



# HOUSE OF LORDS

Unrevised transcript of evidence taken before

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

Inquiry on

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

*Evidence Session No. 5*

*Heard in Public*

*Questions 106 - 125*

TUESDAY 23 JULY 2013

10.40 am

Witnesses: Steve Gray, Elyzabeth Hawkes and Jonathan Senker

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### Members present

Lord Hardie (Chairman)  
Lord Alderdice  
Baroness Andrews  
Baroness Browning  
Lord Faulks  
Baroness Hollins  
Lord Patel of Bradford  
Baroness Shephard of Northwold  
Lord Swinfen  
Lord Turnberg

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### Witnesses

**Steve Gray**, Director of Operations, Asist, **Elyzabeth Hawkes**, Regional Manager, POhWER, and **Jonathan Senker**, Chief Executive, VoiceAbility

**Q106 The Chairman:** Good morning. Thank you for attending. As you are aware, this is being webcast, and you will be given the opportunity to correct the transcript. If anybody wishes to take their jackets off, feel free to do so because of the heat.

Could I start by asking each of you in turn—I will start with Mr Gray, unless anyone is desperate to start—whether you could give us examples of the type of cases that you deal with as providers of independent advocacy services? What tools do you use, and to what extent do you adapt your approach to deal with different types of impairment?

**Steve Gray:** Thank you, Lord Chairman. Of course you are aware that there is obviously a range of duties and powers that IMCAs are instructed around. We actually act on all the powers and duties—so change of accommodation, serious medical treatment, safeguarding and care review. Basically, we act on the whole range of IMCA referrals.

As regards communication, as you are aware I am sure, communication is the key—the cornerstone—of what advocacy is about. Advocacy is fundamentally about someone

expressing their views. In this instance, it is for reasons of capacity, but fundamentally it is about communication—so communication tools are at the core of what we do. Advocates are very experienced at using different tools and different ways of communicating, be it pictures, be it using visual stuff, be it using a range of techniques that we use. We have also developed a toolkit for advocates that enables them to communicate with service users and tries to aid that communication. In essence, the most important thing for advocates is to try, in the situation, to find out a way of communicating or developing a way of communicating—to make all efforts to try to find a way of communicating with the service users, to get their view. Even if somebody, in this instance, may not have capacity, it does not mean that they have not got a view, and we are very keen to see that view in the decision-making process.

**Elyzabeth Hawkes:** Obviously there are the issues that Steve has already covered, in terms of change of accommodation, serious medical treatment, safeguarding and care reviews, but there are also ones specifically in relation to deprivation of liberty safeguards. That needs to be seen as a very important, essential and separate part of the whole process. I think in relation to the communication, we do have the adaptive toolkits that we use, but we also try to build on what someone's communication style might already be—if they have been in a certain life situation when they have developed different ways of communication, particularly non-verbal. People think that just because somebody is non-verbal, they cannot say what they want, and that is not true; they can. They can use pictures; they can use words; they can use symbols; there is Makaton—even down to the basics of using proper translators, proper interpreters for people who are deaf, to make sure that people get the best opportunity to communicate in their way. Only when you have exhausted all that, we use a thing called a talking mat which is about building up somebody's own personal toolkit to help them to communicate.

**Jonathan Senker:** I entirely endorse everything that Steve and Elyzabeth have said. Similarly, we work with people across the broad range of decisions to which people are eligible, either under the mandatory or the discretionary powers. We work with about 2,400 people each year, broadly mirroring the national findings in terms that were shown in the fifth annual IMCA report.

I think Steve and Elyzabeth have covered well some of the issues around communication, and that is absolutely at the heart of how we work. I suppose the other element is about the overall approach that we take and the number of visits that we make. Particularly if we are working with people whose capacity may fluctuate, it may be important to see them in different ways at different times, and use the advice that we may receive on how the person communicates from people who do know them well, albeit they may not be able to independently support people. To some degree, the work of an IMCA can be a little bit like a detective, reaching back to say, “What are this person’s past decisions? What are their past views?”, profiling that person’s life to help that come alive for decision-makers. The extent to which we can do that is quite bound by the resources within the service.

I think the other thing to emphasise is that, while every person that we work with and every decision that we work with is potentially life-changing, IMCAs do not tend to get involved in issues that are superficial or peripheral. The depth of involvement can vary enormously from people where their wishes are very clear, the decision-making processes are relatively straightforward and the issues are relatively uncontentious. At the other extreme, we have had issues that have involved protracted work with the Court of Protection, a good deal of controversy and a good deal of disagreement, or literally life and death issues, quite frequently around “do not attempt to resuscitate” orders. It is important to understand that breadth that there is within the IMCA service also.

**Q107 The Chairman:** It is difficult to generalise, and you have spoken about the breadth of the cases you deal with, but can you give any indication of the number of visits that you would be involved in at one extreme—the most extreme case? Presumably in the easiest cases, it might just be one or two, would it not?

**Jonathan Senker:** That is correct. In the most straightforward of cases, where people's views are very clear, where there is little contention around the outcome, it may be just one or two visits. At the longest, it may be protracted over many months and involve perhaps eight or 10 visits. I can come back to the Committee with some more detail on that if that would be helpful.

**The Chairman:** You mentioned also that you were bound by resources. Everyone is bound by resources, but do you find that the resources are available for the more difficult cases?

**Jonathan Senker:** We need to make a balance and manage the resources that we do have. Overall, there is always more that we could be doing to enable the person's views to really come alive so, yes, we do feel that there is quite a limit on our resources and the time available. That is why we are focusing on just the referrals that we have. With more resources, we could make sure that the service was better known and that access to it was much better. We are very concerned by the differential rates of referral to the service. We recognise that the sole responsibility for making people aware of the service and of their statutory duty should not lie with the IMCA service alone. However, we are also very conscious that IMCAs do, in effect, often act as the main ambassadors for the service on the ground. We feel that there is a great deal more that we could do, both working with people individually but also ensuring that people have access to their statutory rights.

**The Chairman:** Mr Gray, Ms Hawkes, do you have anything to add as supplementary?

**Elyzabeth Hawkes:** Just one point: the amount of time that an IMCA can spend with a person to try represent them fully is also tied up very much in the timescale either of a deprivation, a medical intervention or a change of accommodation. That is where, in relation to better knowledge from the people who are in a position to make the referrals—the decision-makers—more proactive involvement of an IMCA gives that advocate the best chance that they can possibly get to do that work. That comes back to Jonathan's point around the amount of services that we now deliver that do not necessarily have a funded element of awareness-raising, of training and of going out and promoting a service. Historically, that was an integral part of the specification for the contract. Those two things impact on the number of referrals, the real working knowledge within health and social care professionals, and subsequently our ability to be able to do the best we can for that person.

