing, yet she was adamant that she wanted to live at home. Having a best interest assessment and a mental capacity assessment meant that she could make that decision and was able, with support, to go home. I think that is very different from where we were before the Act.

It is a huge culture change. Traditionally, social care and the health service have been a bit paternalistic in their attitudes towards patients and people using services. There is a huge thrust much more towards choice, control and self-determination. Front-line staff, such as care assistants and healthcare assistants, who are largely untrained and unqualified, probably need more assistance to understand the concept the Act is about. Perhaps particularly health professionals find the concept challenging. Social work traditionally has been about empowerment, change, choice and control, but clinicians sometimes find it difficult to feel

that they cannot make a decision unencumbered by the patient's view—but that is a terribly sweeping statement. We are getting there, but you are right: it is a fundamental change because it is a way of practising within human rights essentially, and it has got to be at the forefront of everything you do and all your practice. It is not an add-on.

**Q3 Lord Patel of Bradford:** I would just like to declare an interest: I am a former chairman of the Mental Health Act Commission, and I am currently a patron of a number of mental health charities. Carrying on from the question Baroness Andrews posed, you said that the Act has been used widely and it is understood fairly well in most quarters. Have you any figures about ethnic disparities in the use of the Act, lasting powers of attorney or the use of mental health advocates? Is that data monitored?

**Claire Crawley:** I am going to confess that I think it is monitored, but I am not sure. We could find out and come back to you, if that would be okay. My sense from the last IMCA report is that there is perhaps, as in many things, an underrepresentation of people from black and minority ethnic groups taking up IMCA services. That would probably be because of a lack of awareness of the service being available.

**The Chairman:** I think it would be helpful if we had a formal note on that.

**Lord Patel of Bradford:** Also on what is being done about that.

**Baroness McIntosh of Hudnall:** Can I just pick up the point you made about things that are yet to get bedded in and matters which have not yet worked out as originally anticipated? Is there currently any plan in government to look at the Act again with a view to amending it, or is it the view that it is just keeping on going until these things get bedded in? Are there any areas where amendment is thought to be necessary?

**Nick Goodwin:** I think overall the view is that there is no need fundamentally to amend the Act. However, you will be aware that last year there was some consultation around the Office of the Public Guardian and its ability to move to more digital services, and there is

due to be further consultation on that very shortly. Within that, depending on what the final proposals are, there may well be some proposals for change around the lasting power of attorney provisions, but they are designed to facilitate the OPG to deal with lasting power of attorney in a way that customers want, rather than fundamentally to unpick what is behind the Act in respect of LPA. “Fairly limited at the moment” would be the answer.

**John Hall:** The feeling is that the fundamental framework and principles are sound, and that any changes that we need to make are around ensuring that implementation continues to improve.

**Baroness McIntosh of Hudnall:** So can I just follow that up? As far as the code of practice is concerned, you have all indicated that you think that it is regarded highly by users, but there are some issues that have arisen intermittently—in fact, more than intermittently—over the past couple of years. Is it your view that there is anything that needs to be done to look again at the code of practice, for example, to see whether that can be amended?

**Nick Goodwin:** We were scheduled to look at the code of practice about now to see whether it needs updating. Jonathan Djanogly, then the Minister with responsibility for this area, wrote to Alan Beith on the Justice Select Committee and said that the intention was to defer that so that we could look at the code of practice at the same time that we look at the OPG reforms, so it can be updated all at once. There is still a plan to look at it, but it is a little way in the future. That process would obviously be fairly comprehensive and would draw in observations from around government and around society.

**Anne-Marie Hamilton:** Similarly, in the Department of Health there are no plans to amend the legislation. On the code of practice for the deprivation of liberty safeguards, there are two cases before the Supreme Court in the autumn. They and the report of this Committee

may suggest a need to amend the code of practice, for example. We will need to consider that in due course.

**The Chairman:** I appreciate that you are waiting for the decision of the Supreme Court. I think one of the cases is coming up in October. Obviously you perhaps want to be informed by the decision of this Committee, but once that information is available, can you give us any indication of when you would come up with a revised code of practice?

**Anne-Marie Hamilton:** No, we would need to discuss that with our Ministers.

**The Chairman:** I suppose that is something we could ask the Ministers.

**Anne-Marie Hamilton:** Yes.

**Q4 Baroness Barker:** We all know about the red tape challenge and scything through unnecessary regulation. A lot of the implementation of this Act rested on not just the code of practice but on a lot of regulation. Do you see anything coming out of the red tape challenge that is going to impact on current regulations under the Act?

**Anne-Marie Hamilton:** The red tape challenge was very helpful, and the comments we received are publicly available. There were comments on the Mental Capacity Act and the deprivation of liberty safeguards. Some were positive, some had concerns, particularly around the process for depriving someone of their liberty; for example, the forms involved in doing that. We are considering them, and we will need to decide how we respond in the light of what this Committee finds.

**Baroness Barker:** But it is likely that there is going to be change, rationalisation, a general move towards making it easier for individuals to engage with the legislation and secondary legislation.

**Anne-Marie Hamilton:** That is certainly what people called for in the red tape challenge. That again is something that we would want our Ministers to take a view on as we go forward.

**Baroness Barker:** It is not actually one of our questions today, but I wonder whether I might flag up to you that those of us who were involved in the pre-legislative scrutiny of the Act found that technical issues, digital issues, and the web did not really feature at all. I think they now do, and it is perhaps something that our Committee needs to reflect on. If that is part of the work you are doing, it may perhaps be helpful for you to inform us about that.

**Q5 The Chairman:** The United Nations convention on the Rights of Persons with Disabilities entered into force in May 2008, subsequent to the enactment of the Mental Capacity Act, and was ratified by the United Kingdom in June 2009. Have you considered whether the Act complies with the convention? What was the outcome of that consideration?

**John Hall:** We took legal advice at the time that the convention was made. The legal advice was that the Act was compliant. We understand that since then some concerns have been raised among some of the senior judiciary, and we have started discussions with them. To be doubly sure, we are doing a review this year to get further advice on that, but our view is that it is compliant.

**The Chairman:** You are carrying that out this year.

**John Hall:** That is right.

**The Chairman:** When do you expect that to be completed?

**John Hall:** By the end of the year.

**The Chairman:** Does that include addressing the suggestions from some quarters that the substituted decision-making is not compatible with Article 12?

**John Hall:** That is the nub of the review.

**The Chairman:** What about the research provisions in Sections 30 to 34 of the Act? Are you considering whether they are compatible with the prohibition on medical or scientific experimentation on persons with disabilities without their consent under Article 15?

**John Hall:** We are looking across the whole gamut of issues. This Committee's deliberations will be important to informing that.

**Q6 Baroness Hollins:** Before I ask my question, I should tell you that I am a retired consultant psychiatrist. I worked for 25 years as a consultant in learning disabilities services. I am also a family carer of a man with learning disabilities. I am a past president of the Royal College of Psychiatrists, and I am the current president of the British Medical Association. I want to ask you about implementation. There was initially to be a programme of work on implementation by the Department of Health, including local implementation networks. Can you describe for us the nature of your department's work on implementation and how significant the local implementation networks were and perhaps also whether your expectation was that the department would continue to lead on implementation or whether you saw a particular end point?

