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Witnesses: Hilary Garratt, Moya Sutton and Dr Katherine Rake OBE

Sheila Scott OBE and Nadra Ahmed OBE

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Members present

Lord Hardie (Chairman)
Baroness McIntosh of Hudnall
Baroness Andrews
Baroness Barker
Baroness Browning
Baroness Hollins
Baroness Shephard of Northwold
Lord Swinfen
Lord Turnberg

Examination of Witnesses

Hilary Garratt, Director of Nursing, Commissioning and Health Improvement, NHS England, **Moya Sutton**, Head of Safeguarding, NHS England, and **Dr Katherine Rake OBE**, Chief Executive Officer, Healthwatch England

Q221 The Chairman: Good morning. Welcome to this evidence session. Thank you for your written submissions. The evidence is video recorded and also transcribed, so you should be aware of that. Can I start by referring to the changes that have taken place in the NHS and the reforms in the NHS, and also the changes in the local authorities and the likely changes in social care? How has the Mental Capacity Act featured in those changes and are the health and social care systems in a better or worse position?

Hilary Garratt: I will open on that question. Our new system, from an NHS perspective, creates opportunities for us. There are two major reasons for that. First, it is a clinically led system now, which is different from the system we had before, which was largely managerially led. It is a system that is based on outcomes and measured on outcomes, which includes patients, experience and quality. That means we are on a journey in respect of accountability for process to one that is more around achieving outcomes for patients, particularly our most vulnerable. Those are the two key characteristics of the changes.

Just to explain the changes, we have got 211 CCGs now across the country that are led predominantly by clinicians at governing body level. To support those we have got 27 area teams that have a medical director and a nursing director with responsibility for safeguarding. At CCG level, I should mention that each CCG has to have a lead for the Mental Capacity Act and safeguarding.

We have got 27 area teams and then we have four regions. Of the four regional levels, we have got two key people giving a clinical perspective: the director of nursing, who is responsible for safeguarding, who works in partnership with a medical director as well. That just gives you a flavour of how we have put leadership for safeguarding and the Mental Capacity Act at every level of the system.

At national level, we have got an accountability for safeguarding and the Mental Capacity Act invested in the Chief Nursing Officer portfolio, and I work directly for the Chief Nursing Officer in my director capacity for NHS England. Moya, who I appointed some six months ago, is our Head of Safeguarding. Throughout that whole system, we have got clinical leadership at every level and, with that, an accountability for outcomes as well.

The other big thing that we need to take advantage of, which has the greatest opportunity to work, is the establishment of our partnerships—partnerships locally between CCGs, health and wellbeing boards, local safeguarding boards for adults, our regulators locally, and with the whole range of providers, including the third sector. It is working through those relationships in a new system that we need to take advantage of.

Then we have our partnerships nationally with NHS England, the Department of Health, our regulators, Health Education England. That is demonstrated for one through the new national steering group, which you may have heard about, through the Department of Health. That gives a national steer on the Mental Capacity Act. We have got other forums too, where we work with the Department of Health and other national bodies.

To steer our practice, in terms of mental capacity and safeguarding, we have an assurance and accountability framework for safeguarding our vulnerable people. That sets out clearly our roles, responsibilities and the duties of NHS England at all levels of the system. It sets out how we have to work clearly in partnership to discharge those duties. I will just stop there in case you want to ask any questions.

The Chairman: You are setting out the duties on various people, but what systems are in place to ensure these duties are implemented?

Hilary Garratt: It is a national system. I chair a national safeguarding board for adults and children. On that, we have representatives from each part of the system in NHS England. We have designated professionals, clinical leaders from CCGs, from area teams, from regional groups, and we have clear work streams there. One of the work streams is making sure that we have got clear implementation of the Mental Capacity Act. We have done some rapid appraisals about where we are in terms of capability, confidence, training, etc. Locally, we have local safeguarding forums for each area team, which bring together safeguarding experts from the CCGs that they support and, equally, they do the same. At a local level, our CCGs and area teams are present at local safeguarding boards as well, and some safeguarding boards have sub-groups—sub-boards—that clearly focus on the Mental Capacity Act as well. So, again, it is mirroring the partnerships nationally. It is mirroring those locally and making sure we have shared protocols and shared arrangements.

Q222 Baroness Andrews: Can I ask you to go further into your particular statement that you have done appraisals of where we are? I know that at a time of enormous change—top to bottom, sideways and everything else—it is not going to be easy to hang on to some of the professional understandings because teams will have changed, expertise will have moved and so on. It is obviously really important that what is understood about the MCA and

where it is understood is held on to. Can you say where you are without going into huge structural descriptions?

Hilary Garratt: I am very mindful of the changes and the potential loss of expertise. In April—first of all within the first couple of months—we did a rapid appraisal and, within that, we asked frontline staff at CCG level, representative of a number of CCGs nationally, three key questions: A) have you got a Mental Capacity Act lead and what is their background? B) have you got access to training and advice when you need it? The third question slips my mind.

Moya Sutton: The third question related to the changes from 1 April with regard to the local authority becoming the supervisory body and whether that arrangement had impacted adversely and negatively on the system. I think, if I can perhaps take over from Hilary here, the focus of the questions was very timely for us, prompted by, I have to say, the House of Lords inquiry, because it made us want to test at the frontline how things have moved in a very short period of time.

You are absolutely right: holding on to teams and organisational memory with such major change is obviously very challenging. It is fair to say that we were quite impressed with the response. The rapid reference group responded through the CCGs to say that they felt there was great support with the local authority arrangements and that they had access to advice as and when they required it.

There is an issue with regard to training—we know that—and inconsistency of application. Certainly, after today, that has prompted us to further interrogate a number of key areas. Although we have asked a number of CCGs about the new arrangements, what we want to do is ask every CCG about the new arrangements. What we do not want—we do know there is regional variation—is the CCG in Sefton absolutely flying the flag and everything being fantastic, and our vulnerable patients and families having access to fantastic service and

then, down the road in Knowsley, you have got a completely different set of systems. However, the initial feedback was positive, and we are pleased about that.

Q223 Baroness McIntosh of Hudnall: I just wanted to ask you about this much-used phrase “culture change”, which has come up both from people giving us evidence and in the discourse as we have gone along. There is frequent reference to the need for culture change in order for the provisions of the Mental Capacity Act to be better understood and implemented. First of all, how do you go about creating culture change, particularly within the NHS, which is a very complex organisation and operates at many levels, as you have just described?

Also, it has a systemic responsibility. Clearly, there are areas where it operates at the micro level, but it is a macro-policy level certainly that you are operating at. In particular, can you identify whether there are any aspects of the way that people view the Mental Capacity Act that might make them anxious about implementing it or understanding how to implement it? One of the examples that has been put up to us is that, at a ground level, as it were, people are anxious about the possibility of becoming embroiled in litigation—court cases—and that makes them nervous and not as front foot, if I can put it that way, as they might need to be in order to make the Mental Capacity Act work well. Do you have any reflections on that?

Hilary Garratt: I will open that in terms of the general response around culture. One of the things we have learned through some of national cases—Francis and Winterbourne—is the need to return to the basics and to have clear expressions of what our values are. Throughout the strategies that we have developed in NHS England, we refer to what we call now our six Cs. I will just refer to that.

This was developed by over 10,000 clinicians and care staff, predominantly led originally through nursing—there are a lot of us—but it is inclusive of everybody; it relates to everybody who works in the NHS. It contains a clear articulation—this came from the

frontline—that we need to go back to express what we were trained to do and what we came to do. We have got the values of care, compassion, competence, communication, courage and commitment. However, they are not just words; we have got clear action areas that will support us to implement these. Those action areas are leading to some clear changes, which gives us more confidence. We are just about to issue some guidance to the system on getting the staff right within organisations in terms of using evidence-based tools for making sure you have got the right amount of staff at the right level at the right time.