**Q108 Baroness Browning:** I think you have answered the first part of my question, and that is that you have all confirmed that you deal with people with special needs and people with communication difficulties. But how do you deal, for example, with people either with a learning disability or on the autistic spectrum, or perhaps sometimes both, where actually trying to find out what their view is and what their preference is can be very difficult? Sometimes they will automatically go with whatever is suggested first, in order to be seen to be helpful and willing—and to end the conversation, really. How do you deal with that? Are there enough specialists? I do realise there is a certain regional specialism in some of your organisations. Just looking more broadly, are there enough people with those sorts of specialisms, and are there areas of the country where you can identify that the IMCA service is not working as it should because there are not enough people with those specialisms? Sorry, it is a rather difficult one to bowl to you—to answer for the whole country.

**Elyzabeth Hawkes:** I think between the three of us we have got a relatively broad coverage. From my own experience, in the areas where we provide IMCA services, there are

substantial opportunities for our advocates to gain those specialist communication skills—so not just broad non-instructed advocacy, but actually linked to specific groups. That, again, is a resource issue for us, but over the last two years the skills of the advocates to do that have increased, plus, there are organisations out there who specialise in those particular areas, so the best way to work is within partnership. The chances are that that person may well have had a community advocate that has worked with them in the past, or a member of the family who it is not inappropriate to consult—that we can work with to try to get that whole approach. But we have had many instances where the IMCA has worked in partnership with the person, and with their support mechanism—that is not necessarily family—and then we access specialist skills through the national advocacy qualification and then, supplementary, from specialist organisations around the country.

I would not say there was any real requirement when we are commissioned for IMCA services to actually have to demonstrate that and be really robust about how they can prove that that is a good qualification. There is no form of regulation, for example. That would be a way forward in allowing an assessment of what a good qualification is, what a good training course is and what the right method is. Then that could be personalised to the person, but I still feel that it is very random among different organisations across the country.

**Baroness Browning:** Thank you. That is very helpful.

**The Chairman:** Mr Gray, do you want to add anything?

**Steve Gray:** I can only reiterate some of the points made by Elyzabeth there, really. I will talk about our service. Obviously, we have a range of skills—a range of advocates who we employ for their skill base and their value base. We have a range of people who have specialisms in certain areas, so we draw on those skills. When you are an organisation with a generic team, or with different advocates who are not just IMCAs—they are generic advocates—there is also a resource there that you can use. If somebody is working on a

particular case and somebody has a specialist, you can use those people who actually understand that issue. I agree. I do not think there is a particular need for specific advocates needing to be trained in specific areas; I think it is about all advocates really having a general understanding of all the issues and being trained appropriately.

**Jonathan Senker:** I think Steve is absolutely right that the mandatory training is available, but it provides a floor rather than a ceiling for the level of understanding that people need to have. It does cover communication. It does cover, to an extent, some different specific conditions, but not the depth that is needed. For us, it is very much about ensuring that each individual has a personal development plan that builds on that.

I know the Committee received evidence previously about gaps in provision and providers needing to draw people in, partly where there is a dispute from people who are placed out of borough. That is unfortunate. The Mental Capacity Act is very clear that it is about where it is that the person lives. I am not, however, surprised that sometimes local authorities may wish to pass on the responsibility to another or to dispute it. There are also many, many examples—perhaps it is something that we will come on to in our discussion—of where advocacy is needed, including for people who may lack capacity in relation to particular decisions, and yet the statutory provision does not cover that. In terms of the availability of people with specialist skills, it is very much up to the individual advocacy organisations to ensure that that is in place. I do not think it is sufficiently monitored and evaluated. We know from people who have joined our organisation from other organisations that sometimes there is quite a key gap that we need to address there.

**Q109 Baroness Andrews:** Can I probe a bit more? One question—a simple question, perhaps—is: what sort of range of people come forward to be IMCAs? What are the parameters? Secondly, when you talk about the nature of training—Liz, you have talked about the possibility of a professional qualification, something that would institutionalise—

what sector skill would that link to? How could that be institutionalised? Would it be generic training? Obviously, it sounds as if communications runs across the training programme. Can you see differential elements of progression within a training programme like that? Thirdly, in relation to the geographical lottery, perhaps, is it the absence of the ability to recruit which is reflected in that? Is that lottery something to do with the absence of the professional skills or a commissioning issue, which we will come on to later?

**Steve Gray:** With regard to who become IMCAs, it is a very wide range of people. It is potentially people who have an interest in social care and a very sound value base about why they want that job. From our point of view—how we recruit in our recruitment processes—we do not ask for any particular qualification. It is fundamentally about values and skills, and past experience is the key. Having said that, a lot of people who come to us for a round of recruitments have, for example, social work qualifications or nursing qualifications. So it is very broad on who it actually attracts, but generally it is obviously people who have got an interest in social care.

With regard to the qualification, there already exists, of course, the independent advocacy qualification, which has varying elements to it. Of course, you specialise in IMCA if you want to work as an IMCA, or in DOLS if you want to work in a DOLS area of the work. Then the general generic advocacy is part of the qualification of advocacy for people with adults or learning disabilities. So the qualification framework already exists; that is there and is in place. As an organisation, I have a training arm, and we are able to provide that training in-house to our advocates, and to other organisations outside our organisation. The qualification is there, and it does offer a range of training within that.

Taking Jonathan's point earlier, whether more in-depth training around specific areas needs to be looked at is another issue. Again, I think that links in with the idea that it is left to the organisation, very often, to meet any gaps there in the training.

**Jonathan Senker:** Perhaps I should pick up on the last part of the question, which is: if there is a gap, is that to do with recruitment or with commissioning? I am impressed by the people who come forward for these roles, given the very strong skills mix that is needed. We need somebody who is comfortable sitting on the floor with a young person with learning disabilities, finding a way to communicate, and somebody who is comfortable challenging decisions including quite often in situations with a high potential for people to be adversarial, and to do so in a negotiated and calm way.

I think the critical issue is not recruitment; it is commissioning. I know that we are going to come on to that and the Committee will want to ask more around it. Particularly, the way commissioning is at the moment, it very much focuses on the amount of time that is spent directly in contact with people using the service, or on their behalf. That is incredibly important—we do not want people sitting in the back office—but it does not necessarily make it as possible as it should for organisations to afford the training and the supervision necessary to ensure that people continue to develop their professional skills and abilities. It also means that there is a very tight squeeze on the salaries that we can afford to pay people, and it can mean that people will move on after a period of time to other professions that may be better remunerated than independent mental advocacy tends to be.