**Claire Crawley:** We did a massive amount of implementation of this legislation, probably more than is done on most legislation, because the fundamental challenge of the change of culture was recognised. It was originally planned to have a three-year programme to support the implementation. That was, in fact, extended to five years, so a significant amount of resource went into that. You are right that that was supported by nine local area leads as well as the central policy lead and local implementation networks were enabled and supported, and most of them are still going, I think. Obviously the role of the department is one of oversight and stewardship, but because we recognise that this is such a critical piece of legislation we are still involved in supporting implementation through commissioning. For example, we have commissioned SCIE to carry out work with care homes where it is important that people understand how the Act should work and what it does. We have supported SCIE to produce popular and very successful tools, including Social Work TV on SCIE TV, and we have worked with various professional bodies on a range of other guides,

so in terms of implementation we have done a lot. I do not think we see the job as done; it is just what is appropriate and what levers we now have in this new system. The new Care Bill and the NHS reforms offer us an opportunity to refresh that work because we need to talk to people in the new NHS system about what responsibilities and accountabilities they have under this legislation.

**Baroness Hollins:** How well do you think the Act is known and understood by relevant professionals and others required to apply it, such as carers—you mentioned carers in residential settings—as well as individuals to whom it applies?

**Claire Crawley:** I think it is variable. I think it is growing. My main portfolio lead is adult safeguarding. I attend a number of events to speak, and we have hosted conferences about safeguarding, and mental capacity is always raised by professionals throughout those sessions, whether they are nurses, doctors, social workers, care home owners or inspectors. It is much bigger in the profession than it was, and the Care Bill is an opportunity to refresh and remind people of it. I think it is much less known, probably, among informal carers and family and friends, although all the information and data we are getting from the Office of the Public Guardian demonstrate that that is also growing—phenomenally, actually in terms of doubling and perhaps trebling. It is less important that people, like me as a carer or a family member, know the Act and the code of practice than that I should know what my and my family's rights are under the Act and how they can be protected and promoted. I think we are on a journey, but applications for IMCAs and LPAs show that there seems to have been a jump. There was a very slow start, as we might expect, but there has been quite a significant jump in awareness.

**Baroness Hollins:** I have a couple of supplementary questions. I want to pick up on something that you said about paid carers knowing more. An awful lot of carers have no or

very limited training. Do you think that all carers working in services should have some training on mental capacity?

**Claire Crawley:** Absolutely.

**Baroness Hollins:** Is professional training on the Mental Capacity Act available through appropriate professional bodies? What has the department done to promote such training?

**Claire Crawley:** We have done work with what is now the College of Social Work and with the Social Care Institute for Excellence which is aimed at developing the training of professionals. We have commissioned a number of training programmes, tools and guides that are still out there and being used. As I said earlier, the department's view is that this is as fundamental to health and social care practice as any other legislation. Like the Human Rights Act, it has to be absolutely embedded in everyone's practice every day. It is not an add-on; it is not a specialist thing; it is not something you think about when suddenly you face a problem; it is there in all your work. That is a huge challenge.

**Baroness Hollins:** What about the royal colleges?

**Claire Crawley:** The royal colleges, particularly the Royal College of Psychiatrists, have all been very heavily involved in training their relevant membership groups. If you want more detail of that, I would have to go away and find out more.

**The Chairman:** Can we have a note on that as well?

**Baroness Hollins:** Just one final question: there are some dedicated roles, such as learning disability nurses. I think there were something like 30 learning disability liaison nurses working in acute hospitals. I gather the number is going down, and I think there is only one learning disability consultant nurse, but they have seen their role as working to support the application of the Mental Capacity Act within acute hospitals. Do you have a view within the department about their role in ensuring its application in hospitals and in community settings, where there are more learning disability nurses?

**Claire Crawley:** I think certainly they have a leadership role, but all employers and professionals have a personal, individual role as well. It would be an awful ask to ask so few people to somehow be responsible for that level of awareness. We find leaders in these posts who are absolutely committed to the principles and know how they pan out in practice.

**Q7 Baroness Andrews:** Can I just follow that up with two questions? The code says, “The responsible body should also have procedures, training and awareness programmes”. Are you satisfied that all local authorities have those procedures and training? How do you actually know that? My other question follows from the post-legislative assessment that was made in October 2010, and we are two and a half years away from that. It is about NHS trusts. Again, it is an evidence question, because the assessment revealed an inconsistency in assessing capacity in some trusts to ensure that the Act was fully embedded. In 2010 it said that all such trusts have met the required conditions. How do we know?

**Claire Crawley:** In terms of hard evidence, could I sit here and say, “I absolutely know that every local authority has appropriate plans and training processes in place”? I could not say that because I have no way of getting that evidence. The regulator of the industry, as it were, the Care Quality Commission, does not monitor local authorities or inspect them any more, so I would not know. My understanding is that they are required to do that, and if they are not, they are not meeting their statutory responsibilities. What was the second question?

**Baroness Andrews:** The second question was slightly different and was about NHS trusts and their capacity to ensure that the Act is fully embedded. In 2010, they were finding trusts that had not achieved that, but they said by that point that they thought all trusts had. I wonder what sort of monitoring and evaluation had gone on for the trusts for them to have that assurance.

**Claire Crawley:** That would probably have been the CQC's process, as the regulator, rather than the department's process.

**Lord Turnberg:** To follow on from that, how switched on do you think NHS England and the clinical commissioning groups are to the Mental Capacity Act? Are you having conversations with them?

**Claire Crawley:** We are having conversations. We have got a massive agenda on, so trying to get into that conversation is a challenge for all policy areas, including this. We have a dedicated lead within our team who works on the Mental Capacity Act, and she spends an extraordinary amount of time tracking down the people to talk to, so we are making progress.

**Anne-Marie Hamilton:** Clinical commissioning groups already have clear responsibilities around the Mental Capacity Act, so that is part of what they are expected to do. NHS England is well aware that this legislation is part of its responsibility.

**Claire Crawley:** As part of the authorisation process for CCGs, they had to demonstrate that they had the right processes in place.

**Lord Turnberg:** Did they?

**Claire Crawley:** Yes.

**Q8 Lord Faulks:** Mrs Crawley, a great deal of care is provided by people who are not professional carers, by families and even friends. Are you satisfied that in so far as it is relevant the code of practice for the MCA is sufficiently communicated and understood by most or all them?

**Anne-Marie Hamilton:** I think there are excellent guides. For example, organisations such as Mencap, the National Family Carer Network and the Alzheimer's Society have a lot of materials that family carers can access to help them understand what they have access to through the Mental Capacity Act. The code of practice itself may not be in use by family

carers, but there are other materials that are in use and are very helpful. For example, lasting power of attorney gets discussed on Radio 4's "Moneybox". It is part of the discussion for people to become aware of those rights, and it is leading people to ask for best interest assessments and to be more conscious of the framework within which the care is being provided.

