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Witnesses: David Behan, Rachel Griffiths and Andrea Sutcliffe

Paul Buckley and Marc Seale

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Members present

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

Examination of Witnesses

David Behan, Chief Executive, Care Quality Commission, **Rachel Griffiths**, Mental Capacity Act Policy Manager, Care Quality Commission, and **Andrea Sutcliffe**, Chief Inspector of Adult Social Care, Care Quality Commission

Q197 The Chairman: Good morning and welcome to this evidence session. I am sorry we are a few minutes late in starting your evidence. Could I just remind you that the evidence is recorded and transcribed?

Could I start by asking how the Mental Capacity Act features in the delivery of your functions? How do you relate to others with regulatory or inspection functions with regard to the Act?

David Behan: Thank you, Chair. I am delighted to be here to assist you in your review. I am joined by Andrea Sutcliffe, who has just joined us as Chief Inspector of Adult Social Care, and Rachel Griffiths, who is occupying a post in mental capacity, so we are building our capacity in relation to this work. Any questions that are too difficult for me, Chair, I am going to pass on to my colleagues and they will be able to answer them, I am sure.

To come to your question, we have an important role. Our purpose is to make sure that health and care services provide people with safe, effective, compassionate, high-quality care. We do that so services can improve; we encourage services to improve.

Within that, our responsibilities under the mental capacity legislation are to monitor the implementation and delivery of that legislation. We do that through the inspections we undertake and, as part of our inspections, we assess how far services are using the mental capacity legislation—particularly in relation to the ability of people to consent to treatment. We will do that whether it is in hospitals, private hospitals, community hospitals, or care homes and in domiciliary care.

The Chairman: How effective do you think the monitoring is?

David Behan: This is a new responsibility for us. We have taken this on board and if you look at our Annual Report you will see that, from 2010-11 to 2011-12, there was much more take-up of the mental capacity legislation across services. That report flagged up the variability in the degree of knowledge of the mental capacity legislation. The great variability in that knowledge will impact upon the quality of practice, and our monitoring has identified that variability. We made a number of important recommendations to commissioners and providers of care in our Annual Report last year, which said there is more to be done to ensure people understand the legislation.

In my view, this is less about understanding the legislation and more about understanding what good practice is. In CQC, we are of the view that the issue is about what is best practice—particularly for people who might not have capacity. How do you work with people without capacity? How do you work with those people as individuals, but also their families and their carers, who will have a good degree of knowledge and can be of assistance in arriving at decisions?

An overemphasis on the legislation detracts from a debate about what best practice is. We see that through our work. If I am being brutally honest, Chair, my own staff reflects this variability in knowledge. The knowledge that some of our own inspectors have is variable. When they are out inspecting services, how they use that knowledge to inform their assessments and, ultimately, their judgments is a key issue. Rachel's post is a deliberate part of our strategy to up our game—if I may use the phrase—in relation to mental capacity.

We are busy carrying out a pretty fundamental root-and-branch review of the way that we inspect health and care services. We are building in mental capacity and the practice we would want to see in the way that we are redesigning our methodologies.

In essence, we are asking five questions of all services. Are services safe? Are services effective? Are services caring? Are services responsive and meeting the needs of the people they are there to serve? Fifthly, are those services well led? What is the culture of the organisations?

Our view is that mental capacity and the practice around mental capacity needs to be a feature of all five of those significant questions. As we build our new methodologies, we will ensure that mental capacity is built into the way that we conduct our inspections—whether of hospital services, community healthcare services or, indeed, adult social care services—so that we can give a view about how well people are served by the way those decisions are made about their care and treatment. For those people who are not able to consent, we will assess how they are engaged, i.e. how practitioners go about engaging them and making the appropriate assessments and judgments to support people.

Q198 The Chairman: Your submission states that you would welcome discussion with professional regulators to explore whether it would be appropriate for them to become more active in the regulation of the Mental Capacity Act. What discussions have you had to

date with such organisations? How do you ensure that issues do not fall between two stools, as it were?

David Behan: This is a highly appropriate question. We have had this issue about what the interface is between us as a quality regulator and professional regulators—not just on mental capacity, but much more generally. We have a pretty extensive programme of developing memoranda of understanding with our professional regulator colleagues. We have recently signed and completed an MOU with the General Medical Council and, indeed, published some practice guidance, which goes into some quite granular detail in terms of, “If you find this set of circumstances, this is what you should do and this is who you should contact.” This works for both GMC staff and CQC staff. We are beginning to complete this programme of developing memoranda of understanding. A number already exist and we are reviewing those as we change our methodologies to ensure they are built into the way we operate with our professional regulator colleagues. The Department of Health have convened the Mental Capacity Act Steering Group and we are a member of that—as are the professional regulators.

There is also an important dimension to this, Chair, in relation to the emphasis that this is a professional and practice responsibility. Earlier, I referred to an overreliance on lawyers in relation to mental capacity. We have given too much to the lawyers and not enough to what the best professional practice is. I am certainly looking for the professional associations and regulators to take some lead in relation to this to debunk the complexity. I begin too many conversations about mental capacity with people saying, “This is too complicated.” This is essentially about how you engage with people to ascertain their wishes about how they would like to be treated, whether you do that up front, before people lose the ability to consent, or where people are beginning to lose that ability, by working with them.

Without wanting to digress, Chair, I trained to be a social worker in the very early 1970s. One of the key principles of social casework was client self-determination. It was about asking people what they wanted and working with them to work that out. Somehow, in the 1980s and 1990s this stuff has been forgotten and we need to return to it. This is essentially not just about social work colleagues but how clinicians—there are some on your Committee—work with people who are losing capacity, or before that point, and how other professionals working in health and care can work to support appropriate decision-making about appropriate care and treatment.

Q199 Baroness Andrews: It is very interesting to hear you talk about your new inspection regimes in this context, because you say in your evidence you do not inspect against the five principles that underpin the Act. To an extent, they were the principles that expressed a real culture change—and the aspiration of that culture change. I wanted to be clear about this: as you approach your new inspection regime, do you think you can address those principles? Do you think that can in fact bring a culture change? I agree with everything you have said about practice; however, is that going to be part of the methodology?

David Behan: I do think that is the case, Baroness Andrews. We literally said—it was a very literal statement—we do not use those five principles. However, we are attempting to judge the quality of a person's experience in receiving health and care services. We have been quite rightly criticised for having a pretty mechanistic approach to inspection where we have inspected against those key standards. The phrase used was that we have had a tick-box approach to inspection. Some staff would find that judgment a trifle hard. Nevertheless, over the past few years we have had an approach to inspection based on compliance with standards. What we are signalling in our change is that we want to move

away from an inspection system that is based on compliance with standards, to one that is much more about the judgment of the quality of people's experience of services.

The point I was trying to land about practice is that one of the key elements of good professional practice—Robert Francis highlighted this in his own report—is the importance of listening to people and engaging with them. Once you have listened to them, acting on what they have said is important: it is not just about listening; it is about doing something once they have said it. To use different language, it could be described as care that is personalised. It is built around the individual. If you have care that is personalised around individuals—that listens to them and then acts on that—you will promote people's human rights. The best way to promote people's human rights is to have personalised care: not to treat everybody the same, but to treat everybody as individuals.

