



HM Government

Valuing every voice, respecting every right: Making the case for the Mental Capacity Act

**The Government's response to the House of Lords
Select Committee Report on the Mental Capacity Act 2005**

June 2014



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Select Committee Report on the Mental Capacity Act 2005**

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice and
Secretary of State for Health
by Command of Her Majesty

June 2014

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The five principles of the Mental Capacity Act

One

A person must be assumed to have capacity unless it is established that they lack capacity

Two

A person is not to be treated as unable to make a decision unless all practicable steps to help him/ her to do so have been taken without success

Three

A person is not to be treated as unable to make a decision merely because he/ she makes an unwise decision

Four

An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/ her best interests

Five

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

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“Individuals who may lack capacity”

In this response we refer to “individuals who may lack capacity”. The Mental Capacity Act states that a “*person lacks capacity in relation to a matter if at the material time he or she is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the brain or mind*”.

Capacity is decision and time specific. An individual may lack capacity to make a decision at one time but have the capacity to make the same decision at another. Similarly, an individual may be unable to make a decision regarding a certain matter but at the same time have capacity to make a different decision about something else. Those supporting or caring for individuals who may lack capacity must remember this and the need to re-assess capacity as appropriate.

Valuing every voice, respecting every right:

1. Foreword by the Minister of State for Care Services & the Minister of State for Justice and Civil Liberties

- 1.1 The Government welcomes the report of the House of Lords Select Committee on the Mental Capacity Act 2005. We are grateful to the Select Committee for their diligence and thoroughness in their scrutiny of the Act.
- 1.2 We welcome the Committee's conclusion that the Act is a positive piece of legislation which has the potential to transform lives. We recognise that there is still some way to go to fully realise that potential, and share the Committee's concern at the low levels of awareness and understanding of the Act. Too many people who may lack capacity may be missing out on the legal rights that the MCA gives them. This is not tolerable and we are determined to put this right. This is a big challenge. It is about changing attitudes in society as a whole towards those who may lack capacity. Meeting this challenge will require the widespread support of everyone; those responsible for running services, professionals and the public at large.
- 1.3 The prize however is great: a society where those who lack mental capacity are treated in the same way and enjoy the same rights as those who do not. We hope that the Committee's inquiry and this response will prove to be a turning point and that the MCA will start to benefit the many and not just the few.
- 1.4 Our two Departments have worked closely and with those organisations responsible for implementing the MCA to develop this response. It describes the shared, system-wide approach we will take to realising the full potential of the MCA.
- 1.5 We now urge every individual with a part to play in implementing the MCA, to seize the opportunity and realise our shared ambition to value every voice and respect every right when caring for and supporting individuals that may lack capacity.



Norman Lamb MP
Minister of State for Care Services



Simon Hughes MP
Minister of State for Justice and Civil Liberties

2. Executive summary

- 2.1 On the 13th March 2014, the House of Lords Select Committee on the Mental Capacity Act 2005 published the report of its ten-month investigation. The Government is grateful to the Committee for its invaluable work. We agree with the Committee's overall finding: that while the Mental Capacity Act (MCA) was a "*visionary piece of legislation*", the Act has "*suffered from a lack of awareness and a lack of understanding*".
- 2.2 The Government, together with our partners, have closely considered the 39 recommendations of the House of Lords together with inputs and insights received from our discussions with a wide range of stakeholders. This document presents our response and sets out a system-wide programme of work over the coming year and beyond that we believe will realise a real improvement in implementation of the MCA.
- 2.3 We intend to ensure that implementation is strengthened and co-ordinated and will consider the case for establishing a new independently chaired Mental Capacity Advisory Board. A national Board and its independent chair could also advocate for and raise awareness of the MCA, gather views on priority MCA issues and opportunities and advise the Government on key priorities for action. The Government will hold implementing partners to account, ensuring they deliver against their commitments and responsibilities.
- 2.4 We share the House of Lords' concern at the lack of awareness of the MCA. Everyone has responsibility for raising awareness and every professional who works with individuals who may lack capacity should regard the responsibility to familiarise themselves with the provisions of the MCA as a basic professional duty. The Department of Health will commission a review of current guidance and tools to determine what represents the "gold standard" that can then be widely disseminated. In 2015, the Government will host a national event to both raise awareness of the Act and to hear the views of professionals and the public as to how we can further develop our programme of work.
- 2.5 We will take a comprehensive approach to promoting implementation. Professional training is a priority and the Government, together with Health Education England and the Royal College of General Practitioners, have identified immediate actions. NHS England and the Association of Adult Directors of Social Care (ADASS) have committed to lead on work examining the important role that commissioning has to play in encouraging a culture in keeping with the principles of the MCA. The Care Quality Commission (CQC) has prioritised the MCA in the fundamental revision of its regulation and inspection model.
- 2.6 The Government will ask the Law Commission to consult on and potentially draft a new legislative framework that would allow for the authorisation of a best interests deprivation of liberty in supported living arrangements. In light of this, the Law Commission will consider any improvements that might be made to the Deprivation of Liberty Safeguards (DoLS). In the short term, ADASS will lead a task group to consider the implications of the recent Supreme Court judgment on deprivation of liberty and the Government will commission a revision of the current standard forms that support the DoLS process.

- 2.7 The Office of the Public Guardian (OPG) is undertaking significant work to increase the level of awareness and understanding of Lasting Powers of Attorneys (LPAs) – working with NHS England to provide guidance for front-line staff and with the CQC to make sure questions on LPAs feature in inspections of health and social care providers. HM Courts and Tribunal Service has committed to increasing the staff complement of the Court of Protection and the Government has committed to the revision of the Court of Protection Rules – with a view to having new rules in place by April 2015.
- 2.8 The Government believes the MCA is an Act of fundamental importance which we are committed to embedding across our work programmes. We describe early progress in respect of the Care Act 2014, the Prime Minister’s Challenge on Dementia and our responses to the failings at Winterbourne View and Mid-Staffordshire NHS Foundation Trust.
- 2.9 We urge that all those with a role to play in implementing the MCA seize the opportunity provided by the House of Lords report and this Government response. If we maintain recent momentum and implement the programme of work we describe in this report we believe that we can create a culture that values every voice and respects every right of those who may lack capacity.

3. Introduction: a change in culture

“The Mental Capacity Act was a visionary piece of legislation for its time, which marked a turning point in the statutory rights of people who may lack capacity... with the potential to transform the lives of many. However, its implementation has not met the expectations that it rightly raised. The Act has suffered from a lack of awareness and a lack of understanding. The empowering ethos has not been delivered. The rights conferred by the Act have not been realised.”

House of Lords Select Committee on the Mental Capacity Act, March 2014.

- 3.1 The Government strongly agrees with the above finding of the House of Lords Select Committee. The Mental Capacity Act (the MCA) is held in high regard by the professionals that work with it and the individuals who have benefited from the MCA’s protection of their rights and its promotion of their voice at the heart of decision-making.
- 3.2 But there is much work to be done if the transformative power of the MCA is to be felt by all those people for whom it was intended.

The scale of the challenge & the opportunity

- 3.3 Estimates of the number of people in England who may lack capacity vary but we do know that:
- Up to 670,000 people in England are living with dementia. A diagnosis of dementia does not equate to a lack of capacity but those with dementia are likely to benefit from the MCA at some point in their lives
 - Over 1,000,000 people in England have learning disabilities. Some of them may lack the capacity to make certain decisions from time to time
 - Mental health and mental capacity are not the same thing but many people with serious mental illness may stand to gain from correct application of the MCA
 - In addition to this there are the many who may suffer from temporary mental impairment (for example, following a brain injury) to which the MCA may also apply.
- 3.4 Given this scale, it is perhaps not surprising that many in the field of mental capacity argue that at any point, as many as two million people in England may lack the capacity to make specific decisions at a specific time. The challenge is to ensure that people are empowered and supported to make those decisions and that any decisions which must be taken by others on their behalf take into account their wishes, preferences and best interests.
- 3.5 Anyone, at some time in their lives, may lack some degree of mental capacity. One of the most important aspects of the MCA is the right to prepare for such a time by registering Lasting Powers of Attorney (financial and/ or health and welfare)and giving the power to make decisions regarding their finances or welfare to a trusted family member, friend or other such appointed person.

- 3.6 Reaching everyone in the community likely to be affected and improving their understanding and awareness of the MCA is a challenge for all of us, but one that, if successful, could revolutionise the way people are supported in their legal and financial affairs and by the health and social care sector.

Drawing on success so far

- 3.7 Thanks to the dedication of many front-line professionals and other groups since the Act came into force, we have a foundation to build on. No Act of Parliament can change behaviours and culture overnight, no matter how well written it is. Converting the intentions of Parliament into reality for millions of individuals can take time. However since 2005, when the Act came into force, there have been a number of notable successes. Now we need to press on and draw in many more individuals and professionals. Highlighting the positive is as important as identifying the negative as we seek to move forwards.

- 3.8 Since 2005:

- Hundreds of MCA leads have been appointed in local authorities and in the NHS. The majority have done exceptional work over the last few years and we will rely on their determination to “wave the MCA flag” to help us deliver the improvements we set out in this response.
- Hundreds of Independent Mental Capacity Advocates (IMCAs) have been appointed, supporting thousands of individuals to reach health and care outcomes that are in their best interests and which enhance their well-being. IMCAs represent a talented and committed group of people, dedicated to achieving better outcomes for individuals lacking capacity.
- Over a thousand Best Interests Assessors have been trained and are practising in both the NHS and care homes; they are examining issues of liberty and best interests and asking questions about what is least restrictive care. They are challenging care practice and advocating for individual rights in the day-to-day care of those lacking capacity.
- Thousands of Lasting Powers of Attorney (LPAs) have been registered with the Office of the Public Guardian, ensuring that individuals have the peace of mind that, should they lack capacity in the future to make decisions, then a trusted person will be able to make those decisions on their behalf in a manner in keeping with the individual’s values and beliefs.
- The Court of Protection has considered several hundred cases, making best interests decisions on behalf of individuals lacking capacity. The Court has handed down a number of landmark judgments that have empowered individuals lacking capacity and promoted their rights.
- Thousands have had their rights protected through the Deprivation of Liberty Safeguards (DoLS). In 2012/13 nearly 12,000 DoLS applications were made. These are fewer than we might have expected and increasing the awareness and implementation of DoLS is a key priority, but we should not dismiss this figure. Each of these 12,000 applications represents an individual receiving vital scrutiny, under the law, of the conditions of their care. Without DoLS, many of these individuals would have been denied this basic right.