**Lord Swinfen:** Do you have any system to identify families where informal care is being given by other members of the family so that help can be given to those informal carers, because very often they do not know what they are doing? They are just doing their best.

**Anne-Marie Hamilton:** No, I do not think we have a central system for identifying informal carers. There are so many people providing care of some sort or other to family or friends. I suspect that if they were looking for help or advice a lot of those people would look to organisations such as Age Concern.

**Lord Swinfen:** General practitioners do not have any system?

**Claire Crawley:** No. We have been asking general practitioners for a number of years—at least 10, and probably more—to make sure they flag on patient records where carers are operating, to be able to offer them particular advice and assistance. Of course, we refreshed the carers strategy not long ago, and we do a lot of work with the various carers' groups on how we get information like this across. You are right that GPs are often the first point of call for most family carers and the place they go, so it is really important that GPs know the circumstances. Often, if they are family doctors, they will know the family and will have known it for some time.

**Lord Swinfen:** They should know the family; I am not sure they all do.

**Claire Crawley:** No, I appreciate that.

**Lord Swinfen:** Not under the modern system at any rate.

**Q9 Lord Patel of Bradford:** On the issue of training, have you any evidence or examples of what is happening in further and higher education in respect of Mental Capacity Act training? We have concentrated on the NHS, local authorities and existing professionals, but in terms of newly qualified practitioners, whether care assistants or social workers, is any influence being exerted to say that this needs to be a core part of what they are teaching?

**Claire Crawley:** I would be shocked if it was not, but that is not a sufficient answer. If you want more detail, again we would have to come back to you with it.

**The Chairman:** Could we have a written note on that? You speak about encouraging general practitioners to flag up the records so that people with capacity problems are identified. To what extent are records readily available to other care providers? The reason I ask that question is that I was, unfortunately, admitted to a hospital in Glasgow from court one day with an MI. I had had a previous one, but my records were in Edinburgh. They had to phone the consultant in Edinburgh—this is National Health Service, not private—to get details of the previous episode. Is that a problem in England and Wales? If a GP has flagged up that someone has this problem, would that be communicated to another agency which was dealing with his or her care? Before you answer the question, I should have declared an interest—not as a patient just now—as honorary president of a charity called Capability Scotland, which campaigns for and provides services for people with mental and physical disabilities.

**Anne-Marie Hamilton:** There is an awful lot of work around record sharing within the NHS and across the NHS and the care system and a programme of work around electronic record sharing, but I do not think either Claire or I is familiar with the details. We would be very happy to find out more for you and to send the Committee a note if that would be helpful.

**The Chairman:** The reason I ask that is that it is all very well to say that GPs should flag the record, but if not followed through and the people dealing with secondary care do not know—

**Claire Crawley:** Particularly where people who may lack capacity are admitted to hospital in an emergency, that is a big issue.

**The Chairman:** They of all people might have even more problems than I did in communicating.

**Claire Crawley:** Absolutely.

**Lord Swinfen:** You say that GPs make a note on the patient's notes. That is all very well, but patient confidentiality may well mean that the GP cannot even to talk to close relatives. How do you get over that if someone with a mental incapacity could be in danger of endangering themselves and possibly other people?

**Claire Crawley:** Well, it is very clear that the GP in that case, if you are giving it as an example, has a professional duty of care to that individual and must share the information appropriately. It is recognised that they must do that. It is a delicate balance between confidentiality and sharing, but in the example you give, it is critical that they share information.

**Q10 Baroness Browning:** I had better declare my interests to begin with. I am a vice-president of the National Autistic Society and also of the Alzheimer's Society nationally. I am also the named carer of an adult relative living independently who has Asperger's syndrome. I want to ask you about independent mental capacity advocates. We have heard that the number has doubled in the past five years, but we also know from the report by Lucy Bonnerjea that it is very patchy. It seems to happen in some areas, but not others. Bearing in mind that the guidance to this Act says that an IMCA must—the "must" is in

italics—be instructed and then consulted for people lacking capacity who have no one else to support them, can you explain why five years on this system is so patchy?

**Claire Crawley:** I think it is partly because the Act is not properly embedded yet and people's understanding is not as thorough as it needs to be. The fact that we have seen the numbers going up is positive, but they probably need to go up faster. One issue is that people often have friends or family who they prefer to use as their representatives. Our anxiety is that there may be particular cases, for example, in what is called adult safeguarding, where IMCAs should be involved and are not. Again, a lot of this is a question of awareness and time and building up the knowledge and understanding of when people need to be involved.

**Baroness Browning:** So when you see specific cases where this has not happened—for example, when your department received the Winterbourne View report; I have had the opportunity of speaking to the person who wrote that report and asked the question “Was the Mental Capacity Act used?”, and it was not used or mentioned at all at Winterbourne View, where you may recall that some of the staff received prison sentences—what was your department's reaction when you identified immediately that that was where a weakness lay in terms of the implementation of this Act?

**Claire Crawley:** In terms of our response to Winterbourne View?

**Baroness Browning:** Not the response, but specifically in relation to the fact that Winterbourne View occurred without any reference to the Mental Capacity Act at all.

**Claire Crawley:** What happened at Winterbourne View shocked us all. In the wider context of what was going on there, in a sense one would have been surprised if they had understood and used the Act. Because of the abuse and the poor care, I do not think they had much understanding of any appropriate care or ways of working with people, if that makes sense. It was not the Mental Capacity Act alone that they had no awareness of. They

did not have awareness of any proper working with those particular individuals, by the sound of it. For us, it was probably a salutary reminder that there are some people who are very vulnerable to abuse and exploitation who the Act should be protecting and is not, and we will have to do more about that more generally.

**Baroness Browning:** When you see something that I would describe as a trigger, who exactly in the Department of Health has responsibility for deciding that, yes, your department needs to do something about it?

**Claire Crawley:** I think ultimately it is probably Ministers.

**Baroness Browning:** Ministers? But presumably they would receive some sort of guidance from officials that it was time to act.

**Claire Crawley:** With Winterbourne View, they did not need any guidance from officials. The Ministers were very proactive in how concerned they were in wanting action to be taken.

**Q11 Baroness Browning:** Could I give you another example where the staff almost certainly would have been aware of the Mental Capacity Act? It is the reports that we have received over the years, the first from the charity Mencap, *Death by Indifference*, which involves the death of quite young learning disabled adults who are in acute hospital situations. They are not there because of their learning disability. There has been a supplementary report showing yet further deaths. In a hospital setting like that, you would expect all staff concerned to be up to speed with the Mental Capacity Act. What was your department's response to the reports from Mencap in terms of the Mental Capacity Act?

**Claire Crawley:** I do not feel able to answer that because that was probably led by my colleagues. I do not know whether Anne-Marie knows.

**Anne-Marie Hamilton:** Are you asking who the lead official is or what the reaction was in the department?

**Baroness Browning:** Not specifically. We have heard the word “embedded” used a lot this morning, and of course the objective must be to embed this legislation throughout the system, but when one comes across specific examples like that, which are complex, no doubt, quite clearly the Act is not doing what it is meant to do. Clearly, it is not embedded at all. What triggers a response to try to make it more effective? Who actually takes that responsibility in government?

