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Witnesses: Terry Dafter and Lorraine Currie

Patricia Kearney, Sanchita Hosali and Paul Gantley

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Members present

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

Examination of Witnesses

Terry Dafter, former Joint Chair of the ADASS Mental Health Policy Network, and
Lorraine Currie, Commissioner for MCA/DoLS at Shropshire County Council

Q172 The Chairman: Good morning, Mr Dafter and Ms Currie. Thank you very much for coming along to give evidence and for the written submissions that you have made to the Committee. They are very full and very interesting. Hopefully we can explore your evidence in a little more detail. You will be aware that this evidence session is recorded and broadcast. Mr Dafter, your submission refers to the fact that the sector is moving towards a clearer understanding of what constitutes good practice. What is good practice in the implementation of the Act and what is the role of directors of adult social services?

Terry Dafter: Directors of social services have to take a strong lead around the Mental Capacity Act. If they do not model it and encourage its use, and encourage a culture within their organisations in which social workers and other practitioners feel able to practise the Mental Capacity Act and be supported in making some very difficult decisions sometimes, I think we are failing in our responsibility. For me, good practice within a local authority would be demonstrated by a clear commitment from the director in support of it. There should be some embedding of the Mental Capacity Act in social work practice; good, comprehensive training and awareness-raising among staff; and elected members should

understand and be fully aware of the implications of the Act. There should be a proactive approach to training in the sector, especially the independent sector and partners in health, around the implications. Carer groups, user groups and so on should equally be given full awareness of the Act and its implications for them. There should be a very open and transparent approach to the Act, and a very public commitment to it, because it embraces very strong values and a good value base for a way forward in its thinking around individuals' vulnerability and how we should work with those individuals.

The Chairman: Obviously, all this requires funding, and we are aware of the difficulties of public sector funding at the moment. In your submission, you refer to the grant under the Act still being made available and the question of ring-fencing, which is always a vexed problem in public sector finance.

Terry Dafter: Indeed, absolutely.

The Chairman: Even if there is no ring-fencing by local authorities, could directors not manage their budget in such a way that gives priority to the Mental Capacity Act to achieve these objectives that you mentioned?

Terry Dafter: Absolutely. It was not tongue in cheek; it was simply that I think that all directors like ring-fencing because it means they do not necessarily then have to be vulnerable to losing that funding within the general revenue support grant. If it is ring-fenced, it is ring-fenced, and you can identify it and secure it corporately. In fact, much of what I have described already does not necessarily have to inflict a huge extra cost. Most local authorities have staff development teams and training teams now, so it is a matter of prioritising that work. The leadership comes from the post and the director; the elected member's leadership should be there. We all have communications budgets and partnership arrangements with colleagues. Although that funding is helpful and identified as important, I would be contradicting myself if I were to say that it should not be part of mainstream

delivery in the local social services department. It should not rely on extra funding to do it, because it should be key and integral to our way of working.

Lorraine Currie: Where we have managed to keep the MCA grant discrete, we can achieve a lot for a little by working together. It is not ring-fenced, but in some local authorities we have managed to keep it discrete, and we can achieve a lot where that results in a lead role—for example, someone in my role—across local authorities, often by working in partnership with health, because many of us have joined our budgets together. The importance is of seeing that grant as very discrete, seeing the reason for it and the function of it in providing all the things Terry has just said, and seeing where we can work with other partners to achieve this. That is the important message.

Q173 Baroness Hollins: Good morning. Social work professionals have suggested in their evidence to us that, in contrast to the Mental Capacity Act, safeguarding is prioritised within social care. We have heard reports that the Mental Health Act is more widely followed than the Mental Capacity Act. I wonder whether you agree with that, why that is and what lessons could be learnt for the leadership of the implementation of the Mental Capacity Act.

Lorraine Currie: It is a very difficult question to answer, because it depends on who has given that evidence already. Within the mental health field, the Mental Health Act is better understood, but it is a very specific field and very narrow to a very specific group of people. The professionals involved in that are clearly identified and they understand their roles very well. The Mental Capacity Act, however, is a wonderful piece of legislation and impacts on every aspect of the local authority's work and every aspect of life almost, if I can go that far, from the pharmacist in the pharmacy to people in the library. It is a very wide, overarching piece of legislation. Generic social workers have a better understanding of the Mental Capacity Act in partnership with safeguarding because they are key roles and values for

social workers. Most generic social workers would step to one side the minute there is a suggestion of the need for the Mental Health Act, because they would see that as the role of AMHPs and psychiatrists. Over time, though, we are managing to convince them that their role does involve the Mental Capacity Act in everything that they do.

Baroness Hollins: Are there lessons to learn from safeguarding and the way that is understood?

Lorraine Currie: There are lessons to learn in how it is prioritised, yet the Mental Capacity Act has a stronger legislative framework than safeguarding. Safeguarding is given a very good position, clearly because of the ramifications when things go wrong. The danger from my perspective is that the Mental Capacity Act work is easily subsumed within the greater work of safeguarding and its distinctness is lost. It is one of the things that we really need to guard against: that it is seen as discrete. There is an overlap, but it is a very discrete piece of work. They complement each other and can enhance each other, but it must be seen as discrete or it loses any significance.

Terry Dafter: I would also add that, from a directors' point of view, safeguarding, along with the budget, is one of the two areas that we are most vulnerable on. If we get something wrong in safeguarding, that is a very big matter for us personally in our roles. There is an apparatus and a system in existence around safeguarding that has built up over the years in the light of particular events, scandals and so on. There is an apparatus, set guidance and processes that have been established in order to try to protect people who are vulnerable in those situations.

Similarly with the Mental Health Act and so on, people have been detained under the Mental Health Act for some time—I started 30-odd years ago and I was sectioning people under the old 1959 Act, then the 1983 Act and so on. In a sense there is a history around the Mental Health Act that is longer than the Mental Capacity Act, which is much more recent and

much broader. The lesson we can learn from safeguarding is having good systems in place that everybody is aware of and can be trained in, and that people are clear about what their role is.

Possibly the lesson from the Mental Health Act is actually the training that is given and the fact that to practise under the Mental Health Act you have to have extra training post-qualification. You can only practise the Mental Health Act and detain people under it if you are an AMHP. I am not saying that you should necessarily have something similar for the Mental Capacity Act, but it is a good model. It demonstrates that there is a need for post-qualification training. This is sometimes about dealing with quite complex matters, maybe balancing the views of a family with the views of a person with a disability, and trying to weigh up various views and trying to get an independent view on what is best for that person. It is not easy work, and you do need post-qualification support and training in that work to feel confident and supported. We can learn something from both.

Q174 Baroness Hollins: If the culture is a little risk averse and trying very hard to protect, is there a balance to be struck between that and enabling people?

Terry Dafter: There is.

Baroness Hollins: How do you get that balance better? Are you suggesting that training is most important or that systems are the most important?

Terry Dafter: It is really important. We have come a long way in public services and social services. When I first started, there was a very paternalistic approach. When I was a social worker in a big city 30 years ago, everything was council-run; everything you got was on our terms and on whether I said so, crudely. The assessments were very much for council services on council terms. We have moved an awfully long way from that now. Personalisation and giving people more control is very much moving in a direction where that power is handed to the individual with support and we say, "We will support you to

make your own choices”. Sometimes those choices can be quite contentious, but nevertheless it is a good trend and one to be welcomed.

I feel it is part of a social role and has been for a long time, ever since I have known it, to balance the need to try to encourage people to make choices, to sometimes encourage them to make the wrong choices or difficult choices, and sometimes to balance risk when other professionals are saying, “Hang on a minute. That old lady down the road is wandering. Why aren’t you doing anything about it? Why isn’t she in a home?”. Actually, as social workers we are instinctively usually saying, “No, that’s what she wants to do. She’s happier, and the alternative would be more detrimental for her”. That is what we still have to encourage. Social workers in my organisation, if they make those decisions, should expect my full support and backing. As long as they have not behaved recklessly and they are not behaving inappropriately, that is the sort of culture we should be encouraging. If you have a risk-averse culture, though, and you are forever wondering what is coming around the corner or what the local press is going to say about something—this certainly comes through in personalisation and what people spend their money on, and in this—then you can swing it too much the other way, and I think that is very sad.

Q175 Lord Patel of Bradford: Your answers have been really helpful. There are boxes ticking in my head of how we separate all this. We have asked several times about the relationship between the Mental Health Act and the Mental Capacity Act. Your answer was very helpful on the two or three things. One is that there is a whole issue about risk. Under the Mental Health Act, you are taking people’s liberties away; it is very specialist and there is a team of specialist people. Safeguarding probably mirrors that to some extent. As you said very clearly, the Mental Capacity Act is everybody and everywhere. There is a small bit, though, where you are making that decision finally for somebody: whether we should have the same level of specialist team built in that is similar to the Mental Health Act

and safeguarding. That is one big thing. I suppose they are two different beasts in a sense, but somewhere they cross over.