**Elyzabeth Hawkes:** Just adding to Steve's point about the sort of people who apply for IMCA roles: it is health and social care professionals, but there is also an amount of people who have perhaps spent their time working with vulnerable people in housing situations, and who are particularly strong around human rights and what people are entitled to. It is that background of the right ethics, morals and principles that is what you need to be able to build on, with somebody who is strong and can stand up for the person they represent—so quite tenacious. They do not necessarily have to have a qualification to be able to do that. The issue around the qualification that we have got at the moment is, as Steve said, that we

all deliver that module. We deliver it by affiliating with different organisations, and I think we deliver it to the best of our ability, but there is no national standard. So you could do a qualification with X, and although the modules would be the same and the qualification would be the same, there is no guarantee that what you have to produce—the sort of evidence you did, what you were observed doing—would meet the same standard as the person who did it with Y. That is the issue—that there is no standard. There is quality, but it is not measured across the board. We all have external quality marks, and they look at that, but if I chose to I could set up in business as a deliverer of a national advocacy qualification, and hopefully my outcomes would be very good, but I would not necessarily be as good as the person sitting next to me, and there is no way to ensure that.

**Baroness Andrews:** That was very interesting. Thank you very much.

**Q110 Lord Turnberg:** I was struck by how much overlap there is between the sorts of activities that you perform in your different organisations. Presumably you have advocates working for you who have similar qualifications dealing with similar clients, and you mentioned that there are other organisations out there. So the question really is: how does someone out there know whom to approach? Why would they come to you rather than you? Is it a bit confusing? Do you not work together, or are you in competition with each other? Can you describe the interactions?

**Elyzabeth Hawkes:** I think from my point of view the people referred to an IMCA service would have a provider for their local area commissioned by their local authority. That would be the statutory provider for the county or the borough. That is very clear. For IMCA, the way it is commissioned is—as Jonathan said—where the person is placed. It does not matter where their funding comes from; it is where they actually are at the time. So for that geographical area, you have an IMCA provider. That is relatively clear, I think, and that is how we bid for services.

We are in competition with each other. If a local authority tenders for an IMCA provider in a London borough, we could be in competition with each other. We would go through a competitive tendering process, answering questions about how cost-efficient we were and what the quality of our service was, demonstrated by our quality marks and examples of our casework. But I also think that we can work in partnership as well, because sometimes you will have an area that has, say, Asist being an IMCA provider where VoiceAbility might be providing IMHA, and POhWER might be there doing community advocacy for people with learning disabilities. That is when I do think that we are able to work together to make sure that that person gets the best support. But there is always going to be competition there.

**Lord Turnberg:** So it is partly geographic—

**Elyzabeth Hawkes:** Yes.

**Lord Turnberg:** —and partly competition provoking you into high-quality provision of care.

**Elyzabeth Hawkes:** Potentially, and the desire to provide a good service, obviously.

**Jonathan Senker:** I would like to think that competition provokes high quality. That does depend, though, on the determinant of who is awarded contracts being of quality. That requires that it is the most important thing over price, and that the people making that commissioning judgment have a good register of what a quality service is, which some local authorities are better at than others are.

**Lord Turnberg:** We will not go into whether competition is a good thing in this area or not.

**Q111 Lord Patel of Bradford:** I just want to take you back to something that Baroness Andrews said about the quality of the IMCAs. Clearly, your IMCAs are very skilful and experienced people. What I am interested in is the other people that help the IMCAs, because we said earlier that you have interpreters, whether for different languages or

Makaton. If I give you an example, then you will see what I am getting at. When I was a social worker, ASWs were using Asian interpreters. There were two big problems. One was that one of the Asian interpreters had never ever been trained in or understood what a section was or what a mental health issue was, so they would turn up completely blind in a situation where somebody was throwing TVs out of the bedroom window, and so would say, "What happened there?". Secondly, because of the anxieties about so-called cultural knowledge, we had the interpreter's view of what the assessment was, as opposed to the ASW's. What do you do with people who help IMCAs? Has this come up? Is this an issue at all?

**Steve Gray:** Personally, it is not an issue that we have come across very often. I agree that interpretation in advocacy is always a problem. Advocacy is very much about the communication between one person—a service user—and the advocate, and things can be lost in interpretation. When you are working with interpreters, that disconnect does cause some potential issues sometimes between the advocate and the service user. But, unfortunately, if you do not speak that language you have to use some kind of method to be able to communicate with the person.

Sometimes we are fortunate to have people we are working with in the organisation who may speak a number of different languages, and that is something that we find quite useful, because it means we can draw on that resource. It is an internal resource, and they have an understanding of advocacy and understand what the process is. In that situation, that negates some of those factors. I guess in situations where you do not have that resource internally, you have to go outside. I think it is about being aware of that when you are working with an interpreter and being doubly sure that you are getting it right and are hearing correctly.

**Elyzabeth Hawkes:** I think also, to support that, in the areas that we work in we build various relationships. In some advocacy organisations there are deaf people who are advocates, or people who speak a certain language that are advocates, which is always an

added benefit. But if we work in an area and look to build a partnership with a particular translation service we would, before we agree to use that service, provide it with some local induction into what we did so that it had the knowledge to be able to interpret appropriately. I think that is a case of testing the market and seeing who is a good-quality provider, and building that link; and then also using the person's own system of interpretation, which they potentially have as well, if that is what they are comfortable with.

**Q112 Lord Faulks:** Good morning. I declare an interest as an advocate but an ordinary advocate, as it were, unlike an IMCA. I have to represent people even if I do not agree with their course of action, if they require me to do that. You have a rather different role sometimes. On occasions, you will be supporting the client to make the decision and respecting their wishes. On other occasions, you will be representing their best interests but not necessarily following their wishes. Now this is an acutely difficult choice, I suspect, sometimes for you to make and to reflect your role. Do you think there is anything in the Act—of course, we are scrutinising the Act—which could be improved so as to make that distinction clearer and more helpful for you?

**Jonathan Senker:** It is a really important question. It goes to the heart of how IMCAs work. We have found that the interpretation of the Act is broadly consistent—that our focus is on the person's views and wishes. We are also providing an additional protection for that person by making sure that the decisions are taken in line with the Mental Capacity Act. That does take good judgment. It does take careful supervision.

I think it is interesting how the Mental Capacity Act and the IMCA service works in practice. I shall give you an example of two women in neighbouring hospital beds. Both of them have advanced dementia. Both of them are very clear that they want to return to their own home. For one of them, quite unusually unfortunately, everything possible has been done to support her in her own home previously. People have gone to heroic measures to enable

that to happen, and it has led to some very poor results for her, and there is nothing that people can think of that might change that. The woman in the neighbouring bed has not had that support and is more typical of many of the people that we work with, where there is almost a default choice that if somebody has quite advanced dementia and is finding life rather difficult—if there are key risks—they will move into care or nursing homes.

In both cases, our responsibility has to be to make sure that that person's views—that that person's wishes—are heard loudly and clearly, and everything possible is done to take account of those. In the case of the woman where very little has been done to help her to live in her own home—to adapt it and to provide additional support—we are much more likely to challenge a decision that she needs to move into care than we are with the woman where every effort has been made. That speaks correctly to the code of practice, which makes clear that the responsibility of the IMCA, while it is to make sure that the person has a voice through the process, is to challenge when the decision is not in the person's best interests. As I say, that takes judgment, takes care, and takes proper training and supervision to do.