**Claire Crawley:** I think that is the Minister, and you are right, guided by officials. That is one of the reasons why we are working so hard to ensure that we have proper conversations and outcomes with NHS England and CCGs because, in a sense, that is who we have to work through. The department is in the odd position that it has parliamentary responsibility, it is the steward of the system, it exerts leadership and it dictates the direction of travel, but it has very few levers at its disposal. We have, I think, very much got to build and work through the new bodies if we are talking about hospitals.

**Baroness Browning:** Could I just ask one more supplementary? It is really to the Ministry of Justice. I know you are waiting for the conclusion of court cases, but you have told us this morning that from your department’s perspective, you are not of the view that this Act is in need of revision or review. When your department sees these quite high-profile cases—I have mentioned two, but they are by no means the only ones; there is unfortunately a steady progression of such cases—do you ever speak to the Department of Health about whether this legislation, on which both your departments rely, needs to be looked at seriously in terms of whether it is fit for purpose?

**John Hall:** We work together very closely. We have a number of forums and fora and working groups which we make sure we communicate. My team and the team that was formerly Nick’s work very closely with Anne-Marie’s team, so those conversations are happening in a joined-up fashion, if that is the question you are asking.

**Baroness Browning:** But the conclusion that your Minister came to based on those discussions and your advice was that there was no need to review it. Is that correct?

**John Hall:** Not a fundamental review at this point. That is where we are.

**Baroness Browning:** Does it not worry you somewhat because, although I know you are not the Department of Health, you must see these ongoing high-profile cases?

**John Hall:** I am not going to comment on interdepartmental relationships. We work very closely together, and the views that we take and the advice we give to our Ministers are very much joined up.

**Q12 Baroness McIntosh of Hudnall:** I think Lady Browning has sort of asked the question that I wanted to ask, but I want to take you back to the answer you gave on the question about the code of practice. Although I understood that you were saying that there are some court cases that still have to be resolved, I did not get a sense—I hope you will forgive me for putting it this way; I do not mean it impolitely—that there was a great deal of urgency in your approach to the possible revision of the code of practice, and that is exactly where the issues that Lady Browning has raised are likely to be impacted upon. I wonder whether you might like to give us a slightly refined answer to the question I asked you earlier.

**Claire Crawley:** I hope you will not think these are weaselly words from a civil servant, but the issue is that the code of practice is very good—most people say it is—as is the legislation. It is people putting it into practice that is such a challenge. We could review the code of practice and the Act and spend a lot of resources and time doing that and not make one jot of difference to people on the ground. Our energies are focused, I think rightly, on protecting individuals rather than on revising the code. If the code was followed, those dreadful things would not happen. That is what we struggle with. What are our levers?

What is our ability? How do we work with the regulator, in particular, to make sure that a good code of practice and some very good legislation actually happens?

**Baroness McIntosh of Hudnall:** Fair enough.

**Baroness Andrews:** Given that the system is changing and that the CCG is in place and so on and so forth, is there any opportunity or reason to look again at measures of evaluation and impact? That is what we are grasping at here. You have just identified it so coherently.

**Anne-Marie Hamilton:** I think you are right. In terms of the department's role going forward, we want to work with our system partners, such as the Care Quality Commission, NHS England and others, in understanding what is happening out there and the levers that we have to effect change. Part of that should certainly be evaluating and understanding what is happening and what evidence, qualitative and quantitative, we have to inform that. To respond to the earlier point, we take that forward by working with those system partners. The response to Winterbourne View was led across the social care and NHS sectors and across the whole department with the different teams coming together to work on it. You are right that going forward we need to evaluate and understand.

**Claire Crawley:** We are working with colleagues within the department on what measures will be used to evaluate the performance of NHS England delivering on the mandate. There is some work going on on a range of issues, and we are trying to work with it on safeguarding and the MCA.

**The Chairman:** Can you give us a detailed note on that?

**Anne-Marie Hamilton:** Yes.

**Q13 Baroness Hollins:** I want to pick up something that you said in response to Baroness Andrews at the beginning about the principles of the Mental Capacity Act. Baroness Browning asked about Winterbourne View hospital. You said at the beginning that practice is now based on human rights, although untrained staff may not understand what

that means. At Winterbourne View, they were mainly trained staff, but you said it was not an issue to do with the Mental Capacity Act. I appreciate that it was criminality really, but it was also to do with the lack of respect that those staff were showing to the patients, because it was a hospital. There is a really important issue about how far the evaluation of existing facilities looks at human rights approaches. Is there anything in the evaluations of services that are taking place that might be able to highlight a lack of a human rights approach?

**Claire Crawley:** Actually, that question is very timely for me, because I spent two hours yesterday with the Care Quality Commission talking about just these issues. How could Winterbourne View happen when the regulator was going in, GPs were going in and the local authority was commissioning places? You would have thought that somewhere in the system—it seems almost a complete failure, does it not? I was having exactly those discussions about how the CQC is going to train its inspectors, because perhaps the inspectors are not looking for the right things, and how they talk to people using the services, very much around the points you made. It is not just the staff delivering the service who have to have this approach, it is also the people who are monitoring and regulating them. Winterbourne View was just a dehumanising regime, was it not? It just seemed to be a catalogue of failures.

**Baroness Hollins:** Are you confident that the Care Quality Commission has got this kind of inspection in hand?

**Claire Crawley:** I am absolutely confident that it is working on getting it in hand. It sets great store by that work.

**Q14 Lord Patel of Bradford:** You said early on that the Mental Capacity Act is not an add-on. You are right in that. However, many practitioners have described the deprivation of liberty safeguards as an add-on to the Mental Capacity Act with a very different and less

empowering ethos. Do you agree with that? If you do, what implications has it got for the Mental Capacity Act and its implementation?

**Claire Crawley:** I do not agree with that, and it is not the Government's view. You are absolutely correct to say that they came later. The Act was amended through the Mental Health Act, and one of the reasons for that was that until Bournemouth, which was the high-profile case that brought this all to light and to the fore, there was not really an understanding of the position that people were finding themselves in in care homes and hospitals. Certainly some Members of the Committee will remember that before the Mental Capacity Act got Royal Assent, it did not focus on it particularly. I think they are empowering. Partly it is the way they are misinterpreted or misunderstood. The language does not help. People concentrate on saying "deprivation of liberty" when what they should be concentrating on is the word "safeguards". These are about making sure that people who in their best interest have some restrictions on their liberty—minimal restrictions—to keep them safe have adequate recourse and protection within the law and within the system. I very much see them as empowering because we see a range of people whose treatment is being challenged, including through the Supreme Court and the Court of Protection work. No, I do not accept that. I accept that the very terminology might feel confusing and inappropriate, but the ethos is to allow people to make as many decisions as they can and to be as free as they can.