This response and the Government's approach to the MCA

- 3.9 The Government provides national leadership and advocates for widespread implementation of the MCA. We do this by communicating with all those organisations and professionals in the private and public sectors that have a role in implementing the Act.
- 3.10 In fulfilling this role we listen to, support and empower those who are the real MCA experts – the professionals who work with individuals who may lack capacity and of course, those individuals themselves. Listening to these experts means we can develop policies that work in practice.
- 3.11 Our role is not to dictate from Whitehall how best to implement the MCA. We want to work with the professionals to identify and spread best practice. We know that the best guidance and support for implementation comes from those actively working in the area.
- 3.12 This response is the result of close communication and interaction with our national partners and of listening to the views of the wider MCA community: both through the House of Lords inquiry and directly with us. We are committed to expanding this engagement and over the coming year, as we begin to implement the actions in this response, we shall further increase our efforts.

4. Oversight and monitoring

National governance

This section addresses House of Lords:

Recommendation 3:

We recommend that overall responsibility for implementation of the Mental Capacity Act be given to a single independent body. This does not remove ultimate accountability for its successful implementation from Ministers, but it would locate within a single independent body the responsibility for oversight, co-ordination and monitoring of implementation activity across sectors, which is currently lacking. This new responsibility could be located within a new or existing body. The new independent body would make an annual report to Parliament on the progress of its activities.

Recommendation 4:

The Mental Capacity Act Steering Group is a welcome first step in this direction, and we recommend it be tasked with considering in detail the composition and structure of the independent oversight body, and where this responsibility would best be located.

- 4.1 The MCA is of fundamental importance. Its scope exceeds that of most other legislation. In the health and care sector it supports a range of important national priorities including the Prime Minister’s Dementia Challenge, Transforming Care (the national response to Winterbourne View), and Hard Truths (the Government response to the Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust). It is also a key contributor to achieving the aims of the Equality Act 2010 and the United Nations Convention on the Rights of Persons with Disabilities through its principle of treating all individuals equally and without discrimination.
- 4.2 Of course, the MCA extends far beyond the health and care sector to the world of financial and legal affairs, the emergency services , families, carers and everyone who wants to properly plan for a future where they may at some point struggle to make their own decisions. Wherever an individual can be found who lacks the capacity to make a specific decision, we would hope that the principles of the MCA will govern what happens next.
- 4.3 Given this breadth, encompassing the public and private sectors, stakeholders and organisations of vastly different management structures, designing a single body that can take “overall responsibility for implementation” would be a difficult task. On the one hand it would have to gain a detailed understanding of implementation challenges and develop effective solutions in each of these disparate areas, while on the other it would be tasked with attempting to keep a strategic oversight across the whole system. There would be practical issues with how to draw in all necessary expertise yet keep discussions targeted and focused. If the body is not to be a regulator and if overall accountability is to remain with Ministers, it would lack the necessary levers to effect change.
- 4.4 We think that the establishment of such a body would send out the wrong message. We strongly believe that widespread awareness and implementation of the Act will only happen if we integrate the principles of the Act into all existing systems. The MCA will be a success if everyone with a role to play takes personal responsibility for it, embraces its

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principles and demonstrates its values in their day-to-day lives. The establishment of a new “quango” may lead some to leave responsibility for all of this to someone else as well as diverting resources away from front-line organisations providing services to the public.

- 4.5 Therefore we do not agree with the recommendation to set up the independent body envisaged by the House of Lords Select Committee.
- 4.6 However, we do agree that we lack a mechanism for maintaining oversight across the key sectors where the MCA has a critical role to play: where we can identify links between areas and programmes and through which we can take soundings from a wider group of stakeholders, and from the public, to improve our knowledge of priority issues and inform our policy response.
- 4.7 We will therefore consider the case for establishing, at the national level, a new Mental Capacity Advisory Board. Any such Board would contain representation from all national bodies responsible for the Act and a representative range of stakeholders with an interest in the MCA including service users. The Board would be led by an independent Chair who would be accountable to Ministers at the Ministry of Justice and Department of Health. We are currently working through potential terms of reference and membership to ensure the appropriate balance of representation, with a view to reaching a final decision on the establishment of a Board by autumn 2014
- 4.8 One major task of the Board would be to produce an annual report for Ministers on the “State of the Mental Capacity Act”. This would draw upon the previous year’s work of the Board, summarising the understanding and evidence of progress made in raising awareness of the Act and providing the Board’s recommendations for action over the coming year. This report would be published and would feed into the Government’s policy making process.
- 4.9 We believe that such a Board, led by its independent chair could potentially mark a step change in our ability to reach out across all sectors, to gather vital intelligence as to how we can better embed the benefits of the MCA and in turn, boost public and professional understanding of it.
- 4.10 The Department of Health led MCA Steering Group, which was first convened in October 2013, is leading the health and social care system with respect to the House of Lords report and this Government response. We were pleased to see that the House of Lords acknowledged this group as a “*welcome first step*”. The Group has now met three times and has representation from the main national health and social care partner organisations responsible for implementation. The Group is already having an impact - see “joint statement of ambition for the MCA” (Annex A).
- 4.11 The Steering Group was initially designed to last one year but we plan to modify and evolve this Group to become the main body with responsibility for implementing the MCA across health and social care. The work of the Steering Group would be informed by the new Mental Capacity Advisory Board. The Board’s independent chair would attend the meetings of the MCA Steering Group. The role of the Board would be to gather intelligence as to priority issues and actions. The MCA Steering Group would decide how best to implement these actions and be responsible for holding implementing organisations to account for delivery. The Board could assist delivery by highlighting the work of implementation partners to the much wider MCA stakeholder community.

- 4.12 The MCA Steering Group does not replace member organisations' own MCA governance structures; rather it aims to bring all the main implementing organisations together to develop a joint and complementary action plan. Implementing organisations must assure themselves that their MCA governance processes are up to the task of enabling widespread MCA implementation. As an example, NHS England's National Safeguarding Steering Group has established an MCA group to address actions in light of the House of Lords report and this Government response. The group met for the first time in May. As part of its role, this group will establish a national database of all MCA leads in the NHS, contribute to a national repository of best practice and in addition, identify priority NHS activity from NHS England's MCA budget.
- 4.13 The Department of Health will ask the members of the MCA Steering Group to define and publish a short description of their role and responsibility with respect to the MCA – to provide further clarity on national governance.
- 4.14 The Ministry of Justice will continue to work with the Office of the Public Guardian to strengthen links with other government departments and the financial and legal sectors, to plan and deliver a co-ordinated programme of work alongside the work in health and social care.
- 4.15 We believe our potential model would address the need, identified by the House of Lords, for oversight across all sectors and the creation of a strong independent voice, while at the same time, providing a firm grip on detailed implementation issues. We would review this governance structure 12 months following the first meeting of any new Mental Capacity Advisory Board to determine how effectively it is working and whether changes are needed.
- 4.16 Finally, it is worth noting that the Mental Capacity Act applies also to Wales, although some governance arrangements are separate. We are aware that the Welsh Assembly Government intends to respond in due course to the House of Lords report. It is clearly valuable that Wales and England establish strong lines of communication in order to share best practice in this field as well as identify potential issues of shared concern. The Welsh Assembly Government has representation on the DH-led MCA Steering Group and we shall have discussions in due course as to how any new Mental Capacity Advisory Board could include Wales.

Monitoring

This section addresses House of Lords:

Recommendation 2:

We recommend the Government consider urgently the need for assessing usage of the core principles across the range of decisions affecting people lacking capacity, including in sectors such as banking and policing.

Recommendation 36:

We recommend as a matter of urgency that the Government take steps to establish regular and dedicated monitoring of implementation of the Act, and that this should include all the sectors across which the Act applies.

Recommendation 37:

We recommend that the independent body with overall responsibility for implementation of the Act, be given responsibility for ensuring such monitoring takes place.

Recommendation 38:

We recommend that the Government introduce a robust method for measuring public and professional attitudes to issues of capacity, in order to be able effectively to measure any change in the prevailing culture.

- 4.17 Monitoring implementation of the MCA is a challenge. Fundamentally, the MCA seeks to achieve a change in culture and behaviour in the way professionals interact with those who may lack capacity – for example, supporting them to make their own decisions and understanding their right to make “unwise” decisions if they have the capacity to do so.
- 4.18 Accurately measuring this behaviour is difficult. Often, we have to depend on a series of proxy measures. Some of these are already available, for example, the Health and Social Care Information Centre (HSCIC) records the number of DoLS applications and authorisations and, in addition, the number of IMCA referrals (as part of the DoLS process). The Office of the Public Guardian registers all Lasting Powers of Attorney and also can measure the level of engagement with its public information website and call-centre. Information is available on the use of section 44 of the Act to obtain convictions, and on applications to the Court of Protection for appointment of deputies or other orders. However, collection of data in settings such as financial institutions or the General Register Office presents a larger problem.
- 4.19 Clearly it is important that we have a national picture of MCA awareness and implementation. But we must balance against this the need to avoid any unnecessary burden on other organisations and front-line staff. Even more important is ensuring that those who are charged with implementing the MCA are able to collect and analyse data for evidence of the state of MCA implementation in their areas. Each part of the system should collect information that allows it to fulfil its function and no more.
- 4.20 We have commissioned the Local Government Association to develop a self/ peer-audit tool for local authorities that will allow them to examine and report on the extent to which they have embedded the MCA in social care. We expect this to be ready for use by early 2015. Separately, NHS England is investigating the possibility of self-audit tools for NHS Trusts. Additionally, the Winterbourne View Joint Improvement Programme Team has commissioned, together with Care England, a tool for provider board members to assure themselves that the MCA is properly embedded in their services. This will be published in the summer of 2014.
- 4.21 A key new source of information on MCA implementation will be the Care Quality Commission’s enhanced inspection and regulatory regime for the MCA and DoLS. When this new system has been fully rolled out over the coming year we expect that analysis of CQC inspection reports will yield considerable insight into the level of MCA implementation.
- 4.22 We are determined that the voice of those who have experienced the use of the MCA should be heard in the process of developing and delivering our programme of work. All our efforts are directed towards protecting and empowering individuals who may lack capacity to make specific decisions at some point in their lives. If we do not listen to and understand

the challenges and concerns these individuals have, we cannot hope to run a system that supports them as they would expect.