Personalised care should be the model. I do not mean that people get personalised budgets, but that care is personalised. If I live in a care home and I have never eaten cheese, then personalisation is making sure that I do not get cheese sandwiches at teatime. Some of these are quite simple things; they are not great big complicated issues. Our job is to assess whether that care is meeting people's needs and looking at those kinds of issues. Our question about whether services are caring is essentially designed to get at whether people with capacity or without capacity are receiving care that is personalised, which promotes their human rights.

You do not need a lawyer to do that; you need professionals who know how to assess capacity and who, after having assessed capacity, can then put together care plans that identify how somebody's care is going to be promoted. If we go into services and we do not see care plans, alarm bells will be ringing, because I will be thinking, "How are you going to promote people's best interests if you do not have a proper assessment and a good plan in place?"

Q200 Lord Swinfen: If I heard you correctly, you said that best practice was more important than the Mental Capacity Act. Does best practice always comply with the law or not?

David Behan: I hope I did not say it was “instead of” the Mental Capacity Act.

Lord Swinfen: You did not say “instead of”; you said “more important than”.

David Behan: I was trying to emphasise that practice is more important than lawyers interpreting the law. Effectively, what I was saying was, “Please do not give this issue to the lawyers; give it to the professionals and practitioners to work out how best to do this.” That was the point I was trying to land. If I have done that clumsily, you have my apologies.

Lord Swinfen: Do you think it still complies with the law? I know you are not a lawyer—neither am I—but could you answer as a layman?

David Behan: We are together on that. It is essential that practice complies with the law. However, it is also essential that we treat the law as a framework. My belief is that the mental capacity legislation is a framework within which best practice needs to be demonstrated. It is for professionals to make their judgments and decisions about how they are going to operate within that framework and make decisions that are in the interest of individuals.

Earlier, answering the Chair’s question, I referred to the variability we see. Within that variability, you can see people who understand the legislation and are working within the framework and the principles—to come back to Baroness Andrews’s question. You can see those being delivered. Through our work, we also see situations and cases where we do not think that this is the case—where people are not working within the principles. I have already referred to that very practical example. Looking at a care plan, it is very difficult for us to arrive at a judgment as to whether that care plan is going to deliver services that will

meet an individual's needs and promote their wellbeing if there has not been a proper assessment of somebody's capacity and capability.

This afternoon, your Lordships are considering the Third Reading of the Care Bill. One of the principles in the Care Bill is to move from what I would argue we have had historically in social care legislation, which is the principle of less eligibility, to a principle that is about promoting people's wellbeing. This is a seismic shift in the way our legislation is framed. If you can take the Care Bill, when it receives Royal Assent, alongside legislation like the mental capacity legislation, which has that principle of doing no harm and, indeed, promoting people's wellbeing, you have a double lock on how the law provides a framework within which that best practice should operate.

Q201 Baroness Andrews: My question—it has been covered, but I am going to ask it anyway—is really about this conflation between the problems that we have seen in health and social care in recent years and the lack of good care, which is causing such a challenge and such anxiety to inspection regimes. Within that, there is the particular issue we are facing about the difficulties of implementing the Act and assessing capacity, the assumption of incapacity rather than capacity, and so on and so forth—all the things that have been brought up in evidence to us.

To what extent would you say that the failure of the MCA to be implemented properly is a reflection of the wider failure that you say you are addressing in your evidence? We have two sorts of evidence in a way. We have statements from you and others saying, “If you have a good care setting, they understand the principles of approach to a person with incapacity,” and we have other sets of evidence that say, “You can have a residential home that is inspected and meets the test, yet within that there is a particular problem with people with mental incapacity, because whatever is missing—failure to understand or a lack of communication skills—is having a real negative impact on that person.”

The question is about those related issues and how you would help the Committee to interpret and improve on them.

David Behan: This goes back to the question you asked earlier about whether we have shifted the culture; this was also behind your question, Chair.

What our evidence would show—I make this statement quite deliberately—is that there is too much variability in a) people’s understanding of the legislation and b) how that understanding influences their practice. In our last report, we made recommendations to both commissioners and providers of care—the people who run hospitals and care homes—about what they need to do to ensure their staff understand not only what the legislation says, but that they are then able to translate and interpret the legislation as to how it impacts on practice.

Two examples come to mind. I am interested in hospitals and how they get to a do-not-resuscitate decision. How do they get to a nil-by-mouth decision? Who is involved in that decision? How is that decision taken? For people without capacity or with variable capacity, how are relatives engaged in that? In our inspection processes, it is not just about saying, “Tell me how you implement the mental capacity legislation around here.” That is one way to do it, but I am sure if you asked that question what you would get would be, “We do it very well. Here is our adult-centred training programme. Here is the curriculum,” etc.

The real question, however, is not, “Do you run a curriculum for mental capacity?” but, “What does this mean for the way you make decisions around here? How are those decisions made? How does that impact on the quality of people’s experience of services?” In that respect, our role as the regulator is to shine a light on those issues; to mix my metaphors, our role is to hold up a mirror to people and say, “What we found when we visited this service is x, y and z. We think there are some areas for improvement here.”

We are not the answer; we are only part of the answer. The answer must come from the way that commissioners—health and local authorities—commission services and the way that providers take on their responsibility to ensure their staff are aware of the legislation and are able to operate that.

Baroness Andrews: May I ask about training? This is an issue you have raised. It has come to us from many different directions that there needs to be better training in the Act. I take everything you say: the Act is the starting point, not the finishing point. However, you refer to the curriculum and so on; do you think there is a role for improved or more systematic or more generalised training? Do you think that is relevant?

David Behan: Yes, I do. If you look at the turnover we have in care homes and hospitals with healthcare assistants, there is a role for it. Where you have bank and agency staff working in both hospitals and care homes, it is not just that you have this rapid turnover of people; you also have bank and agency people coming in and out of these services. It is absolutely essential that all staff who work in health and care—whether that is working with younger disabled adults or older people—need to understand the legislation.

However, they need to understand it not so they can tick a box to say they understand the legislation; they need to understand it so they know what the practical implications are of working with an 85-year-old who is quite confused because she has dementia. If there is a son and a daughter, one of whom lives in Australia and one of whom lives in Canada, who are the next relatives who are going to be involved and engaged in those decisions? These are not hypothetical positions; these are real situations. 65% of people in all of our acute hospitals are aged over 65; these are occurrences that happen on a regular basis. The average age in a care home is over 85. These should be the default settings of these services, not the exceptions. Our work has shown that we are a long way from this being

the default setting in all of our services. That gives the stretch of what more needs to be done.