**Lord Patel of Bradford:** Have you seen any discrepancies in terms of people understanding whether they should use the Mental Health Act or the Mental Capacity Act? Many would be almost de facto detained in these care homes.

**Claire Crawley:** Winterbourne View was an example. Nobody seemed to know about the Mental Capacity Act. I do not think there is confusion in the law, but people do not always understand which legislation they should be operating, and often it should be the Mental

Capacity Act. We are working with colleagues on the mental health policy area to try to pull that apart, yet make it a coherent whole for people. We are doing some work on that.

**Lord Patel of Bradford:** Is that something that the Care Quality Commission's mental health arm should be homing in on?

**Claire Crawley:** The person who leads on the Mental Health Act—a very senior member of staff—also leads on the Mental Capacity Act, so that is one way of bringing that together.

**The Chairman:** I think we need to move on to Question 8.

**Q15 Lord Swinfen:** You have just been talking about deprivation of liberty. Are the standards being operated the same throughout the whole country? If not, what is being done to bring the lowest standards up to the highest standards?

**Anne-Marie Hamilton:** I think everybody operating the deprivation of liberty safeguards is using the same safeguards, but there are regional variations in terms of the number of authorisations being applied for. We can see regional variations in the extent to which the safeguards are being used. The Care Quality Commission's annual report flags that. We are discussing with the Care Quality Commission what it might do. When the original implementation programme happened, regional managers spent a lot of time going up and down the country talking to areas about how to raise awareness and how to get smaller providers familiar with this. There was an awful lot of work done. It is probably inevitable that there will be regional variations because the population make-up differs across the country. Some areas have higher populations of older people, some areas have more hospitals and more care homes and some care homes have higher populations of people with dementia. Variation is inevitable in terms of the number of safeguarding authorisations that you see, but we think that there is also something within that that means that it is not being implemented uniformly across the country and that some areas are doing this better than others.

**Lord Swinfen:** Your office could be learning lessons while looking at this. What are you doing to make certain that the lessons you learn to improve standards are promulgated throughout the country?

**Anne-Marie Hamilton:** That is something that the Care Quality Commission, as the regulator, talks about in its annual report, stating the issues it has identified and how it might build them into its processes going forward.

**Lord Swinfen:** Reports are very good, but they very often lie on the shelf. What are you actually doing to make certain that the recommendations are implemented?

**Anne-Marie Hamilton:** In terms of the Department of Health's role? It is the role of the regulator to share that. The Department of Health continues to fund best practice guidance through the Social Care Institute for Excellence. We continue to try to raise awareness through the work that we commissioned from SCIE. We play the role that we described earlier in bringing together the different system partners, including NHS England, whose responsibility is to address this throughout the NHS. Local authorities have a statutory obligation to have this locally.

**Q16 Baroness Barker:** Lasting power of attorney is perhaps the part of this legislation that impacts on the general public first and most directly and is therefore very important. You said that there had been 750,000 LPAs. Can you tell us the time period for that? How does that compare to enduring power of attorney rates before the Act? Is the rate as high as we would have anticipated when the legislation went through?

**Nick Goodwin:** The actual figure is slightly under 750,000. LPAs have been registered since October 2007. That is about 2,000 a month at current volumes. It is very difficult to compare that with the previous system of EPAs. There is a lot of public information on the volumes, but I can give more on that.

**Baroness Barker:** I think we would like a lot more detail on not just when they are registered but when they are activated. We would like to know from different practitioners, such as people in memory clinics, how they are panning out with people and their families. At the time the legislation went through, there was considerable concern that the cost would be off-putting to people. We would like to have whatever data you have on that. If we can have a pretty full report on that, that would be helpful.

Also, advance decisions were a very important part of this legislation. They were controversial when they came in, but I think some people have changed their mind. What data do you have on the use of advance decisions?

**Claire Crawley:** I think the honest answer is that we do not collect that data. I am sorry; that is not satisfactory from your point of view, but I do not think we do.

**Baroness Barker:** Does anybody in the course of their professional duties?

**Claire Crawley:** Not that I am aware of.

**Lord Swinfen:** What about the solicitor who draws up the lasting power of attorney? Do they have to register it anywhere?

**Claire Crawley:** The lasting power of attorney is registered with the Office of the Public Guardian.

**Lord Swinfen:** It should be able to produce the answer for you.

**Claire Crawley:** Advance decisions are different from LPAs.

**Lord Swinfen:** All right, but the modern one, does that have to be registered anywhere?

**Claire Crawley:** The lasting power of attorney has to be registered with the Office of the Public Guardian, which may have data. Advance decisions can be just written by an individual on a piece of paper and signed, so they are not registered anywhere.

**Lord Swinfen:** They just get put in a drawer and when the time comes no one can find them.

**Baroness Barker:** The intention was that they would be part of a patient's record and available to practitioners at the time of treatment. For example, if somebody had a fluctuating mental health condition, they could say, at a period when they had capacity, "I know from experience that when I lack capacity I may make certain unwise decisions. If I do that, I wish you to ignore what I say at that point". The anecdotal feedback from a number of practitioners is that they have been helpful. It is a great shame that there has been no systematic look at their effect across the NHS.

**Claire Crawley:** Yes, I can see that. One of the reasons why the inquiry is going to be so helpful for us is in getting that different perspective of what is useful and what is not. Like all public bodies, we have restrictions about overwhelming the system with so much data collection that it cannot get on and do its job, but I understand the point you are making, and it is very interesting.

**Q17 Baroness Andrews:** May I pursue that, Lord Chair? At paragraph 9.38, the code of practice clearly analyses the complications that arise about the business of logging an advance decision and in determining whether it even exists: "It is the responsibility of the person making the advance decision to make sure their decision will be drawn to the attention of healthcare professionals". We are dealing with people in intermittent states of confusion, very often. When you come to look at the code of practice again and the evaluation methods, it might well be worth looking to see, on the basis of what experience you can collect, whether there is something that can be done to tighten this up. This was such an important—it is increasingly important—issue for self-determination.

That was not going to be my question. This is my question. I have personally gone through the process of LPA, and it is not easy. I know that you tried to simplify it, but the terminology is still very complex and unusual, and the form is very long. Someone described it to me as being like reading a Russian novel because by the time you are halfway through,

you have forgotten whether you are the donor or the attorney. Is there some way in anticipation that you can have another go at that?

**Nick Goodwin:** Yes.

**Baroness Andrews:** Good.

**Nick Goodwin:** It is a very common criticism. That is what the OPG is trying to simplify. We anticipate that in a short number of weeks, we will have made the first step on that. It will be a bit of a journey to get there. The first step will be a new online tool that will mean that, if you have gone through that laborious process of filling in all the information, the form is not sent back to you because you have got a few bits in the wrong box,

**Baroness Andrews:** That is exactly what has happened. They come back to you with another charge because you have the terminology wrong, which is causing a bit of aggro. It might be worth taking evidence from somebody who is aggrieved.