- 4.23 The Department of Health will tap into existing stakeholder and citizen voice and user groups to gather views to inform the implementation of this response. Such is the reach and scope of the MCA that rather than attempt to establish a dedicated “MCA user group”, often it is more effective and informative to work through proven and established groups, for example, for people with dementia or learning disability. The Department is also planning to conduct an event in collaboration a local branch of Healthwatch England to inform our communications to the general public.
- 4.24 We shall consider the feasibility of undertaking a bespoke population survey, or adding questions to existing surveys to test public and professional attitudes. The Ministry of Justice is working to agree a mechanism for assessing knowledge and attitudes with the police and the financial sector through one off surveys and qualitative interviews which will provide a snapshot to inform future work.
- 4.25 The role of qualitative information in painting an accurate picture of MCA implementation should not be underestimated – as shown by the valuable evidence presented to the House of Lords Committee. The Government will work with our partners to determine the best mix of quantitative data returns, qualitative surveys and wider system proxy measurements (ideally already being collected through programmes where the MCA has significant relevance) that together allow us to measure MCA progress. We would consult on our approach to monitoring with any new Mental Capacity Advisory Board and subsequently make this available for public information.

Reporting progress

This section addresses House of Lords:

Recommendation 39

We recommend that, no more than 12 months after publication of this Report, the Liaison Committee seek evidence from the Government on the actions they have taken in response to the two key recommendations made in the summary of this report.

- 4.26 The Government will provide an update to the Liaison Committee in 2015 on the actions taken in response to the Select Committee’s recommendations.

5. Increasing awareness

This section addresses House of Lords:

Recommendation 1:

In the first instance we recommend that the Government address as a matter of urgency the issue of low awareness among those affected, their families and carers, professionals and the wider public.

Recommendation 6:

We recommend the Government work with professional regulators and the medical Royal Colleges to ensure that the Act is given a higher profile. This work should emphasise the empowering ethos of the Act, and the best interests process as set out in section 4 of the Act.

Recommendation 12:

We recommend that, in the first instance, the Mental Capacity Act Steering Group give consideration to how the specific information needs of the different groups affected by the Act can best be met.

- 5.1 Raising awareness of the MCA is everyone's responsibility. This is not a problem that can be solved through a one-off communications campaign. Every professional who works with individuals who may lack capacity should regard it as one of their basic professional duties to familiarise themselves with the Act and consider how they can better apply its principles.
- 5.2 We encourage all professionals working with individuals who may lack capacity to make the most of the opportunity afforded by the House of Lords report and this Government response to raise awareness and understanding of the MCA in their organisations.
- 5.3 The Department of Health will run an internal MCA awareness campaign over the coming year to draw the attention of all policy makers in the Department to how the MCA can support them in reaching their goals. The MCA does not exist in a vacuum and our greatest chance of realising the benefits the MCA is likely to bring is through embedding MCA principles across Government.
- 5.4 Since the MCA came into force, a range of supporting guidance and tools have been developed. Some of these are widely known such as the MCA Code of Practice. But others are less familiar. Some of this material varies in quality.
- 5.5 As such, we will ask the Social Care Institute for Excellence (SCIE) to conduct a rapid but comprehensive review of MCA guidance and associated materials for the health and care sector. The aim will be to identify those materials that best provide different MCA audiences (e.g. social workers, nurses, ambulance services) with the information and tools that they require. These materials can then be jointly endorsed by national system partners and their existence advertised. We expect this review to be complete by the end of 2014.
- 5.6 The SCIE review may identify gaps in our combined MCA resources. Should this be the case then the Department of Health led MCA Steering Group will identify priority commissions and sources of funding from across the system. Our preference is that wherever possible, we should draw on the skills and expertise of those working at the front-line to develop

materials that understand the reality of practical implementation of the Act. We shall only seek to develop guidance at the national level where there is a clear gap that cannot otherwise be filled.

- 5.7 We believe that the current MCA Code of Practice still represents a valuable and respected source of guidance for professionals. Following the SCIE review, we will determine whether amendments or additions to the Code of Practice would be valuable.
- 5.8 Following the identification of available guidance and tools, the next step will be to make these available to all who need it. Naturally this will include embracing the very latest in digital technology as a default.
- 5.9 In the short-term, we would expect the on-line home for much of the material to be hosted by one of the existing national MCA implementation partners.
- 5.10 We will work together to ensure co ordination of awareness raising. The active involvement of all implementing partners and stakeholders in dissemination of this material would be vital. We would expect any new advisory board to play a key part this.
- 5.11 The Government for its part will hold a national MCA event in 2015 both to raise awareness of the Act and to listen to professionals and the public about how the system as a whole can have greater impact. This event will require the active contribution of the entire system.
- 5.12 Our ultimate aim remains empowering front-line professionals and members of the public by promoting an understanding of the key rights afforded, in law, by the Act. The Department of Health will work with system partners and through the MCA Steering Group to develop a “credit-card sized” statement of rights under the MCA for both professionals and the public. We will encourage distribution of this to all professionals in the health and care sector and to all individuals (and where appropriate their families and friends) when capacity assessments are to be undertaken. We will consider the use of similar material for other professional groups.
- 5.13 The House of Lords Select Committee rightly identified the important role that the medical royal colleges have to play in increasing the awareness and understanding of the MCA amongst their membership. In response to the House of Lords report, the Academy of Medical Royal Colleges considered the MCA on the agenda of their recent Council meeting, the Academy’s highest decision-making body. As a result of this meeting, the Academy has decided to convene a small group of five or six members together with the Royal College of Nursing to identify the types of activities that the medical royal colleges and other professional organisations could feasibly undertake. These activities would then be circulated to all Academy members as a set of proposals for them to action within their own organisations as appropriate. The Academy will feed back its progress on this work via its membership of the Department of Health led MCA Steering Group.
- 5.14 At a national level, the police is committed to working with us to raise the profile of the MCA in police forces. A national policing conference on adult abuse later this year will include advice and guidance on interface with the MCA. In addition, the College of Policing will work to develop guidance and training in this area

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- 5.15 One sector that will benefit greatly from increased awareness and understanding of the MCA is the social housing sector. A significant number of individuals living in social housing may lack capacity to make certain decisions at certain times and as such it is vital that the all housing staff are aware of their responsibilities under the Act. The Government is encouraged to hear that the newly formed Housing and Safeguarding Adults Alliance will consider the important of the MCA in social housing and consider practical steps that can be taken to boost awareness and understanding of the Act.
- 5.16 It is important also that carers have access to information about the MCA so that they understand the rights it confers on individuals who may lack capacity. Likewise, it is vital that when making best interests decisions, professionals consult with those who know the individual best – which would include families and carers wherever possible. The Standing Commission on Carers advises Government on priority issues for carers to inform policy development. The Standing Commission will consider the House of Lords report and this Government response at its upcoming meeting with a view to identifying carers' information needs with respect to the MCA.
- 5.17 To communicate the benefits of the MCA, it can be helpful to demonstrate MCA principles by using practical scenarios where successful applications of the principles can be shown to realise tangible rewards. As such, the Government will ask all the members of the Department of Health's MCA Steering Group to identify illustrative case studies to draw attention to what information might be required. For example, for an individual suffering from the long-term effects of alcohol abuse requiring treatment at Accident and Emergency or, alternatively, a young adult with learning disabilities admitted to a residential centre for the first time. We will make these publicly available by early 2015.
- 5.18 We ask that all implementation partners and stakeholders plan their own MCA awareness raising strategies and think innovatively about how they can achieve the most successful outcome possible for individuals who may lack capacity.

6. Promoting implementation

- 6.1 At an individual level, implementation of the Act means ensuring that, in the case of a professional, their knowledge and awareness of the MCA results in a positive behaviour change in their care and treatment of those that may lack capacity that is consistent with the principles of the Act.

Professional training

This section addresses House of Lords:

Recommendation 7:

We recommend that the GMC: ensure that there is leadership in psychiatry within all medical schools in order to give a higher profile to mental health; place proper emphasis on the Mental Capacity Act in its publication 'Good Medical Practice'; enhance training on the Mental Capacity Act in all post-graduate education, especially for GPs.

Recommendation 8:

The proposed fourth year of training for GPs provides an opportunity to embed and enhance understanding of the Mental Capacity Act with this group of practitioners. We recommend that the Government supports the proposal in light of the vital role which GPs play in providing health care in the community.

- 6.2 The House of Lords highlighted the “poor understanding of the Act” amongst General Practitioners. GPs have a crucial role to play in implementing the MCA. GPs often represent the first professional point of contact for members of the public and as such, have the first opportunity – and responsibility – to ensure that their rights under the MCA are respected and championed. Capacity should be re-assessed before all significant health and care decisions are made but GPs, when making that first assessment, have the chance to set the standard, for the rest of the health profession.
- 6.3 Awareness and implementation among GPs is increasingly important given the emphasis on choice and patient-centred care. “No decision about me without me” applies as much to individuals who lack capacity as it does to individuals with capacity. GPs should seek to offer as much information to individuals lacking capacity as they would to any other patient – exploring how best they might provide this information in accordance with an individual’s needs. Where the individual is judged, after all appropriate efforts have been made to support them, to be unable to make a specific decision, GPs should seek to involve their family and friends to gain an understanding of the likely preferences, wishes and beliefs, before arriving at a best interests decision.
- 6.4 The Royal College of General Practitioners (RCGP), in its evidence to the House of Lords, described its work to help embed the MCA into the GP curriculum and to develop and increase awareness of educational resources for GPs relating to the MCA. In response to the House of Lord report, the RCGP has committed to highlighting the importance of the MCA throughout its communications and media outlets. The RCGP recognises it is now the responsibility of all health and social care professionals to assess capacity in any person with an impairment of or a disturbance in their functioning of their mind or brain. The RCGP

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will aim to improve the confidence and ability of all GPs and their staff in capacity assessments and best interests considerations. Additionally, the RCGP is exploring how making Read codes for e-recording of capacity assessment more consistent; this should assist summary record recording of assessments and related advance care planning, and enhance our understanding of the level of implementation of the MCA in general practice. In addition, the RCGP has committed to work with NHS England to explore how GPs can play their part in ensuring the MCA is actively considered in the commissioning process.