So my sense is that the Act is sufficiently clear, and the interpretation of the code of practice is sufficiently clear, but it does mean that organisations need to ensure that people are properly trained and supervised. By and large, I believe that that is what is happening.

**Elyzabeth Hawkes:** It is very difficult. It is a conflict. Take a safeguarding example. You are supporting two different clients. One client wants to make a decision that they still wished to live with this person even though they have spent all their money. Potentially, if you looked at their overall life, if you removed them from that person they would have nobody, they would have no social inclusion and their life as such would be a complete wreck. Just because somebody wants to make an unwise decision does not mean it is a bad one. Take another example where somebody chose to live somewhere where they were continually

abused, at risk to life. I think you would have to represent what was best for that person in relation to safeguarding. But I think that is really difficult. The advocates need the support and supervision to be able to take them through that process, because that is quite a call to make.

**Jonathan Senker:** I think there is also a contextual point that it is easier to advance somebody's wishes knowing that they may be harmful if we have confidence that there is actually somebody out there who is concerned about the harm. The decision-maker is taking their responsibility very seriously, so they can weigh up the fact that somebody may object to something with the harmful impact of that. It is a little bit more difficult to be a strong advocate for something that will be harmful to an individual if there is not that correct pushback and responsibility taken by the decision-maker to weigh up the person's wishes and views with the other elements of the best-interests checklist.

**Steve Gray:** I think what is central here, of course, is what I think Jonathan and Elyzabeth alluded to earlier: in all instances when somebody lacks capacity, it is about making sure that view is heard, and it is about making sure that that is central to the decision-making process. As I see the concept of best interests, we are basically working together, because in one way you will be asking for the person's views—what they actually want to happen, what their view is of the situation. In the report, that will be clearly stated: "This is what the person wants". But you also have the freedom to ask questions. At the same time as "This is clearly what the person wants", using non-instructed advocacy tools, for example, you can ask questions of decision-makers around the areas about the decision that you are making. I agree about also challenging when appropriate. The two things—the person's view, and the best-interests decisions and questions around them—can be raised by using non-instructed advocacy techniques.

**Q113 Lord Faulks:** Could I just ask you one more question? It is about the Court of Protection and the various decisions it has been reaching. There is a particular decision called CC v KK. Have you generally found that the decisions of the Court of Protection have been a) sufficiently publicised and obviously accessible to you, and b) helpful at all in performing your role?

**Steve Gray:** Obviously, we access certain materials and certain information so as to be able to keep up to date with case law, because it is a very important element of the IMCA work. It is a fascinating and rapidly changing area of legislation, and that is what makes the Mental Capacity Act interesting—it is developing all the time, so we have to keep on top of it.

With regard to being helpful, at the moment case law is obviously changing, and that does raise problems in interpretation of the case law. That sometimes affects how decisions are made. An example is the case you are alluding to and DOLS cases where you have different changes in what is seen as deprivation. Different case law suggests something, and you are waiting for other cases to be resolved. That does create problems, because that is not clear. Perhaps not so much for IMCAs but for other people—BIAs, best-interests assessors, for example—it can cause some difficulty, but it is something we have to ensure we keep on top of when working as an IMCA.

**Elyzabeth Hawkes:** I agree. I think it is accessible for us, if we make the effort to go and make sure that we look for it and include that in our mandatory training. I also think there is benefit to having joint training for best-interests assessors, with DOLS teams and with supervisory bodies, for development in the local area, so that we actually work those examples into best practice and how that will inform our practice in the future. It is there; it is just our responsibility to go and look for it.

**Jonathan Senker:** That is right. It is at the moment our responsibility to go and look. CC v KK really changes what information may need to be available to people before making a

decision. Similarly, case law has developed and changed a lot on the deprivation of liberty safeguards, particularly in the Cheshire West judgment. At the moment, it is up to not just advocacy organisations but other practitioners to go out there and look for the information and, with a piece of legislation that is so fundamental to people's rights and to people's lives, there do need to be stronger central channels to actually disseminate practice—not just to advocacy organisations and independent mental capacity advocates, but to social workers, doctors, nurses, lawyers and, in some cases, to bankers and other people. There is a real gap there; there is no single point of authoritative information. There is also a need—Elizabeth has mentioned the deprivation of liberty safeguards, which is very much now dependent on case law—for the code of practice to be re-looked at, to see whether there is a way of providing clearer and better information.

**Steve Gray:** I agree completely with Jonathan on that point, around DOLS in particular. Things have changed so much in the last few years that new guidance around that would be very useful.

**Q114 Lord Turnberg:** You have spoken a little about training and quality assurance. Do you do your own training, or do people train on a course elsewhere? How do you assure quality?

**Steve Gray:** Basically, we provide training in-house at the moment. We register with City & Guilds and also work through BILD. That is an accredited training provider so it in many ways looks at the quality, because obviously it assesses the work. I guess the main element of our part of the qualification is the provision of the training; it is the training days that we do internally. We provide our own training, and it is assessed and monitored by an external body. We do not do that assessing ourselves.

**Elyzabeth Hawkes:** I would agree. We are affiliated—like a satellite unit—with BILD, with our own internal assessors subject to external verification to make sure that that is all

accredited learning. We also add on to that joint training within local authorities or health institutions, particularly for IMCAs, so that they do some of their mental capacity training, safeguarding training and DOLS training with members of DOLS teams supervising who they will work with on a day-to-day basis, so we try to localise that training. If you look, any of our organisations will have a safeguarding policy for how we respond and how we report, but that needs to be meshed in with the local authorities or it is not going to work. It needs to be of a national standard, but it also needs to be locally responsive, so that is why that link locally is important in actual application and practice.

**Jonathan Senker:** We commission our training from other organisations and then build on that in individuals' personal development plans. I think training is an essential part of delivering a quality service. I think the other part of your question was around quality assurance. We have the quality performance mark, which I know POhWER and Asist also hold, which is an externally evaluated quality mark but one that will need to be reviewed. We also rely very much on our supervisory systems—auditing people's files; discussing with them how they are working with people; going out and observing people's work, because it is very much about people's practice skills as much as people's ability to describe what their practice skills are; drawing teams together so that they can learn from each other's experience and share some of the knowledge that we spoke earlier about, the knowledge that is needed in working with people with different specific conditions; as well as the more quantitative evaluation of the work that we do: of outputs, outcomes and so on.

**Lord Turnberg:** Do you turn people down when they apply to work for you?

**Elyzabeth Hawkes:** Yes.

**Steve Gray:** Obviously, people come through a recruitment process, similar to anywhere else. Obviously if they do not meet the line, they are not going to be employed.

**Elyzabeth Hawkes:** It is also worth adding that anybody we do employ is on a probationary contract, subject to completion and achievement of certain elements of their training before that contract is ever made substantive.