**Nick Goodwin:** Again, there has been consultation on this. The aim is to make it much more user-friendly and to improve the process in the Office of the Public Guardian. There have already been some improvements. We have reduced the statutory waiting time and there are some minor amendments intended to improve customer service. At the same that the online tool comes in in a few weeks' time, there will be further detail. There were some issues that we consulted on last time that we needed to refine a bit. To get fully digital by 2015, for example, would probably require some priming. There will be more detail on that very shortly. Certainly we are with you in terms of the frustrations and improving the user experience.

**The Chairman:** When those details are available, can you make them available to the Committee?

**John Hall:** I understand that you are going to be questioning the Public Guardian. He will be able to give you a lot more of this information.

**The Chairman:** I think we will go to courts and regulation because Lord Faulks has to leave early. I should also say that that our adviser has to leave early to attend a funeral, so it is no disrespect if either or both of them walk out in the middle of your evidence.

**Q18 Lord Faulks:** Thank you, Lord Chair. I should have declared an interest earlier in that I am a practising barrister and from time to time I act on behalf of those who lack mental capacity and for doctors and healthcare professionals in cases where mental capacity is sometimes an issue. I want to ask you about the Court of Protection, which was set up, or at least expanded in its scope, by the Mental Capacity Act as a single integrated framework, as recommended by the Law Commission. In general terms, are you satisfied that it is being effective?

**John Hall:** The Court of Protection was bringing together those things for the first time. It was one of the big challenges of implementing the Mental Capacity Act. It has been a slow journey with some hiccups along the way, but we are very much getting there. In terms of case load, the emphasis is still on finance issues rather than health and welfare issues, which is what you would expect. We have made some changes and amendments along the way, particularly in terms of moving the administration from the Office of the Public Guardian to HMCTS to make things run a bit more smoothly from the court's perspective. There was an anomaly in the Act which meant that no deputy judges were able to sit, and that created a bit of a backlog, but we have made some amendments to the Act to circumvent that. We think we are heading in the right direction, but there is still more work to do.

**Lord Faulks:** I see that actually the Act says: "The court may sit at any place in England and Wales, on any day and at any time". In practice, are there a lot of delays? You have just described some of the improvements. Do you think it is responding quickly enough in general terms?

**John Hall:** There have been problems with backlog, but again that is getting better. The change around moving the administration from the Office of the Public Guardian to HMCTS has improved that because of buildings. Even though the court is a separate jurisdiction, it can sit anywhere within HMCTS's estate, so that has definitely got better. We now have regional sittings as well as sittings in London, so people do not have to travel all the way to London to have their hearings.

**Lord Faulks:** There have been some changes brought about by the LASPO Act and there is now a consultation on changes to legal aid. Have any of those changes had an impact on the availability of legal aid and therefore impeded in any way access to the Court of Protection?

**John Hall:** As far as I understand it there have been no changes in the way that legal aid is available for cases in the Court of Protection as a result of either of the two reforms.

**Lord Faulks:** You just described changes to the Office of the Public Guardian and the potential impact on the MCA. Is there anything you want to add?

**Nick Goodwin:** Sorry, could you repeat that?

**Lord Faulks:** What impact do you think that changes in the Office of the Public Guardian will have, if any, on the application of the MCA?

**John Hall:** We hope that they will improve the application of the MCA. The volumes, particularly of lasting power of attorney, have been increasing, but there is clearly a lot more to do. The Office of the Public Guardian has taken a kind of gentle approach to publicising the need for everyone to get a lasting power of attorney. Its concern—which is right—is that it did not want the office to be overwhelmed with more applications than it can handle. There is a twin-track approach of gradually raising awareness and expectations and improving the infrastructure. Digital delivery will be a key part of that. As the system

becomes more robust and more able to handle the capacity, communications and awareness-raising will increase at a similar rate.

**Lord Faulks:** There was a recent, highly publicised case of someone being sent to prison by the Court of Protection. That hearing was not carried out in public in the way that you would normally expect a hearing to take place. I think there has been criticism of that. Can you reassure us that that will not happen again?

**John Hall:** You would not expect me, I am sure, to comment on individual sentencing decisions.

**Lord Faulks:** No, but as a matter of principle.

**John Hall:** As a matter of principle, the president has given guidance saying that all imprisonment proceedings in the Court of Protection should be heard in open court. More broadly, I know there have been concerns around transparency and openness in the Court of Protection and in the family courts. Ministers had already asked the president of the Family Division to do a review and assessment of what changes might be needed for the family courts. The Secretary of State has also written to him to ask him to look at the Court of Protection alongside that work and will be discussing the president's proposals with him shortly.

**Lord Faulks:** Would it be fair to say that that was an exceptional case?

**John Hall:** It is the only case we are aware of at the moment where someone has been imprisoned.

**Lord Faulks:** Are you satisfied that the regulatory framework is robust enough? There are a number of different regulators, effectively, although, as I understand it, the CQC is responsible for the quality of care. The Care Bill currently going through Parliament proposes new powers. Are you satisfied that the regulatory framework is sufficiently robust?

**John Hall:** That is not my department.

**Anne-Marie Hamilton:** The regulatory framework has a number of parts. Obviously, the Court of Protection plays an important role in challenging decisions. Independent mental capacity advocates are also an important part of it, as is the role of the relevant person's representative in the deprivation of liberty safeguards in being able to request a review. As you say, the Care Quality Commission as the regulator also has a key role in monitoring compliance. It takes that role very seriously and is looking at what more it can do to enhance it further. The Care Bill adds to its regulatory tools for that.

**Lord Faulks:** Do you think the Court of Protection needs any additional powers?

**John Hall:** Not at present that we are aware of, but there is a very new president of the Family Division. He is also president of the Court of Protection and he will take a view in the discussions.

**Q19 Baroness McIntosh of Hudnall:** Lady Browning has had to leave, unfortunately, or she would have taken you back towards the area which she raised with you earlier in the discussions: broadly what one might call the culture of care and the lessons that you might have learned from the high-profile cases. We have already touched on some of that. Can you say what the most significant findings were as far as your departments were concerned as regards the care being given to people who lack capacity? Can you reflect on a matter that probably exercises quite a lot of people, which is that at the level of implementation, which you rightly identified as being the real difficulty, we are looking at a large number of people giving care who are probably undertrained and certainly underpaid by any standards, given the sensitive nature of the care that they are delivering? Can you indicate in what way you are able from the departmental position to influence the private sector providers in getting them to think about their cost base and where they should appropriately be putting resources?

**Anne-Marie Hamilton:** In answer to the first part about what we can learn from Winterbourne View and other instances, there are specific issues around the management culture within those organisations focusing on, for example, financial targets rather than the care of the people they are caring for and not focusing enough on taking account of an individual's best interest and putting the person at the heart of the decisions being made about their care. In Winterbourne View, the care planning was poor and little attention was being paid to what family and friends were saying and what the individual users wanted. Obviously there were a lot of out-of-area care placements within Winterbourne View which were not being reviewed and the person was not being put at the centre of the decisions being made about them.

In terms of the low-paid workforce, obviously there are legal requirements around the minimum wage. Our Minister has been calling attention to that a lot recently for private providers. They are under a duty to meet those requirements.