Lorraine Currie: Do you mean a specialist team in terms of assessing capacity or do you mean for the deprivation of liberty safeguards?

Lord Patel of Bradford: I think both in some way. I know it is difficult because it is such a long continuum, but it feels like these are based on risks, anxieties for people; they are specialist teams and they know their business.

Lorraine Currie: This is developing within practice. There are many different levels of decision-making with the Mental Capacity Act, and practitioners do really need to be encouraged in their confidence to make decisions. The big difference between safeguarding and the Mental Capacity Act is that you act alone, pretty much. It may be as a result of a multidisciplinary meeting, but ultimately one practitioner puts their name to their assessment. That is the difference compared with the confidence that people gain from safeguarding.

Our director is very clear in supporting a protocol for who can make which decision at which level, because we have to say that not all staff are equally competent. Sometimes if you have a lot of factors, a high level of risk and safeguarding concerns, you need an experienced practitioner. Those kinds of protocols are very helpful in not leaving everybody just feeling that they are at sea. The code of practice only talks about best-interest decisions, but more and more we do have best-interest meetings—not for the everyday “Which socks do I wear today?” but for the more complex decisions. We would expect that to be an information-gathering exercise in a multidisciplinary way, with one person then taking responsibility for decision-making, but fully supported by family, carers and everyone else who contributes to that process.

Q176 Baroness Browning: I just wanted to ask you about your reply to Baroness Hollins about getting this balance right between enablement and protection. It was part of the Act that people should, like everybody else, be able to make a wrong decision. Could I ask you just to reflect upon the fact that, if one of us makes a wrong decision that has quite serious consequences down the track, we are at least able to rationalise it and learn from that mistake? For many people without capacity, or for people with fluctuating or partial capacity—I am particularly thinking here of young adults with autism or learning disabilities—how do you get the balance right there? The consequences could be quite dire and they do not have the ability like us to perhaps learn from it and recover from it.

Lorraine Currie: The Act offers an answer to every problem or challenge. This is why it is a culture change; we are trying to embed values into practitioners. That is very much about supporting the person's ability to make a decision, and accepting that those sometimes will be risky and we do not like them, we do not like to be challenged, and I personally think it is good that we have been challenged as practitioners. That does not mean we draw a line in the sand, though, and say, "Okay, you are making that risky choice, so you're on your own". We have just supported a 99 year-old woman in the last week to return home from a care home. Everybody thinks this is a very risky decision. It has not been made easily; it has been properly made sitting on the principles of the Mental Capacity Act, and she will be supported in that. We also will have a back-up plan for if that risky decision fails.

It is about generic social work practice—the meat and drink of social work practice is to support people—and not saying, "If we don't like your decision, we won't support you". Obviously, there are some decisions and ways people choose to live that we are not easily able to engage with, but we still offer the whole range of social work support to people. We ensure that that decision is multi-disciplinary, that there is a back-up plan and that, as far as possible, it is resourced for the person's quality of life and to respect their choice.

Baroness Browning: I have just been driven by my 100 year-old uncle. I have to say all those things came in to my mind.

Q177 Baroness McIntosh of Hudnall: You have pretty much covered all the things that I was going to ask you directly, but I have two other questions. First of all, I think if I were losing or lacked capacity, I would very much like to be where you are, because it strikes me that both of you have expanded both in theory and in practice exactly how the Act should work and how it evidently does work where you are practising. It seems to me, though, that the evidence we have demonstrates, at least anecdotally, that that is not universally the case. I just wonder whether I could pull out this thread of the default towards protection against litigation or protection against reputational harm. Probably just on human grounds, it feels to me to be where people who are less confident about how to use the Act than you both are might feel themselves drawn towards. Can you just tell us what you think could be done to help the people who are less on top of it than you are?

Lorraine Currie: In Shropshire, we had some money from the Department of Health that we bid for a few years back to do an audit of the Mental Capacity Act in practice. We learnt an awful lot from that. We learnt that our practitioners did not feel confident; they had the head knowledge, but they did not feel confident in practice. We were able to change what we offered. We were able to change our training, we were able to give them clear guidance about what is expected of them at what level, and we were able to look at a staff competency framework. All those things and many others that we have put into practice can be applied regionally and nationally.

Certainly, the work Terry and I have done has been because of regional networks coming together. I chair the regional DoLS Leads Group for the West Midlands, and we are sharing practice. For example, we are trying to look at the variance in figures across the region, how we can influence that and what we can do to try to move towards consistency: having a

lead person in post and then having that person able to relate to wider networks, local implementation networks, regional networks and then into something like the ADASS network that we have been discussing. We have changed the world while we have been in the waiting room.

Terry Dafter: We have sorted it all out.

Lorraine Currie: We are discussing the good practice that is out there and how we can bring that into play more regionally and nationally. These are things that can be done very easily and simply to help improve practice across the board.

Baroness McIntosh of Hudnall: Can I just pursue that a little bit? Obviously, within your own local authorities, I would infer from what you say that you have succeeded in taking people along with you to the point where you can confidently say that you know what that best practice is and how to implement it. I assume that your colleagues who are not part of social work practice, who are in other bits of the local authority forest, can see what the benefits are and trust you. There presumably is a job to be done not just with your own colleagues but other people as well.

Terry Dafter: There is. We have been reflecting on this coming here today. ADASS and the Mental Health Network has a part to play here because good practice and having a good, structured approach to the Mental Capacity Act should chime and resonate with carers, users, families and so on. This is something that they would want social services to be like. I do not think they would want to be part of a service that is very overprotective and reactive in its approach. ADASS has not done enough, though, in demonstrating what a good model is, demonstrating how it could and should work, and then encouraging.

I went to Lorraine's meeting as part of preparing for coming today. I was quite inspired because it was a group of people who all knew the Act absolutely off the tops of their heads. Part of the discussion was almost above my head at times, but it was a fantastic model

because it involved peers, it was talking about practice, and it was sharing quantitative data: how many they had done, the percentage of people who applied who have actually been approved, the position on the ground, what evidence there was locally and how good practice could be shared. That network is strong in the West Midlands, and it is pretty strong in the north-west; it is not as strong in some other parts of the country.

ADASS needs to, and will as a result of this, encourage much more networking and encourage other networks across the country to begin to act and reflect in a similar way. In a sense, it is a shame. You could argue that it is inevitable, and I do not want to sound defensive because I am not. It is relatively new, it is relatively complicated, and in some areas it has frankly been given more priority than others. In some areas, they have had other priorities to think about. Nevertheless, beginning where we started, I do not think there is any model or framework that would say, "This is good practice. This is really what you should be doing, these are the sorts of areas you should be covering, and let's actually share that together". Sometimes directors are only too happy to have an off-the-shelf framework to say, "Well, actually that's great". Let us think about how we are going to benchmark ourselves against some of these approaches. I would hope that ADASS can take more of a lead here and begin to share and model good practice around this. Frankly, where it is working well, it is working very well and people are best served. We should try going for that nationally.

Lorraine Currie: We, the people in practice, lost the national and regional leads from the Department of Health. We really missed that; it went too soon. We had regional and national leads for the Mental Capacity Act; the deprivation of liberty safeguards swooped in, and pretty soon after that we lost that centralised lead. We have not really had anywhere to look to answer the questions: what is the definitive interpretation of this legislation?; how do you actually want us to act in this situation?; is it good to have a lot of DoLS requests or

is it actually bad to have a lot of DoLS requests? We get caught up in figures and we have not yet really sat down and said, “Yes, we have a lot, but is that good or is that bad?”. Is it better to look at how many we are authorising per number in or look at that against our population. There is so much data, and yet we are missing that very central direction. That is the one thing that would really help us: a clear focus on having the lead in each authority to carry on that work.

Q178 The Chairman: Do you think the impetus should come from central government then on the national rollout of your good model? I know you have said that ADASS should do more, but should there be some encouragement from central government?

Lorraine Currie: Yes, it is the encouragement. There would be an imperative to action if there were a very clear direction to where we are heading and what we should be looking to achieve. It is very easy then for directors to prioritise that and to galvanise to action, rather than people like me trying to agitate everybody into action.

Terry Dafter: Of course, we are not inspected as a local authority anymore. I am sure two or three years ago, when there were star ratings and CQC used to come in—or CSCI as it was—and give us a star rating based on a range of performance and performance indicators. I am sure this would have been integral to their evaluation. Of course, we are not anymore, so we are relying much more now on peer reviews, peer support and so on. That is why I was mentioning ADASS, in a sense, as a vehicle for this, because in a way this is the new world of evaluating the local authority on social care.

The Chairman: Can I just ask one final question on this? The Act does not require the routine reporting of decisions, so how do you actually monitor what is happening on the ground?