There is also a work stream, for example, on measuring culture, but we need to do that frequently, so it is not just a one-off test. We need to make sure that in measuring culture we are measuring how staff feel, how patients feel and how we correlate that with patient outcomes. Investing in leadership is really important to us as well. We have invested quite a significant amount of money to make sure that our ward managers and team leaders in the community get the right leadership development and we give them the confidence to do the right things.

Measuring outcomes is a real clear action area in there, and we need to be transparent about those outcomes as well. They include patient experience—how people feel about the services—and making sure that the correlation, as I said, between positive staff and positive patient experience is really clearly demonstrated.

The other thing about culture is really making sure our medical leadership of the CCGs—clinical leadership of the CCGs—is a real signal generator and role model for these values. We need to make sure they have appropriate value-based conversations with their other colleagues—be that in primary care or within any provider, with the local authorities, in terms of partners or whatever.

One of the key features is to make sure we recruit for values and retain for values, so people's PDPs and appraisals feature value-based competencies, and that we get feedback

from patients on how people are performing as well. The other really key thing for us is about fostering teamwork: nurses influence doctors; doctors influence allied health professionals. It is that sense of teamwork that gives patients more confidence that they are being cared for in a holistic way. The measurement of values has to feature in all that we do now, and this will be a journey. We are talking about the measurement of values we need to measure an individual's performance on, and values of teamwork performance on values and organisational work performance on values as well.

The other thing about values is that we need to collaborate at a local level so we develop early warning systems, which will give us a sense when the culture is not quite right. We really need to keep an eye on safety, quality and performance issues at a local level. That is where our commissioners, providers, regulators and partners get together locally through our quality surveillance groups, so that they can have honest discussions around culture and values.

Q224 The Chairman: Can I just stop you? We are fairly constrained for time, so it is important that you try to get the message over as concisely as possible. Can I move to Dr Rake to see what contribution you wish to make at this point?

Dr Rake: Thank you very much. Just to briefly introduce the new role of Healthwatch: we are a new organisation, with Healthwatch locally in 152 local areas. We have been specifically tasked to look at the health and social care system through the eyes of the individual consumer. You get quite a different perspective, so I just wanted to reflect a little bit both on the reforms that you were talking about and the cultural issue.

One of the things I would say around the reforms is, whilst there is an enormous potential there, individuals are actually incredibly confused by the array of reforms that we see currently. Clearly, one of the culture changes that we need to see happening across health particularly, but health and social care, is the move from the practitioner knowing best and

doing to people, to where individuals are feeling fully empowered and engaged as individuals. We know that currently people do not feel adequately listened to, engaged and involved in the decisions that affect their lives. Whilst, clearly, professional competence and expertise is absolutely critical, it is only a part of the issue and the individual also brings their own understanding and knowledge of their condition and their outcomes.

Part of our role is really to be independent of the system and to operate as a national challenge, but also locally, to make sure that the policy statements—the strong policy statements that you have in the MCA and elsewhere—are reflected in reality. One of the pictures that we are seeing right across the country is of enormous diversity. We think it is absolutely critical that we narrow the gap between policy practice and we use every tool possible to do that—not least the inspection regimes—making sure it is properly embedded in training, but also that we work locally with those who are consuming the services to make sure that they feel empowered in order to challenge and take up their rights.

Q225 Baroness Hollins: I want to ask about the response to Winterbourne View and the confidential inquiry for people with learning disabilities and premature mortality. I also wanted to pick up on this issue of culture, because the responses have been very much about the role of clinicians in establishing the culture. I pick up from doctors and psychiatry that actually non-clinical managers are often seen as constraining a values-based approach. I just wondered if you had a quick comment, any of you, about the role of non-clinical managers in culture change.

Hilary Garratt: The six Cs apply to everybody working in health. They equally apply to non-clinical managers. It is part of what I said before: making sure that appraisals are based on values as much as managerial competence. Training equally applies to non-clinical managers as well, so I do not really see a distinction there.

Baroness Hollins: Of course, but I suppose I just wondered whether you had picked up any concerns about those issues.

Moya Sutton: Certainly my experience working in a number of provider trusts has been that there has been a move over the past few years to develop what is commonly known as clinical business units. Now forget the word “business” for a moment in terms of this conversation. The power of that particular organisational culture that is prevalent in provider trusts is that, within those units, they have non-clinical managers working very much in partnership with a senior doctor—a senior clinical director—and a senior nurse at deputy director or assistant director level, so that they can all try to understand the impact of managerial decisions on clinical practice and vice versa.

I would say that it is perhaps not 100%, but certainly there are areas across the country where that tripartite relationship works really well. I think the opportunity is to really ensure that, at board level, at governing body level—and it is what we have seen following the Francis report—the clinical outcomes and the outcomes for patients are absolutely the critical key performance indicators, indicators of success, alongside any of the other information that the non-clinical manager may have to assure themselves on.

Baroness Hollins: I suspect that there may be some barriers there to achieving culture change, but let us move on.

Q226 Lord Turnberg: I just wanted to follow up on Dr Rake’s comments about Healthwatch. What she said chimes very much with the evidence we have been receiving, but I just wonder: who listens to you? Where do you put your influence? Can you get anyone to do anything in response to your comments?

Dr Rake: At a local level, Healthwatch has a statutory place on the health and wellbeing boards and so has some influence at a local level, and they also have the power to escalate to us at a national level. We have advisory powers over quite a wide range of bodies: the

Care Quality Commission, Monitor, NHS England, each individual local authority and, critically, also the Secretary of State for Health. Whilst people are not obliged to take on board our advice, they are obliged to respond to us in the public domain to our advice. We feel that that would give us some strong statutory authority, with a strong evidence base. One of the issues we are wanting to deal with is building an evidence base from the grassroots up in relation to what the application of things like the MCA is like at a local level, and to take that right up to the national level. So there is a local level influencing role on the health and wellbeing board, and then our specific statutory powers over that wide range of bodies.

Lord Turnberg: Have you any examples of where that has worked?

Dr Rake: Not yet, because we are a brand new organisation and one must use one's statutory powers advisedly. That certainly keeps them sharp. However, we will be doing so and we have already raised concerns right across the health and social care system with the operation of complaints advocacy and the complaints system. We think there is a very critical issue with IMCAs and making sure that, where people have worries about how the Mental Capacity Act is being applied, they have ready recourse to independent mental capacity advocates in order to make sure that their concerns are quickly and appropriately redressed. One of the advantages, if you like, of our very broad remit across health and social care is that we see the breadth of the challenge around making sure that we get an effective complaints and concerns system.

Q227 Baroness Hollins: The Government is looking very much to NHS England to respond to Winterbourne View and the confidential inquiry into the premature mortality of people with learning disabilities, who are a particularly vulnerable group. There have been very serious failings. How does NHS England work with the Department of Health in its

response—in planning its response—and how are you making sure that the Mental Capacity Act is fully embedded in the way that you are responding to these failings?

Hilary Garratt: We have been working very closely with the DH, and the response to Winterbourne is a specific example. We have got a concordat that sets down our actions clearly and we have key people in post that are focusing on those actions, mainly around people and place. What was the second part of the question?

Baroness Hollins: It was really: how are you working? You are working with the Department of Health on the Winterbourne View response, presumably.

Hilary Garratt: Absolutely. So, we are clear about the actions that we need to take. We have got clear governance structures within NHS England, so we can report on progress with clear timelines and key people's names. We have invested support so CCGs are clear about their responsibilities and we are tracking progress. I am not sure you are aware of some of the actions, but we are tracking everybody with learning difficulties who is receiving care to make sure that their plan is personalised and that they are receiving care in the most appropriate place.