**Jonathan Senker:** I would just underpin that. We are very conscious of how responsible the role is, and the duty that lies with us to make sure that people are competent to carry out that role. So absolutely—if people are not able to do that well, we do not want to employ them. When we do employ them, we want to do everything reasonable to enhance their ability to do the role effectively, but ultimately we will always decide whether the person can provide a good service to people.

**Steve Gray:** Internally, we do things like supervision. Supervision is a very important element when you are working with people and service users. Supervision is actually a very good way of checking what is going on out there and how advocates are performing. Also, there are things like database audits. We can look at what people are doing and look at their notes, check those and check what is going on out there. Shadowing is something that you can do. You can go out with advocates, shadow them, follow what they are doing, check out what they are doing. Of course, there is monitoring—getting feedback from decision-makers. We are very keen at the moment on getting feedback from decision-makers after they have been involved with the service. We ask, “What do you think about the service? Was it useful?”. That is an important element for developing the service and seeing whether there are any gaps in quality or whether things are not being provided quite correctly.

**Lord Turnberg:** So, continuing professional development of people is—

**Steve Gray:** Essential.

**Elyzabeth Hawkes:** Building on the feedback point, I also think that there is the opportunity to build feedback, particularly from clients. Even if somebody has used the IMCA service, they can still give feedback on how they found your advocacy support, and we have

developed an outcome style that allows people to measure their journey. It has a range of different achievements—social inclusion, feeling safe. It is all to do with social outcomes, and people can still do that. One of the best ways to know you have done a job well is if somebody feels that they are in the right place and they have some control over their lives. That is one of the best outcomes you can get.

**Q115 Lord Swinfen:** You all do the same work. Do you train each other? Do you learn lessons from each other? Do you have conferences, or are you just working in little boxes?

**Jonathan Senker:** We actually received some training from Asist and found that incredibly valuable. I believe it is absolutely essential that different organisations work co-operatively, share information and share knowledge. At the moment, we do that rather informally by the links that we develop between organisations. We recognise that there is a very strong need for some umbrella organisation to help draw organisations together. There is a gap at the moment for the advocacy sector, and that is something that we, together with other organisations, are going to need to address in the coming time.

**Steve Gray:** Traditionally, Action for Advocacy has always provided this service. I believe it is not trading at the moment, but it is looking with its trustees at how it moves forward. I think we would all agree that Action for Advocacy, as an umbrella organisation, provided a useful mechanism for sharing information nationally. I agree; I think that was very useful.

**Q116 Baroness Andrews:** Just a point of clarification. Coming out of all this, as far as I can see, you are saying that you need to rationalise in some senses, and it is really important that you have national standards rather than a national qualification. Very briefly, how difficult will that be to achieve? Will you have the support of contextual and supporting professions and the people you work with to do that? Is that something which people in this field would want you to do?

**Jonathan Senker:** I think that both are needed. The national training that is available is required. There also needs to be a stronger, updated quality mark for IMCA services. There is one at the moment. It needs to be revised and developed further. That is achievable. The plans for doing that appear to be a little bit unclear at the moment.

**Baroness Andrews:** What does that depend on? If someone is going to clarify that, who is that person or body going to be?

**Jonathan Senker:** The organisation that was responsible for that quality performance mark is no longer in operation. That was Action for Advocacy. I understand that there is some funding that is held by the Department of Health to take forward that work, but that an organisation to do so needs to be identified.

**Steve Gray:** What is key around whatever organisation that is is that that organisation is independent of providers. That would be a very important element.

**Baroness Andrews:** So are you talking about a training organisation here, a commissioning organisation, or a central government department, or—

**Jonathan Senker:** We are talking about an organisation that would develop and administer a quality assessment tool for advocacy organisations, not for the individual advocate. There is a gap there. The other way of approaching this, which also has potential benefit, is to look at professional regulation of individual advocates. There is a very, very strong case for there to be a professional body for individual advocates. It is a key profession providing a very good and important role to generally very high standards. Like other professions that do that, it is right and proper that it is appropriately regulated so that standards are maintained and so that there is some additional assurance for individuals using the service, and their carers and family, about the quality of the individuals with whom they are interacting.

**The Chairman:** I am conscious about the time and the number of questions we still have to cover, so I wonder if I could ask the witnesses to be briefer. There is an opportunity to submit additional information in writing. Can we move on to the next question?

**Q117 Baroness Andrews:** I hope this is quite a brief question. You have said already that you think the code of practice should be updated. You have not said anything about whether you think the Mental Capacity Act itself could be changed in a way that would make your job more effective. We have had evidence saying that there are issues around the definition of serious medical treatment, for example, and I know that, in terms of the IMCA, it “may”—not “must”—be provided before decisions regarding care reviews. That came in under regulations. Is there anything we could recommend that you would think would make a difference to the way you operated by changing the law?

**Elyzabeth Hawkes:** I think that the Mental Capacity Act usually refer to “should” not “must”, and “may” not “will”. It leaves it open to discretion whether that referral will be made, and I think that could be stronger. I also think that when the Mental Capacity Act refers to safeguarding it says how somebody does not necessarily need to be unbefriended—to not have anybody appropriate to consult. They can still benefit from the input of an IMCA. I do not know how, but I think there is work that can be done with the Mental Capacity Act to direct health and social care professionals more in their statutory duty to make a referral sometimes, perhaps at the point when capacity is about to be assessed. Best practice says that you should perhaps involve the IMCA sooner to give them a better chance: that you should perhaps involve the IMCA around that first point. My personal view is that it would support people to access an IMCA if the Act was more direct about a professional’s duty to consider and to make a referral. If that referral then turns out to be inappropriate, that is okay, because sometimes they are anyway—if somebody regains capacity because they are not dehydrated or they have had antibiotics and they are not

infected any more. I think that gives people the best chance to actually use the IMCA to support them.

**Steve Gray:** I think it would be nice to expand on the point about the definition of who is consultable.

**Baroness Andrews:** Who is consultable?

**Steve Gray:** Yes, who is consultable. The Act talks quite usefully about somebody's interest in the welfare of the person. For some decision-makers, it would be useful if the concept of "Who do we speak to? Who do you talk to? Are these people consultable?" was fleshed out a little more, perhaps in the code of practice, so that it was clear about who was consultable and who was not consultable under the Act.

**Jonathan Senker:** I would agree broadly with the evidence that the Committee has received so far: that it is a good Act that is patchily implemented within local authorities and generally not well implemented within the NHS. There are a good number of things that we think could be done to improve the implementation. How long do we have?

**The Chairman:** Could you submit in writing a list of things that you think could be improved? That would be very useful.

**Jonathan Senker:** Absolutely. Would it be helpful perhaps to mention a couple of them? Certainly there is much too little focus on supported decision-making, enabling people to have a voice and supporting people to make their decisions. Social workers, we find, tend to focus on testing capacity rather than thinking about how to improve capacity and better training and guidance. A colleague of mine talks about people putting on their Mental Capacity Act hat but then forgetting that they should never take it off—that this needs to be a part of the mainstream of the operation.