Lorraine Currie: In order to test the water in any way, the lead for the authority has to be proactive. There are various ways to audit. I can to some extent say what we do and what

we do across the West Midlands. If documentation for assessing capacity, for example, across generic social work practice is part of the social work electronic systems that we all love, it is possible to do some monitoring of that and certainly to check very basic things like how many assessments and whether they were followed by best-interest decisions. We can do simple things. We can also look at the quality of them and do that regularly. In the West Midlands, certainly with DoLS authorisations, we have reviewed the forms, we have amended them and we have agreed West Midlands versions, so the forms should look the same anywhere in the West Midlands. We have also done that by working in practice with the best-interest assessors to look at what quality is in an assessment: what should be there and what makes good-quality assessments. The forms have then matched that. We have done that with our authorisers as well: what we expect from them when they approve these very serious decisions.

Now we are moving to a situation where we can do peer audit. In November across the West Midlands, we will share random selections of assessments with each other and comment on the quality, the content and the decision-making. That is just one area; that is the West Midlands. There are similar things going on, but it needs each area to initiate that itself. That is why there needs to be the focus on the person to take the lead and the dedication to the budget to do that.

Q179 Lord Swinfen: Obviously the Mental Capacity Act is embedded into social care work, but how do you ensure that providers of care services, whether in residential homes or people's own homes, comply with the Act? What concerns do you have about the workforce issues identified in that sector? You have poorly paid and unskilled staff with high levels of staff turnover. What implication does this have for the Mental Capacity Act?

Lorraine Currie: Again, I believe that it is about partnership working. There still exists in most places what was originally a local implementation network, and that has tended to go

on to become some kind of operational network. We work with our partners in that: the care homes, domiciliary providers, the police, ambulance service, hospices and hospitals. They are all involved in those operational groups, and we share good practice and expectations with them. I certainly see it as part of my role as the lead to disseminate information to them to make sure that they are aware of changes, case-law decisions and just basic information. We produce posters and leaflets that we share with them—all those kinds of things.

Also, at the heart of our contract with care providers, we are certain that the MCA is embedded into the contractual requirements. It is easy to put that on paper, but we then have to test that in practice. We provide an awful lot of training because we have a dedicated role and a training role. The greatest take up is from the independent sector, because with the grant still being available, for the large part we have been able to make the training free for those people in the independent sector. That is a great encourager for them to continue to come along. Also, when there is that change of staff, which there is, we train a couple of thousand people each year from hospitals and care homes as well as the local authority. It is keeping that momentum going, because the Mental Capacity Act is ever changing. Our understanding of it is ever changing, and it evolves in different directions, so we offer them as much support as we can in order to ensure best practice.

Terry Dafter: I do worry about the sector for the very reasons that you have outlined. There is this huge turnover and staff problems. They are in competition with the retail sector and with a lot of other areas. Often the level of training and support is poor: you train 2,000 and 500 people move on within the year and you have to start all over again. This is a problem in the care sector generally, not just in relation to the Mental Capacity Act. I do take your point that it is something that we have to be mindful of and aware of generally, not just around the Mental Capacity Act.

Lorraine has covered most of it. I think you do have to build it into your contracting arrangements; you have to make sure people are trained within that home and that there is leadership from the top—that the manager and the deputy manager are well trained and well versed in the Act. You have to check out the number of referrals you are getting per home and worry about a home that you do not necessarily get any referrals from and equally worry about ones where there is perhaps an overzealous application of the Act. You start to ask the people who monitor your contracts to bear those figures in mind along with other reporting figures that we take around the sector.

There is some relationship with CQC, of course, and monitoring standards through your local CQC office too, and taking a view with them. Equally, it is just talking to social workers and families about the kinds of receptions that they get if these sorts of decisions are starting to come to the fore. Are these organisations that are receptive to discussions around the Mental Capacity Act, that are not behaving defensively and that see it as something constructive? Are they organisations that encourage their staff to do the same? That is what you need to aim for, but I take the point entirely that it is a sector under severe strain and severe pressure. I do not have an answer to that, I am afraid.

Lord Swinfen: What sort of proportion of those working are from Europe and the world generally, rather than British? Do you have language problems as a result, and does this exacerbate the situation?

Terry Dafter: I could not comment too widely, because in the authority I cover it is not a big issue. It generally recruits locally. I am aware, though, that in neighbouring big inner-city areas it is more of a problem, and I think that is an issue in some parts of the country. I do not have the data to hand that could give you a comprehensive answer to that, but it is a problem in some parts of the country.

Q180 Lord Patel of Bradford: In respect of best-interest decision-making, you have touched upon a number of factors within the Mental Capacity Act. There are also a number of factors outside the Mental Capacity Act that have been identified. We live in harsher economic times, so there are the pressures on hospital beds and the costs of residential care versus home care. Is it naive to assume that somebody would not make a decision based on those external factors such as costs when you are doing best interests?

Lorraine Currie: In my experience, best-interest assessors are incredible professionals. This has been a new role and it has become a fantastic role. They are best-interest assessors working within DoLS, and there are wider questions about best-interest decisions in social work practice. Again, though, I have found that people make very wise decisions. The best-interest framework is about the way in which the decision is made, rather than so much focused on the decision itself. It requires people to collect evidence in the correct way and to consult with the people they need to consult with.

All of us, though, are too aware that resources are finite and limited. We could probably describe a tailor-made service for every service user that we come into contact with, but that is not the real world. People are aware that best interest does not mean that you can have the best possible service that there is. As we have trained and as we train other assessors and social workers, we are trained to consider the options on the table. Sometimes those options are limited, and that compromises decision-making. That is absolutely true, and it would be wrong to deny that.

For some reason, locally we have recently had a number of DoLS referrals for people with neurological injuries. We found ourselves authorising perhaps three deprivations of liberty for the same person because we were unable or the staff were unable to identify appropriate rehab resources. That person may actually be deprived of their liberty in a more restrictive hospital setting because they are waiting for those resources to be available

for them. You would not find a best-interest assessor in that context saying it is not in their best interest to be there because the end result of that would be the person could leave the hospital to no resources. It is striking the balance between the person's safety and having some aspiration about what is in the person's wider best interest within available resources. I think people generally do balance that well. I think we have been very well trained in local authorities that we have to take account of resources.

Terry Dafter: It would be naive to suggest that the resources available to somebody within the local authority budget or the health budget are not a factor in making those decisions. You cannot avoid that.

Lord Patel of Bradford: Can I just ask another question? This is slightly wide of the mark, but you two have provided such clear answers to all the questions, I had to ask you. You might want to go away and think about it, but is there an issue around black and minority ethnic communities, whether it is overuse, underuse or anything you know in terms of what is happening about the Mental Capacity Act?

Lorraine Currie: I do not believe the data would bear that out, but again it is a very personal, quick response to your question. I do not know that we are very good at knowing what data we want to collect and why. I think perhaps we tend just to collect the usual, generic data. Certainly for DoLS we would collect the ethnic monitoring sheet, but I would not know whether we collect very good qualitative data about types of care homes, types of restraint, or whether certain populations within a generic area may be more likely to experience restraint. There may be some very good questions that could be asked, but I do not think anybody has asked them or collected the data. I may be wrong and there may be lots of research out there, but I am not aware of it.

Terry Dafter: I am happy to do some more work, and if there are any figures around that, I will send them in writing to the Committee.

The Chairman: That would be very helpful.

Terry Dafter: I will have a look into it.

Q181 Lord Alderdice: You have been mentioning data and figures. We have been looking a little at the numbers of DoLS applications in regard to the number of people to whom they might be applicable. Do you find that managing authorities are able to identify a deprivation of liberty? Are you confident that applications are being made when they are needed? How do you explain what appear to be substantial current regional variations?

Lorraine Currie: Some managing authorities are able to identify a deprivation of liberty. It is very pertinent that we are sitting here today while the Supreme Court is trying to decide what it thinks deprivation of liberty means. We are expecting a lot of staff who possibly get paid £7 an hour to make decisions on a very complex subject.

I could not say I am entirely confident that referrals come in when they should do. I think we have to create a welcoming culture, where they are free to put in referrals, even for those to be found to be inappropriate. I personally would rather have those and find the person to be ineligible or the safeguards to be not applicable. I welcome that sort of dialogue with our managing authorities.

I think they hold a lot of fear of getting it wrong because the tariff has been set quite high for their applications. It is very much tied to training. Where we do training, usually an application will follow. There is confidence in the process itself, so once a care home or a hospital ward has made an application, they tend to feel more comfortable to make them again. We monitor our care homes very carefully; we know the ones out there who have not been on training and have not made any DoLS referrals.

It is a wide question to answer; the variations are there and we cannot get away from them. We collect data regionally, so we collect it across the West Midlands per 100,000 of population, which is slightly more informative, and we discuss that. If something stands out,

we discuss that regionally between the leads groups. The number of referrals we have authorised sits at around 50% to 60% across the West Midlands, so we have moved from having great extremes to more consistency. I think that is because of the work we have done collectively in looking at good standards.