I have a slight hesitation in talking about training in relation to this. This is probably a personal opinion, rather than something we have found. I hold my hand up; I did this myself in the 1980s. In respect of some of the equalities legislation, I said, “Every member of staff in this area I am responsible for needs to go through equalities training.” We sheep-dipped people through this equalities training and we wondered why it did not make a difference. What I would want to do is exercise a cautionary note about the solution to this being to push everybody through mental capacity training. The issue is about workshops, so that people can understand what the practical implications of this are. Some of this is on-the-job support for people. It is about using cases to have a review and a conversation with people who are making these decisions so that they are doing it in real time. It is about having senior practitioners and registered managers who can coach staff through making the appropriate decisions, rather than just seeing it as a training programme.

It is much more about development. This is where you begin to get a change in culture—rather than saying, “Let us put every member of staff through mental capacity training; have you done it?” and the aim being to get x number of people through mental capacity training. Actually, the aim is to ensure that, when we make decisions, we are making good decisions based on people’s needs that promote their welfare. That is the cultural shift we are after.

Q202 Baroness McIntosh of Hudnall: I would like to explore that a little bit more. I was very interested in the five principles you have established. The last of them—it happens to be the last; I am sure that is not a reflection of priorities—was about whether services were well led. This term “culture change” is bandied about an awful lot now. It is the answer to every problem that we find in the delivery of services—whether it is for young

people or people without capacity or whatever. It is always, “We need a culture change.” It is very easy to say and very difficult to do, as far as I can see.

Fundamentally, however, there is an issue here, is there not, about leadership? We tend to concentrate on thinking about the people at the bottom of the pecking order and worry about whether they are properly trained, but the way you get culture change is by modelling it and you have to model it all the way through the—I am trying not to use the word, but let us use it anyway—hierarchy of any organisation. It has to start from the people whose responsibility it is to make sure that the culture is appropriate. Beyond what you have already told us, I am wondering what else you can tell us about the role of the regulator in promoting good leadership within these settings—to ensure that we do not just talk about culture change, but that we actually model it and ensure that it gets embedded.

David Behan: If I may say so, you have gone right to the heart of one of the reasons we need to change the way we inspect health and care services. If you look at what we inspected previously, we did not inspect the leadership, governance and culture of organisations. However, what we know—this is not just from Robert Francis’s report; there is a raft of literature on this now from many sectors, not just health and care—is the importance of the relationship between leadership culture and what gets done in organisations. If the signal from the very top of the organisation, from the chairman and chief executive of a board—whether it is an NHS board or a private company board—is, “What matters around here is financial balance and targets,” I am sure that is what will get done. If the signal is, “What matters around here is quality and safety,” I am sure that is also what will get done.

The reality is that—this is what Robert Francis has said and I absolutely agree with him—quality and safety did not receive the attention it required. What happened at Mid Staffs was that it did not get that attention. His report is seminal. The debate about too many

recommendations misses the point; his report is the definitive report. It is seminal, because it actually has caused a debate about quality, safety and the importance of listening to people. In my personal view, if I may, Chair, I have not seen the likes of this in my career to date—to be absolutely frank with you.

There is a change in conversation going on and that is supported by research. I am interested in some of the work that people like Jill Maben, Professor of Nursing at King's College London, have done in relation to this relationship between patient satisfaction and staff satisfaction. It is almost intuitively obvious that, if you do not have high staff satisfaction, you are not going to get high patient satisfaction. How do people who run organisations set the culture of those organisations about valuing staff? This goes back to Kay's question about supporting their development, not training, to ensure that the important things are being done.

One of the significant changes is that we will look at the culture of leadership. We have asked the King's Fund to do some work on reviewing all the evidence and literature about what is good leadership in services. That is informing the way we are developing our new approach to assessing leadership and culture in organisations. We will build that learning into our methodologies.

We are seven inspections into the 18 inspections of hospitals we said we would do before Christmas. These are our new inspections. I have managed to spend some time on two of the inspections, where I have seen how we are changing the way we explore—with the chief executive, chair, non-executive directors and, in foundation trusts, the governors—the leadership and the way they set their culture. How does that governance work? We are reviewing board minutes and what goes to the board. Do these boards meet in private? Do they meet in public? If they meet in private, what then becomes public? How open is the culture? How do they deal with never events? How do they deal with serious untoward

incidents? Are these things that are kept within the board or are they analysed and then reported to the board in public session, so it is obvious that people can learn from them? Those are some of the questions we have been asking.

Q203 Baroness McIntosh of Hudnall: I am sorry to interrupt you, but, on that issue, what is the value or efficacy of the Mental Capacity Act specifically in relation to the kind of education you are thinking you might need to do with people? Particularly since you have mentioned board members and non-executives, do you talk to them about the Mental Capacity Act when you are inspecting? Do you ask them to be familiar with it? In what way is the Act a useful tool for you?

David Behan: I did an inspection at Bournemouth last Friday. As we gathered together to review what we had learnt and what we still needed to learn, I asked that three specific conversations went on with key executives within the trust. One was, “What is the policy on nil by mouth?” The second was, “What was their policy on do not resuscitate? How do they apply that?” The third was, “What was their policy in relation to the Mental Capacity Act? How do they know they are delivering it?”

As I say, these are seven of our first 18 inspections. The wave-2 inspections will build this in based on the learning that we extract. Rachel’s post exists specifically to ensure we have this capacity. As part of our preparations for this session, Chair, I know that Rachel has been engaging with the people who are designing our methodologies to make sure this is hardwired into the way we operate. I do not want to overlabour this, but the reason I talk about nil by mouth and do not resuscitate is that my experience of inspecting services is that, if you ask people, “Do you have a policy on the Equal Opportunities Act, the Health and Safety Act or lifting and handling?” etc., they will say yes and they will give it to you.

The Chairman: You have already made that point. However, Baroness McIntosh was wondering about the non-executive directors. What do you do to inspect that, at board level, non-executive directors are aware of that and their obligations?

David Behan: Chair, my point—not to push back on that—is that we do not have a checklist to work our way through with non-executive directors. The key question we are trying to answer is this: how well run is this place? How do you deal with these things? It is not about running through a checklist.

In answer to both of your specific questions, we have not landed this properly. There was a specific interview between two inspectors and two non-executive directors. They had key lines of enquiry, as they are called, which are the issues that had come out from our analysis, about how those hospitals are run. There was a specific conversation that went on for about an hour and a half, I understand, in Bournemouth, with two non-executive directors. At the same time, similar questions would be asked of the chairman and the chief executive and of the governors in a foundation trust. We come together and say, “This is what we heard here; this is what we heard here; does that triangulate?” As you take a diagonal slice through an organisation, is there consistency in how people talk about this? We will be looking for consistency between what a ward sister is saying and what a non-executive director is saying about the way in which things like mental capacity are taken forward.

The Chairman: We have a lot of business to get through; I wonder if we can perhaps move to Baroness Shephard.

David Behan: I am with you, Chair.

Q204 Baroness Shephard of Northwold: I have a very brief question. You told us you did your training in the early 1970s. You will therefore be familiar with the introduction of the Mental Health Act 1983. There were very clear guidelines—not to say statutory requirements—in that Act for involving all, for example, of a hospital’s hierarchy—I will use

the word—including people of the governing body, in what was required by the Act if people were going to be deprived of their liberty. Most people seem to feel that the Act worked quite well. I was one of the very early commissioners. We found that there was good understanding and, if there was not, after a visit one was soon put into place. Why is there such difficulty, do you think, with the implementation of the Mental Capacity Act, comparing the two?