One of the proposals that I know Members of this Committee supported to amend the Care Bill would see an increasing role for advocacy in assessment, care planning and review

as well as in safeguarding. I think those are essential ways of enabling people to have a voice, rather than waiting for other people to take decisions and for that decision to be known before that person gets that support. So, for example, the IMCA role will not be triggered at the moment by somebody who is living a generally unhappy life in, for example, a care home, unless somebody picks up on that and says, “Actually, there’s a decision to be made here about whether this person should continue to be living here”. I do not think that is good enough, and one way of addressing that is by making sure that there is the involvement of advocacy, assessment, care planning and review for people who need it most—broadly people whose capacity for decisions that may arise through that may be comprised.

**The Chairman:** Could you just submit the rest in writing, because I am conscious that we are really running out of time. Can we move on to the next question? Lord Patel.

**Q118 Lord Patel of Bradford:** Mine is around the role of advocacy. Is it different under the deprivation of liberty safeguards, when you compare it to the role of advocacy under the Mental Capacity Act provisions? Is the role of advocacy under the safeguards adequate?

**Steve Gray:** The role is different. The role between IMCA and IMHA is different. It is primarily different in the way it is instructed. With IMCA, it is instructed by the decision-maker when the decision has been made and around that particular decision. With IMHA, of course, the person is made aware of their rights by the hospital or the trust, and basically they become the instructing person: they instruct the advocate. That is one of the main differences between IMHA and IMCA.

Of course, IMHA becomes very much like a more generic role, in many ways. Part of the responsibility in IMHA is about “These are your rights under the Act”. But it is very much like a generic advocacy role—about supporting the person through that period of detention. Also, it tends to be wider in its remit. So, for example, whereas IMCA is very specific to specific decisions—we have already talked about change of accommodation, serious medical

treatment and so on—IMHA, in my view, is a lot wider. They will deal with a range of issues involved in that person's care during the period of the detention. Those, for me, are some of the main points.

**Elyzabeth Hawkes:** Could you just repeat the question again for me, please?

**Lord Patel of Bradford:** Is the role of advocacy under DOLS different from the role of advocacy under the Mental Capacity Act? Is the role of advocacy adequate enough.

**Elyzabeth Hawkes:** It is a separate set of skills. It is a different timeframe. There are statutory requirements. I think it should be—and it is—a specific set of training. It should not just be added into IMCA—“Oh, it's just DOLS added on the end”—because of all the issue types other than serious medical treatment, DOLS referrals are the ones with the greatest national fluctuations you will see, particularly around 39Ds, when there is an advocate to support somebody that is being a paid person's representative. It should be an individual service. There is a definite set of skills, particularly with timeframes. For 39As, you only have those five days. You have to do a concise report that is in time, as the person is not going to have their view represented. So it is different, and a different set of skills, and it should be an experienced IMCA who has had the additional DOLS training who provides that service.

**Steve Gray:** Sorry, my first answer was about IMHA. I thought that was what the original question was.

**Lord Patel of Bradford:** It was just about DOLS.

**Jonathan Senker:** Obviously the structures are different. We find the role to be broadly similar in advancing the person's interests, ensuring that those are taken account of, challenging decisions, and particularly challenging or requesting a review of the deprivations where necessary. I think there is a difference with Section 39D, where our role is to support an unpaid representative. There we have examples of very good practice where we have

been able to empower and support relatives and friends to really safeguard the individual and to make sure that decisions are reviewed. We also have frequent examples where the relative or friend does not have the information support to understand how important the role is. While we attempt to provide that, often they are grateful for the provision of care that is available; they do not want to rock the boat and they do not want further involvement. An important proposal might be that everyone who is subjected to a deprivation of liberty safeguard does have that paid representative who could work effectively alongside family members and friends where necessary, and the level of involvement that may be needed could vary considerably according to the ability of friends and family to carry forward the role. Given that we are talking about depriving people of their liberty—it is such an important move—we need to make sure that there is every safeguard available to people. There is a key gap there.

**Steve Gray:** In regard to DOLS, one issue for advocates working with DOLS is the time constraints sometimes that actually happen around DOLS. Obviously, we work on a seven-day week here, not a working week. Sometimes the amount of time you have to work with the person is cut down immensely. That can really affect the amount of work input into that decision-making process. Quickly, probably the review process around DOLS could be strengthened in some way to encourage an independent element to the reassessments, very often. If you look at the Mental Health Act and the way the tribunal system works, there is an element of independence in that system. It would be very useful in some way—I do not know how it would work—to provide additional safeguards in that situation.

**Q119 Baroness Browning:** Could I just follow up on Mr Senker's last contribution? You said that it is essential that we close this gap of a paid IMCA working alongside family and friends when the deprivation of liberties is at stake. Do you think we have closed the Bournemouth gap?

**Jonathan Senker:** I do not think we have done. I do not know whether the decision-making around L, the man at the heart of Bournemouth, would be different now than it was when he was detained. I do not have issues particularly with the framework; I think the implementation is very poor or very patchy, and we are seeing increasingly that DOLS acts as something of a sticking plaster for poor community care planning and practice. The kind of conditions that are being agreed are that the person can go out from time to time with support from staff. That should not require us to go through this process; that should be a matter of good community care planning. In one instance, one of the conditions was that the person should have regular social work input rather than a locum social worker where that was very strongly and obviously required. DOLS are acting as a sticking plaster over poor community care planning. The extent of the protections they provide is high in areas that engage with it. We know of certain areas where they really discuss these issues. They have provider forums and social work forums that look at the issues and thrash them out in advance. They do well. Areas that do not, do not.

**Baroness Browning:** It would be nice to have something in writing, if you would not mind, just setting out what you think the problem still is with the so-called Bournemouth gap, because we had hoped we had filled it.

**Jonathan Senker:** Of course. I think it is around implementation.

**The Chairman:** Baroness Hollins, I think you were going to ask a question that Mr Gray has already answered.

**Q120 Baroness Hollins:** I think so, although I just wondered: are IMCAs and IMHAs ever the same person? Do people ever do both roles? Is that confusing for them? I suppose one issue is that, of course, sometimes it will be somebody with a learning disability needing an IMHA, and sometimes somebody with a serious mental illness is going to be needing an IMCA. I just wondered whether there was any confusion in practice.

**Jonathan Senker:** I think it is more confusing when there are two distinct different people than it is when there is one person. I would tend to think that, were I in that situation, I would like to tell my story once rather than twice, and would like to build up some continuity. Whether it is one person or two people depends usually on whether it is one organisation or two organisations. Many commissioners, very sensibly, have drawn together IMCA and IMHA contracts so that they will be let to the same provider, which enables that continuity. That is not always the case

**Lord Swinfen:** In your experience, are commissioning plans making sufficient provision for advocacy? Has local commissioning led to an effective market in advocacy services, or are there problems such as supply fragmentation and quality control?