This process needs to start in the care homes and in the hospitals, and it almost should be the other way round, where if we were out there and we were required to inspect them and to say whether they needed to put in requests, then maybe we could be asked to comment on our confidence. While it sits with them, though, it is about how much formal and informal training we provide them. We visit them and we go out and provide them with information. It is still very early, and it is again about having that centralised view of why there are so many variations across the country. I can speak for the West Midlands, but not for other parts of the country.

Lord Alderdice: Could I just press you a little as to how far you think it is to do with differences of need and how far it is to do with differences of training, expectation or personalities that are key to it, or whatever? You will find that there are different levels of problems in different regions; it is different in urban areas and rural areas for example. How far is it to do with those kinds of differences and how far is it to do with other kinds?

Lorraine Currie: It is like the layers of an onion. Again, it is about different cultures; the culture in care homes often needs to change. The Mental Capacity Act is the forerunner of establishing good practice. If we get our care homes to implement the Mental Capacity Act properly, look at restraint and restriction, the techniques they use and the tactics they use, and the types of support they need to cope with some very challenging situations, that may lead on to helping them to encourage staff to know when this has gone beyond the Mental Capacity Act, what they can do under Section 5, and when it has moved in to DoLS.

Terry Dafter: It is interesting, because I was talking to a director from a large county who was saying there were variations even within his county in parts of the county where there is quite a high use of DoLS and other parts where there is very little. It is not just regional; it is almost within big counties as well. I do think this is something we need to do more work on because, as Lorraine describes it, it is partly to do with training and awareness, but it is also need. There may be some homes where it just would not be at all appropriate to make any referrals because most people have capacity. Again, I think this is just something that we need to do more work on, and begin to have more of a dialogue around this and get underneath some of this data.

Something is going on, and we are all making assumptions around what that might be, but, again, part of the proposal that we are considering within ADASS is to actually try to do a piece of work around this to try to unpick this more. It is not right; there is something going on and we need to get to the bottom of it.

Q182 Baroness Browning: How do local authorities ensure in practice that their role as a supervisory body, where for example you assess applications for DoLS, is independent of their role in relevant decisions on care? At that point, where there is almost a crossover between the two responsibilities, is there a particular process or something that is put in place to demonstrate transparency?

Lorraine Currie: The processes sit quite separately within most authorities. There is a crossover sometimes, in that the best-interest assessor may also be a care manager. That is not always the case. For example, we have substantive best-interest assessors, so they are not involved with care management. The DoLS referrals would come in and there is a DoLS process that will go along a parallel line. It will not necessarily link with care management other than the required consultation and communication.

The difference comes at the end, where quite often the people who are authorising those DoLS requests may be senior managers within adult social care. They will have knowledge and they will have experience of care management for that individual. Sometimes a number of these individuals will be funding their own care; they may not be funded at all and not have had any care management, or minimal care management.

We have actually found the loop works quite well the other way round. Generally, the best-interest assessor may pick up some inadequacies in care management or they may pick up that perhaps the MCA has not been as properly considered as it should have been. They can then work to influence that back round into care management to the benefit of the service user. We have found some real benefits in that, rather than sensing any kind of constraint in the role. I have found it a very positive thing, but I think there is a requirement to keep a distinction between best-interest assessors and authorisers acting—in the case of BIAs—as independent professionals and not being constrained by their care management role.

Q183 Baroness Barker: From the start, there has been a suspicion that the local authorities being the bodies that commission any care services would be a weakness in the Bill, because they would be reluctant to find against the body that commissions and employs them. In light of your experience, do you think that criticism was right?

Terry Dafter: I would be worried if that were the case, because I think generally we commission a number of services that are there to help quality-control what we are doing. I have an independent chair of my adult safeguarding board who spends a lot of time telling me off for the failings of the board and what it should be doing. I would not dream of not renewing his contract; it is what I pay him for. It is the same with this. You would expect healthy challenge and healthy feedback on the way that you are operating, but that should be helpful. It is part of the quality control of your department and your directorate. You

would not want somebody to say it is all okay, because it is never all okay, is it? You are never there; there are always issues that need resolving. In a sense, I feel it is inherent in the role. We commission advocacy services, independent chairs for safeguarding and so on. I do not think it is unique within the kinds of services we commission sometimes. I just think you need to try to treat it healthily and see it as a healthy challenge, not something that is disreputable. It is what you pay for.

Lorraine Currie: We retendered our contract recently, and that commissioning process throughout was not based in any way on: "How many times they have criticised us?". We are looking at the quality of that provision, and to some extent the quality of that provision is how many times they have challenged us. It is a healthy relationship that we have with them, and we almost look forward to them raising things that we can address. We work in partnership with them, they are part of our operational and our regional networks, and we value the role that they have.

Baroness Barker: That is good to know.

Terry Dafter: That is definitely what I would hope.

Q184 Baroness Barker: Finally, access to justice is something that people are concerned about. There are lots of concerns about the speed and the capacity of people to get to the Court of Protection. People like BASW have suggested using more mediation IMCA-type services in order to speed things up. What do you say to that?

Lorraine Currie: We have said that we would welcome a tribunal system, for that being seen to be a quicker resolution for people. However, it is a very big and a careful decision to be made. The Court of Protection needs to be more accessible and cheaper. There is no other way really to say that. There are a number of possibilities out there. Removing the need for expert witnesses would make the whole process a lot cheaper. I am a BIA, and a lot of BIAs feel that we are experts in our field, and yet the minute that we step into the

Court of Protection, experts are commissioned at huge cost. We need to remove the need for expert witnesses as routine—not in every case, randomly—have more regional hearings for the Court of Protection and more nominated local judges who could speed up that process so that this was something that happened regionally and your case was heard more quickly. Often these are people who may not have a lot of time, and these cases can take a long time, but similarly they can be heard very quickly if the need is urgent.

Although tribunals sound like a great idea—and I think I am mid-way to changing my mind on my view—if they are not resourced and if representation is not made freely available to people, that would be a huge burden for somebody to bear. If local authorities were suddenly expected to have to develop a local tribunal and resource it, it may result in something worse than what we currently have, and I would hate to advocate something that made things worse. Without a doubt, it needs to be speedier and cost less, but there are changes to the Court of Protection as it currently stands that could achieve that. We would not lose the expertise; some of these judges have built up such a fantastic body of expertise now that we really value. It would be a loss.

The Chairman: So, you are really saying that you would prefer satellite courts in local areas with the expertise of the judges of the Court of Protection, almost like the Court going on circuit.

Lorraine Currie: Yes, something along those lines could speed the process up, and the removal of experts could make that less expensive for local authorities.

Terry Dafter: There is a real body of evidence on this now, is there not?

Lord Swinfen: You mentioned experts giving evidence. Where do the experts come from? Are they just people doing your job in a different part of the country?

Lorraine Currie: I would not know how they get on to an expert list. I do not know that, but experts are generally people who, I believe, call themselves experts. Their expertise

then comes because they have done this X times in the Court of Protection. They will be psychiatrists or psychologists who are therefore seen to have more expertise in the field, but there are some recent court decisions preferring the evidence of people who do this more day in, day out and possibly know the service user better.

The Chairman: Thank you very much indeed for a very interesting session.

Terry Dafter: Just for the record, could I just let you know that I am no longer Joint Chair of the ADASS Network since last week? I have had to take on other responsibilities within ADASS. I am a member of the network.

The Chairman: Thank you very much.

Examination of Witnesses

Patricia Kearney, Director of Innovation and Development, Social Care Institute for Excellence, **Sanchita Hosali**, Deputy Director, British Institute of Human Rights and **Paul Gantley**, former Implementation Manager for the Mental Capacity Act, Department of Health (2005-11)

Q185 The Chairman: Good morning. Welcome to this evidence session and thank you for your written submissions, which were very helpful. We can perhaps explore some of the issues in a little more detail this morning. Could I start by asking Mr Gantley first of all to give us his assessment of the effectiveness of the Government's MCA implementation programme?

Paul Gantley: If you start from the narrow perspective, which was that we were expecting to bring into place a series of new processes and services, it was effective in that when we gathered in 2005 we were supposed to bring in 2007 various things, which happened. There was a new Court of Protection, a new Office of the Public Guardian, a new IMCA service from scratch in about 150 or so local authorities, each commissioned on time, a new fence was put into place, a code of practice that had three versions at different times, there were lasting powers of attorney and so on. From a narrow perspective, we were effective and we achieved those targets.

Then in 2009 the deprivation of liberty safeguards were introduced, which was the second phase of implementation. The period 2007 to 2009, from the Department of Health's perspective, was certainly a much tougher timescale. That was much more process driven. It required us to engage with universities to train people against a very unusual timescale. From that perspective, we can say we did achieve the targets and timescales to bring the legislation, the organisations and processes into place.