- 6.5 The General Medical Council (GMC), in response to the House of Lords seventh recommendation, has confirmed to the Government that it is actively taking forward consideration of the House of Lords seventh recommendation at their upcoming Strategy and Policy Board meeting, following which they will send the House of Lords Committee the detail of their response.
- 6.6 The Government for its part fully supports the integration of the MCA into GP training, not just in any fourth year of GP training but throughout.
- 6.7 But GP training represents only a small part of the story. The values of the MCA should be integral to all health and social care professional training. Training that is not compliant with the MCA will not be fully fit for purpose.
- 6.8 Health Education England (HEE) provides national leadership for planning and developing the whole healthcare workforce and as such has a lead role in ensuring that professional training across the board is not just MCA-compliant but fosters and promotes a culture with the principles of the MCA at its heart. The Government's 2014/15 mandate for Health Education England states that *"HEE should work with the Department of Health, healthcare providers, clinical leaders and other partners to improve skills and capability to respond both to the needs of people who may lack capacity as well as maximise the opportunities for people to be involved in decisions about their care, reflecting the provisions of the Mental Capacity Act."*
- 6.9 In response to the House of Lords report, HEE is conducting a desk-top review of its training programmes to determine their compliance with the principles of the MCA. The results of this review shall be fed into the MCA Steering Group together with any proposed corrective actions. HEE will also consider the benefit of including MCA compliance as a feature of its standard contract with education providers.
- 6.10 Qualified social workers have a key role to play in implementing the MCA; the Government is clear that social workers must be familiar with, and actively use the MCA to support individuals. In response to the House of Lords report, the Chief Social Worker for Adults will write to the sector stressing the importance of the MCA as an essential tool in modern social work and inviting ideas about how to strengthen the role of social workers in leading the change for a social care culture that truly embraces the values of the MCA.
- 6.11 Specifically, the Government recognises the need for more qualified Best Interests Assessors (BIA). A sufficient number of Best Interest Assessors is an essential prerequisite of full implementation of the Deprivation of Liberty Safeguards (DoLS – see later chapter). But best interests decisions are a fundamental part of the entire Mental Capacity Act and of all social work with adults where capacity is an issue.

6.12 The Government’s ambition for the future is that all qualified social workers will have received training in the Mental Capacity Act. A social worker must be able to conduct best interests decisions to fulfil their professional obligations – as is the same for all qualified health and social care professionals. Clearly this ambition will not be realised overnight and the first priority is to scope out how MCA training can be made more widely (and more economically) available. As such, the Government has agreed to commission a working group to examine this issue and provide recommendations to the MCA Steering Group by the end of 2014.

System design

6.13 The health and social care sector consists of multiple organisations with distinct responsibilities but shared ambitions. Navigating the interfaces between these organisations and ensuring that the activities of all are aligned to achieve the best outcomes for individuals lacking capacity is a complex task.

This section addresses House of Lords:

Recommendation 9:

We recommend that the Government, and subsequently the independent oversight body, work with the Association of Directors of Adult Social Services and NHS England to encourage wider use of commissioning as a tool for ensuring compliance.

Recommendation 10:

We recommend that the ‘refresh’ of the NHS Mandate in 2014 include requirements explicitly connected to the implementation of the Mental Capacity Act, based on evidence of good practice gathered from Clinical Commissioning Groups.

Recommendation 11:

We further recommend that NHS England and ADASS take steps to ensure that the empowering ethos of the Mental Capacity Act is understood and given visibility within commissioning, even where this may appear to conflict with the safeguarding agenda.

6.14 The importance of commissioning in ensuring and encouraging MCA compliant care cannot be overstated. The simple act of asking providers to provide evidence as to how the services they provide comply with the MCA can provide the impetus for much wider cultural change.

6.15 Turning to health care commissioning: the Government notes and endorses the recommendation contained within the Care Quality Commissions most recent annual report on the Deprivation of Liberty Safeguards that *“NHS England includes expectations on the effective use of the Deprivation of Liberty Safeguards in the standard contract for providers”*.

6.16 We have heard of impressive best practice in the health system around the commissioner/provider interface. For example, one Clinical Commissioning Group (CCG) asks for regular updates from their providers as to how financial resources destined for improving MCA compliance are bringing about improved outcomes for individuals lacking capacity. This in turn provides the incentive for the provider management to task their MCA lead with conducting sampling of patient records and consent forms to determine what proportion have had mental capacity assessments. Approaching this sampling with a view to

supporting front-line staff improve their MCA awareness and implementation (not with a view to apportioning blame) the MCA lead is able to use this lever to bring about positive change.

- 6.17 The Government agrees with the House of Lords that there should be wider use of commissioning as a tool for ensuring compliance. NHS England has agreed to explore best practice in the use of commissioning as a tool for encouraging implementation of the MCA. This group will include representation from Clinical Commissioning Groups and will aim to report its initial findings in 2015. NHS England is considering, as a first step in this process, conducting a limited “census” of a small number of Trusts to determine the current degree to which the MCA features in commissioning.
- 6.18 The Department of Health is determined to support NHS England in its commitment to greater awareness and implementation of the MCA. The updated Mandate to the NHS for 2015/16 will be published in the autumn, and the recommendation of the House of Lords regarding inclusion of specific MCA elements will be considered as part of this process. Of course, we should highlight that as an Act of Parliament, it is a statutory obligation for the NHS to be compliant with the MCA.
- 6.19 Similarly in social care commissioning, MCA compliance should also be seen as an essential component of good quality care. In response to the House of Lords report, the Association of Adult Directors of Social Care (ADASS) has agreed to initiate work to examine how the MCA is currently reflected in the commissioning of social care in order to learn from good practice and to identify necessary improvements. Relevant partners will be identified, such as NHS England. ADASS shall report on their findings, via the DH-led MCA Steering Group in early 2015. The conclusion of this work may result in a good practice guide for local authority commissioners.
- 6.20 There has been much discussion regarding the links and tensions between safeguarding and the Mental Capacity Act. We are aware that many stakeholders are concerned with what they view as the “risk-averse” or “paternalistic nature” of safeguarding and the potentially detrimental effect this can have on the empowering agenda of the MCA. Our view is that if the principles contained in the Statement of Government Policy on Adult Safeguarding¹ are followed locally, that tension is substantially reduced.
- 6.21 It is important to take a broader view of these issues. Professionals need to be aware of their responsibilities in regard to safeguarding and the MCA in all that they do. Of course, the two do have interdependencies and professionals should ensure the empowering ethos of the MCA is built into the safeguarding discussion as is often already the case. Indeed, the first of the six principles referred to in the Statement of Government Policy on Adult Safeguarding is “*empowerment – presumption of person-led decisions and informed consent.*” Traditionally, there has been a tendency in health and care organisations to assign responsibility for the MCA to the named safeguarding lead. It is not for Government to determine other organisation’s management arrangements but we would urge that in such an arrangement care is taken to ensure that the “MCA voice” is heard in equal

¹ <https://www.gov.uk/government/publications/adult-safeguarding-statement-of-government-policy-10-may-2013>

measure to the “safeguarding voice”. If this is not happening, then steps should be taken to ensure that the MCA does indeed have a strong advocate within the organisation.

- 6.22 We should also not lose sight of the importance of implementation of the MCA within the financial sector. We have commenced work with the Financial Conduct Authority to ensure effective implementation of the MCA in the policies, procedures and products offered by financial institutions and that checks against the MCA are made by the relevant regulatory bodies.
- 6.23 The Department of Health is determined to maximise its role as steward of the health and care system. Through our MCA Steering Group we have made positive strides towards bringing the combined efforts of our health and care partners to bear on the challenge of improving implementation of the MCA. But we must continue our efforts to ensure all those with a role to play are doing so. We encourage Health and Wellbeing Boards, Clinical Commissioning Groups, Healthwatch England and Health and Social Care Overview and Scrutiny Committees to add consideration of the House of Lords report and this Government response to their upcoming meetings and to consider what practical actions they can take to further MCA implementation and awareness. We ask that actions determined be fed back up through the appropriate governance structures in order to inform the Government’s overall response.

System regulation

This section addresses House of Lords:

Recommendation 5:

We recommend that the standards against which the CQC inspects should explicitly incorporate compliance with the Mental Capacity Act, as a core requirement that must be met by all health and care providers. Meeting the requirements of the empowering ethos of the Act, and especially in terms of actively enabling supported decision-making, must be given equal status with the appropriate use of the deprivation of liberty safeguards, or their replacement provisions.

- 6.24 The Care Quality Commission (CQC) inspects all health and social care services in England ensuring they provide people with safe, effective, compassionate and high-quality care, and encouraging them to make improvements. Where services fail to meet expected quality and safety standards, the CQC can take enforcement action, including de-registering health and care providers.
- 6.25 The CQC has a vital role to play in inspecting health and care providers for MCA compliance and has clearly stated in its most recent annual report on DoLS that there is *“is no excuse for services providing health or social care to anyone over 16, not to have achieved clear policies and practice that comply with the MCA”*. We welcome this strong commitment.
- 6.26 CQC has already published, initially for consultation, Provider Handbooks for all regulated sectors (adult social care, acute health services, primary care services and mental health) which emphasise explicitly the requirement to work in accordance with the Code of Practice to the MCA.

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- 6.27 CQC is embarking on a fundamental revision of its regulation and inspection model. As part of this, the CQC's three Chief Inspectors (of hospitals, community health services and social care services) have committed to ensuring that MCA principles are central to this new approach.
- 6.28 From now until October 2014, the CQC is piloting its revised model for regulation and inspection across all sectors. Inspection is against the five questions: is a service safe, effective, caring, compassionate and well-led. The MCA is highlighted in 'safe' and 'effective', with further references in 'caring' and 'well-led'. Key lines of enquiry stress that their inspectors will be looking for compliance with the empowering ethos of the MCA.
- 6.29 CQC already has, and will continue to have, a duty to monitor the use of the Deprivation of Liberty Safeguards (DoLS) in all hospitals and care homes in England, producing an annual public report. The CQC is currently consulting on how best it can ensure that providers improve the way they conform with both the wider MCA and the DoLS including whether the application of "limiters" may be a useful tool for encouraging improvement (meaning a service provider would be unable to achieve a certain rating if MCA, including DoLS, compliance was not judged to be acceptable).
- 6.30 Internally, CQC has revised its corporate induction for all staff, which is delivered fortnightly by senior executives and subject-matter experts. This now includes a specific session on the MCA. CQC is also currently revising its internal and external websites to ensure that they reflect the importance of the MCA, and revising and extending its training for operational and other CQC staff. All operational staff are to be given mandatory MCA training, which is currently being scoped and arranged.

Care planning

This section addresses House of Lords:

Recommendation 26:

We recommend that the Government, working with the independent oversight body: urgently address the low level of awareness among the general public of advance decisions to refuse treatment; promote better understanding among health care staff of advance decisions, in order to ensure that they are followed when valid and applicable; promote early engagement between health care staff and patients about advance decisions to ensure that such decisions can meet the test of being valid and applicable when the need arises; promote the inclusion of advance decisions in electronic medical records to meet the need for better recording, storage and communication of such decisions.

- 6.31 The MCA should be at the heart of care assessment and planning for those who may lack mental capacity. In keeping with the ethos of person-centred care and choice, professionals must seek to support those who lack capacity to make their own decisions about the nature of the care they receive. Where this is not possible, professionals should explore (with the individual, family, friends and others) the likely preferences, views and beliefs of that individual to arrive at a best interests decision.
- 6.32 So much flows from the initial assessment of needs and care planning that it is simply essential that the principles of the MCA are fully integrated into this process – not to do so could mean that an individual may spend years receiving care that is not in their best

interests and which therefore does not enhance their well-being as should be expected. The introduction of the Care Act 2014 (to come into force in April 2015) provides a huge opportunity to embed the MCA into care planning and we urge all care providers and local authorities to take advantage of this.