David Behan: That is a big question.

Baroness Shephard of Northwold: I meant it to be brief. I am sorry. It does seem to be quite relevant.

David Behan: No, it is an important question; I do not mean to be dismissive of the question in any way, shape or form.

The 1983 Act was largely based on the 1959 Act, which describes a whole bunch of services and a demography that we have moved past. We are 50 years on from that. The population that is there to be served and the services that are there to meet the population's needs have changed quite dramatically. That is the answer I would give to what is different. We have more people living into old age, where dementia and issues around capacity are an issue. There are more people with profound disabilities that raise some challenging questions around consent and the ability to consent. The job has become infinitely more complicated over the last 30 years compared with 1983. I do not mean it was easy in 1983; it has become more complicated. That would be the answer I would give you.

Baroness Shephard of Northwold: The answer you have given me is really talking about volume, in a way, rather than complexity. However, I do not want to hold the Committee up. This is an issue we have explored with other witnesses; that is the thing. I wondered whether you had a view on why one worked and the other seems more difficult. I accept

complexity; I accept volume; however, there are also principles, and that is what I was trying to get at. We may get at that later on.

The Chairman: Yes. If not, perhaps you could submit something in writing in elaboration to your answer to the question.

David Behan: If I am failing in my answers, Chair, I apologise.

The Chairman: It is only the pressure of time. Could we move on?

Q205 Baroness Barker: As the regulator of health and social care, you have a unique insight into the way in which this legislation works, which is very important to us. On the issue of variability, a number of the social work organisations have said to us that the Act is not really being used in the way that was intended, i.e. enabling and empowering people without capacity. It is actually being used to substitute safeguarding legislation. They have talked in particular about different professions taking that stance. For you, as the regulator, what do you see as the balance between being seen to take action—and ensure services are safe and so on—and ensuring that professions do implement the enabling ethos of the legislation?

David Behan: There has been some defensiveness around a lot of practice. There has been caution about taking risk. That is understandable at times, in the way that where risk is seen to go horribly wrong the debate tends to turn on who is to blame, rather than what learning can be extracted and how services can be improved and developed. That is not to say that there is not an important place for accountability. We often scramble these things in a horrible way. It is defensiveness. As I have already said, the level of knowledge around the legislation is not sufficient. In a sense, there is ignorance as well. This is not necessarily about people doing things wilfully wrong.

However, we do need to balance empowering people. This goes back to the first question. It is about the ambition, which is about empowering. The best way to do that is through

personalisation. That is carrying out individual assessments and having individual care plans that are about meeting individual need. That is the best way to ensure there is a human-rights approach to practice. The legislation strikes the legal framework within which that practice can be organised and arranged. That is our view; it is what we are doing in seeking to build this into our inspection methodologies, and it is what we will continue to do.

Do we need to ensure that people's wellbeing is safeguarded? Yes, we do. This is why I referred to the Bill that is in this House later this afternoon. It begins by stating that the overriding objective of the system is to promote people's wellbeing—and that is entirely consistent with this Act.

Q206 Baroness Hollins: You have talked quite a bit about revising your standards. One of your five areas, however, was about whether a service is responsive to people's needs. I wanted to focus a little bit on people with learning disabilities, who are often thought of as being a separate group, but are actually present in all of the services you inspect. They cannot be seen as a separate group and thought about separately. One of my questions is whether you have considered checking how responsive all services are to the needs of people with learning disabilities—particularly in respect of their capacity.

You have talked about personalisation as if it is more of an attitude than a skill, but there is quite a lot of skill in assessing people's needs, assessing their capacity and making the kind of adjustments that might be needed in order to be able to assess capacity and for people to be able to make full use of services. One example you have given is about do not resuscitate and things like that, but you could look to see how specifically that or any of these difficult decisions are being applied to people with learning disabilities, who are particularly vulnerable and who are present in every service. I do not know whether you have an answer to that.

David Behan: Andrea will help on this as well, because she will lead the inspections of a number of services that are delivered to people with learning disabilities and will do some joint work with the other two chief inspectors around exactly this—to pick up on Baroness Barker’s point and the point you are also making in relation to this.

However, one of the things that we have more reflected on than actually said overtly is that, if we can get our inspection methodologies right for people who are viewed as being vulnerable by virtue of their circumstances, we can get this right for everybody. From Mencap’s *Death by Indifference* report and the response that has come through from Sir Jonathan Michael’s enquiry into this, we know that services for people with learning disabilities and acute health needs are not as personalised as they could be. People are not listened to; their families are not engaged. In *Death by Indifference*, that contributed to people dying, quite frankly.

There is much more that can be done in relation to this. I am sorry, Chair, if I am repeating myself again, but it does come back to personalisation being an attitude and a skill. It is not one or the other. If we are getting those basic assessments right and getting care plans in place, where we are listening to people and engaging their families, there is a greater chance that we will get these things right. This is why there is an important role in our inspections to assess how well services are meeting the needs of those most vulnerable people and those without consent. We do look at that now and we will continue to build that into our methodologies.

Andrea, you are going to lead on this work for adult social care.

Andrea Sutcliffe: Yes, thank you. Building on what David has just said, we will be taking that overarching framework of five questions in terms of looking at the extent to which services are safe, effective, caring, responsive and well led. This absolutely impacts on

services for people with learning disabilities. However, the point you are making about them being present in all the services we are regulating is very well made.

Across the three chief inspectors, the most recent reflection we have had is thinking through learning lessons from what Ofsted do in terms of looking at schools and focusing on what schools judged to be “good” or “outstanding” are doing for the pupils who have the greatest needs. A school does not get to be “outstanding” unless they can demonstrate they are approaching that particular cohort of pupils appropriately.

What we have been reflecting on is that people with learning disabilities or dementia are our special vulnerable group. If we looked at all of our services specifically for those people in order to answer these questions, we would have a very good insight into the way services were being delivered for everybody. If they are getting it right for people with learning disabilities, we have a fighting chance that they are getting it right for other people as well.

Baroness Hollins: This is very important. There are so many worrying stories: for example, people with learning disabilities not having investigations or treatment and going home, because of a failure to sort out their capacity and use the Mental Capacity Act properly. To me it seems like a very good area to look at, whichever service the person is attending.

Andrea Sutcliffe: I would entirely agree with you. It is about taking that whole-person perspective and focusing on what is the most appropriate thing we should be doing to support people, acting in their best interests, which, again, is an important principle for us to be taking forward, and not presuming that people either do or do not have capacity to agree or not to a particular course of action.

David said the Mental Capacity Act gave us a good framework; it ought to be integral to the work that we are doing both in delivering services and, for us, as the regulator and inspector of those services, building on that principle.

Q207 Lord Swinfen: Your written submission states that you do not think you require further statutory powers. Can you elaborate on why this is, when you also identify a potential gap in regulation and supervisory bodies, and you make it clear that you do not inspect against the five principles of the Mental Capacity Act?