**Elyzabeth Hawkes:** Commissioning plans are in place. They are sometimes fragmented, because the commissioner for an IMHA service may not be the same commissioning team within the same local authority for an IMCA service. Historically, the money for some parts of advocacy came from different pots. PCT money commissioned IMHA. That is all being pulled together, which I think is a positive effect. Those commissioning plans could be more co-ordinated, so that you do not get fragmentation of services and you do get a whole-person approach. As Jonathan referred to, I might be sectioned under the Mental Health Act and need to have some treatment that is not related to my mental health. Therefore, if I lack capacity, I should technically be entitled to an IMCA. So it is about having that whole-person approach, rather than boxed services.

**Jonathan Senker:** At the moment, commissioning plans are clearly insufficient for advocacy. IMCA, for example, provides a vital safety net for people who are most vulnerable and facing the biggest decision. But it is reactive: it is only after a decision is identified. It is variable in the implementation of the discretionary elements of it. It is variable in the mandatory elements of it. If we look at the referral rates, it only covers certain decisions. It covers

where I live. It does not cover who I live with or how I live. We need to make sure there is much more effective support, independent support and advocacy support; to enhance people's capacity; and to support people who may have formal capacity but may face enormous hurdles due to the power imbalance that there can be with services, people who cannot get their voices across. Given that there are always going to be finite resources and a finite amount that can be done within commissioning, the key trigger points that people tell us are most important in their lives and the decisions that get made are around assessment, care planning, safeguarding and review. Much stronger commissioning plans are needed to address those areas.

**Steve Gray:** I think what Jonathan alluded to there was that there is a massive area in which people need support outside IMCA. Bearing in mind that we are talking about advocacy services, there are wider issues here, part of which are commissioning general, generic services. A lot of people do not fit the IMCA remit, so I think it is about making commissioners aware of that, and the importance of that in ensuring that people have their voice heard within what are some very challenging times.

**Q121 Baroness Shephard of Northwold:** The report produced by the Department of Health on the first five years of IMCA does reveal extraordinarily huge variation in the rates of IMCA referral across different authorities. I really would like to hear your views on the reasons for this. I think, Ms Hawkes, you work in the east of England.

**Elyzabeth Hawkes:** Central and east.

**Baroness Shephard of Northwold:** Central and east. Bedfordshire appears to be either singularly without problems or singularly in difficulty in solving them—one or the other. I wonder if we could have some of your views on the variation rate.

**Jonathan Senker:** It is extremely concerning, because we are talking about a variation in whether people's legal entitlement is met. We have found that it depends so much on local

leadership. Where there are effective Mental Capacity Act leads, preferably supported by senior managers within local authorities, they raise awareness, discuss the issues within provider forums, discuss the issues within professional groups with social workers, and ensure that there is effective training within the NHS—the variance in referrals around serious medical treatment is also deeply, deeply concerning. We have found that it depends very much on local leadership.

We think that a lot more is needed in order to make it matter to senior managers within local authorities and within the NHS. It needs to be properly monitored. Training needs to be provided—so, for example, looking at the NHS, were the CQC to be holding NHS providers' toes to the fire in the amount of mandatory training that is being provided on the Mental Capacity Act to clinicians and so on, I think we would start to see some improvements. At the moment we see good local authorities that get it—that encourage referrals and build it into their systems—and some good NHS providers that do that, again by integrating it within their working groups and within their referral forms and systems. But there do not seem to be strong incentives to ensure that that happens more generally.

**Baroness Shephard of Northwold:** Can I ask you therefore: from whom should the local leadership come? Secondly, who ought to be stimulating the existence of the local leadership?

**Jonathan Senker:** I think it does need to be coming from a senior level—from directors of adult social services—because it is very much about the culture of how authorities work. I think it is about ensuring that there is an effective Mental Capacity Act lead and providing good support and resources to them. Within the NHS, it is from the chief executive downwards.

**Baroness Shephard of Northwold:** If there are whole bits of local authorities and local health services that appear to be performing, shall we say, less frequently than others—I

make no other judgment—would that be a matter for the CQC or for the Department of Health? Who would be keeping an eye out for these statistics?

**Jonathan Senker:** I think these are really key questions, and I am not sure that I have the answer. Certainly, I think that the CQC should be inspecting hospitals and explicitly drawing attention to issues around training and referral rates in the Mental Capacity Act. I know that when they inspect care homes, they look at the training that staff have, but I think there is a variance in how searching their questioning is around that. Certainly, the CQC can perform an important role in this.

**Baroness Shephard of Northwold:** But who would be performing that role with local authorities?

**Jonathan Senker:** I am not certain of the answer to that one.

**Baroness Shephard of Northwold:** Okay. Thank you. That is fine.

**Elyzabeth Hawkes:** I think, from my point of view, there is a definite role for us as advocacy providers to make sure that we fulfil our duties to make the service accessible and available, but I also think that there are limits as to how we can do that. If you take serious medical treatment as an example and you think of that within an acute care setting, you potentially have the doctors who would be the people who would do that. They would perhaps be house officers, middle grades on that rotation. You have a moving body of staff who you continually have to educate, plus—with the greatest respect—a group of consultants who do not necessarily see any responsibility under the Mental Capacity Act as the first thing on their agenda. They learn about informed consent, but how does the Mental Capacity Act and their responsibilities under that lead into that informed consent? How can you say that you have taken consent if you do not have that set of rules in your head? That is where I think, fundamentally—again, I am not sure of the answer—there needs to be a more robust way, whether it is training, whether it is reaccreditation, whether it is CME, of making sure that

that knowledge is there and is put into practice. That is in relation to all staff who have that responsibility. That would be my view on serious medical treatment.

On the other issue, around low referrals and how we act on that, sometimes the commissioning monitoring is done by commissioners who do not necessarily have a clinical or an operational input into that. I think there is a need for greater partnership working between commissioners of services and deliverers of services in that monitoring of performance of contracts, with our input, in terms of our activity.

**Q122 Baroness Shephard of Northwold:** Can I just ask you—actually, it would be a question to any of you—in the light of the statistics in this report, in the roles that you fulfil have you been aware of any activity that would indicate that someone else was worried about the disparity? In other words—well, you know what I mean.

**Elyzabeth Hawkes:** Yes. Are you referring to the disparity between the detail on the DoH database and our inputting into that?

**Baroness Shephard of Northwold:** I am worried about the disparity revealed by the statistics in this report, which is where I got the statistic about Bedfordshire. Maybe that is how things are there, but you are concerned about this disparity. We are. All I am asking is: when this information became available, were you aware of any particular leadership being exercised nationally by the Department of Health, or anything saying, “Look here, this won’t do”?