We can say that there is a legacy: the local implementation networks by and large carry on, the regional networks carry on, and there is an online knowledge community that has more than 4,000 members and which we set up as a parting gift. If we are judged against that standard, we were effective. That is not the same as saying the Act is fully implemented or understood. That is a different test. That would be my comment in relation to that.

Q186 The Chairman: Can you tell us why the programme was stopped in 2011, and do you know what programmes or resources are still produced on a national scale?

Paul Gantley: The original implementation programme was cross-government. The lead department at the outset was the Department for Constitutional Affairs and is now the Ministry of Justice. It is interesting to note that despite some comments in Parliament at times that this is one of the most significant pieces of health and social care legislation of recent years, it was not led as a piece of health and social care legislation. It was led by the Department for Constitutional Affairs and by the Ministry of Justice, which is an interesting thing to note.

When it came to 2007, and the Office of the Public Guardian and the Court of Protection were in their new form, the Department for Constitutional Affairs considered its implementation done. Its business was getting those new processes into place. The Department of Health continued in the first instance because we were looking to continue to embed, for example, the IMCA service, which was still relatively new. Then of course we had a quite different beast to contend with in terms of implementation, which was the deprivation of liberty safeguards. The continuation at that point was not so much about implementing the Mental Capacity Act; it was about implementing the deprivation of liberty safeguards. It was a different direction.

When it came to 2011, when we did depart, I think that was part of a wider decision around the Department of Health austerity cuts and so forth. I do not think there was necessarily a

particular decision that said our time was done. It was very much that people doing a similar task were going across the board. I might not argue this, but you could argue that six years was a good run for a central government implementation programme. I suppose that knowing whether something has been achieved depends on what you were seeking to achieve at the outset. I am not sure we necessarily had that. I was asked very early on, possibly at the first meeting I went to of the cross-implementation programme, when I would know that I had succeeded in training everybody on the Mental Capacity Act. I said, "You could have my resignation whenever you want it". How do you know that you have trained three million workers? How do you know you have communicated with three million carers? How do you know you have got something through as a message to two million people lacking capacity? How do you know? I think it is difficult to answer that question.

The end came because of a wider political moment. That has left behind a legacy. We have the local implementation networks, the regional networks and the online community that continue. There is some success there; there is ongoing funding that is maintaining the profile locally and regionally. What is lost at the centre, though, is a central focus. For example, we finished in roughly March 2011, and in February 2011 we issued some guidance around the case law as it was at the time, but there has been no more guidance from central government about case law. The resources that come from the centre now are much more around reporting and auditing. There are annual reports from the Health and Social Care Information Centre around deprivation of liberty safeguards; there is an annual report from the Department of Health around IMCA activity; the Department of Health has had some commissioned research come through, some of which I am sure has been shared with you. The central emphasis now, though, is more about activity and numbers. One of the things the field has commented on missing is something that is more analytical or something that is

more about guidance—for example, with case law development. That would be perceived to be a gap that others have reported to me in the last two and a half years.

Patricia Kearney: Shall I say something from the Social Care Institute for Excellence? Our remit is to gather and analyse knowledge about what works and disseminate that into practical resources. This is an interesting topic from our point of view, because it is fair to say that I do not think there is a rigorous evidence base yet for the impact of this work. I would also say that I think it is fair not to expect it in the case of emerging practice like this. The legislation is on the whole well drafted, and its principles and definitions well regarded in this sector, but that is only the start of it. It is a hearts and minds job around cultural change. Cultural change and culture is how we do things around here, so we are talking about major professional behaviour change as well as public awareness and perception. Those are ongoing activities.

There are several challenges. There is a huge and diverse constituency of professional audiences before you even get to think about carers and people who use services, so that kind of shift takes time. The Act has supported and informed a growing understanding running alongside the Act's implementation around personalisation and person-centred care, and dignity. Our dignity guide is our most visited resource. Interestingly, that is always linked backed to the MCA. The landscape has changed too: the recent focus on MCA and DoLS monitoring that CQC has announced, the Care Bill's aspirations around individual care and control, and the establishment of adult safeguarding boards. These are all movements that I think enforce and take forward the spirit of the MCA. It is about seeing it as a staged process. We have the frameworks in place: the what to do and why to do it. We are still moving on the how to do it and what the impact is if you do it right.

Sanchita Hosali: I would probably echo a lot of what has already been said. From the British Institute of Human Rights' perspective, we do a lot of practice-based work with both

service providers, and advocacy groups and individuals accessing services. We have a perspective that works with both sides of the coin. From our practice-based work, the message we get time and time again from all the audiences is a real lack of understanding about the MCA and what it really means in practice. Quite astonishingly for us, there seems to be the almost complete invisibility of the role of human rights in that whole process and the fact that we have mental capacity law in order to protect people's most basic rights. There is a real divorcing from what our human rights standards say and how that can work in practice. We see a lot of people who are quite confused by the MCA and what it actually means, and a lot of people working in safeguarding who are very familiar with concepts like best interests or dignity, but then are very confused about what that means in practice.

Actually, the work that we do in practice shows how you can use a human rights approach to drive that culture change forward and to say, "What we are talking about here is a way of giving unifying values, but also providing a framework to make some very difficult decisions in". A human rights approach is how you look at the rights that people have, the responsibilities and duties that practitioners have, but also what that looks like in practice going through the way that you balance those different rights.

For us, we work quite broadly in the health and social care context, but also much more broadly with public bodies and officials. What we are seeing with the MCA is symptomatic of a much wider issue: that people just do not really know their basic rights, or their duties if they are a public authority. If we had that level of quite basic understanding, it would be much easier when we get into very specific practice-based settings around, "What we are talking about in the MCA is not something new or scary; it is about what those rights mean in this setting". There is a basic building blocks thing that needs to happen, and that would make a lot of the implementation around the MCA a lot more realistic and a lot easier to

grasp for a lot of professionals and practitioners, as well as for the individuals who should be at the heart of the Act.

Q187 Lord Turnberg: My question follows on from that. Whenever there is an Act of Parliament that depends on large numbers of people out there to implement it, I suppose it is inevitable that there is going to be a bit of variation in how that is enacted. I am sure that is one of the difficulties, and we are told that there are big regional variations in things like IMCA referrals and DoLS applications. What I am really interested in knowing is how you get the balance right between central directive and leaving it to local people to set it in motion and to do it. We do not always get that right. Local initiative is very important, but how much central direction do you need?

Paul Gantley: My experience would suggest now that there is something illusory about central control. My reflections would be you can provide the law, you can provide the code of practice and you can provide guidance, but that only really comes alive locally and it is only really implemented locally. The variations are a problem, whether it be IMCA referrals or the DoLS numbers, which in a way are the only numbers we have to look at in terms of this legislation, because the rest is kind of abstract. They are a problem, but I am not sure it is a brand new problem in the sense that we often hear about postcode lotteries. Just for a point of comparison for myself, I was looking earlier in the week at last year's Mental Health Act figures. I saw there that per 100,000 population, it was roughly 80 in London, 30 something in most of the country, and no one outside of London above about 50. To take the Mental Health Act, which has been around for a long time, you have more than twice as many people being admitted in London compared with most of the rest of the country.

Lord Turnberg: That might be the people.

Paul Gantley: There could be all sorts of reasons for that, but once you get into numbers the issue is that unless in advance or as things develop you set some kind of notional number

as to what should be being achieved either locally or regionally because of variations you understand, it is all a bit of what I think/what you think.

One of the things that we were told when the deprivation of liberty safeguards were first coming into place was, “We’ve got very low numbers because our training has been so good”, and other people would say, “They’ve got very low numbers because their training has been inadequate”. Individual trainers would say, “If you look at where all the high numbers of activity are, it is all the places where I’ve trained the people”. That would be their CV’s USP. It is tricky. A postcode lottery seems to be inevitable, unless you have some quite sophisticated way of saying what the right figure is for that region. The fundamental answer to your question is that the real work is done locally in bringing about change and bringing about implementation and the centre can set the scene.

Q188 Lord Turnberg: We know of some places that do well by whatever measure. How do we spread that good practice?

Paul Gantley: That is key. This may be answering a slightly different question, but I think it flows, if you can just let me develop the logic. At the start, we were required to explain the law to people. It is a new piece of legislation, so you have to tell people what Section 4 or Section 44 is. We then realised that was not really doing it. Telling people what the law is is only getting so far because people only understand the law as they operate it. If you take this law, you have an untrained workforce in the care homes, a somewhat better trained workforce in other settings and a highly trained workforce in another setting. You then have family carers, all of whom are bound by the code of practice. To try to describe the law to all those people in all those environments is very difficult. Working with SCIE colleagues in particular, we discovered that we had to demonstrate the law in action. SCIE television for example starts to show how you make a best-interest decision for someone in a care home around safety, or how you make decisions with people around finance.