Baroness Hollins: Can I just interrupt you for a minute? One of the difficulties, for example, arising from the confidential inquiry is the difficulty in identifying people with learning disabilities, and I wondered whether you were doing anything in response to that as part of your response.

Hilary Garratt: Yes. We have some resource allocated to that. We are working at a primary care level—at GP practice level—to make sure that they are identifying people appropriately with learning difficulties. We have a register.

Baroness Hollins: That has been in place for a really long time, but what about when people arrive in hospital because that is where the simple failings really seemed to show there was an issue? A lot of the failings were in hospitals, were they not?

Hilary Garratt: Yes. Again, it is about providing support to providers as well. I was going to come on to that. We have got primary care and we have got provider support as well; making sure we have people in the right places who can support people when they need support and obviously work through into making sure that they have got the right package of care. There are clear work streams associated with the Winterbourne recommendations and a clear line of sight, so that gets reported at board level through appropriate structures.

Baroness Hollins: Is the Mental Capacity Act—the use of the Mental Capacity Act—embedded in the response?

Hilary Garratt: What we need to do is go back and check that. We are investing resource. We have advertised for more resource to come into NHS England to do that cross-check in terms of what we now know from the mental capacity review that we have done. We have to go back in terms of Francis and Winterbourne to make sure that, in relation to the Mental Capacity Act, the actions are as strong as they can be in terms of recommendations.

Moya Sutton: Just very briefly, your comments are very well made about the failings in the provider trusts in hospitals. Certainly my experience has been that, over the past year, board reports have had to be presented to the board outlining progress against the Monitor framework around caring for patients with learning disabilities. Certainly some of the good practice that has emerged is that, once a patient is identified as having a learning disability, they have a bespoke passport that they bring with them whenever they are admitted to the A&E department, which sets out their personal-centred planning requirements. There is a lot more to be done in terms of really focusing and using the six Cs on caring for patients who have particular needs with learning disabilities and really trying to get the system understanding what their requirements are—what the patient's needs are.

Baroness Hollins: The difficulty is about identifying people. You said, “Once people have been identified”; do you think the Mental Capacity Act will help people to identify?

Moya Sutton: I think it is probably a question that will come in a moment. Our horizon scanning of how the Act has been implemented and where it has touched patients and frontline practice shows there is a whole range of inconsistencies. There are some individual approaches to how the Mental Capacity Act is viewed, which is perhaps not in the best interest of our patients. There is a huge piece of work to do in terms of training staff and getting some expert within NHS England who has got this subject matter and is really leading on this subject matter to help us move forward. There is still a fair way to go. In truth, we started to put a forensic lens on what the issues are here, which is very helpful. What we need to do now is to identify those things that need to be put in place to address those sorts of issues and be held accountable on that.

Q228 Baroness Barker: I have two questions—I have a question and a supplementary. I would like to ask the first question primarily of Dr Rake. On the relationship between the Mental Capacity Act and safeguarding, how does the work of your organisation contribute to ensuring that there is an appropriate balance between safeguarding and empowerment, given that you work principally within medical settings?

Dr Rake: We work across health and social care. We are there as a watchdog. We have a watchdog function at a local level. Our role for local Healthwatch is to signpost people to appropriate support at a local level and, where they have direct concerns, to make sure those are escalated. It is useful to have this question, because it follows on in a sense from what is going to be the response to Winterbourne View and the other tragedies that have affected the health system. One of the responses is that we do need to make sure that appropriate early warning systems are in place. That is a responsibility across a whole range of organisations, but we have taken that responsibility particularly seriously with the new inspectorate regimes.

We have had early meetings with the new Chief Inspector of Hospitals, the new Chief Inspector of Social Care and we are due a meeting with the new Chief Inspector of Primary Care to make sure that, where Healthwatch locally are hearing concerns either directly from individuals or from family and friends, they are either escalating that directly into safeguarding or they are signalling to the inspectorates that there are issues at a local level, so they can upgrade their inspection function locally.

We are not there to do safeguarding and are not there unfortunately in all instances to do complaints advocacy, although we would very much like to be in a position where we could offer that sort of service across the country. But at the moment, as you will be aware, those sorts of complaints advocacies are commissioned locally and it is a matter of local discretion as to exactly how that is commissioned. One of our concerns is making sure that we have a more consistent offer of support to individuals that are concerned around mental capacity, but also around health and social care issues in general, so that they know where to go to get the support they need if they have got a concern or a complaint about the services they are receiving.

The Chairman: Did I understand that you would like to take over the responsibility for complaints advocacy?

Dr Rake: Currently the system is enormously complicated and very few people are aware of that support function or what to expect when they access that support function. At a minimum, we would like to suggest some standards for complaint advocacy across health and social care. But we also think there is a piece of work to be done to raise awareness of the fact that you can get support if you need it, and we think we have a powerful brand offer in that space.

Q229 Baroness Barker: Following on from that, to NHS England, is it correct to say that your work on the Mental Capacity Act is carried out and evaluated through safeguarding

objectives? If it is, is that appropriate? How do you ensure there is an appropriate balance between safeguarding and empowerment?

Moya Sutton: Certainly, safeguarding within the new structure incorporates a whole range of areas—from child sexual exploitation right the way through to safeguarding adults. Certainly, we felt that the leadership, cultures and values of individuals working in the safeguarding field were perhaps appropriately equipped to also lead on the Mental Capacity Act agenda. It is fair to say that what we have been trying to do since we came into being is to establish some very high level and very practical leadership development programmes for the new system, so that we can make sure that everybody has access to the appropriate training and information and support as necessary.

It is probably fair to say that we have found some areas where somebody may have a whole gamut of experience of child safeguarding and perhaps needs further development in terms of adult safeguarding. It is fair to say that we have recognised that. It is a very interesting point. We talk about, certainly in NHS England, the importance of safeguarding and safety being hand in hand, and that the Francis inquiry was about safeguarding individuals, not about clinical issues. It was about a myriad of issues. However, for me, there are a number of points where we have to be very clear about the balance between safeguarding and empowerment. That is about our staff—our frontline staff—being very clear about capacity. It is being very clear about the risk of our patients making unwise decisions, and managing those risks and allowing them the liberty to make some of those decisions.

That is about people understanding that this is not about being subjective; this is about being very objective in your assessment. We hear examples up and down the country whereby we have patients perhaps that have been admitted to residential care homes, where there have been some issues and the home staff have thought, “We need to actually deprive this

individual of their liberty because they are trying to leave and are a risk to themselves and to others.”

We use this piece of information. It is actually very helpful as a training tool, but it needs massively updating. It talks about the power of really thinking about the patient’s safety, thinking about the patient as a person or the person as a person—the resident as a person—and really understanding why they are behaving in the way that they are behaving. We have examples where we have had residents wanting to leave the home and being very concerned about their safety. Actually, when they have really tried to understand the behaviours, what they have recognised is the individual was a prolific pianist, was a librarian, or loved gardening, and she or he is in a setting that is alien to them. They have lost all their connection with their past, and we have been able to demonstrate that, when we have really tried to understand the person as a person, we have actually been able to empower them to be safe without taking specific steps to stop them being an individual.

That is where we hope, as NHS England, we can try to embed this across the whole of the system—that our patients should be empowered and that we should support their decision-making. I would hope that we will try to strike that balance between safeguarding and empowerment. However, it is difficult, and if you speak to some of consultants, they would say that they think perhaps our patients are making unwise decisions, so there is a lot of work to be done there.

The Chairman: We have a lot to get through in a limited time. I wonder if witnesses could try to keep their answers to the point and be as concise as possible.

Q230 Baroness Shephard of Northwold: In oral evidence, the Department of Health has argued that it is the responsibility of NHS England to address the regional variations in the applications of deprivation of liberty safeguards. Now, we have had mention of regional variations already in a slightly broader context. Do you agree with the fact that they are

placing responsibility on NHS England and, if so, what are you doing to address variations? In your answer, would you like to give perhaps a very brief example of the kinds of variations that you are experiencing—in other words, best and worst?