- 6.33 The Department of Health has commissioned the Social Care Institute of Excellence (SCIE) to produce a report detailing how MCA principles can be embedded into the process of care planning. We expect this to be ready in early 2015. In tandem, the Department has commissioned a multi-media tool to complement this work and provide local authorities, providers and those using services with an easy-access tool to assist them realise the potential positive impact of integrating the MCA into care planning.
- 6.34 Advance decisions to refuse treatment (ADRTs) form an important part of the care and treatment planning process as do health and welfare Lasting Powers of Attorney (LPAs). We support the House of Lords recommendation that further work be done to raise awareness and understanding of ADRTs. The report of the Select Committee quite rightly draws attention to current best practice in some hospital trusts. For example, the standard operating procedure introduced in Warrington and Halton Hospitals NHS Foundation Trust. This is exactly the type of best practice that the national level needs to capture and help disseminate across the wider NHS.
- 6.35 We would ask the new Mental Capacity Advisory Board to include advance decision-making in its programme of work and we urge our system partners to use their networks to increase information on ADRTs so that more individuals may realise the right to assert their wishes in this manner.

Digital

- 6.36 Key to raising awareness will be a greater realisation of the potential of digital resources. As well as providing a means for the rapid and wide dissemination of information, digital can connect those with an interest in the MCA as never before – providing the means for practitioners in separate organisations and in different parts of the country to exchange ideas around best practice and collaborate to mutual benefit. Greater use of digital media also provides the opportunity for Government to receive input from a wider stakeholder community to better inform policy development.
- 6.37 The Department of Health will pursue the possibility of a live online discussion event in late 2014 to share insights into the system's response to the House of Lords report and gather further ideas from interested stakeholders and the public.

Independent Mental Capacity Advocates (IMCAs)

This section addresses House of Lords:

Recommendation 22:

We recommend that local authorities use their discretionary powers to appoint IMCAs more widely than is currently the case. To support this, we recommend the Government issue guidance to local authorities and health service commissioners about the benefits of wider and earlier use of IMCA services. We believe the costs of greater IMCA involvement should be balanced against the resources required in lengthy disputes or ultimately in litigation.

Recommendation 23:

Given the importance of the role of IMCAs in the lives of vulnerable adults we believe that the role requires further professionalisation to ensure consistency of service. This should be achieved through national standards and mandatory training in the Mental Capacity Act and the role of the IMCA within that. We recommend that responsibility for such standards and training be undertaken by the independent oversight body which we recommend in chapter 4, enabling peer support and consistency between IMCA services.

Recommendation 24:

We recommend that the Government consider the establishment of a form of self-referral for IMCA services to prevent the damaging delay that occurred in the case of Mr Steven Neary.

- 6.38 Independent Mental Capacity Advocates (IMCAs) are one of the major success stories of the MCA and we endorse the House of Lords support for them. They do impressive work supporting people in some of the most vulnerable situations to achieve outcomes that suit them and enhance their well-being.
- 6.38 We have considered how the benefits of the IMCA service could be promoted more widely and as such, have decided to build on the new duties to provide advocacy in the Care Act 2014, linking these to the existing duties to provide advocacy under the MCA. As a result, more people will benefit from advocacy and at an earlier stage. IMCAs and other advocates will be involved in supported decision making as part of the assessment of people's care needs, their care planning and their care reviews.
- 6.39 The statutory guidance for the Care Act will set out how to bring these two forms of advocacy together. The guidance will state that while there is no legal requirement for the same advocacy organisation to provide advocacy under the MCA and under the Care Act, there are nevertheless substantial benefits in the same organisations providing advocacy under both Acts. The guidance also indicates that self-referral should be facilitated. We would ask any new Mental Capacity Advisory Board to consider the need for further guidance in this area (informed by the review of current guidance and materials to be undertaken by the Social Care Institute for Excellence).
- 6.40 We encourage local authorities to make all appropriate use of advocacy services. We are aware of variability across local authorities in terms of their use of advocacy and we would encourage local authorities with relatively low referral rates to consider whether this is a legitimate variance or whether action needs to be taken to improve awareness, understanding and use of advocates for the benefit of individuals resident in their areas. This extends to the need to ensure commissioners are aware of the role of statutory advocacy and that professionals in health and social care are alerted to the legal requirement to refer people to the IMCA service, for example, as part of their induction training and as part of supervision.
- 6.41 We agree with the House of Lords that the IMCA sector would benefit from further professionalism. The Government has drawn up draft regulations under the Care Act, under which a local authority must require advocates: to have a suitable level of relevant experience; to have appropriate training; to be competent to their task; to have integrity and be of good character; to demonstrate the ability to act independently of the local authority; and to have arrangements in place to receive appropriate supervision

- 6.42 Furthermore, we have commissioned the National Development Team for Inclusion (NDTi) to undertake a review of the Advocacy Quality Performance Mark and the Code of Practice, which had previously been administered by Action for Advocacy. NDTi organised a series of workshops involving more than 60 organisations and had discussions with local authority commissioners, as part of the review, and the launch of the revised Quality Performance Mark, which took place in Parliament in March 2014. This is a highly innovative, sector led quality assurance programme, which assists advocacy organisations to professionalise and develop quality advocacy.
- 6.43 With the clarification by the Official Solicitor that his role is one of ‘last resort’, IMCAs and Relevant Person’s Representatives (RPRs) have increasingly been asked by the Court to act as litigation friend for people who lack capacity to litigate yet who wish to seek a Court decision on a best interests decision or who wish to challenge a deprivation of liberty. To better assist IMCAs and RPRs on their potential role as “litigation friends”, we have commissioned guidance on this issue that we expect to be available in the autumn of 2014.
- 6.44 The Department of Health has already held a meeting of IMCA representatives to discuss the issues raised in the House of Lords report. The Department shall analyse the outputs of this meeting and look to meet jointly with all the main providers of IMCA services to discuss how we might progress the issues identified.

Public health

- 6.45 Public Health England (PHE) is responsible for supporting the public so they can protect and improve their own health. PHE has extensive programmes around dementia and learning disability – working closely with Department of Health colleagues and the NHS to achieve further improvements in the care and support provided to these individuals. PHE is a member of the MCA Steering Group, thereby providing one route by which PHE’s insight on capacity issues can be fed into the wider health and social care discussion and enabling PHE to ensure its approach compliments the work of other system partners.
- 6.46 But the importance of capacity in public health stretches far wider than dementia and learning disabilities. We face some enormous public health challenges over the coming years: encouraging healthier eating, increasing levels of physical activity, reducing excessive alcohol consumption – to name just a few. As we endeavour to support individuals to make healthier choices we must ensure that those who may lack capacity are not left behind. Taking those extra steps to support those who may lack capacity – whether it be tailoring the information we provide or ensuring the accessibility of our public health services – will be essential if we are to prevent these individuals experiencing an avoidable health inequality.
- 6.47 PHE has unparalleled expertise in the area of public health monitoring, surveillance and evidence gathering. In response to the House of Lords report, PHE will conduct a review and analysis of national and international evidence on mental capacity as it relates to public health, utilising as part of this review the Mental Health Intelligence Network (a joint venture with NHS England) and PHE’s Dementia Intelligence Network. This review will complement the review of guidance and best practice tools being conducted by the Social Care Institute for Excellence (SCIE). PHE’s review will focus primarily on non-operational evidence (including the extent of current academic and theoretical knowledge). SCIE’s review aims to support front-line professionals in their day-to-day work. PHE’s review will report initial findings in early 2015.

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6.48 Potentially the strongest voice furthering the rights of those lacking capacity with respect to public health efforts is that of the Directors of Public Health (DPH). Every local authority has a DPH – the statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health. With a lead role on the local authority Health and Wellbeing Board, the DPH is in a unique position to champion the needs of individuals lacking capacity. PHE and DH will work together to engage the Directors: to improve our understanding of the contribution they can make to increasing awareness and improving understanding of the MCA. We shall communicate with all DPHs and hold an engagement event by the end of 2014 – following which, PHE shall lead in collating lessons learned in terms of how DPHs can contribute to the MCA agenda – disseminating this to the field.

7. Deprivation of Liberty Safeguards

- 7.1 This section covers the following House of Lords Recommendations and is also our update in response to the recommendation by the House of Commons Post Legislative Scrutiny Committee on the Mental Health Act 1983 regarding DoLS.

This section addresses House of Lords:

Recommendation 13:

We recommend that the Government undertake a comprehensive review of the DoLS legislation with a view to replacing it with provisions that are compatible in style and ethos with the Mental Capacity Act. The model of widespread consultation that preceded the Mental Capacity Act itself should be followed, with adequate time allowed for effective Parliamentary scrutiny.

Recommendation 14:

We further recommend that the independent body with responsibility for oversight and coordination of implementation of the Mental Capacity Act develop a comprehensive implementation action plan to accompany new legislation, in consultation with professionals, individuals, families and unpaid carers.

Recommendation 15:

We recommend that replacement legislative provisions make a clear link to the principles of the Mental Capacity Act to ensure consistency with the empowering ethos of the Act as a whole.

Recommendation 16:

We recommend that replacement legislative provisions and associated forms be drafted in clear and simple terms, to ensure they can be understood and applied effectively by professionals, individuals, families and carers.

Recommendation 17:

Better understanding of the purpose behind the safeguards is urgently required, and we recommend that achieving this be made a priority by the independent oversight body.

Recommendation 18:

We recommend that the Government consider how the role of the Relevant Person's Representative could be strengthened in replacement legislative provisions to provide an effective safeguard.

Recommendation 19:

We recommend that effective oversight of any future supervisory body function be provided for in the replacement provisions for the Deprivation of Liberty Safeguards.

Recommendation 20:

We recommend that replacement legislative provisions extend to those accommodated in supported living arrangements.

Recommendation 21:

We consider that a 'new Bournemouth gap' has been inadvertently created by the attempt to prevent overlap with the Mental Health Act 1983. We recommend that replacement legislative provisions close this gap.