David Behan: What we were saying in relation to this was that the Act itself works. It is a good piece of legislation. To come back to your earlier questions, the issue that we have identified in our monitoring—this was behind your question as well, Baroness Shephard—is the way in which it is being delivered and supported to be delivered. As I have already indicated, we wish to build this into our new methodologies and give it an important place in our inspecting methodologies.

We do not have a responsibility for assessing the role of local authorities in commissioning decisions that are made. As a regulator, our responsibilities are focused on the provision of care and the quality of that provision. That said, this year we have written to local authorities if we feel our monitoring has exposed whether they have been carrying out their supervisory responsibilities in an appropriate way. Where we have identified that we feel supervisory bodies have not been discharging those responsibilities, we have written to those authorities and asked them to review how they are taking forward those supervisory responsibilities.

What we were saying in our evidence to you is that we think the powers we have to monitor the implementation of the mental capacity legislation are sufficient. We are going to change the way we inspect hospitals; we will build this in. This is how we intend to move forward.

Lord Swinfen: When you write to local authorities, do you get satisfactory responses and do you go and inspect again?

David Behan: We do not inspect local authorities.

Lord Swinfen: No, I know you do not.

David Behan: However, we will go in again and look at whether this is improving. Of course, we have this ongoing responsibility to monitor the implementation of the legislation, which means we will pick this up through our ongoing monitoring. We are due to produce an Annual Report and we will be looking to build this into that.

Lord Swinfen: Are your inspections under notice or do you simply turn up?

David Behan: The majority of our inspections are unannounced inspections, so we simply turn up. Clearly, they are planned from our point of view, but approximately 97% of our inspections of services are unannounced inspections.

Q208 Baroness Barker: The evidence that has been put to us is that DoLS, the deprivation of liberty standards, are not being applied in all cases where they should be. Could you tell us what your role is in the inspection and regulation of DoLS? If we were to envisage a point when those standards were being properly implemented, what would it take to get there?

David Behan: Again, our responsibility in relation to DoLS is to monitor the implementation of the legislation as it relates to the deprivation of liberty. We do that through our inspection process. Where we identify that it should be applied—whether that is in people being inappropriately restrained or consent not being sought—we can take action, and in certain circumstances we do take action. Where we take action, we will take action under the Health and Social Care Act, which is where our regulatory powers come from, as distinct from our monitoring powers under the mental capacity legislation.

What we have put in our Annual Report, Baroness Barker, is where we have taken the action and what we have done. However, one of the things I was saying at the beginning of this session was that there is more that we can do. Some of the variability in services we talked about we also have in the way we take this forward. One of Rachel's roles is to work

with us so that we can grow our capacity and capability within the organisation to ensure that we are doing both our monitoring and our regulatory activity in an appropriate way.

I am not for one minute saying that we have this sorted. There is more for us to do, but it comes back to Baroness McIntosh's question: we need to model what best practice is in the way we conduct ourselves. When Robert Francis attended our board meeting in the earlier part of the summer, he made this point about the importance of the regulator modelling what the appropriate behaviour is. We cannot talk about variability in understanding the Mental Capacity Act and then have variability in our own understanding. It strikes me that we need to be better than that—and that is what Rachel's role is for and about.

Q209 The Chairman: Can I ask a question of Rachel Griffiths? Do you have experience of implementation of the Act? The General Medical Council's written evidence states that when the Act was implemented, regional implementation advisers were an effective vehicle for assisting systems and professionals in each health authority in England and local health boards in Wales. Do you consider that it would assist to reintroduce such advisers to help secure the change of culture we have been discussing?

Rachel Griffiths: It is possible. Those regional leads were immensely useful and very influential. However, we have moved on somewhat. For example, I note that all clinical commissioning groups have to have a Mental Capacity Act named lead in order to be instituted. I was very pleased to see that, as you can imagine.

I would be sorry to see those roles not taken advantage of within local health economies to improve the Mental Capacity Act—both highlighting and implementation. As well as regional leads in those early days post-2007, local authorities all had Mental Capacity Act named leads who worked under the umbrella of the Department of Health. Although some of them still have those, quite a lot have either subsumed it into adult safeguarding or have got rid of it altogether. Where there are Mental Capacity Act leads, the understanding is stronger. For

example, I know that hospitals with MCA leads do demonstrate more of an understanding of appropriate practice.

The Chairman: Thank you very much for your evidence. It has been very helpful.

Examination of Witnesses

Paul Buckley, Director of Education and Standards, General Medical Council, and
Marc Seale, Chief Executive and Registrar, Health and Care Professions Council

Q210 The Chairman: Good morning. You were present during the previous session, so you have heard my warnings about broadcasting and transcription of evidence. Welcome to this second evidence session today. Can I start by asking the same question I asked of the previous witnesses? How does the Mental Capacity Act feature in the delivery of your functions, and how do you relate to each other and others with regulatory or inspection functions with regard to the Act? Can I start with Mr Buckley?

Paul Buckley: Thank you very much. The GMC's function is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Our focus is on professional standards. It is largely in that role that we highlight the importance of the Act to doctors. It features in our standards work. It features in our educational work. We set outcomes in relation to undergraduate education, but also we approve postgraduate curricula that refer to the Act and the importance of understanding it. It features in our education work and it also features in the outreach work that we do where we engage with the profession. Ultimately, of course, it may feature in our fitness-to-practise determinations where we are taking action where there has been serious breach of good medical practice. It is very strongly reflected in our functions.

In terms of how we relate to other organisations, you heard from David Behan about the memorandum of understanding that exists between the CQC and the GMC. There are opportunities for exchanging of information where the need to do so arises.

Marc Seale: In relation to the Health and Care Professions Council, there is a strong interrelationship. Firstly, we are a regulator of individuals and we set the standards of education and training for those individuals. We are essentially the systems regulators of university programmes, and we require the universities to ensure that graduates who are coming onto the register meet the required standards and proficiency. That includes an understanding of the legislation relevant to their particular profession.

As a regulator of around about 320,000 individuals, we expect all of those individuals, whatever profession they are from, to have an up-to-date understanding of the relevant legislation. We expect those individuals to be up to date. If they are not and if there are complaints or allegations they are not meeting those standards, we pick that up in our fitness-to-practise process.

This is also very important in terms of what we do as a regulator in relation to our communications. We spend a lot of time meeting and talking to the universities, talking to employers and actually meeting individual registrants. We would expect, as an organisation, to discuss any problems with all three groups to see whether there is a problem out there and, therefore, whether we need to adjust our standards. There is a loop between setting standards, approving university courses, running fitness to practise and, as a regulator, going back to those individuals and making sure those standards are adhered to.

Q211 Baroness Shephard of Northwold: This question was also asked of the earlier witnesses. The failings of hospitals and care services, as we all know, have received huge publicity recently. In your view, to what extent is the apparent failure to implement the

Mental Capacity Act in these settings the result of wider failings in healthcare professional and care standards? Is it symptomatic, in other words?