Moya Sutton: We have got a number of sources. I will try to be very succinct. We have got the national steering group which is led by DH, of which we are an active partner. We have met once. We have been given a list of homework to do, which we are currently compiling. What that is asking from NHS England is: what data sources do we currently have; what information are we collecting; what information we would like to collect; where is it showing best practice and not-so-best practice? I think it is fair to say that what we found when the Mental Capacity Act was implemented in 2005 and then over the subsequent years was that we had national and regional leaders gathering some of this data. Now, under the new system, that has become quite fragmented and we are going to appoint an individual, as I said, to try to develop a minimum data set for NHS England to be really clear about the information that we need to collect.

It is about staff that are trained. It is about leadership at every level. It is about how many DoLS referrals have been made and what the outcomes of those DoLS referrals have been. It is also about the patient experience and where we have found frontline staff, patients and their families understanding the processes. We have some great examples in the Midlands, in Birmingham, where they present to their safeguarding adults board a whole myriad of data that they collect showing performance against some key performance indicators. We have some examples in Yorkshire, in the Barnsley area, of frontline investigation with staff about their understanding of mental capacity and DoLS. We want to try to get the minimum data set for both qualitative information and quantitative information that sets the benchmark. Then it will be easier for us to see where those variations are happening and where we need to put some of our efforts.

Baroness Shephard of Northwold: What would you do with those that are performing the least effectively? How would you actually deal with it?

Moya Sutton: We need to understand what the issues are. If there are fundamental failings in terms of not achieving targets that have been set for training staff, etc., then we need to put a focus on the governing body or the board in terms of what those issues are and how we can support them. We have to be supportive in terms of trying to get the system in place, but then I think we have to be very critical and challenging where we have got areas of outstanding practice compared with areas of practice that is not acceptable.

Baroness Shephard of Northwold: Do you have meetings with providers of Healthwatch as well?

Moya Sutton: Most definitely. We ran a national conference two weeks ago last Friday on safeguarding, and Healthwatch colleagues were at that conference. I suppose, as you said, Katherine, these are fairly new relationships that we are needing to develop, but certainly that intelligence, and the intelligence from our quality surveillance groups, should focus our attention on areas where performance is not acceptable.

Dr Rake: The general reflection is the direct levers for improvement are complex, and we are very concerned that regional variation will become even more of a pattern across health and social care. I am very keen that we do everything we can to raise where we have got concerns, but the ability to directly intervene has become very complex.

Q231 Baroness Browning: Hilary Garratt was talking about a measuring culture, but the only real tangible statistics in relation to the MCA are really around the provision of IMCAs and also the application of DoLS. Without wanting to ask you to go into the tick-box culture, I wonder if you have got any suggestions to make about how we can gather and quantify so that we can evaluate statistical evidence about how well the MCA is working, given that it covers such a wide range and you have got the geographic spread as well.

Moya Sutton: I think it ties into my previous question. What was very helpful at the national steering group, which had representation from Public Health England, Monitor, CQC, Social Care, etc., was that we recognised we do not collect an awful lot of information in terms of the effective implementation of the Mental Capacity Act. I suppose, going back to being very clear about the national minimum data sets, we can compare areas and try to minimise the regional variation. However, the importance for us is it is not just about collecting the data; it is about what the experience was, and the equality and diversity issues of accessing support, etc. Do we know—and I do not know if we do know—how many of our IMCAs are accessing interpreter services if they are required, etc.?

I think we can gather data at that level, but it does not really describe the cultural impact of: so what difference did the Mental Capacity Act make to that patient, that family, etc.? I think we know what the issues are; the challenge for us is to try to get the system in place whereby we can be really clear about the outcomes.

Baroness Browning: You did mention earlier, for learning disabled people, the use of the personal passport. I am a great fan of the personal passport because they cover more than just the learning disabled; I can see all sorts of things. Can you just explain this to us? When somebody has a personal passport—we have had examples of them given to the Committee—who initiates that someone needs one and where do they tangibly, physically, get the passport from? It seems to me that if they arrive in hospital, they could be given one in hospital and people help them fill it in then. However, that patient experience is all about them and their having an input into it. How does that work in practice? Presumably, the use of a passport could also be an indicator as far as the MCA is concerned.

Moya Sutton: That is a very valid question. I would cite, as an example, my experience of working in a provider trust that cared for patients with neurological difficulties. We worked with an outstanding mental health trust that had learning disability services—Mersey Care,

who are, in my view, real exemplars of working with people with learning disabilities to empower them to describe, through whatever medium they can, their own particular personal needs.

It is probably fair to say that, in a huge acute trust, having that focus is probably more of a challenge. I am a great fan of them, not just for, as you say, patients with learning disabilities but for patients who are terminally ill and who want to describe their wishes. I am also a great fan of using them with babies—parents describing what makes their baby happy when they are not at the bedside.

This is a piece of work that nationally we would want to champion using the best in the business. Our national steering group, which is very much about the minimum data set, is one particular body to which we have worked, but we also have our own NHS England steering group. We want to have a work stream looking at all of these issues after this inquiry, and we will appoint a lead, as I said, who has that expertise, so we will be able to demonstrate some really good practice going forward.

Q232 Lord Swinfen: NHS England is the commissioner of primary care. How do you ensure that GPs and other providers adhere to the Mental Capacity Act?

Moya Sutton: It is a challenge. I think it would be unfair for us to say that it is not a challenge. In the new system, the area teams are responsible for managing the performance of primary care. We have to look at it at a number of levels. We have got GPs that sit on the governing bodies of the CCGs. We have got GPs who work in practices as a federation of GPs. Then we have got the individual GP. Training is an issue; we know that. What we also need to consider is using appraisal, using revalidation, using the standard contract, and using leadership at the area team level to work with our GPs. Most practices do have a safeguarding lead. We have got to really work with them to support their leadership at a

local level of safeguarding generally, including mental capacity. It is an issue where we have got a lot of work to do.

Hilary Garratt: It is also about working with our Chief Inspector of Primary Care to make sure that we can support them as regulators to enable GPs to be the best practitioners they can be and also the best employers they can be as well, because they obviously are independent employers of other staff too.

Lord Swinfen: Thinking of my own GP and practice, it is rare to see exactly the same GP each time. Do you find it easier to work where GPs see the same patients the whole time, or the same families the whole time, so that they build up a picture of the patient? Very often they seem to be coming to it absolutely cold.

Moya Sutton: That is a very valid point. I think any of us would talk about the positive experience of seeing a GP that knows you and your family, and can really understand the community and the environment in which you live. Where possible, we would want to aspire to that. I think our Chief Inspector of Primary Care would want that to be an aspiration and an ambition. Practically, it may well be something that is challenging in some areas, as opposed to other areas. There is the whole debate about out-of-hours. We are trying to really bring that clinical focus right through the CCGs to the local primary care services to try to get some safe systems in place in terms of really understanding family need.

Q233 Lord Turnberg: The CCGs have got to have an MCA/DoLS lead. What requirements do you place on CCGs to have that, and have any been refused authorisation because they did not meet the standard?

Hilary Garratt: You are absolutely right. The relevant criteria for CCG authorisation is that they did have to have a DoLS lead, a clear job plan and clear policies and procedures to support the role. As I said before, after the authorisation, we did a rapid appraisal about who the people were and whether they were confident, etc. Were any CCGs refused and

delayed? Yes. They were not refused; they were delayed authorisation with conditions. It was just a couple actually, who were in the process of recruiting. Those delays—delaying authorisations or authorisations with conditions—have now been lifted because recruitment is complete. I think that demonstrates that we do have rigour in the assurance systems.