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- 7.2 The Deprivation of Liberty Safeguards (DoLS) system has been a focus of attention over the last few months. The House of Lords report described the legislation as “not fit for purpose”.
- 7.3 Before we set out our response to the criticism of DoLS we should first remember why DoLS were established. Too often the “noise” of negative criticism surrounding DoLS blinds us to the positive message at the heart of the legislation.
- 7.4 DoLS and the Court of Protection together ensure that no individual lacking mental capacity can be deprived of their liberty except in accordance with a procedure prescribed by law and with a means of challenging the lawfulness of the deprivation of liberty in court. DoLS therefore represent a fundamental means of protecting an individual’s right to liberty under Article 5 of the European Convention on Human Rights.
- 7.5 DoLS were designed as part of the MCA, albeit introduced two years after the MCA first came into force. It was always the intention that DoLS should be rooted in the empowering ethos of the MCA. At the heart of DoLS is the best interests assessment – no-one can be deprived of their liberty unless it is deemed to be in their best interests. Too many commentators can be side-tracked by the word “deprivation” and forget the word “safeguards”. To be clear: DoLS were designed to prevent unlawful deprivations of liberty, to both protect and empower individuals and to further their human rights.
- 7.6 However, we agree that implementation of DoLS are not at the level we would have expected. We have already highlighted the problem together with our system partners and urged improved awareness and understanding of the legislation. However, we have also been surprised and disappointed that some of the positive messages about DoLS have been lost during recent debate.
- 7.7 In the last year, almost 12,000 authorisations were applied for. We know that this number is lower than expected when we framed the legislation, but nevertheless, this is not a trivial number. 12,000 have had their fundamental right to liberty protected by this legal regime. All of these people have had the circumstances of their care in hospital and care homes assessed and examined through an independent process to ensure their best interests are being put first.
- 7.8 The professionals involved in the DoLS process deserve credit for the work they have done since the safeguards were introduced. They have seen first-hand the benefits DoLS can bring. This was reflected in the evidence provided to the House of Lords. For example:
- *“We do hear of excellent outcomes from the use of the Safeguards where it was possible to significantly reduce restrictions on personal freedom”* (Social Care Institute for Excellence)
 - *“Deprivation of Liberty Safeguards (DoLS) work well where properly applied”* (British Association of Social Workers)
 - *“Feedback from families and carers is that where DoLS are effectively used, they can be very positive”* (Age UK)

- 7.9 However others also believe, like the Select Committee, that the legislation needs re-working. For example:
- *“The DoLS regime has a number of weaknesses inherent in its structure, which create an environment in which such rights violations can occur”* (Liberty)
 - *“They are extremely difficult schedules to follow. When you write a judgment on them, you feel as if you have been in a washing machine and spin dryer”* (Mr Justice Charles)
 - *“The primary concern with the DOLS is their complexity and bureaucracy”* (BMA)
- 7.10 The range of views on DoLS was perhaps best conveyed through research funded by the Government (through the National Institute for Health Research) and conducted by the Centre for Policy Studies at the University of Bristol (published in April 2014). The study found that DoLS encourages detailed scrutiny of care practices, leading in some cases to adjustments to care arrangements to make them less restrictive. A majority of the Best Interests Assessors who contributed to the study said that they thought DoLS had a positive impact on the human rights of service users. But the study did indicate that more work is needed to raise managing authorities’ awareness and understanding of DoLS.
- 7.11 We do not believe that there is a fundamental flaw in the legislative framework underpinning the current deprivation of liberty system. However, in the light of recent developments, we need to make the current system work better in the short to medium term, whilst putting in place a sustainable, effective system in the long-term.

Making the current system work better in the short to medium term

- 7.12 A major barrier (if not *the* major barrier) to widespread successful implementation of the current system is a lack of awareness and understanding of it. Too few professionals are aware of their responsibility under the MCA to reduce wherever possible, the restrictions and restraint placed on individuals who may lack capacity. Likewise, too many are unaware of their responsibility to be alert to situations when the conditions of an individual’s care may unavoidably amount to a deprivation of liberty. These are basic responsibilities that are incumbent on all professionals involved in the care of those lacking capacity no matter what their position in the organisation or their precise job role.
- 7.13 This lack of awareness and understanding is demonstrated by the worrying view in some places that DoLS is somehow a “negative” tool used by unscrupulous staff as a means to justify unnecessary control over the freedom of individuals under their care. Others have been known to see a DoLS authorisation as a mark against them – evidence that they have not successfully applied the MCA principle of least restrictive care. Both beliefs are false.
- 7.14 DoLS should be regarded (in keeping with how it was originally conceived) as a hugely positive tool that shines a light on the circumstances of an individual’s care to determine if a deprivation of liberty is necessary to deliver the care envisaged and in the best interests of the individual. In such circumstances, rather than a mark against an organisation it is quite the opposite – a marker of the organisation’s respect for the rights of those it cares for and a commitment to put these first at all times.

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- 7.15 The implications of the recent Supreme Court judgment on the meaning of deprivation of liberty² are still emerging but it is clear that, handled appropriately by the health and social care system, the judgment could have a significant positive effect – both in raising awareness of DoLS and the need for deprivations of liberty to be authorised but also in empowering individuals and protecting their rights. As such, the judgment has been welcomed by many stakeholders and professionals.
- 7.16 The House of Lords has rightly asserted that “*better understanding of the purpose behind the safeguards is urgently required*”. The Government and our system partners agree wholeheartedly and we would make this a priority for any new Mental Capacity Advisory Board.
- 7.17 But there are actions that the Government and system partners can, and will take, immediately – conscious as we are that increased awareness raising and understanding alone may not be sufficient to achieve the level of implementation required.
- 7.18 ADASS (the Association of Directors of Adult Social Services) has committed to lead a time-limited task group to assist local authorities and work through the implications of the Supreme Court judgement. This may result in the need for written guidance. Local Authorities should be recording the number of DoLS applications received and authorised - information that will likely be helpful in guiding this task group. We encourage local authority DoLS leads to kept in touch with regional leads in order to help build a clear picture of the situation on the front-line.
- 7.19 The task group will contain key partners (including CQC, NHS England, DH, and representation from local authority solicitors) and will aim to publish an initial read-out of its findings by the end of August 2014. Its work will be informed by input from the care provider sector. To this end, the Care Provider Alliance has agreed to lead an event where care providers can put forward and discuss their concerns following on from the Supreme Court judgment.
- 7.20 We are also aware that the Court of Protection is already considering how it might streamline its processes in anticipation of a potential increase in deprivation of liberty applications. The Government welcomes the rapid action of the Court in this respect. We are committed to assisting this process, ensuring that the rights of the individual are promoted.
- 7.21 We have listened to those who view the DOLS forms as unnecessarily bureaucratic and cumbersome and are determined to streamline them. We will therefore commission a project to consider the value of each of these forms and to redraft them (or redesign from scratch) with a view to creating a new set that better balances the need to robustly protect and enhance an individual’s rights with the need for a more streamlined and less burdensome system. The project will complete by the end of November 2014.

² http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

- 7.22 In parallel to the review of the standard DoLS forms, the Government will commission up to-date guidance on deprivation of liberty case law – to be published by the end of 2014. Many stakeholders have told us that such guidance would be very beneficial to front-line practitioners and we have determined to meet this need.
- 7.23 We discussed care planning earlier in this response and the importance of the MCA being integral to this. The same applies to DoLS. A DoLS authorisation should only be considered as part of an individual’s care plan – it is not an add-on to be weighed up in isolation. There are clear benefits to be had both to the individual and the local authority by ensuring that DoLS is integrated into care planning. Where a potential deprivation of liberty is identified, the first step should always be to examine how the care plan can be amended to reduce any restrictions or restraints and thereby avoid a deprivation of liberty in the first place.
- 7.24 One particular area that stakeholders highlight as an area of confusion is the interface between deprivation of liberty under the MCA (including DoLS) and the Mental Health Act 1983 and the determination of which regime should be used in particular circumstances. In response to this, we have committed to drafting a new chapter for the revised Mental Health Act Code of Practice on this topic. The draft revised Code of Practice will go out to public consultation this summer and we would encourage DoLS practitioners, particularly in the hospital setting (where the confusion most often arises) to make their views heard to help us shape the best possible guidance on this complicated area.

Creating a sustainable, effective system in the long-term

- 7.25 It is incumbent on Government to ensure that the legislation underpinning deprivation of liberty is effective and sustainable in the long-term.
- 7.26 The most pressing area in need of attention is arguably that of community care arrangements, including supported living. Individuals who lack capacity, and are deprived of their liberty in supported living arrangements must have this deprivation authorised by the Court of Protection – the DoLS system can only be used in care homes and hospitals. Whilst the Court will remain the only route available in the medium term, the Government is in agreement with the House of Lords that a new legal framework and provisions for supported living should be considered. We are committed to ensuring that, wherever possible, individuals can receive care in community settings, closer to their support networks. This policy, together with the widened test provided by the Supreme Court as to what constitutes a deprivation of liberty means, in our view, that it may be unsustainable, too resource intensive and most importantly, not appropriate from a service-user’s point of view, to refer all supported living cases to the Court of Protection.
- 7.27 The Government has therefore asked the Law Commission to undertake a review as part of the Commission's forthcoming work programme (to be agreed shortly with the Lord Chancellor) that will consult on and then potentially draft a new legal framework to allow for the authorisation of a best interests deprivation of liberty in supported living arrangements. We shall agree precise terms of reference with the Law Commission in due course but the new system shall be rooted firmly in the MCA. We are clear that this work must include wide stakeholder consultation and careful consideration of the many issues at play. This work will not complete for a few years; hence the importance that the current system is fully implemented without delay.

- 7.28 The current legislation underpinning the Deprivation of Liberty Safeguards represents a more complex area. We do have sympathy with the argument that the DoLS legislation can be difficult to interpret and can at times appear complex. But “scrapping DoLS” and starting from scratch is not the simple solution that some would suggest. We must be realistic when it comes to the constraints under which any new system would need to operate. The apparent complexity of DoLS does in part, reflect the complexity of ensuring compliance with the European Convention on Human Rights (including ensuring “deprivation of liberty” is interpreted consistently with changing ECtHR case law). Also, with the need to map the legislative boundary with other Acts of Parliament (such as the Mental Health Act 1983) and the need to satisfy the requirements for independent checks and a means of appeal – to name just a few.
- 7.29 However, it is clear this area is worthy of further consideration. The Government will therefore ask the Law Commission, as part of the work on supported living described above, to consider the learning points that can be applied to DoLS and any improvements that can be made in light of its work (and indeed any changes that will need to be made to DoLS to take account of the new supported living provisions). Any changes to DoLS would seek to address those recommendations made by the House of Lords: namely to ensure the provisions are in keeping with the ethos of the Mental Capacity Act (any improved DoLS would continue to be part of the MCA), that they are clearly drafted and easily understood, that consideration is taken as to how to strengthen the role of the Relevant Person’s Representative and that the effective oversight of the supervisory body be ensured.
- 7.30 Finally, regarding the recommendation from the House of Lords regarding what it calls “a new Bournemouth Gap”. We do not consider there is a new “Bournemouth Gap”. If necessary, the inherent jurisdiction of the High Court could provide any further authorisation that may be required to deprive a patient detained under the Mental Health Act 1983 of their liberty for medical treatment unrelated to the patient’s mental disorder. Given the small number of cases in which this will arise, we do not propose to introduce legislative amendments.
- 7.31 We will keep the need to refresh the DoLS Code of Practice under review but we do not intend to undertake major work in this area until the Law Commission has reported its findings. If, following the work of the ADASS-led task group, minor amendments to the Code would seem valuable, the Government will consult and take a decision on this through the DH-led MCA Steering Group.