One of the ways you have to do it in the end, whether it is nationally or locally, is you have to show it in action. You have to start from where the person is and then the law follows. The problem when you introduce a piece of legislation is that you start from the law, which in a way is the wrong way round in terms of trying to understand it for people on the ground.

Patricia Kearney: Just to follow on from what Paul says, just quickly about the data, this is not unique to the MCA. If you look at data around looked-after children in a local authority, does that mean it is a very vigorous local authority and very responsive to children's needs or is it repressive practice that we are looking at? I think other people have said this: we do need some better and further analysis of the data that is coming in. Data are data, and you have to work out what it means in terms of variation.

I just want to say a little about how you embed learning following a pronouncement, a policy change or a law change. Our work on personalisation is an interesting model, because when we started off producing resources on that, people were saying, "This word is not in the dictionary". That is where it was. We started with a rough guide, which explained why and what it was, but we followed that up and realised we had to follow that up over time with resources that said, "What does this mean for me?". We have a whole range of small briefings for particular audiences—for example, people with autism and their carers, accident and emergency departments, safeguarding professionals—and then emerging topics like personal budgets. How does this keep fitting in and being the underpinning and the centrality that drives an awful lot of other work in social care? I think we are just getting to the stage—the codes of practice might be worth reviewing—of deciding whether we need to tease them out a bit more into specialist audiences and general audiences, if I can put it like that. Specialist does not necessarily mean an untrained professional and general does not necessarily in this case mean a highly trained professional. It means, "It is what I do not

normally do". Accident and emergency departments, for example, might be a bit more general than you would think.

Q189 Baroness McIntosh of Hudnall: This slightly anticipates a question we will come to later, but Mr Gantley, when you were embarking on this programme of implementation, was it any part of your team's remit to think more widely than just the people who were going to have to implement the legislation and the people who were going to be directly affected by it? That is, did it strike anyone that a wider public health information campaign either was or might be necessary? If it did strike people, what did you do? It occurs to me that actually most of the discussion that goes on around this Act is focused on the people who are directly involved with it and very much less on setting it in a wider social context. If you compare that with the public health campaigns around things like HIV, it is understood that people are likely to be touched by the impact of that issue. Was there or is there any recognition of that in relation to issues to do with mental capacity?

Paul Gantley: I would say we became aware of that as things unfolded. Rosie Varley, who was the Chair of the Public Guardian Board, advocated that things like lasting powers of attorney and advance decisions to refuse treatment should be on the national curriculum. These should be things that teenagers think about early in their life. The Act was put into the kind of context that you are talking about. We certainly produced booklets that were distributed to be made available in GP surgeries and the waiting areas in local authorities. We produced material that was for the public. They would sit there to be picked up, but they were not aimed in the way that you say.

Baroness McIntosh of Hudnall: You had to be in a surgery to get them.

Paul Gantley: Yes, precisely. There is certainly now a valid question and a potential task for public health professionals to pick up on. The Act is about planning for the future as much as it is one in which you lack capacity. That I think has not had as much publicity as it could

have done. Off the top of my head, I think it was in 2009 that “The One Show” did a programme on lasting powers of attorney, and the Office of the Public Guardian was swamped the following week; there was a spike in applications. Periodically radio programmes such as “Money Box” and things like that have of their own volition looked at this, but it is a task that is still to be done.

Baroness McIntosh of Hudnall: We might come back to it later in the questioning.

Sanchita Hosali: I just want to pick up on a couple of the issues raised around centrality and guidance. On centrality, a lot of the practitioners and advocacy groups we work with do find the lack of centrally driven approaches to guidance quite difficult. There is a lot of local-level guidance explaining the MCA codes of practice, for example, and some of them are very good; some of them may be not so good. The issue then becomes to what extent it is actually legally accurate and reflecting the code of practice. That creates some very big concerns in terms of the postcode lottery and what is actually happening. While work does happen locally, there does need to be a level of central guidance driven home. Often groups and practitioners find they fall somewhere between the Ministry of Justice and the Department of Health because these issues cross over both of them. There is a little bit of: “Who is responsible for what?”. The idea is that things do happen locally, but there needs to be some kind of centrality. The fact that there are variations can mean lots of different things, both good and bad, but the fact is there are variations, and that, in and of itself, is not a good thing.

Then on the idea of codes of practice, we had some briefing meetings and brought quite few groups and practitioners together. The thing that came out from those was the fact that the code of practice is so impenetrable, and it is very different from other types of codes of practice. It almost seems as though it is trying to be an explanation of the law as opposed to an explanation of what it means in practice. Some of the comparisons that the groups we

worked with drew out were about equality law, where you have different types of codes of practice produced for different audiences. They include very practical examples of what that actually means and looks like in real life. That is a direction of travel that could be very helpful for the code of practice. Again, that is something that can be tailored for lots of different groups.

I would echo the importance of being relevant and starting with the person. As I said at the start, the whole point of this law is to protect the individual, but to protect their rights as well. It is not just protectionism; it is also ensuring that they can enjoy their rights and not have their rights restricted unnecessarily. It is really important to place that person at the heart of any issue to do with the MCA but actually being really practical and relevant about what that means and thinking about what in practice it looks like for those practitioners and how they balance a person's rights. For us, that is where a rights-based approach comes in to offer a framework to bring together all these things. The MCA is not operating in isolation, and often there is confusion with the Mental Health Act, where that comes in and how those two pieces of law sit together, as well as safeguarding policies and all sorts of things. It is thinking about what the approach is that is being taken across the board.

Q190 Baroness Hollins: Do you think the Mental Capacity Act presents unique challenges for implementation because of the wide range of professionals and individuals affected by it and, as Lady McIntosh has emphasised, the wide range of people who need to know about it? Are there any other similarly wide-ranging policies that we can learn from?

Patricia Kearney: I do not think it is unique. There are lots of examples of directors who have a wide audience, such as the Putting People First concordat. I would probably just expand that a bit to take up Baroness McIntosh's point about the power of a public campaign. If you look at the dementia awareness campaign and how that fits in with all the dementia legislation and guidance, it is an enormous push. Sometimes the gradation

between professional and public is not always that great. In fact, not realising that what you are doing constitutes restraint or deprivation of liberty is quite a shock. That works with the public, family carers and professionals. We found this out when we tested out our e-learning resources. The testing was really to see how the navigation works and whether you can get round it. There was shock from the professionals looking at the examples and saying, "Oh heck. I do that". The awareness works both ways, and we have learnt a lot from the implementation so far as to how to focus a public campaign.

Sanchita Hosali: I would agree with that. There are a lot of very good campaigns and programmes that have happened. We have mentioned dignity and dignity champions, and the dementia programme that is happening. These are all things in which there are some really good examples of good practice, but from our perspective working across the whole spectrum of health and social care, there are lots of things that are doing almost similar things, but not quite, and are very specific to the fields they are in. Rather than having an approach that looks at the whole person or the way health and social care is provided, we are focusing on dementia, but actually dementia has a huge element of the MCA attached to it. Dignity also has a huge part of the MCA attached to it. One of the things that we are quite conscious of is that there are lots of pockets of programmes, campaigns and activity that deal with isolated issues as opposed to looking at some of the much broader root causes, which those things could then sit alongside.

Patricia Kearney: If I could just add a quick supplementary to that, our resources and our training and consultancy have recognised that you have to start with a triangle of safeguarding, the MCA and dignity within a human-rights approach. When people see that triangle they think, "Oh, right. If I do that, I am half way to that", and actually they are part and parcel of the same thing. That is the ultimate message to get across.

Paul Gantley: I would not claim it was unique, and clearly colleagues would contradict me if I tried to. What I think was a rare challenge, though, was the range of the number people who had to receive the information. That is unusual, in the sense that there was an ambition to try to communicate with all those eight million people, and that is difficult to do because they have such varying needs. If it is right that there are two million people today in England and Wales who lack capacity, there are many millions of decisions being made about those people. To try to contextualise all those decisions for all those people is a rare challenge.

The discussions are slightly about how you best set about communicating with that, which I think is a slightly different discussion. With the benefit of hindsight, I would say that you probably spend a bit less time on the law than you thought you had to and you spend more time on trying to find the entry or the in for the person who needs to understand the law. It is this inevitability of having to describe the law in the first place, if you are an implementation programme for a piece of law, that means it takes you a while to get the second stage. The second stage is a much more creative one in which you can communicate in a variety of ways. The first stage is frankly a bit dry, because you have to communicate facts about a piece of law. It is difficult to do that without simply stating the law and variations of it.

Q191 Baroness Browning: Mr Gantley, can I just ask about your experience from the Department of Health? People who are diagnosed with any condition very often say that having been to the hospital and got a diagnosis, whatever it happens to be, they then founder trying to find out about a condition. I know we have moved on and many hospitals have their own information desks and offices now, but this is a moving population so all the people who perhaps lack capacity today will be a different population perhaps from those who are seeking that information in two years' time. Suddenly something has happened in their lives or their carers suddenly have responsibility. In the past, how has the Department

of Health approached this dissemination of information to a moving population who will be quite different in the future from what they are today? This is not unique to the Mental Capacity Act. It is something that we have all thought about for a very long time.