Through our national steering group work, we are now supporting area teams to dig a bit deeper in terms of their competence—MCA lead competence at CCG level. Through their regular governance meetings, they can have a more in-depth conversation and more in-depth review of what is happening locally at CCG levels in terms of their being able to exercise their duties under the MCA.

Lord Turnberg: From what you say, it sounds as if you have set up all the processes and the mechanisms to ensure that things happen in the right way, but what we hear on the ground is that there is a long way to go—a discrepancy between what you are putting out and what is happening. How do we fill that gap?

Hilary Garratt: First of all, it is about being realistic about the challenges and getting to know what the challenges are. Through the rapid appraisal and the deep dives we are doing now, we are getting to grips with some of the issues that Moya and I have already highlighted in terms of confidence, training, and the ability to be exemplars of personalised care. It is using our resources wisely to make sure that we fill those gaps through areas we have already highlighted. Another one is information: the minimum data set, how to performance manage, and how to support people.

Lord Turnberg: I suppose you produce all those very nice documents with all the right words in them, but does anyone read them? That is part of the problem.

Hilary Garratt: Some of this is about having the right clinical conversations at the clinical level with patients, with communities, with the public and with our partners. It is the human application of what we have described.

Q234 Baroness McIntosh of Hudnall: Since you have used the word “human”, can I pick this up and take you back to the question I asked some while ago about the impediments to people being able to fulfil the obligations that you are asking them to meet? It often is not about whether they have got the right documents or whether you have got the right documents; it is often about how they feel. What I am wondering is whether you have identified, or have ways of identifying, what the obstacles are. What are the fears and the apprehensions that staff who are actually having to do this stuff feel may make them less likely to do all the things that you, quite rightly, want them to do?

Moya Sutton: It comes back to the culture and it comes back to the training. Because I have worked at the frontline and I have managed nurses who have sought advice with regard to mental capacity and DoLS, I know that it is an area whereby they need to feel very confident in their decision-making. Certainly, going back to your point about it being all very well having the documents, I can guarantee you that this was produced by NHS Midlands and East. Around 20,000 of them were issued to frontline staff. It is an aide-memoir. They keep it in their pocket. It is very easy to assess capacity using the tools within here. They have actually asked for us to update this and to put it on a mobile phone as an application, because they want to be able to get the right information to help them make the right decisions. They are faced with so many other challenges that they need the best tools. In the ambulance service across the North, what they produced was some keyrings with some capacity-assessing information, so if they arrived at a house, they could very quickly remind themselves. It is a specific area whereby we need to give more confidence to the frontline practitioners. You are right: there is an issue perhaps with people being concerned about litigation, and that comes back to a lack of real understanding about what will happen if you do and what will happen if you do not. Actually, if it is the right thing to do it, let us make sure that the structure in your organisation supports you to make that right decision.

Dr Rake: Imagine the power of that multiplied if you had an equivalent tool in the hand of the individual or family and friends. I do think one of the challenges here in terms of narrowing the gap between policy and practice is to recognise that there are several people involved in this transaction, and actually the most important person is the person receiving the services. We need to make sure there is an equivalent weight on the kinds of tools that empower the individual consumer as well.

Q235 Baroness Andrews: This is another variation on the training question. First of all, can I ask you: what are the terms of reference of the national steering committee that you have been referring to and on which you now sit, which is obviously very recent and is, for example, collecting data? Where, in those terms of reference, does training consistency feature?

Hilary Garratt: This is the multi-agency training group I have been referring to. I do not think we have the terms of reference with us, but they do centre on establishing what the gaps are and how we can offer mutual support.

Baroness Andrews: Mutual professional support?

Hilary Garratt: Organisational support.

Baroness Andrews: Including Healthwatch, we were told.

Dr Rake: I am not aware that we are a member of that group. I do not think we are.

Hilary Garratt: I do not think you are a member of the group. We have the membership with us. We will just make a quick reference to it.

Moya Sutton: I will find it—carry on.

Hilary Garratt: This is from memory: minimum data set; making sure recommendations are carried forward from particularly this inquiry. Those are the main things that I recall from memory.

Baroness Andrews: However, you are not addressing these longer issues, quite clearly. I am thinking of the direction, quality and consistency of training.

Hilary Garratt: We are looking at consistency of training. We have Health Education England on the group.

Baroness Andrews: Very good. You have referred to training a lot and you talked specifically about doctors. You have talked about having tools for nursing and care staff. What is the real priority in training? If you could do something over the next year, which group would you focus on and what would you do that would be different? Secondly, how does this feed into the new CCG requirement? Is there a requirement on CCGs to take some of this forward as well?

Moya Sutton: I would not want to say, “Well, let’s just train the GPs and put our focus there.” I think we cannot do that. This agenda is too diverse for us to put our attention in one area. It is about frontline staff across the whole board. How would we do it different? My experience has been that the difference—and I would equate it to the difference of multi-agency training for safeguarding children—is that when you put professionals around a table with a virtual situation in the middle of that table, they talk about the importance of the individual and what the individual wants. I absolutely endorse that fact. We have to put our patients, residents and service users right in the middle of this—not do it to them but work with them on this agenda.

Multi-agency training, using scenarios and thinking about the contribution that you as individual practitioners make and what outcome you are looking to achieve based on the needs of the individual is absolutely critical. Where I have seen that work really well, it has been empowering for the practitioners, but it has been majorly empowering for the individual.

Baroness Andrews: So it is cross-disciplinary, and that includes the care staff as well.

Moya Sutton: Most definitely.

Baroness Andrews: Absolutely. And it is patient focused, with the patient with you helping to inform your own training.

Moya Sutton: Personally, I think there is great benefit from doing that. I am a real admirer of patients and families being involved in interviewing and recruitment. We know that the CQC new inspection regime with regard to outcome-driven care certainly for children is about really listening to the voice of the child and the family. We know that when the CQC inspect organisations against learning disability care, they will be taking patients and families with them. I think that this agenda is growing in its importance.

The Chairman: Thank you very much. Before you leave, could I ask you to send to the clerk the terms of reference that you mentioned and also the various pamphlets that you have referred to? It might be useful if we had a copy of them so that they can go into the record—and a copy of the membership of the steering group. Thank you very much.

Examination of Witnesses

Sheila Scott OBE, Chief Executive, National Care Association, and **Nadra Ahmed OBE**, Chairman, National Care Association

Q236 The Chairman: Good morning. I do not know if you were present when we started the other session, but this is recorded and also transcribed. Welcome to this session and thank you for your written evidence. In your written evidence, you expressed the view that the Mental Capacity Act is one of the most important pieces of legislation relevant to care homes that has been implemented in recent years. Can you maybe just expand on that?

Sheila Scott: Certainly. I truly believe that. The National Care Association believes that too, but I truly believe that this was the most important piece of legislation. We get a lot of individual pieces of legislation, but this was something new and ground-breaking. This was something that social care providers, often working alone, with various qualifications, could take, and if they implemented it properly, not only did it give confidence to the families of the people they were caring for who were being assessed under the Mental Capacity Act, but it also gave a framework within which care providers and their care staff could operate. They knew—or they know, because we have told them—that if they implemented it properly, if they made decisions within the best-interest framework, even if sometimes it did not work quite as well as they had anticipated, then they would be protected. The work that our members do is some of the most challenging work that there is: working with people with dementia and people with very serious conditions that mean that they do not have mental capacity. Before that, there was a bit of hit-and-miss. Now, we do not think it is hit-and-miss.

The Chairman: Do you have anything to add to that?

Nadra Ahmed: I would just endorse it. It was very welcome. Once we were able to get the message out, providers began to see the positive impact this could have within their services, and they have embraced it. It is an important piece of legislation.

The Chairman: You referred to best interests, but to what extent do you take into account the need to empower the residents?