8. Lasting Powers of Attorney

This section addresses House of Lords:

Recommendation 25

We recommend that the Government, working with the independent oversight body recommended in chapter 4, and the Office of the Public Guardian:

- Address the poor levels of understanding of LPAs among professional groups, especially in the health and social care sector, paying specific attention to the status of Lasting Powers of Attorney in decision-making;
- Consider how best to ensure that information concerning registered Lasting Powers of Attorney can be shared between public bodies, and where appropriate with private sector bodies such as banks and utilities;
- Issue guidance to local authorities that their new responsibilities for provision of information in relation to care contained in the Care Bill should include information on Lasting Powers of Attorney;
- Consider how attorneys and deputies faced with non-compliance by public bodies or private companies can be supported in the absence of specific sanctions; review the apparent anomalies in the current arrangements with regard to successive replacement attorneys, and the status in England of Scottish Powers of Attorney.

Awareness raising

- 8.1 The Government agrees with the House of Lords that uptake of Lasting Powers of Attorney is low.
- 8.2 Many individuals make a Lasting Power of Attorney only following a health crisis, when there is a clear and immediate need. The reluctance to plan ahead mirrors the situation with will making, which many people think they can “put off” until they are older.
- 8.3 Our vision is instead for the registering of Lasting Powers of Attorney to become a matter of course and to be considered as a “life planning” arrangement – much like life assurance policies. We are considering a “life planning day” to take place in 2015 which will raise awareness of Lasting Powers of Attorney and other life planning mechanisms such as will making and advance decisions.
- 8.4 The Office of the Public Guardian (OPG) is already undertaking significant levels of work with those who use both Lasting Powers of Attorneys and Court of Protection deputyship orders. It is vital that we increase understanding of Lasting Powers of Attorney and Court of Protection deputyship orders, and how attorneys and deputies can be involved in decision-making and the enforcement of the rights of those who may lack capacity.
- 8.5 The OPG is working with NHS England on guidance for front line clinicians explaining the role of LPAs and deputyships and how they should work with them. It is hoped that once this work has been progressed, further work will be undertaken with colleagues in Wales to see what can be adopted there. Work will be undertaken with the Care Quality Commission

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to ensure that questions on level of knowledge of Lasting Powers of Attorney and Deputyships are part of the inspections they conduct within the health and social care sector. This work is in its early stages but should herald a significant increase in the understanding of Lasting Powers of Attorney.

- 8.6 Outside of the health and social care sector the OPG is undertaking a significant amount of work with the financial sector to raise understanding of LPAs. This includes chairing a task and finish group commissioned by the Prime Minister's Dementia Friendly Communities Champion Group. Work is being done to draft a leaflet highlighting the responsibilities and implications of acting on behalf of another person when given authority either informally or with a legal document. The leaflet can be used by a person with dementia or a person acting on their behalf to explain how they can manage personal information with organisations across a range of sectors.
- 8.7 The Care Act (England) and Social Services and Well-Being Bill (Wales) both state that local authorities must establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers. The OPG is already undertaking work with local authorities to ensure information on LPAs is included in guidance on care. Local authorities are a key stakeholder for the OPG who are in regular contact with such groups as the Association of Directors of Adult Social Services (ADASS), Association of Public Authority Deputies (APAD) and Local Government Association (LGA).
- 8.8 The OPG is currently piloting the 'Lasting Powers of Attorney Champions' scheme working with local authorities to promote lasting powers of attorney. This means that they will ensure that their relevant staff are aware of Lasting Powers of Attorney and Deputyships and will seek opportunities to actively promote them. The champions will also arrange drop in sessions where the public can attend to receive advice and assistance in making a Lasting Powers of Attorney.
- 8.9 In addition to the above, the Ministry of Justice will investigate what work can be undertaken with the Local Government Association to further raise awareness.

Information sharing

- 8.10 The OPG does, where it can, share information between public bodies and where appropriate with private sector bodies. The OPG also shares, where it can, anonymised information in relation to complaints and issues that it receives when it feels it would be useful for other bodies to have in order to be able to improve their services.
- 8.11 The register containing details of all registered Lasting Powers of Attorney, Enduring Powers of Attorney and Court appointed Deputyship orders can be searched when a request is received by the OPG. In order to make it easier for public and private bodies and the general public to check whether a Lasting Power of Attorney, Enduring Power of Attorney or deputyship order is in place, the Office of the Public Guardian is looking to make the register accessible electronically.
- 8.12 Plans also include the introduction of an intermediate tier of access for accredited parties. This would allow health care professionals and financial institutions to request specific, structured information, restricted to their area of interest at a level beyond that provided by the basic search available to the public. It is also intended that a limited group of bodies

will be able to get more detailed information via the electronic register – this will be determined by their need for that information in order to carry out their duties.

- 8.13 A test version of the electronic register should be available for testing with a limited group of users in late summer 2014 with a public access final version available later in 2014.

Supporting LPAs and deputies

- 8.14 As the Select Committee made clear, it is difficult to enforce compliance on the part of public bodies and private companies when there are no specific sanctions. It should also be remembered that financial institutions have no legal duty to open or run a bank account for any person.
- 8.15 However, the OPG regularly shares information with the financial sector in relation to complaints received and works with institutions to improve awareness and compliance. Fewer complaints are received in relation to the health sector but where they are received they are anonymised and shared with the relevant bodies or directly with officials at the Department of Health in order to improve the service provided to OPG customers. In some instances, the OPG will sign post individuals to other authorities who can help them resolve their issues, such as local authorities, the Care Quality Commission or the Social Services Inspectorate.
- 8.16 It is important that overarching governance bodies and associations such as the Financial Conduct Authority and the Care Quality Commission have an important role to play in encouraging and ensuring compliance in their relevant areas. Government and the OPG will continue to work with such bodies to improve service.

Replacement Attorneys

- 8.17 The Court of Protection has made a clear ruling in this matter so that the legal position is now clear. Section 10(8) (b) of the legislation provides that a replacement attorney can only replace an original attorney and cannot replace a replacement attorney. However, the court indicated that the same goal may be achieved by making two Lasting Powers of Attorney, with a condition that the second instrument will not come into effect until the first instrument has ceased to be operable for any reason. Whilst there are those that feel that this is an anomaly, the Government is aware that the Office of the Public Guardian does not receive a significant number of complaints or feedback that this is a significant issue for most people.
- 8.18 Government will continue to keep this area under review and ensure that a suitable balance is achieved so that for example, making a Lasting Power of Attorney is not unnecessarily complex.

The status of foreign Powers of Attorney

- 8.19 Government accepts that the Mental Capacity Act appears to offer two routes to provide recognition of foreign powers. Firstly if the power is classified as a ‘protective measure’ in line with paragraph 5 of Schedule 3 of the Act this would have the result of triggering mandatory recognition under paragraph 19(1) of Schedule 3 if the relevant conditions are satisfied. The second route is by operation of paragraph 13 of Schedule 3 of the Act regarding residency.

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- 8.20 Our initial view is that ‘foreign powers’ can be recognised under that Act but that this is not mandatory and that financial institutions and other bodies in England and Wales may insist on sight of an Order made by the court in the UK confirming that Attorneys are authorised to act under the foreign power. There is the potential for Scottish powers of attorney not to be recognised in England.
- 8.21 We accept that clarity should be provided on both the route to be taken for the recognition of a foreign power and the formal requirements to be complied with for the power to be accepted. The Government recognises the importance of ratifying the Hague Convention 2000 as this will bring about international co-operation to deal with the affairs of individuals across member states and intends to take steps to commence this work with a view to achieving ratification.

9. Court of Protection

Resource and rule changes

This section addresses House of Lords:

Recommendation 27

We recommend the Government consider increasing the staff complement of authorised officers, following consultation with the Court of Protection, to achieve a significant reduction in the time taken to deal with non-contentious property and financial affairs cases.

Recommendation 28

We also recommend that the Government consider as a matter of urgency the updating of the Rules of the Court, as recommended by the ad hoc Rules Committee and, as necessary, in light of subsequent changes.

- 9.1 HM Courts and Tribunal Service has committed to increasing the staff complement of the Court of Protection, both in technical roles and administrative roles, in order to better manage the increase in the volume of work handled by the Court and to bring about a reduction in the time taken to deal with non-contentious property and financial affairs cases. The recruitment will start in the coming months and it is expected that staff will be in post by the end of the year.
- 9.2 The Government has committed to taking forward the revision of the Court of Protection Rules and had previously agreed with the President of the Court of Protection that we would await the outcomes from the House of Lords Report prior to commencing the work. Following the publication of the Report, the President has written to the Lord Chancellor regarding the formation of the Rules Committee. It is our intention to have the new Rules in place by April 2015.

Information

This section addresses House of Lords:

Recommendation 29

We recommend that the Government consider enabling the Court to address the needs of its audiences either by giving it greater control of the information provided on www.gov.uk or by enabling the Court to have a dedicated website.

- 9.3 The Government's Digital Strategy is for a single government web domain for the public to access information about government services. Government Digital Service (GDS) sets standards for information provision, web best practice and user needs.
- 9.4 The Government agrees that the availability of increased information regarding the Court of Protection would go some way to improving accessibility of the Court and we will work with GDS to develop the content on the Court of Protection. We will also consider other means of releasing information about the court appropriate to different users .

Mediation

This section addresses House of Lords:

Recommendation 30

We are persuaded that mediation would be beneficial in many more cases prior to initiating proceedings in the Court of Protection. We recommend that consideration be given to making mediation a pre-requisite for launching proceedings, especially in cases concerning property and financial affairs where the costs fall to 'P'.

- 9.5 We are committed to making sure that, where appropriate, more people make use of mediation rather than go through the confrontational and stressful experience of going to court. Since the inception of the Court of Protection, the question of the role of mediation has been raised and discussed in a variety of contexts. It has also been suggested that if cases coming to the Court were more inquisitorial and less weighted then mediation may not be needed.
- 9.6 We will commence evidence gathering regarding areas of Court of Protection work where mediation may or may not be appropriate. Our initial thoughts are that mediation will be suitable for some property and affairs cases but not in those cases where the application relates to issues regarding health and welfare. Neither do we think that it would be appropriate to make mediation a pre requisite for launching proceedings as this should be approached voluntarily by the parties in order to be effective and in other instances could delay important cases reaching court.
- 9.7 We will also continue to liaise with the Office of the Public Guardian regarding their mediation pilot, which although on a small scale, may still provide us with some useful evidence to inform further work.