Paul Gantley: For want of a better description, I think you have silos. You have policies on dementia or you have policies on strokes or something. People communicate almost through those diagnoses, so you have a campaign around dementia awareness or something. The problem with the Mental Capacity Act in that sense is that it covers all that. It is about all those things.

There was what struck me as a very sensible suggestion by the Nuffield Council on Bioethics a couple of years back—it might have been 2009, but I can find it if you want me to. They said that anybody who was diagnosed with dementia should be helped or encouraged to make a welfare power of attorney. That should be part of the discussion. Of course, whether they do or not is for them to decide. They went further. They said a lasting power of attorney should be free because it is a social good. That is a separate matter.

That is an example of extending the clinical interaction or the diagnostic moment into a wider thing around planning and around awareness: “Do you know?”. You do not have to talk about the Mental Capacity Act at that point; you have to talk about the things that you might need and they flow from the Mental Capacity Act. You could have the discussion even without ever mentioning the Mental Capacity Act. It is about that invisible, silent integration of these things into those moments, and we are a long way from that. I am not sure that those clinicians would see it as part of their role at the moment to help someone plan. Many will, but many will not. It is about that contextualisation of following the moment for someone.

Baroness Browning: Is this something that clinicians should focus on? One of the difficulties with a diagnosis, whatever it is—if someone is suddenly diagnosed with MS, for

example—is that the clinician deals with the diagnosis; they do not necessarily give them the number of the local support group.

Paul Gantley: Yes, all that. You get into labelling and a social model of illness starts to include those things. A clinical model maybe does not veer beyond the treatment.

Q192 Lord Swinfen: The Government's submission outlines significant training and guidance, and the Committee has seen a range of guidance produced by different organisations, yet we have heard significant evidence of widespread non-compliance. Can training and guidance achieve cultural change or is more needed?

Sanchita Hosali: Training is part of cultural change, but it is not all cultural change. That is something that we have seen that is quite problematic, not necessarily specific to the MCA but with the implementation programmes in general. You take a piece of law and you train on the piece of law, and then somehow it is reduced to training. I am not saying that is all that happened with the implementation programme. It is actually much more about an approach, and culture change takes a long time. It is not going to happen overnight. There are no magic wands—that somehow we have changed a culture. It is about looking at the ways in which we do change culture and testing what works, what does not work and finding out the ways in which we can bring those changes.

We have certainly seen some really positive results using a human rights-based approach to the organisation of healthcare service providers in the way rights are permeated, from top strategy down to service delivery, and what that service actually looks like in practice. That picks up from the previous point as well. An example of that would be our work with Mersey Care NHS Trust and the Learning Disability Directorate, and obviously a lot of what we are talking about has very particular meaning within that context. For the last few years, we have been working with them on what a rights-based service actually looks like. It is things like genuine empowerment and participation of service users in the process. It is not

consultation; it is the creation of service user groups that are part of the process of hiring staff and investigating various incidents and part of the process of risk management and planning when there is a diagnosis, and the kind of information that is available. It is bringing in not just those individuals but individuals from across the whole staff team. It is clinicians, but it is also support staff and other people involved in that service as well as external independent advocacy and family groups, and thinking about an approach that brings all those groups together.

The human rights framework can be very helpful in that, and we have seen some really good results from our evaluations of that work. We have seen it above 70% among staff, service users and carers that that kind of approach has been good for mental well-being, but it has also been good for changes in attitudes and behaviours, particularly among the staff team. It becomes about having a language to have conversations. We talk about people's rights, but we also talk about duties and about ways to balance those in meaningful and practical ways. It does not become emotional disagreements and arguments. It does not become about different people's internal moral compasses; it is a framework for approaching the whole process. We have seen some really good results with that, particularly in learning disability and mental health, which obviously has real resonance for the way people approach issues around the Mental Capacity Act.

Patricia Kearney: I would echo that. One of the issues is not just that we are moving into different populations but that a diagnosis does not automatically imply lack of capacity, or that there is lack of capacity today but not tomorrow and then back the day after. Fluctuating capacity is something that organisations and professionals really need to get their heads around. Rather than taking the diagnosis—and therefore a presumption about capacity—taking the liberty a person needs to have to enjoy their life is a much better way into it.

Just to give you a quick example, one of our social care films is about Raymond and his money. Raymond is an 80 year-old person with dementia, and his main professional contact is a carer who comes in, and he wants to spend £50 on lottery tickets. A lot of people would see that as an unwise decision, whether you had dementia or not. It is about how you go through the process to make sure the five principles of the Mental Capacity Act are put into play by the carer: thinking about capacity, recording the decision and the process, and actually making sure Raymond gets to do what Raymond wants to do, and it is perfectly all right. That is a massive shift from wanting to keep people safe, which is essentially proper and good—and you cannot take too much umbrage with people wanting to do that—to a very different way of regarding what the carer does and what the person using these services wants to do.

Lord Swinfen: How is this affected by the high turnover of staff, which we understand are often poorly trained as well as being poorly paid?

Patricia Kearney: There are two things. One is that the high turnover of staff in social care is an issue across a whole range of activities. I would not want to underestimate the difficulty of that. The CQC is looking more closely at induction training, for example, as a way to address what is part of a wider problem. We have found—and I think colleagues might say the same—that when we meet with frontline practitioners, there is often an instinctive wish to do good. When people start to understand what the MCA is trying to do, it makes sense. Then they are caught up in whether they have the right to make this judgment, which the MCA helps them with, and whether they are working in an organisation that is risk averse or risk enabling. All the issues about health and safety and so on play into those anxieties. It is something about how the organisation gives permission for staff, whatever level they are at, to work in a human rights way.

Q193 Lord Alderdice: In a way, this slightly goes back to one of the things that Lady Browning was saying earlier. There is sometimes a tendency in a human rights framework in this context to see the rights being on the side of the patient or client and the responsibilities being on the side of the staff. In fact, though, there are responsibilities on the side of the patient and rights on the side of the staff. If Raymond decides to spend his £50 on lottery tickets, there are consequences. How far do you go in bailing him out of the consequences and how far do you not? There are issues of learning and so on. How do you work to ensure that the human rights culture that you are developing does not ignore the responsibilities on the side of the patient, the rights on the side of the staff and, indeed, of course both in respect of carers?

Sanchita Hosali: First, you have to be quite careful about using the language of responsibilities within a legal framework. You have to be clear about what we are talking about when we talk about legal duties and responsibilities, and moral obligations in the way we should behave and treat each other. Recognising that everybody in that situation has rights is a very productive starting point. Certainly, for the main part, the majority of our work started off working with practitioners and staff providing services. We have found that it is actually staff, particularly in middle management and frontline, who are very engaged by the human-rights approach. All of a sudden, it gives them something that is very practical and very realistic. It is the kind of thing that they can relate to because it relates to their values. However, it is also the recognition that they have rights as well in these situations. That can be quite a valuable move forward in terms of the culture change and process of bringing people with you. It is the recognition that all of us in this situation have rights and that there are different responsibilities, and that we need to make sure that all our rights are respected. That can be quite helpful.

Certainly, a big part of our work is about understanding what human rights really mean, and what they mean not just in law but in practice and relevance. That requires a level of expertise, experience and working together. It is not just off the shelf: “Everyone is going to understand human rights”. We recognise that that requires some work. Our practice work shows that if you take that approach of raising the capacity and awareness of each of those different groups that are involved in this situation, it actually becomes a framework that allows you to recognise everybody’s rights in that situation and to come to decisions that respect people’s rights.

For example, our work would look not just at the rights of patients and service users to access an outside space but at the rights of staff not to be subjected to bullying or harassment as well, and at the way that would fit into a framework to make sure that they are being protected. That is a really important part of the human rights approach. It is a human rights approach: it is all the humans in that situation. That is the staff and the service users, and the families and the advocates as well. The advocacy service is a really important part that goes back to that issue around culture change, information and who has access to those issues. It is also the idea that there are issues about making sure that there is independent advocacy and people have access to those services.

In a previous question, though, one of the issues was also around not just access to support groups but also who was commissioning these services. There is massively high staff turnover across lots of services, but what is the role of commissioners in addressing some of those issues? To what extent do commissioners use their power to ensure there are levels of knowledge and understanding within our various different services? I would say there is definitely huge appetite for learning. I would echo what Patricia said. People very rarely go into health and social care because they want to do harm to other people. It is often about reconnecting them with those values and what that actually means in practice. Certainly, we

have held six events on the human rights approach to healthcare—three events this year. We were oversubscribed by about 120% because there just is not access to that kind of support.