Paul Buckley: Perhaps I could start with that. Yes, there is a connection. Similarly to Mr Behan, we would start from the point of view that the primary failing is in relation to professional standards. The failure to understand or apply principles within the MCA is a symptom of that more fundamental professional failing. The primary failing is not in relation to the Act itself. It is one removed from the underlying professional failure to act in accordance with the standards that we set. Clearly, however, there is a relationship, because if the importance of the Act were properly understood, perhaps we may not see some of these failures that have been so well documented, not least this year.

Marc Seale: In relation to the professions that we regulate, so far we have not been involved in the recent debacles that have come to light. However, as a regulator you must never be complacent. Just because you have not detected something does not mean it is not there. It might mean that you do not have the systems and processes to detect it in the first place. That is very much the philosophy of the way we run the HCPC.

You also have to divide the world very much in terms of professional regulation. The professional regulation we run in the UK generally is very good at training highly competent individuals who come on to the registers; the vast majority meet those standards throughout their professional careers and deliver fantastic care. There is a very small minority of individuals who do not. In terms of what we do, we pick those individuals up in fitness to practise. Again, what we are looking for is whether there are themes. Are there things going on amongst professionals? We then have to go back to the universities and the professional bodies and increase those standards. Standards are at the heart of professional regulation.

However, we have to be acutely aware of the issue of more and more of health and care being delivered by non-professionals. This is a good thing because the cost of that delivery is better. It is more efficient, and as a regulator we absolutely support that, but unless you have statutory standards—particularly standards of education and training—there is no way that you can hold these individuals to account and stop them moving around. If you move, particularly, into the care arena, we as a regulator are very adamant that statutory regulation of one sort or another should be brought into that area. Until that is done, there is a missing piece from the jigsaw and we will continue to be unable to do anything as a statutory regulator.

Baroness Andrews: Can I follow up on that? The weight of material and methodologies you put out in terms of guidance is obviously hugely significant and very important for the regulation of the profession. Mr Behan's evidence was that, although those frameworks were absolutely vital, what really counts is the quality of experience and the interchange between the patient, and the understanding that the professional has of a condition, whether it is a communication difficulty or whatever else. The question he asked was, "How do they know they are delivering the care required by the best application of the MCA?" What would you say that looked like in relation to the weight of stuff that you are producing in terms of standards, regulation and identifying failure? Do you agree with him about that?

Paul Buckley: One of the challenges that everyone faces in this area is the sheer amount of information. There is an intimidating amount of information that doctors and—I am sure—other healthcare professionals feel they may need to be able to get to grips with and assimilate, if they are to be effective. One of the things that we have tried to do is boil this down to a few simple principles and make those accessible to doctors in a way they can really engage with. We are in the middle of a huge programme of work to try to become more effective at that. However, we know from research we have done that one of the

barriers to effective practice is sheer information overload. Rather than presenting doctors with a tome on the Mental Capacity Act, what we are trying to do is simplify and find ways, perhaps through new technology and other means, of engaging doctors in some of the simple principles they can feel confident on. If they can base their practice on those principles, by virtue of doing that they will be on the right side in terms of the MCA and other pieces of legislation.

Q212 Lord Alderdice: You have both talked about the importance of undergraduate as well as postgraduate education and training. One thing that has become apparent in the evidence we have received is that when it comes to psychiatrists there is a reasonable understanding of mental capacity, but with general practitioners and others it is less impressive. I am a little puzzled why the GMC does not seem to require that all medical schools have a professor of psychiatry, so that that side of understanding—not just of the Act, but of the approach—is imbued in young doctors in their training and not left to postgraduate. In some cases, where there has been a professor of psychiatry for 30 years or more, it has been abandoned in recent times—yet this is an area where the GMC has a very important and powerful role.

Paul Buckley: Our approach has been to set outcomes but to allow some flexibility in the way that medical schools deliver on those outcomes. We do have a specific outcome in relation to assessing a patient in relation to a capacity issue. We are very clear that any medical student graduating needs to be able to do that. How the medical school decides to arrange themselves and what people they employ and so on is—we have taken the view—a matter for them. We are absolutely clear about the outcome that we are seeking.

We do know, from anecdotal evidence, that many new graduates find this an enormously challenging and worrying area of practice for them. We are looking at the impact of our guidance in the new *Tomorrow's Doctors* at the moment. One of the questions we are asking

the research team to look at systematically is this question of how confident graduates feel about practising in relation to this outcome, because we would like to have greater evidence than the anecdotal evidence we have. There is an issue, but we are very clear on the outcome we are seeking, which is a mandatory outcome for all graduates in that area.

Q213 Lord Turnberg: You told us, quite rightly, that your main role is in education and training, development of curricula and making sure standards are high and then, at the end of the day, when someone fails, holding them to account. However, what we keep hearing all the time is that the Mental Capacity Act and its practice require a change in culture. Do the regulators have a role in changing the culture and, if so, how?

Paul Buckley: We certainly have a role in promoting a partnership culture between doctors and patients. That is something the GMC has been doing for some 20 years or more. We also have an outreach programme, as I mentioned at the beginning, where we are going out to doctors to engage them in conversations about good practice and our principles. Yes, we do have a role to play in changing culture and we are actively seeking to become more effective in doing exactly that.

Marc Seale: On this whole issue of culture, I use the phrase in relation to organisations. My experience of being a chief executive is that, if you want to change the culture of an organisation, it is a very slow and incredibly challenging process, which takes decades rather than weeks or months. However, the role of the regulator is fundamental in the concept of professionalism: our expectations, as citizens and society, of what we expect a professional to do and how to behave in certain situations. Our role is absolutely critical in ensuring that professionalism is taken up by those individuals going into the programme.

For example, about 20% to 25% of our complaints come from professionals who are concerned about the performance of their fellow professionals, which is one of the core things that professionals do. We have to ensure that those individuals not only set their

own standards but require their fellow professionals to meet those standards as well. We have a big role in that relationship and how those individuals behave in particular organisations. I am not sure that we have a direct influence on the way the culture of those organisations develops or is controlled.

Q214 Baroness Hollins: May I ask a supplementary question? I wanted to follow up on Lord Alderdice's question in the context of culture. It seems to me that the culture in medical schools is actually part of the problem. We keep hearing that doctors are not very good at this. It is all very well for it to be an outcome, but I wonder whether, in line with your idea about reducing things to basic principles, you could actually advise medical schools on those schools where they are more effective at producing those outcomes. They might find their priorities are in the wrong place in terms of whom they are employing, because medical schools are focusing more much on their research outputs than their teaching outputs. That would be my possible criticism of your approach.

Paul Buckley: All medical schools will have areas of strength and areas where they need to develop what they do. In relation to the overall issue around education and training, it has taken some time for the system to catch up with the fact that we have an ageing population whose needs are changing. As it happens, this very morning an important report has been published, *Securing the Future of Excellent Patient Care*, about the future shape of training in medicine in the UK by Professor David Greenaway, the Vice-Chancellor of Nottingham. One of the things that report says is that we need doctors, as they come through, to be much better equipped to deal with patients in the round in a more holistic way and to be skilled not just in their individual specialty but a broader range of professional competencies, which will enable the kind of personalised care that Mr Behan was referring to.