**Baroness McIntosh of Hudnall:** I just want to pick you up on that. The minimum wage is very low—we all have to recognise that—and the kind of care that is being delivered is of an extremely personal and sensitive nature. Is it appropriate that the standard that should be applied to care providers is that they employ people at the minimum wage?

**Claire Crawley:** No, it is not. I wanted to come back more generally, although I will not lose sight of that problem. The issue that Baroness Hollins raised earlier was that, interestingly enough, Winterbourne View was staffed by qualified staff; it was not the lowest paid or the poorest trained, and we need to think about how that could be the case. In the statement the Government made, they said that fees for services should reflect the true costs that providers have to pay. It is a hugely challenging environment for care providers. I do not think there is no relationship between low wages and poor quality, but there are other people earning that money who are delivering brilliant care.

There is something else as well as money, and I think you would agree that lots of people do not just do it for the money. They could go elsewhere such as Sainsbury's—poor old Sainsbury's always gets this. It is more complicated than “Cheap, bad; expensive, good”. There is something about culture—I am sorry to keep using that word. It is that culture and attitude and whether we care for the staff in other ways as well as in monetary ways. Do we give them a career path? Do we acknowledge that it is hard work? It is really hard work. I have worked in residential care with some very challenging individuals—and that was just the staff. It is really hard work. Physically it can be quite hard, but emotionally it is incredibly draining and demanding. I do not know that we have really got the culture within our health and social care sector to know how to support that bit of staff. How do we support the person who has had a dreadful day on the ward, or who feels dreadful that they are running around and know that they should be stopping to feed someone, or know that Mrs M just wants someone to sit and talk to her and is terribly depressed and isolated? It is a huge issue. We are aware of it. We are struggling about how we respond, but one of the big things that has come out of Francis is all this talk about compassion and care, and that has to be for the workforce as well. If you have an uncared-for workforce, they cannot deliver good care.

**Q20 Baroness Barker:** In the high-profile cases we have had, what was the role of the safeguarding vulnerable adults boards? Where were they when all this was going on?

**Claire Crawley:** Are you talking about the social workers doing safeguarding investigations or vetting and barring, or both?

**Baroness Barker:** We have had the safeguarding vulnerable adults boards for some time, and the legislation is about to change and put them on a different footing. Following your previous answer, how do we make sure that they do not just have the task but have the ability to make it happen? Secondly, most people who have a relative with a mental health

condition know that there is mental health legislation. They may not know what it is, but if something goes wrong, they know there is legislation. Is the fact that most relatives are completely unaware of the Mental Capacity Act a significant factor in bad practice not being challenged?

**Claire Crawley:** Ooh, there is a lot in there. I shall start with the boards. They are going to be made statutory and to have statutory membership and statutory functions including some more transparency about what they do and about listening to the community and what it wants them to do. Where were they in Winterbourne View? Nowhere to be seen, it seems. One of the things that struck me very forcibly on reading the serious case review that Baroness Browning referred to earlier was that a number of people turned up at the local Accident and Emergency department from Winterbourne View—all from the same place, if not the same individuals—with really quite severe injuries, such as missing front teeth, dislocated collarbones and lacerations, and the A&E staff accepted the staff's word that it was because members of staff had had to defend themselves. In a sense, the whole system has to be much more vigilant and aware because I do not imagine the board knew about that until the serious case review. There is something about being able to spot abuse. The police also took the staff's word for granted. Having the police, the NHS and local authorities as core members of these statutory boards and giving them much clearer functions and powers under the law will make a difference, but it is not a replacement for vigilance, awareness and understanding. I am sorry; I have forgotten the second part of your question.

**Baroness Barker:** It was about relatives' and carers' knowledge of the Act.

**Claire Crawley:** I used to be of the view that knowledge of the Act, a bit like the Mental Health Act, is not so important as long as you know your rights, but my view has changed about that because people feel much more confident in saying, "Actually, this is my

entitlement; you have to do this". This is the work we have tried to do. We are working more with partner organisations because the department has a critical view, but it is a bit like the Government's role with the Human Rights Act. It can do so much, and should support and promote it, but we need every partner in the system to do their part. We need CQC, the local authority and the NHS to play their full part. They are contributors; they are not passive recipients of what the Government do. They have a role in this system. We have a role in ensuring that they carry that role out. Your point about relatives and carers is really interesting because we keep talking about raising expectations and the rising expectations of people who want more from the system and know their rights. Maybe in this case that is not true and maybe we need to reflect on that. When you have much more evidence as a Committee, it will be interesting for us to see our way through that.

**Q21 Lord Turnberg:** You made an impassioned plea for better care for staff, quite rightly. Do you think that the Care Quality Commission has a role when it makes its inspections in ensuring that the staff are supported?

**Claire Crawley:** That was very much part of the conversation I was having with CQC yesterday, saying that care does not happen in a vacuum, we have to recognise that this is a very tough job and asking what is its role and its inspectors' role in supporting improvement in practice and care and looking after staff as well as the people using the service, as well as telling them what they are not doing right. There is something about. Hopefully, we are all in this business for the same reason: to improve the lives of people, to make a good impact. We need to work much more collaboratively to do that and to understand each other. I think there have been too many adversarial relationships between providers and local authorities and between providers and the regulator. We need to work together positively to improve care.

**Lord Turnberg:** Are the regulators perceived as being inspectors with a severe visage or are they regarded as friends to make sure that things are happening correctly?

**Claire Crawley:** I think the former, largely.

**Lord Turnberg:** That is not very helpful for supporting the staff.

**Claire Crawley:** No. Some areas are building on that. Some CQC teams are doing some of that work, but we have really good examples of local authorities or what were PCTs having, for example, small clinical support teams who will go into a nursing home that is struggling with some of the care and help it to build up its standards. That is the approach that we want. This is not about driving people out of business but about keeping people in business and improving their services.

**Anne-Marie Hamilton:** The Care Quality Commission works alongside other bodies within the system. We mentioned the Social Care Institute for Excellence, and there are similar bodies on the NHS side that have a specific improvement function in terms of working with providers in the sector.

**Lord Patel of Bradford:** Just a quick point in respect of the inspectors: I suppose one should recognise that the mental health inspectors of the Care Quality Commission were the old commissioners, who were visitorial members and not inspectors. So one thing there is that their role was never to inspect and always to visit and interview detained patients. That is one element where all the evidence, or a majority of the evidence, was gleaned from actually talking to patients and not from other inspection tools. For me, a lot of Winterbourne View would be tackled if we honed in on that visitorial talking to patients.

**Anne-Marie Hamilton:** The Care Quality Commission piloted a study in 2011-12 around how they could try to understand more from what the users think in terms of the deprivation of liberty safeguards. I think they plan to learn from that in terms of how they

can make that a bigger part of their role going forward, because I think they recognise and would agree with what you said.

**Claire Crawley:** This has obviously given the CQC quite a shake-up, all this. I know they have recognised, for example, the need to return to specialism inspection. It is a big ask of a generalist sometimes to understand all the various types of provision that are being regulated, and they are really looking at their methodology—you know, how do you get actual evidence from people and much better training for their own staff, because actually the quality of an inspection in a sense is only as good as the quality of your inspectors.