Sheila Scott: Absolutely, and it is one of the most difficult decisions. This Act of Parliament did empower younger adults with learning disabilities in particular, particularly those where families and the staff of care homes were very protective, to do an assessment. Sometimes, the person had capacity to make an individual decision; for other more complex decisions, they do not have the capacity. However, how to implement this has been quite a challenge

for care homes, particularly those for younger adults. We undertook some awareness training in the very early days on behalf of the Department for Constitutional Affairs, and we had a parent who was also a care home owner who stood up and was very anxious about what was being said, in that she did not want anybody to be making the decisions for her daughter except herself. I happen to know that lady, and I know she has come a long way since then. Her daughter could not make complex decisions about a medical procedure, for instance, but she can make individual decisions. Sometimes those decisions are painful, particularly when it comes to people's social lives. I think for our members that is the most challenging thing: the care of younger adults with a learning disability who want to lead lives like everybody else, and the anxiety about whether they understand some of the decisions they are making.

Q237 Baroness McIntosh of Hudnall: It is very cheering, in a way, to hear your enthusiasm for the Act. We have heard that a lot. People have said this was an extremely enlightened piece of legislation; it was ground-breaking, life-changing and all of those things. What we also know is that the evidence is suggesting that there is a good deal of non-compliance, or difficulty in complying, amongst all those who have a responsibility to comply with it. I wondered whether you could tell us what you think this comes down to in terms of the perspective of your members, and how you can best model and promote good practice and what leads to that, and what are the things that are likely to lead to more compliance.

Nadra Ahmed: One of the most important bits about any piece of legislation, and what makes it work, is that everybody sings from the same hymn sheet. The compliance and the understanding must go across the board and not be just with social-care providers, just with families or just with clinicians. Wherever we have heard issues, it has been about this lack of multi-agency and multi-disciplinary working. That is very clear, because we talk about

integration but we do not understand and develop it in the right way in various areas. In some areas it works perfectly. When you look at training and education and the work that we undertook, we know that local authorities undertook it in different ways and, just getting the end of what was being said about GPs, they took it in a different way. One of the greatest barriers to anything working really well is when you are not putting the best interests of the service user at the heart of everything and multi-disciplinary work is going on around it without encompassing the good practice that might be coming from a social-care provider and not a GP, but the GP is not going to accept that because this is the way they understood it. Those are the main barriers that we find.

Baroness McIntosh of Hudnall: That is interesting as an analysis, but how do you begin to break through the walls of those silos? What are the mechanisms, or the tools, that you have to do that?

Nadra Ahmed: I was going to come on to say that. The best piece of work is to drive forward this working together. Training and education needs to take place not just in silos; it needs to be much more proactive about people working together and understanding the training, so the social care worker who does the Mental Capacity Act awareness training is the same as somebody else who may be working in a hospital or in the field. Indeed, why would parents not be involved in understanding what the Mental Capacity Act means to the wellbeing of the individual? When I ran care services, I had residents—those who wanted to—sitting in on my training. I had first-aiders among my residents—those that were able to complete that course. Some would walk in and out, but why would they not be involved in some of that if they choose to be so? There is a real public bit of this that we are missing. It always comes down to funding. I was talking to a local authority only yesterday about some piece of work, because there is money around for Mental Capacity Act awareness training, and they were telling me that the awareness training was not being taken up. I was talking to

them about, “How do we open this up, then? Can I push the boundaries here?” There are always reasons why it is ring-fenced.

Baroness McIntosh of Hudnall: I was going to say: can you? Are people willing to be pushed?

Sheila Scott: This is about confidence, is it not?

Nadra Ahmed: Yes. We are in conversation, and Sheila and I spend a lot of time pushing those barriers. We will continue to work at pushing those barriers, because if we really want integration and we really want to work this, then that is what we have got to do.

Sheila Scott: We need to empower our care workers. Some of them may not have the most advanced education, but we wanted to empower them because every one of them has to use this Act, because the person that is doing the caring sometimes has to make a very quick decision. We developed a manual, which the Department of Health saw at the time and were happy with, which looked at the functions of daily living first of all, because if somebody cannot make a decision about anything, you would be doing an awful lot of assessment and not much caring. We developed a way through that, and then an assessment for more complex decisions, just to simplify it and to give people confidence. I could send you a copy if you would like to have one. However, I suspect that for some people, particularly those leading very busy professional lives, this is just one more hurdle to get over. I have no basis for saying that; I suspect that that might be the case. I was invited to go and speak at a Royal College of Nursing conference about the Mental Capacity Act when the Act was being implemented. I am a nurse, so I can say this. Nurses did not want to take the responsibility: “It is clearly for other people.” They have come a long way since then. I am sure that nurses use the Mental Capacity Act. As I was listening to the NHS people, I was thinking, “There is a lack of confidence here that perhaps we need to find a way forward with.”

Q238 Baroness Andrews: I was fascinated, Ms Ahmed, when you said there is a real public bit of this we are missing. I think you were talking about involving families in that sense too, but will the changes in the NHS—particularly the health and wellbeing boards and that opportunity for integration—make a difference? Will that create opportunities for you?

Nadra Ahmed: I really hope so. I am a very optimistic person, so I really do hope so. The problem we have is that, as representatives of the social care sector, we find the barriers to get on to anything that works, like those health and wellbeing boards and the CCGs, are enormous.

Baroness Andrews: You are not invited, or you cannot get invited.

Nadra Ahmed: We cannot get invited. We try. We knock on doors, but there seem to be glass ceilings.

Baroness Andrews: Is that true now, when the health and wellbeing boards are being set up?

Nadra Ahmed: It is still true, yes.

Sheila Scott: Because we are providers.

Nadra Ahmed: When we speak at our events, where we have 200-plus providers sitting in a conference centre, we will say, “How many of you have engaged with your CCG?” We are lucky if we get one hand up. That is the barrier that we have. We really do feel very passionately about this. We are not talking about taking over the world; we just want a voice at the table, because there are a lot of care facilities out there—not all of them are members, sadly—and a lot of those people are doing really good work, and some of that practice can be shared and we can save money. We can actually save money with the NHS, because we do the Mental Capacity Act training for half the price that they are paying at this moment in time. I am not touting for work or anything like that; I am just saying that these

are the little simple things. Sheila may be able to, but I cannot get to speak to a chairman of a CCG at the moment in my locality.

Baroness Andrews: Can we know exactly why? Is it that they are refusing your phone calls, or that you get blocked at some point?

Sheila Scott: It is because we are providers of services from the private sector.

Nadra Ahmed: It is because we are providers. We are seen as a conflict.

Sheila Scott: I think it is the private sector, maybe. Also, there are thousands of us, and I think sometimes people are nervous of engaging with us because they might have to engage with everybody, whereas we would like to think we could represent everybody.

Q239 Lord Turnberg: You spoke very movingly about the balance that has to be struck between enabling and protecting. I just wonder how you will get your members to do that in an appropriate way.

Sheila Scott: That is a really interesting question. Sometimes we are really enabling people to make their own decisions to move forward with their lives. That is particularly true of younger adults. Young people leave the education sector, and if they come into a care home, it is our duty to try to move them to independent living, and then later in life they will come back to us, but sometimes we are having to protect people. I do not know if this has been raised with you at all up until now, but many local authorities—the cynic in me would say it is for financial reasons—are trying to move younger adults from living in care homes to independent living. We do not object to that, but people need some serious training and support to move from life in a care home to independent living. This is the moment to do a Mental Capacity Act assessment to see if the right decisions are being made for the people who are having these decisions made. Local authorities are tending to make those assessments—or perhaps not—without consulting the people who are closest. They will say they are thinking about it, but they will not use our members to be part of that very

important decision that is being made for younger adults all over the country. This has been going on for several years now.