Q194 Baroness Barker: Throughout our sessions, we keep bumping up against the lack of awareness on the part of the general public about this legislation, not just of the principles and all that but of the very practical stuff like lasting powers of attorney or advance decisions to refuse treatment. Given your experience, what sorts of things do you think could be done to change that? I did note your point about the civic education syllabus and so on.

Paul Gantley: Let me go back to the previous answer first. There is a role for people to disseminate some of that information as they go—to see their professional role as being wider than the immediate treatment or social care issue. The impact assessment for the Act talked about codifying the common law and that there would be no radical or wholesale change. That has not been the case. One of the successes of the Mental Capacity Act has been to muddy the waters a bit and to raise issues about what proper care is. Complacency would be too strong, but the situation was not as good as everybody thought it was. At its worst, people almost seemed to say that capacity or incapacity was kind of invented by the Mental Capacity Act, which is slightly odd. There is a wider role for all professionals in disseminating information as they go.

Other than that, again I mention Rosie Varley, who was the Chair of the Public Guardian Board. She thought there should be a Mental Capacity Act champion or champions to talk about these kinds of things. That is not to talk about the issues that professionals want to talk about, which is what deprivation of liberty is, or things that professionals are forced to talk about, but to talk about these wider advantages of the Act for people.

My own belief—and people at this point always mention “The Archers” or “EastEnders”, and I am not going to do that—is that if I do not know about it, what is going to convince me is

to hear a compelling personal story that someone has: “In a moment of difficulty or crisis, it was really useful for us as a family to have a lasting power of attorney”, or, at the most extreme, someone had a good death as they wanted because their advance decision to refuse treatment was enacted. I think the answer lies in disseminating the experiences and stories of the people who are the ordinary members of public and the recipients of services. I do not think it is a matter for the professionals. I heard a consultant geriatrician who has a lasting power of attorney and has a personal condition of his own speak very compellingly of when he went into a crisis and into hospital; his lasting power of attorney was used. He was a professional who knew all about the legislation, but the most compelling part of the story was the personal part. Something happened that he wanted to have happened. Somebody represented him. That is the story that needs telling. It is then a question of where you do that through the relevant articles, journals and the relevant media. I do not think it is a story for the professionals. It is a story for people themselves, for want of a better distinction.

Baroness Hollins: Do you think it is very widespread for members of the public to believe that they can make end-of-life decisions for their family members without a lasting power of attorney?

Paul Gantley: I do not think it is. There was a great deal of concern, as you and others will probably recall, through the passage of the Bill about these matters. The reality in the time since Royal Assent and coming into practice has been there have been far fewer of these. There is no momentum; it is a very unusual thing. If you talk to most healthcare professionals, they will say that it is something they rarely, if ever, come across.

Patricia Kearney: This is purely anecdotal. We get a lot of inquiries to our service from professionals and from the public—or their carers usually, rather than the public as a whole. First of all, that shows that the debate is still alive; implementation is not finished as far as people out there are concerned. Anecdotally, a lot of our queries from the public are

around precisely these matters and the role of the Court of Protection and the Office of the Public Guardian. I know you are taking evidence separately about that. We find that the website is much clearer than it used to be, but people tend not to know about it. When we move them on to that, they find it very helpful, but why do they not know about it? We do not have the answer to that, but I think some very simple and straightforward publicising about the role of the Court of Protection would be very helpful—in Tesco maybe.

Q195 Lord Swinfen: How do you ensure, when you have made a lasting power of attorney on end-of-life decisions and you are not well, that the people who are looking after you actually see that power of attorney and follow your instructions?

Sanchita Hosali: I would say that is why things like access to advocacy and independent advocacy are really important. I agree that we do need those personal stories in a much wider public and general debate about it. With these issues, we need our practitioners on the ground. We work in one particular mental health unit, for example, where there is one nurse who is very good at doing this but other nurses do not necessarily know about it. It is about those practitioners knowing, but also individuals having access to advocates who know these things, are there to support them to make these decisions, give them the information, and can then be the monitor of what happens in that situation.

Paul Gantley: One of the plans that I do not think has yet come to fruition in all the attempts to bring a new healthcare record into place was that each of us as individual patients would have something called “my personal space”, and that was viewed as the place where I would put the existence of my lasting power of attorney or the existence of my advance decision to refuse treatment. Somewhere else I would make it known that they were there. That was a technical or an IT solution to the problem. In the meantime, all that you can encourage is that, if I have one, it is something I must make known to my GP, for

example, or somebody else. If I take the responsibility to make something, as things stand it follows that I must take responsibility to make it known to others.

Baroness Barker: Whatever they happen to think about it, professionals all seem to know not only what they have to do but what everybody else has to do to be compliant with the Mental Health Act. In stark contrast, we keep hearing time and again that while social care staff may well be compliant, there is a feeling that different professions, in particular medics, are not. What do you think can be done to deal with that?

Paul Gantley: I am a social worker by background. If we accept that in the first place, which is not necessarily a universal view, one of the things that social carers are often obliged to do at the start of a social care interaction is to work out whether there is a legal duty to do anything: whether someone has a legal right to a service or whether I have a legal right to intervene. Social care has a legal framework that sets the event in motion. The medical professions tend to rely in the first instance on trusted clinical practice, and I do not think their first instinct, whether it is an emergency or an elective moment, is to stop and ask whether there is an entitlement to this or, “If I do this, will there be legal consequences?”. Their instincts at that point are based on trusted peer clinical practice. There is a distinction in the way the law frames those two things, which might be part of the explanation for that.

At its starkest, a nurse said to me in a particular event, “If someone is on my ward, I will make a decision for them whether they lack capacity or not”. That is a cultural issue that says a lot. There is probably a more advanced culture of trying to reach a mutual agreement and something called empowerment in social care, broadly speaking. There is more of a reliance on knowing what the right intervention is and achieving that intervention for someone in a healthcare setting, just as a sweeping generalisation.

One of the reasons that often clinicians do not go through what they should go through, which is a proper consultation process and so on, is because they have already worked out what is going to happen in the end, because the right intervention for this person is treatment A or treatment B. In the worst case scenario, they are just busy and they think there is no point in going through the consultation: "It is not going to achieve anything because we already know what the outcome is". It is the difference between what the law says you should do and what people do either because they are busy or because they know they are going to get to that place anyway.

It is how you get all the aspirations of the Mental Capacity Act, which are about how people should behave to get to that outcome, into practice when there is no incentive for those people to do that, because they are going to get there anyway. It is a cultural change to convince those people that it is a better world and that I receive a better service as a patient if I am involved in that transaction. It is how you achieve that culture change. You can only achieve that culture change through negotiation, through debate and through a certain amount of pain. It is not something that you can demand of people.

Q196 Baroness McIntosh of Hudnall: I think we have pretty much covered this, but I am just interested in it as a wrapping-up issue. You said something earlier on, Ms Kearney, about the moment that we are at with all these issues. You implied that we were very early in a process that was likely to be long and iterative. People have to learn and feed the learnt stuff into the process, and that then generates more learning. That is perfectly uncontentious. However, are we doing this work too soon? You implied there just was not really enough evidence to know how this is all working. If we link that to the answer that Mr Gantley just gave about culture change and about how you get practitioners, whether they be medical or social work practitioners, to understand how to engage with this Act and

to make it work, we are thinking, “Well, it has been five years. We ought to be seeing something happening”. Is that reasonable?

Patricia Kearney: I think it is absolutely the proper time to be shifting.

Baroness McIntosh of Hudnall: Good. That is a relief then.

Patricia Kearney: It is highly significant that our most recent publication resource about DoLS in practice has for the first time been able to put practice examples in because we are starting to get them. I think we should seize the moment. Data analyses, views of where good practice is happening and examples of that are starting to emerge. We should be looking for them vigorously, because the quickest way to get a culture shift is for me to see someone like me doing what I am being told to do.

Sanchita Hosali: I would absolutely echo that and agree with it. Now is absolutely the time to be doing this. As I said at the top, there has been such a disconnect between why we have the MCA and what it is all about. This is really timely to reconnect with that, but also to provide an avenue for the good practice that is going on, to get that message out there and to flag up where some of the issues are. While change and culture change is an ongoing practice, you cannot just leave it to continue in perpetuity. There will be points at which we need to stop and take a step back. With not just the big national scandals that we all know about but the local-level good practice work that is going on, now is the time to do that.

Paul Gantley: I would say that the Mental Capacity Act is a force for good and it has actually provoked some of these debates and some of these issues. Some of it is about whether people understand the law or not, but fundamentally to comply with the law is to behave well and to show best practice. The impact assessment said, “It sets out an expectation that best practice in attitudes and behaviour should be the norm for everyone”. We should still strive for that, but we need to show people what that best practice is. It is very difficult to make a demand of people that they are falling below best practice if we do

not know what that best practice is. We need to somehow demonstrate to people what best practice is, and then that gives them something to strive for.

The Chairman: Thank you very much for your evidence. This concludes the public session and we will go into private session now.