**Q22 Lord Swinfen:** Has practice under the Mental Capacity Act led to greater or less involvement of carers and families in decision-making? Have there been tensions between involvement of carers in decision-making and the aims of autonomy? If so, what have these been?

**Anne-Marie Hamilton:** I think we would say yes, it has led to greater involvement of families, as we understand it, in terms of the best interest assessment and the family and friends and carers of people being consulted as part of that decision-making process. I think there are bound to be tensions, and I am sure there have always been tensions between family views and the views of the person involved. The best interest assessments puts a process in place to discuss those views and reach a decision, hopefully as far as possible that the person themselves wants, respecting their capacity to make that decision. It may well be that some family members are not so happy with that outcome, but I think those tensions have probably always been there. The Mental Capacity Act puts a framework in place to enable a decision to be made in the individual's best interests.

**Q23 Lord Alderdice:** The question that I would like to put to you is whether you are satisfied that the relationship between the Mental Capacity Act and mental health legislation is really fully and properly understood, and whether there are any difficulties that arise

amongst practitioners, particularly where there is medical work involved. I draw attention to the fact that I am a retired consultant psychiatrist from Northern Ireland, and have involvement in a number of mental health charities.

That leads on to the second part of my question, which is of course that in Northern Ireland we have had the Bamford review some years ago, which recommended a more unified framework across mental health and mental capacity. It has not been implemented yet; the department of health took the lead on that, and I think there has been a little bit of hold-up in bringing along the Department of Justice in Northern Ireland, despite the fact that the Minister is a former social worker and very keen to see it happening. I wonder if you could perhaps help us understand if you do see any dilemma between the two, and if you think that a more unified approach would be helpful in addressing any problems that might be arising.

**Anne-Marie Hamilton:** The relationship between the Mental Health Act and the Mental Capacity Act is clear in law, but I think you are right that in practice it is not always understood by professionals using it. There are probably particular issues around people detained under the Mental Health Act and whether or not the Mental Capacity Act could be used in those circumstances. Professionals understand and are aware of both, but probably in reality there is confusion about how the two are used in practice. That may reflect the fact that the Mental Health Act has obviously been in existence for considerably longer than the Mental Capacity Act, so it may be a question of time and experience and practice, as people get more familiar with both pieces of legislation. In terms of whether or not it would make sense to bring them into a unifying piece of legislation, I suppose in a sense that they have a different ethos and approach and are clear in law. I am not sure whether that would add value, but it is not something we have discussed with our Ministers, for example.

**Claire Crawley:** We have commissioned some research about this, because we are aware that it is an issue for people, and we have only recently received that so will need to look at

that research and what it says. But one of the things it does say quite clearly, I think, is that within psychiatric mental health settings there is poor understanding of the Mental Capacity Act, so we will need to look at that—and look at it jointly with our colleagues in mental health.

**Lord Alderdice:** You have suggested that one of the reasons might be just because the mental health legislation has been around for longer. Are there any other reasons why it might not be clear in people's minds, as practitioners?

**Anne-Marie Hamilton:** I think the research that we received, which we would be happy to send to you and which reported this year, did particularly identify it as an issue within the hospital settings. Maybe that is because people are more familiar with using the Mental Health Act, which I suppose relates to what I said about use and custom. It suggested as well that there might be issues around the complexity of the process that people need to adhere to for the deprivation of liberty safeguards, and that that might also be something that people were experiencing. So it may well be not only understanding of it, but also “How do you use that piece of legislation in practice?”.

**Lord Alderdice:** Lord Chairman, I would certainly be interested in taking up the offer of sight of the research work. That would be very helpful. Could I just be clear whether there has been any discussion with the department of health and social services and the Department of Justice in Northern Ireland about their approach to Bamford and implementation?

**Claire Crawley:** I am unaware of that.

**Anne-Marie Hamilton:** I am, similarly.

**Claire Crawley:** It might be that we could go back and ask colleagues.

**Lord Alderdice:** I would find that very helpful.

**Claire Crawley:** Okay. We will do that.

**The Chairman:** Again, just a note confirming one way or another.

**Q24 Lord Faulks:** If you could help me, I wonder if you could just give us an example of where there is a potential tension between the two different Acts—a concrete example.

**Claire Crawley:** In law or in practice?

**Lord Faulks:** In practice.

**Claire Crawley:** It is difficult to use Winterbourne View as an example, because so much was wrong at Winterbourne View, but clearly there were people there who should have been treated under the Mental Capacity Act and were not. They were detained under the Mental Health Act—if they were detained at all, actually, because I have sense that some were probably illegally detained, because they were neither detained under the Mental Health Act or the Mental Capacity Act. So in sense, although it is an extreme example, I am sure in lesser severity that is mirrored around the country, I would have thought; it cannot be the only one.

**Lord Patel of Bradford:** Just on that, if any of the patients were detained under the Mental Health Act, then there is potential for a second opinion. Now, that is a big issue if people are almost de facto detained using the Mental Capacity Act, but there is nobody else coming in.

**Claire Crawley:** They have to be reviewed under DOLS—

**Lord Patel of Bradford:** By the local authority.

**Claire Crawley:** Yes. They have to be reviewed, and also people can apply to the Court of Protection and challenge that detention.

**Anne-Marie Hamilton:** Everybody deprived of their liberty through the deprivation of liberty safeguards has a relevant person's representative. They may also have an independent mental capacity advocate. Those people can request a review at any point in the process. So if that is working properly for someone, they can request a review of the deprivation of

liberty. Then, as my colleague said, after a year it would be reviewed anyway, because the deprivation could not be for longer than a year without review.

**Lord Patel of Bradford:** All the more reasons the CQC mental health people need to get back to specialisms, understanding the difference between the two laws, I think.

**Lord Swinfen:** Are the local authorities very often not the people running the care homes or responsible for them, so in actual fact they are reviewing themselves?

**Claire Crawley:** No, local authorities very rarely run care homes these days. The vast majority are in the independent sector.

**Lord Swinfen:** Yes, but I know that some of them are still run by local authorities.

**Claire Crawley:** Very, very, very few.

**Anne-Marie Hamilton:** And I think the Mental Capacity Act and deprivation of liberty best interest assessors have to be separate from the local authority, so that there is not that conflict of interest in those cases where that is the case.

**Claire Crawley:** I think perhaps the biggest challenge is one professional challenging another's judgment and decision, and I am sure that is true in most professions.

**The Chairman:** Lord Turnberg, a final question?

**Lord Turnberg:** I think my questions about the CQC have been asked; we have dealt with those.

**The Chairman:** Well, thank you very much to all of the witnesses for the marathon. You have lasted very well, and I hope you get a well deserved lunch or something from the departments.

**Claire Crawley:** I do not think so.

**The Chairman:** Thank you very much.

**Baroness Barker:** Lord Chairman, I completely forgot to declare my interests. I got stuck straight into the questions, so can I refer people to them in the list?