Lord Turnberg: So, local authorities will say that people in one of your homes should come out.

Sheila Scott: Yes.

Lord Turnberg: They do not ask. Do they say they are not going to pay for them anymore? Is that what it is?

Sheila Scott: They want them to go into supported living. That may well be right, but there need to be some fairly detailed assessments and support for those people. I am afraid that is not happening everywhere at the moment.

The Chairman: Are you saying that social workers do not engage with the care home staff in the assessment of residents?

Sheila Scott: Yes, I am.

Nadra Ahmed: We have heard of instances that are quite scary in that a provider has not even known. A social worker has come along and said, "I am going to take so-and-so out for coffee," and they have gone and shown them a facility and said, "This is a lovely flat. Would you not like to live here?" Of course, they are seeing that as a lovely, beautiful new environment, and at the point where they are making that assessment there is no call on a provider or the people who care for them to discuss it. As Sheila says, we are not against supported living, because for some people it is absolutely great and it is right and they are living very happily, but when you do an assessment you have to take into consideration why somebody is stable in that facility. They may be stable because of the support that they are getting around them during the time that they are there. If you take that support away from them, what will the impact be on them when they are living alone? I am a trustee of a very large learning disability service, and we had a very scary incident where this happened. Two

young girls were put into a flat together. They looked like they were fine, and all the assessments were done. We had our reservations, but they were not taken into consideration. These two young ladies went to the local pub for a drink in the evening, got chatted up and handed over their address and phone numbers. That night, we got a very panicky phone call in the middle of the night from one of the girls because there were these lads hammering on the door. So, whilst we are not against it, we have to be really clear about what we are saying and how that capacity assessment is done. If it was done properly and our considerations were taken into the equation, they may still be living there but we may be more careful about how we protect them.

Sheila Scott: Families are often not included at this point either. I am not saying every local authority is doing this, but there are too many to feel comfortable with it.

Q240 Baroness Shephard of Northwold: In your sector, there are clear workforce issues. One of them is that there can be high levels of staff turnover and quite low levels of pay. There are implications, if there is a high turnover, for knowledge of the Mental Capacity Act. How do you advise your members to cope with that? I am not saying that it will be the same in every part of the country; I do know for a fact that in rural areas there is a problem, simply because the population is sparse. How do you cope with that? Do you just keep on with the training?

Nadra Ahmed: Training is one of the most expensive activities in a care service. If we did not do it, we would not be providing a quality service. There is no quick fix or easy answer to not going down that route. People are training. I think the high turnover has made people look at different methodologies of training, which includes e-learning. Whilst that is okay if you have got the baseline knowledge, for me, being an ex-teacher, that face-to-face interaction is much better. It is a dilemma. You are absolutely right. With the turnover, what happens is that, as a provider, you take somebody on; you do the CRB or DBS check,

which you are required to do; and then you do the five statutory training sessions with them. There is an investment in that person, but because of the pay scales or the situation, where that no longer suits the person, six months later they may be fishing around for another job and so you are doing it again. So, the providers are actually getting the trained and experienced people, which is fine. Mental capacity is not one of the first ones you put them through, but you do have that within the induction package. It is not a satisfactory answer, but I think it definitely is an issue. We see the Mental Capacity Act as being also something that is a protection for the staff. We are very keen that if you implement this properly and it is embedded in your service, you are protecting not only the service user but also the staff. That is where the quality agenda comes into our world.

Sheila Scott: This is a good moment, though, if I might, to mention that Camilla Cavendish has just submitted a report to the Department of Health. Work is just starting. Her recommendation of a basic certificate of fundamental care—I think that is what she called it—is something that we find quite exciting, because if you look at the Common Induction Standards that every new member of staff is supposed to have, they have got increasingly woolly.

Baroness Shephard of Northwold: Not practical, do you mean?

Sheila Scott: Yes. Thank you. This is the moment for us to be raising these sorts of issues with Ministers in the Department of Health about the training that is given around the Mental Capacity Act. I think it is there in the Common Induction Standards; it is just difficult to find it. I think it is there within the safeguarding part, but it should be part of that basic fundamental training that nobody can work unsupervised until they have had. They do not need to know it all, but they need to understand how you assess training, which is very simple and straightforward. The four points that demonstrate to whomever it is that this person can make a decision are fairly straightforward, and they just need to understand it.

At that stage in their working life they are not going to be making very complex decisions, but they will be required from time to time to make decisions, so it is something that they need to understand.

Lord Swinfen: I will stay on decisions. How are they handled on a day-to-day basis? What types of decisions are made by the frontline staff and what are passed up the chain of control and responsibility? When you have best-interest decisions to make, are they formalised and documented?

Sheila Scott: Yes. What I call the functions of daily living, which just gives a little protection to care homes, where an assessment is made on a regular basis, but not for every decision, as to whether or not that person has mental capacity, is one thing. I would anticipate that a decision about anything more complex than that would be made by a senior care worker, assistant manager or manager, and I would expect it to be documented. I have no doubts about that. There is no point in having this piece of legislation that gives a framework and protection both to service users and to the staff if you do not document it, because if you do not document it, it does not exist.

Q241 Baroness Browning: The submissions that we have received, which have been a great many, have focused on the need for simplification of the deprivation of liberty safeguards, either through amendment of the Act or the Code of Practice or the regulations. I wonder what your view on this is. Do they need to be simplified?

Sheila Scott: My view is that we all need to be singing from the same hymn sheet first. Other professionals may come into our care homes, either from the local authority or from the regulator, and say to one of our members, "That person is being deprived of their liberty and you need to apply immediately to the local authority" or in another area the local authority area will come and say, "No, this is wrong." Not everybody has a good understanding, because we still get plenty of phone calls about it, but I think we have a good

understanding of what deprivation of liberty looks like. The first thing is that perhaps the regulator needs to make sure that all their staff have an understanding of what the Code of Practice says about what deprivation of liberty is. Secondly, everybody says how complex the paperwork is. I am not sure that that involves a change to regulation. I think it involves a complete review, not just of the public sector professionals but also the people who are involved with the assessments, to make sure. In many areas this has worked really well, first of all. Secondly, I have been surprised how many DoLS have been applied for and how many have been granted. I did not think there would be as many as there have been. I have to say I am not up to date with the figures now, but certainly in the early days I was surprised at how many people were the subject of DoLS. Apart from that, as long as everybody is working with the same understanding of how somebody is deprived of their liberty, I think that would be a really beneficial thing for us. We have got a couple of comments here from members who say the same thing: two different counties with two different interpretations of what a DoL looks like.

Nadra Ahmed: The concern would always be that, when you are going for simplification, you do not water things down; that this has been worked out. It is the implementation. It is the paperwork and the process. Perhaps that needs to be looked at in greater detail. It perhaps is a simplification of the process rather than the actual application. We are all blinded with science when it comes to paperwork now; there is so much of it and the bureaucracy is so great that people struggle with it. Perhaps that is more what we would be in line with.

Baroness Browning: Your main concern, then, is this variation in interpretation. I think you are going to get a question in a moment about definitions; I am going to leave that to the person who is going to ask you that.

Q242 Baroness Barker: It is very interesting, because I would say that the weight of evidence that we have had from a number of organisations—including the Alzheimer’s Society, the College of Emergency Medicine and Mind—is that the numbers on DoLS are much lower than they had anticipated. For example, the Alzheimer’s Society say there are about 200,000 people who have dementia, many of whom are in care homes; in 2012-13, there were just under 12,000 applications for DoLS, of which 50% were approved. They seem to think that is quite low. In that context and given what you said is a slightly different interpretation, what work have you undertaken to support people whom you work with in understanding how to meet their obligations under the Deprivation of Liberty Standards? I suppose that really means: how do they understand the law to apply in given situations?