You are right to pose the challenge to the regulator. I guess what I would say is that the system is responding—albeit perhaps not as quickly as everyone would want.

Marc Seale: Could I add an important point that I have not mentioned? For any professional, it is not only about your initial education. It is not a case of, “That is it; get on with it,” and then you work in a particular area for 40 years. The whole concept of continuing professional development—the idea that you should refresh, renew and expand your education throughout your career—is a vital role that regulators have to play. Without that, there will be problems. As a regulator, we require registrants to undertake what we call continuing professional development. We audit them and we expect those individuals to improve throughout their career. The challenge is that you can start off as somebody who has literally come off a programme of physiotherapy on day one and know a little bit about everything; 30 years later, you could be a Nobel Prize winner in a particular area of genetics as a clinical scientist. It is not just a question of keeping up to date with the basics of what you do as a professional, but also, if you have specialised, you must make sure you meet those standards.

As a regulator—not just in the UK, but across the world—one of the big challenges we have is ensuring that those professionals maintain and enhance their professionalism and those standards throughout their career, not just focusing on the initial dollop of education they get when they are in their late teens and early twenties.

Q215 Lord Faulks: Mr Buckley, you say in your evidence that, for the most part, the Mental Capacity Act reflected what was enshrined in good practice. You also say that the feedback you have in medical settings is not systematic; it tends to be somewhat anecdotal. There are two things I would like to ask you. Firstly, albeit that this is somewhat anecdotal, can you give us particular examples where you think there is some evidence of doctors falling short in their application of the Mental Capacity Act? Is there a particular area?

I will declare an interest here or make the admission that I am a lawyer. The second question is this. On a number of occasions, doctors are asked to help the court on the

question of capacity, but courts are uncertain as to which sort of doctors should be giving that evidence. Do you think all doctors should be able to assist the court with capacity? What do you think about either of those two points?

Paul Buckley: On the first point, as to what areas doctors find difficult, the whole area of treating patients with learning disabilities is one that doctors have, from time to time, struggled with. Certainly, the discussions we have had with, for example, Mencap, have highlighted the fact that there are some real challenges for doctors in providing effective care for that group of patients. That is one of the reasons we have developed particular learning materials and a special part of our website that is devoted to good principles around the care of patients with learning disabilities. That is one thing that we are doing to try to address that gap.

In relation to the second point, there may have been a tendency in the past to think issues around capacity were for particular specialties. If you were in another speciality—not psychiatry or care of the elderly—it was perhaps not so much of an issue. Certainly, however, I was very struck by a statistic in the report from the Royal College of Physicians of London last year, which pointed out that one in four inpatients in hospital has had a diagnosis of dementia. What that underlines is that these issues around capacity are issues for all of the medical professions who are in contact with patients—not for particular specialisms. That is why the shape of training review report, which I referred to earlier, is so important in saying to the profession, “These are issues for all doctors, not just for particular groups.”

On the particular issue of who should give evidence in court, all doctors need to understand what is required in terms of assessing capacity, because that is something any doctor in touch with patients might need to be able to deal with. Whether that would be appropriate

in terms of expert witness evidence, I do not think I am probably best qualified to pronounce on.

Q216 Lord Swinfen: Mr Buckley, you report that you receive enquiries from IMCAs and IMCA providers, which suggests that some doctors are fully informed about the IMCA entitlements of patients. As a professional regulator, how do you respond to such enquiries?

Paul Buckley: In terms of the immediate enquiry, we will point the enquirer to, for example, our guidance on consent and what is said in that document reflecting what is in the MCA. They are then clear that the professional regulator does regard this as an important issue and that we have issued guidance to the profession on it, and that then empowers them to go back and have the conversations that they need to have, understanding where we are coming from. That is the first thing that we are doing in terms of the immediate enquiry.

In terms of the broader programme of work, as I said, we are reaching out. We have this new network of regional liaison advisers, who are now offering workshops to doctors in response to demand. Consent is one of the areas where there is a demand for their services. This is not the MCA specifically, but the issues around consent, which, of course, are reflected in the MCA. Our colleagues have delivered well over a dozen workshops to several hundred doctors in this year alone. There is enormous demand for doctors to understand what their responsibilities are and, going back to my earlier point, to try to communicate this in a simple way so that they can immediately see what it is they need to be doing. One of the challenges for us is to see how we can harness new technology and deliver information to doctors in a way they can readily understand. Those are the two things that we would do in relation to your point.

Q217 Baroness Barker: When we received evidence from other medical bodies such as the BMA and, in particular, the Royal College of General Practitioners, they flagged up to us

that your colleagues in general practice have a particular problem when it comes to involvement in assisting people with advanced decisions, because they do not know the status of their involvement. Crucially, however, they do not know how that decision will be communicated through the system. I wondered if we might ask you—not necessarily now—to respond to us. You might talk to us, or do a written submission, about how your work and the work of other people like the RCGP might work together for the benefit of patients.

Paul Buckley: I would be very happy to provide a submission on that. We are working closely with the RCGP over their proposal to extend the length of their training from three years to four years. One of the reasons they are seeking to extend the length of that training is so that there can be better coverage in the curriculum of this sort of issue.

Marc Seale: May I make a couple of points? On this question around standards and guidance, as a regulator, if we were getting lots of questions on guidance it would seem to indicate to us there is a problem in terms of how they are written or constructed. Your standards and guidance must not be set in concrete, because the profession is developing on almost an hourly basis.

We have a constant Forth Bridge-type exercise where we are revising our standards on a three-year cycle. For example, if there are a lot of questions from a profession and they do not understand what they should do, we would revise our standards or guidance—or, indeed, if, for example, you were to come up with a suggestion or recommendation in terms of what should be included in our standards, we would go round a route of consulting on those and making sure they are fit for purpose.

In terms of advanced decisions to refuse treatment, that is actually one of the areas where, in fact, we are aware of a potential issue out there in relation to the professions that we regulate. It is very much to do with the context of where some of our professions work. In relation to paramedics, they can be in situations—I am aware of one of these situations—

where they go to a house late at night and there is an individual who has had a heart attack, and there are very distressed relations who are saying, “We have this document that tells you what to do.” The paramedic has the dilemma: “Do I get on intervening and trying to deal with that patient, or should I sit back and read this 20-page rather legal document about what I should do?” Our advice has been that what they should do is get somebody to phone back to the ambulance station and read out what the document says while the other individual gets on treating the patient.

In certain contexts, we do have issues like that, which go back to the legislation. However, as I said, if it becomes a big issue, what we would do is change our guidance to the individuals that have to use it.

Baroness Andrews: May I pursue what you have just said about the potential for four-year GP training instead of three years? This has come up before. Is it being driven in part by the changes in demography and the whole shape of health and care services having to shift towards an older population, where these issues will become much more dominant, or are there other factors? One of the issues, following the earlier evidence, is to what extent the notion of personalisation involves a different professional attitude and different professional skills. We had the debate earlier about whether it was attitude or skill; is this something that is going to be a greater part of GP training as well?