**Elyzabeth Hawkes:** No.

**Jonathan Senker:** I am afraid not, no.

**Q123 Lord Turnberg:** Two brief questions. Supposing everyone out there suddenly realises the value of your service and comes out of the woodwork, do you have the capacity to respond? Do you have enough people or enough money? The other brief question, and

maybe you do not want to answer this, is: do you know whether the CCGs—the clinical commissioning groups—have any of this on their agendas?

**Steve Gray:** With regard to the numbers, resources are finite, I guess. If we suddenly had loads of referrals it would be a problem. Funding has been cut for our IMCA contract over the period. I guess, yes, if we suddenly had loads of referrals it would be an issue. If at that stage it became an issue, we would have to go back to our commissioners and say, “This is now an issue”. Sorry, what was your second question?

**Lord Turnberg:** I asked about CCGs.

**Steve Gray:** It is interesting, because for general advocacy CCGs are an issue for us. Our area has six CCGs at the moment, and before it was one contract. At the moment we are in negotiation with a lot of different CCGs, which is quite difficult. They are aware of generic services. In our county they do not commission the IMCA service; that is done by the local authority. I cannot answer the question about whether they are aware of it but fragmentation can be difficult for advocacy generally—for making the right contacts and making sure that things are on the agenda.

**Elyzabeth Hawkes:** We have done a lot of work with CCGs recently around some of the health complaints advocacy that has come into local funding. That has given us the opportunity to talk about other forms of advocacy. There is, in my opinion, a lack of knowledge about the value of advocacy and the statutory duty for some of the services to refer. For example, very briefly, I went to see a CCG about what IMCA services were and had to give impromptu training on the Mental Capacity Act. You cannot do one without the other knowledge being there first, and it is not there.

**The Chairman:** Lord Alderdice, I think to some extent this question has been answered, but maybe you want to ask it.

**Q124 Lord Alderdice:** I just want to press a little, because I think you said that there is not currently a national professional body or national standards. You indicated an interest in some kind of statutory regulation. There are usually two ways in which a national professional body develops. One is that all the people in the area get together for a national conference and put something together on paper which they gradually develop over a year or two. The second is that there is a current national professional body, of a more generic kind, that sets up some kind of sub-group that says, “Okay, we will act as your professional body and you will be a specialist group within that”. Have you any particular views on whether it is likely that either of these will be adopted? It sounded as though you thought it would be a good idea to have some kind of national professional body; how do you see it coming into existence?

**Jonathan Senker:** I would imagine that the logical choice would probably be the Health and Care Professions Council. It exists and regulates other professions. That would probably provide a relatively quick route to achieving this.

**Lord Alderdice:** But it accepts professional organisations that exist. It does not set them up itself, so you would have to set up a professional organisation and then seek to be regulated by it.

**Steve Gray:** One of the other issues around this is the concept of a protected title. If you start looking at professional bodies and whether you have a professional advocate or some kind of protected title—

**Lord Alderdice:** That is a subsequent issue of statutory regulation. Usually, for example in something such as psychotherapy or counselling, you first have a professional body and then seek regulation, registration and so on. It sounds as though you are quite a way back in the process.

**Elyzabeth Hawkes:** I think we are a long way back. Recently, I think audiologists and some of the complementary therapies wanted to be accepted as professions that can be regulated and registered. That is a challenge if you enter into another organisation. I think it is something that advocacy providers nationally need to decide, in partnership, how they wish to take that forward. I do not think it is something that we can do as individuals.

**Steve Gray:** But clearly, if you develop a body and you move along to talk about protected titles, registration and so on, that would of course incur a cost for organisations. That would potentially be an issue for smaller organisations. Also, if you are talking about protecting the role of a protected title, will we want to say that only certain people can advocate? That would potentially prevent smaller grass-roots organisations coming into being because they could not advocate. When you think about where advocacy came from, it was the grass roots and communities coming together to raise issues. That is something that you have to consider: who would this exclude and what costs would be incurred by organisations? In the end, it should not just be big organisations that are able to survive in that kind of marketplace.

**The Chairman:** I think the last question to be asked is whether you have anything further to add and about changes to legislation or implementation. Could I ask you to submit the answer to that in writing, as you will for the changes anyway? I have been asked by Baroness Andrews, who had to leave, to raise one matter. She picked up that one of you mentioned that it was no longer part of your role to promote the existence of your services. If she has picked that up correctly, has this had an impact on referrals? What happened to change that role?

**Jonathan Senker:** I do not think she heard that entirely correctly. I think the point we made as a panel was that our commissioning arrangements have become increasingly restrictive and focused on just paying for the work that is done with individuals and work on their

behalf, which tends to give lower priority to encouraging referrals and raising awareness. Each of our organisations is still very determined to do that work but we feel that it is under increasing pressure as that role is not sufficiently built into contracts and pricing. We are very conscious of our informal positions as ambassadors not just for our own services and the independent Mental Capacity Act Advocacy Service, but for the Mental Capacity Act and its ways of working. We do our best to maintain that, but it is coming under increasing pressure. At the extreme, we are seeing spot-purchasing contracts, which will pay only when someone has already been referred and, in one case, a Dutch auction where providers were encouraged, on a live event, to produce a lower and lower price. Those things can mean that that wider role gets squeezed out. What we hear generally is that we have a good Act poorly implemented. We cannot afford to lose any of the resources that help to implement it more effectively. It is that risk that we have been talking about.

**Q125 Baroness Browning:** We have recently received the report from Baroness Neuberger on the Liverpool care pathway, which makes reference to the role of IMCAs. There will be changes, thank goodness, but, until now, have you and the people you work with been conscious of the fact that, in end-of-life matters, the NHS and care homes—NHS hospitals particularly—have not called on IMCAs when they should?

**Jonathan Senker:** Yes, very much so. We have been involved with people quite frequently and become aware, incidentally, that they are on a “do not attempt to resuscitate” order. We have called people to account on that and in almost all cases made sure that the “do not attempt to resuscitate” order was either rescinded or that it was there as the result of a proper process of involvement and consultation. However, we have found that it is a recurrent problem in a number of different hospitals, and we are very interested in exploring with NHS England how we generalise some of the learning, particularly around “do not attempt to resuscitate” orders, which may or may not be addressed by the changes to the

Liverpool care pathway. I suspect it will not of itself be addressed, so that is a “yes”, unfortunately: it is something that we come across quite regularly and frequently.

**Baroness Browning:** Thank you. As a result of that report, every case in hospital at the moment is, we are told, being looked at, but there will be a six-month gap while the new procedures that will follow are worked out. With regard to your service and end-of-life matters, if you have not already done so, could you make this Committee aware, through the Chairman, of what you think should be done, the correct procedures that should be followed and the role of IMCAs in end-of-life matters?

**Jonathan Senker:** Yes, we would be happy to submit evidence on that.

**The Chairman:** Thank you very much for your time this morning; it has been very enlightening. Apart from the information that you have indicated you will submit to the Committee Clerk, could I encourage you, if you have not already done so, to give serious consideration to submitting written evidence?

**Jonathan Senker:** Thank you very much.