Nadra Ahmed: Part of it is to do with the training, because we supply quite a lot of training and we still get quite a lot of requests for people to understand it. I do not know whether we have got specifics, Sheila, have we?

Sheila Scott: I was part of a working group with other people in the same position as me who were saying, “We do not think this applies to us, because people are not really kept in care homes. If you thought that people were being detained in care homes, then you would have to look for another arrangement.” However, we worked this through, because then some of the fears that arose were that because somebody is assessed within a risk assessment as not being able to leave the home on their own, that does not mean to say that they are detained against their will; it means that they can go out but they just should not go out unescorted. We had a great debate about whether that applied to DoLS or not, and the expectation was at that time, and I think the guidance within the Code of Practice is, that as long as people can go out when they want to, or, if they cannot go immediately, as soon as possible afterwards when there is somebody available, that is not directly a DoL. It is not just about us—members of staff—going out with them; it is about family and friends being

able to go out with them as well, or volunteers or IMCAs. It is just about personal safety, say for a person with dementia. That is why we did not necessarily think that people would be subject to DoLS in most care homes. There have been different interpretations that have meant that DoLS have been made, but most of those have been granted at the request of the care home owner or manager, who wanted to be absolutely clear that, although this person could not go out, they had taken the appropriate steps. I know I am not necessarily answering your question, but I am trying.

Baroness Barker: I think you are perfectly highlighting to us what is lying behind some of these statistics, and that is extremely helpful to us. People seem to love the Act, but the application of it in practice has turned out to be very different.

Sheila Scott: Yes. I think that the Bournemouth decision and similar decisions—we were part of another case—were about where people really were not allowed to do anything.

Q243 Baroness McIntosh of Hudnall: It was more than them not being allowed to do anything; in that case, it was also about them losing contact with people who were important to them. Could you just take the Bournemouth example and consider, just briefly if you can, from your experience in your care settings, how the effect of DoLS would now change the way in which you might approach that particular obviously quite difficult situation?

Sheila Scott: We were involved in an appeal case where it was an older person who, for their own protection, was separated from their family. This is where the complications arise, is it not? I know the vast majority of, but not all, care homes want people coming in; they want visitors. It is only to protect people, normally from physical or financial abuse. I think that the vast majority of care homes welcome people coming in. I certainly did when I was a care home owner; I am sure Nadra did too. It is the best thing that happens when people come in. I know that it applies to some settings, but in the sorts of settings that we represent, I do not think what happened is likely to happen. We all have to have our wits

about us all the time; that is why we have a regulator, to push that protection barrier some more. I just do not think that it is that normal for people from the outside world coming into a care home; there are always people coming in and out. I think there is some more protection than there was in the Bournemouth case.

Nadra Ahmed: I know of a care home where there is a gentleman who becomes violent whenever his wife comes. It is a major issue. He becomes a different person. It creates massive tension in that home for all the staff to control after she has left. He does not go out with her, and the sons are in agreement that he does not, but that has caused a massive issue with the wife, because she feels that if he was allowed to have more contact with her, he would be calmer. But the evidence does not show that. She feels very much as though she has been isolated by this decision, which the sons are in agreement with, and they have the history. The home have done absolutely the right things in the way they have approached it, but it has created a tension.

Baroness Barker: Seven years in to this Act, are you confident that people would recognise a deprivation of liberty and would know what the safeguards are that should be put in place?

Nadra Ahmed: I am not sure I would be confident, but I think we do have a piece of work that needs to go on around the way the process is working.

Sheila Scott: I am confident that the people that we represent know.

Nadra Ahmed: Yes, our members get advice.

Sheila Scott: They know how far they take it, because it has not proved to be the challenge that I had expected, but I am not confident that everybody knows, and I am not confident that some other services—different services from ours—know. I do not think it is too big a challenge; I just think that people have not got the information yet. I was surprised to have sat there and heard people say, “It is early days.” It is not early days. We are well in here.

Some more awareness-raising and some more training and education needs to be done, and I suspect it needs to be done by all of us together. I get more calls now about the ambulance service than I do about anything else. It is something new; people are more aware now. If somebody says, "My mother has said she does not want any active resuscitation to be going on," for instance, even though it is there in writing, ambulance staff are nervous of that. I have started to speak to the ambulance service's representatives just about the issue, not about training, but some joint training across the piece would be very helpful at this moment.

Q244 Baroness Hollins: Do you think your members get the appropriate combination of review, challenge and support about DoLS? If so, where from?

Sheila Scott: A lot of that responsibility lies with local authorities. Within our world, they are the lead authority. I would expect them to get it from us, but I would also expect them to be getting information from local authorities.

Baroness Hollins: I can see from your website that you do provide support to your members around such issues, but on the question of review and challenge, you would look to the local authorities.

Sheila Scott: Yes.

Baroness Hollins: Do you think it is happening?

Sheila Scott: It happens from both sides. It is one of the areas where a home is confident to challenge a decision that is made if they think it is wrong, and obviously local authorities do. There is some additional challenge from the Care Quality Commission inspectors, because they have a responsibility to check out anybody for whom a DoLS has been decided. It is one of those areas that people are prepared to have a professional talk about when there is a CQC visit, because I think that happens on both sides; it is both from the regulator themselves and from the provider.

Q245 Baroness Andrews: You have talked about the fact that you did not expect so many DoLS to be issued and you have talked a bit about many areas working well, but there are clearly big regional variations. I am just wondering whether you have any statistics that would allow us to see some of those patterns, and whether you can think of anything that can be done to address them.

Sheila Scott: I could write to you with more information. What has surprised us has been that there are some real regional variations about interpretation of the law and about paperwork—I would have thought the paperwork would be the same wherever—but also about what a DoLS is and what the responsibilities of the various parties are. One of our board members has raised quite frequently at board meetings the way DoLS is implemented in one particular area. She has got a care home in the North East and one in Somerset, so that is quite diverse. In one area she believes it is working the way it was intended to, and in the other area she thinks that the local authority is being over-strenuous in its actions.

Baroness Andrews: So, essentially, that is to say it is creating more DoLS. It is gold-plating, or misinterpreting—pushing the boundaries out.

Sheila Scott: That is what I think, yes.

Nadra Ahmed: There is too much inconsistency. A national understanding is not there at the moment.

Baroness Andrews: Is there anything that can be done with the Code of Practice or case studies or practice or further clarification or training or guidance? We know that is all a local variability as well, but thinking about the Code of Practice as the standard, is there anything that can be done?

Sheila Scott: There could be some much clearer statements around where a DoLS fits into, say, a care home for people with dementia. That does allow local interpretation. In my opinion, locking a front door is a normal safety precaution—I lock my own front door—but

a front door may be locked following a risk assessment. It is whether or not the person can go out. The Code of Practice fudges that a little bit. It does not say yes; it does not say no. I think probably some people working on DoLS in the local authorities are looking to protect their own decision making as well as anything else. A bit more clarity around those particular areas might be helpful.

Baroness Andrews: Do you think that clarity can be attained?

Sheila Scott: Yes, I do.

Q246 The Chairman: Thank you. Could I ask you to provide some specific examples in writing of the local authorities that you mentioned who do not consult care homes or families before taking a decision to move, which you referred to in evidence? That might be quite helpful, if there are specific examples.

Sheila Scott: Yes.

Nadra Ahmed: We have some, yes.

The Chairman: You also offered a copy of your manual; please submit that as well.

Baroness Andrews: Lord Chairman, I wonder if we could ask Sheila and her colleague to provide two case studies for us that would show how the Code of Practice could pick up on those differences in terms of the application or the interpretation of DoLS that distinguish between the appropriate protection of people without capacity to go out and get confused and endanger themselves, and the actual deprivation of liberty, which is a human rights issue.

Nadra Ahmed: We would be happy to.

The Chairman: Thank you very much. Thank you very much for your evidence.