Paul Buckley: As I recall, the educational case for extending training in general practice was driven by three things. One was greater exposure to mental health as part of GP training. The second thing was greater exposure to paediatrics as part of general practice training. The third was a sense that those coming through newly on to the GP register were competent to do what they needed to do, but they were not confident about doing it. There was a strong feeling in the Royal College that in order to get general practitioners who were more confident, they needed to have a bit longer in their training programme to

give them a more secure basis on which to go on and practise. It was a combination of factors, but, certainly, mental health and its relationship to demographic changes is definitely a factor in that.

Baroness Andrews: It is a real opportunity for the principles and practices around the MCA to begin to be more embedded in general practice training, perhaps.

Paul Buckley: One could see that, yes.

Q218 Baroness McIntosh of Hudnall: Mr Seale, you probably heard the question Lady Barker asked of the preceding witnesses about this difficulty that we have seen arising in evidence of the MCA being used inappropriately occasionally—perhaps frequently—as a safeguarding mechanism, rather than an enabling mechanism. It is very easy to see why people faced with a potentially difficult situation where risks are involved might take a rather risk-averse approach to how that situation is resolved. As regulators, how do you see your role in trying to ensure that the balance between avoiding disaster and enabling free decision-making is struck?

Marc Seale: The first thing is that we try to be an evidence-based regulator. If there is an issue out there, as a regulator we need to go and collect it, talk to our stakeholders, consult and find out what the scale of the problem is. To date, we have not seen any evidence there is a problem out there in terms of the professionals we regulate by looking at fitness to practise. Fitness to practise, however, is the safety net at the bottom of the system. Things have to be very bad before you get picked up by fitness to practise.

If the view of the Committee is that there is a problem out there, we would take it away and look to see what the problem is. We would then have to feed it back into either long-term education or, in terms of the short term, going to the professional bodies and, in certain circumstances, writing to every relevant registrant that we deal with. Again, because we are a multi-professional regulator, if you take some professions—I should not pick on

professions—such as clinical scientists or biomedical scientists, it is potentially less of an issue than if, let us say, you are forensic psychologist working in a secure hospital.

Baroness McIntosh of Hudnall: I was struck by something Mr Buckley said a moment ago in response to Lady Andrews about the difference between competence and confidence; it is quite relevant here, is it not? In fact, people can know what they should do and still feel very uncertain about how they do it. Clearly, that can be addressed in training. However, going back to your earlier observations about continuing professional development, how do you model, through your regulation, to the people who are registered with you, what good continuing professional development might include and how you know when you have done it? This issue about making a difficult decision in a very volatile situation would be a good example, would it not, of where somebody's experience would be as relevant as their training?

Marc Seale: That is quite a complicated question; can I try to divide it up?

Baroness McIntosh of Hudnall: I am sorry.

Marc Seale: One of the key things in terms of the confidence of a professional is how long they have been working. There is a period for, let us say, the first two or three years somebody is on the register in which they might not be as confident as somebody who has been around for 20 years. Certainly, for example in Scotland they have a process called Flying Start, where they support newly graduated professionals into the system, particularly in the first year, when they can contact people; they can phone people up and actually get advice in terms of what to do. This is a really important stage in terms of making sure those individuals end up as confident professionals.

In the other area, there is a sense that the Holy Grail of regulation is this issue about how you ensure the continuing competence of individuals throughout their career. There are various systems—and this is not a UK problem; it is a global issue. First of all, what we have

to work out is what professionals should do throughout their career that enhances their practice and skills. We use a system called continuing professional development, and we allow the professional to decide from the portfolio of things what they need to do in terms of CPD. If they do not do the CPD, we can remove them from the register; we stop them from renewing their registration. There is a stopgap.

However, the question is this: does CPD actually reflect continual professional competence? If we wanted to, we could set up an incredibly system; we could ask each registrant to come and have a process, which maybe lasts for a couple of days, and run them through a system to say, “Yes, they are competent.” The problem is the cost of doing that. There is the cost of those individuals turning up and the backfilling and all the other things you have to do. In a sense, no regulator anywhere has cracked that problem. Certainly, however, we are looking for a solution—though we have not come up with one so far.

Q219 The Chairman: Why do you not follow the Scottish model of the Flying Start in England?

Marc Seale: Again, one of the challenges of being a regulator is we regulate professionals across four different systems of the NHS—whether it is Northern Ireland, Wales or Scotland. Certainly, it is my observation as a regulator that Scotland is sometimes able to implement very quickly the systems and processes they have, because it is a much smaller system, and often quite radically in terms of how they deliver health and how they get their professionals on board. It is certainly something we think is an extremely good idea and, if we had the opportunity to speak to England, Wales and Northern Ireland, we would say, “This is a good idea; what do you think about doing it?”

The Chairman: Would that be something for the GMC or the BMA?

Marc Seale: I have enough challenges dealing with my own regulation to think of advising the GMC. That is your prerogative.

Paul Buckley: There is an important point coming out of what Mr Seale has said in relation to the UK dimension. Of course, the MCA is legislation for England and Wales, but, as UK regulators, we have to talk in generic terms that fit with the UK dimension. One of the criticisms made of regulators sometimes is that people cannot see specific pieces of legislation, like the MCA, reflected in them. That is because we often have to deal with legislation in generic terms. We are going to be looking at whether, in determinations that are relevant to practice in England and Wales, we could refer specifically to the MCA in order to give it profile so that, while reflecting the principles, we are also talking in terms of the specific piece of legislation that is relevant. This is a slight aside, but I thought it was important to mention that.

The Chairman: It just occurred to me that, if there is a system of encouraging new doctors, supervising them and helping them to give them confidence in the first year and beyond, it seems, in principle, to be quite a good system. I wondered if it had been thought of in England and Wales.

Paul Buckley: There are a number of programmes like that. For general practitioners they have something called a first-five programme, which is for the first five years after they get on to the GP register. In other specialties, there are things called clinical fellowships, which people may take after they are on the specialist register to provide them with additional support. This is something that is now recognised; the system is responding.

Q220 Lord Alderdice: I have one question for you, Mr Seale, and then a question for both of you. The submission by the GMC reflects positively on the Government's mental capacity implementation programme. Have professionals regulated by the HCPC had a similarly positive experience? To both of you, is there a continuing need for central or local points of support and advice on the MCA?

Marc Seale: I do not know, because none of the professions or professional bodies has approached us about it. That does not mean there is not a problem and, certainly, as we go through our cycle of meeting the professional bodies on a formal basis, it is one of the issues that we will be addressing. However, we have had no information or feedback on there being an issue at the current moment in time.

Lord Alderdice: To both of you, is there a continuing need for particular points of support nationally or locally?

Paul Buckley: I would see the advantage of there being a home where, if there are issues that arise, those can be taken delivery of and dealt with—so yes.

Marc Seale: We will very much wait for the Committee to produce its report and see what your advice is on that and, if it is appropriate, take it forward. However, we do not have an opinion at this current moment in time.

The Chairman: Thank you very much indeed. This has been very helpful.