Access to Court /Legal Aid

This section addresses House of Lords:

Recommendation 31

We recommend that the Government, and in future the independent oversight body, provide clearer guidance to public authorities regarding which disputes under the Act must be proactively referred to the Court by local authorities. This should include situations in which it is the person who is alleged to lack capacity who disagrees with the proposed course of action. Efforts must be made to disseminate this guidance to families and carers as well as to local authorities.

Recommendation 32

We note the pressures on legal aid, but we are concerned by the inconsistent provision of non-means tested legal aid for cases concerning a deprivation of liberty, including those where there is a dispute over whether a deprivation is taking place. We cannot see a justification for such inconsistency and we recommend that the gap in protection that it creates be remedied as a matter of urgency.

Recommendation 33

We recommend that the Government reconsider the provision of resources to the Official Solicitor, with a view to determining whether some cases merit the same unconditional support as is currently afforded to medical treatment decisions.

Recommendation 34

We further recommend that the Government review the policy underlying the availability of legal aid for those who lack the mental capacity to litigate and therefore cannot represent themselves. For such people, denial of legal aid may result in having no access to Court. No-one who is found to lack the mental capacity to litigate should be denied access to Court solely because they do not have the means to pay for representation.

9.8 The Government agrees with the House of Lords that clearer guidance should be provided to public authorities on which disputes should be immediately referred to the court. We will begin by reviewing the evidence submitted to the Committee and will hold discussions with stakeholders, including lawyers, in the Court User Group and with the Official Solicitor to determine the content of guidance or Practice Directions. Dissemination of guidance will be part of the wider work outlined above to raise awareness. This will also form part of our general awareness raising with the public.

The Official Solicitor

9.9 We recognise the importance of the role of the Official Solicitor in providing legal representation to those who lack capacity.

9.10 We will explore whether changes could be made to existing arrangements with the Official Solicitor.

9.11 If additional budget and staffing were provided to fund the litigation of certain classes of persons lacking mental capacity in the Court of Protection, then the provision of support would be done on a principled basis.

Legal Aid

9.12 Civil legal aid is available to anyone who meets a means and merits test, provided that the case is within the scope of the scheme. Each application is considered on an individual basis and is subject to statutory tests of the applicant's means and the merits of the case. The scheme focuses limited resources on those who need them most, for cases that most justify it.

9.13 With the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) and consequent drafting of the Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013, the Government clarified that non means tested legal aid should only continue whilst a challenge to an existing statutory authorisation was being pursued under section 21A of the Mental Capacity Act 2005. Other Mental Capacity Act 2005 matters (that is, not proceedings under section 21A) that are within the scope of civil legal aid are subject to a means test (as well as to a merits test) including cases involving medical treatment, welfare issues and other 'best interest' decisions.

9.14 We do not agree that proceedings which broadly relate to the deprivation of liberty should by themselves not be subject to the means test. However, there are a number of very specific exemptions to the means test. One of these is in respect of certain proceedings under the Mental Health Act 1983 where statutory detention is being challenged; these cases have historically been exempted from means testing. We regard proceedings in the Court of Protection under section 21A of the Mental Capacity Act 2005, where the individual is someone in respect of whom an authorisation is in force under paragraph 2 of

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Schedule A1 to that Act, as analogous to those Mental Health Act proceedings which are not subject to a means test. As a result, the relevant legislation also provides that in the Mental Capacity Act cases described above, 'legal representation' (a specific form of civil legal service) may be provided without a determination as to financial eligibility.

- 9.15 We do not take the same view however, regarding other kinds of proceedings described in the Committee's report, most of which involve an administrative authorisation of detention by a statutory (as distinct from a judicial) body.
- 9.16 The means limits can only be waived when the particular circumstances set out in regulations 9-12 of the Civil Legal Aid (Financial Resources and Payment of Services) Regulations 2013 apply, for example in multiparty actions of significant wider public interest, inquests, cross-border disputes, proceedings relating to domestic violence and forced marriage. If these circumstances do not arise, there is no discretion to waive the upper limits. The financial limits have to be imposed in respect of eligibility for legal aid as there is limited resource. The current means test was designed with fairness, simplicity and administrative efficiency in mind.

Criminal Law

This section addresses House of Lords:

Recommendation 35:

We recommend that the Government initiate a review of whether the offence in section 44 of the Act meets the test of legal certainty; and if it does not, to bring forward new legislative provisions. The results of this review should be published within 12 months of publication of our Report.

- 9.17 We want to ensure that the criminal offence contained in the Act is used correctly.
- 9.18 We are grateful for the evidence supplied to the Committee which highlights the potential under use of the criminal offence contained in Section 44 of the Act. We will undertake a review to be completed this year, to assess whether this is the case and to consider other factors which affect charging decisions.
- 9.19 The Ministry of Justice is committed to protecting vulnerable individuals from ill treatment and neglect and wants to ensure that anyone responsible is dealt with appropriately by the criminal justice system.

10. Programmatic links

- 10.1 The scope of the MCA is so vast that for those who are less familiar with the Act it can appear difficult to pinpoint the specific contribution the MCA can make to their particular areas of work. One of the great opportunities for realising the potential of the MCA is identifying these areas, integrating the MCA and realising the contribution the Act can make to people's lives. Improvements in the awareness and understanding of the Act will lead to benefits across a range of priorities – as such, the MCA represents a smart investment.
- 10.2 This section seeks to demonstrate programmes of work where the MCA has a key role to play in increasing the likelihood of success. We draw attention to some of the key programmatic links and our plans for strengthening these. We urge professionals to ask themselves: how can the MCA contribute to delivering the health and care outcomes that my target population desires?

A: The Care Act 2014

- 10.3 The Government's Care Bill received Royal Assent on Wednesday 14 May, with most provisions coming into force in April 2015. The Care Act heralds a fundamental reform in social care in England, placing people at the centre of everything we do and ensuring their well-being is at the heart of every decision made. For the thousands of people receiving care and support who lack the capacity to make certain decisions, the Care Act will work side-by-side with the MCA in ensuring they are supported to exercise choice in their care and support and that, where this is not possible, decisions are taken in their best interests.
- 10.4 "Well-being" as defined by the Care Act will appear immediately familiar to those who work with the MCA. The definition includes: an individual's right to exercise control over their day-to-day life; the assumption that the individual is best-placed to judge what is best for them; the importance of the individual's views, wishes, feelings and beliefs; the importance of the individual participating as much as possible in decision-making; and the need to ensure restrictions on rights and freedom of action are kept to the minimum necessary.
- 10.5 To highlight a few of the Care Act's provisions where the principles of the MCA will play a fundamental role:
- Care and Support Planning: the Act will put into law an individual's entitlement to a care and support plan. Vitaly, for those lacking mental capacity, the local authority must help an individual to decide how best their needs can be met
 - Information and advice: the Act states that information must be accessible to and proportionate to the needs of those for whom it is being provided
 - Assessment of needs: that focuses on an individual's strengths and capabilities, not just their deficits – an approach that should empower those who may lack capacity
 - Duty to provide independent advocacy: to those who need it most to assist in the assessment, care planning and safeguarding process – this will work alongside the rights to Independent Mental Capacity Advocates (IMCAs) for those lacking capacity to make certain important decisions.

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10.6 During this summer's consultation on the statutory guidance for the Care Act we shall encourage contributions about how the Care Act, the regulations and the guidance apply to all people who use services, including those who may lack capacity.

B: Prime Minister's Challenge on Dementia

10.7 The Prime Minister's Challenge on Dementia identified dementia as one of the biggest challenges facing society today – a challenge that can only be tackled through approaches that draw on all parts of society. The Prime Minister's Challenge on Dementia is closely linked to the principles of the Mental Capacity Act. Thorough implementation of the MCA is important to successful realisation of the Challenge for all people with dementia, their families and carers.

10.8 The vision of the Challenge on Dementia is a society where people with dementia can say, amongst other things:

- *"I understand so I am able to make decisions"* – supported in law by the MCA's fundamental principle that those lacking capacity should be supported as much as possible to make their own decisions.
- *"I am confident my end-of-life wishes will be respected"* – enforced by the right for advance decisions and health and welfare Lasting Powers of Attorney under the MCA.
- *"I feel included as part of society. I am treated with dignity and respect"* – underpinned by the MCA's person-centred and best interests ethos.
- *"I know how to participate in research"* – the MCA specifically legislated to protect individuals who lack capacity and take part in research, whilst valuing the potentially huge benefits research may bring.

10.9 The Dementia Challenge and the Government's approach to mental capacity are closely linked and mutually reinforcing. We have identified a number of priority areas for joint collaboration over the coming year.

- The Dementia Action Alliance is a wide collaboration of organisations across England working together to bring about a society-wide response to dementia. Representation from the Mental Capacity Act Steering Group will join the Dementia Action Alliance quarterly meeting in autumn 2014, in order to scope actions that we can jointly address.
- Improving dementia awareness in the health and social care workforce. Health Education England is leading this work stream. We will ask HEE to ensure that efforts to improve awareness and understanding of dementia are closely linked to HEE's work to give greater prominence to the MCA across its training programmes.
- Post-Diagnosis Support Working Group. Providing those diagnosed with dementia with timely and accurate information (including about their rights under the MCA) is vital to ensuring their well-being. The Department will foster links between our MCA work and this group with a view to promoting good practice on MCA awareness and information provision.
- Dementia-Friendly Communities Champion Group. This Group has worked with partners across the community to look at what can be done to improve the ways that communities understand and act on dementia. The MCA Steering Group shall invite this Group to present their specific work on mental capacity issues with a view to identifying collaboration opportunities.

10.10 The Government is committed to closer alignment of our work on dementia and mental capacity. We will work to ensure closer alignment between the MCA Steering Group and the Dementia Programme Board.

C: Hard Truths – the Government response to the Francis Inquiry into the Mid-Staffordshire NHS Foundation Trust Public Inquiry

10.11 The Government’s response to the failings at Mid-Staffordshire called for a “*fundamental culture change*” across the health and social care system to put patients first at all times. If this culture change is to be realised for the thousands of individuals who lack capacity, then the principles of the Mental Capacity Act must be embraced throughout. As the Statement of Common Purpose in *Hard Truths* asserted: “*we will listen most carefully to those whose voices are weakest and find it hardest to speak for themselves*”.

10.12 *Hard Truths* should mark a watershed moment in building a future health and care system where those lacking capacity receive a standard of care and support equal to that experienced by those with capacity. To quote from the Government response:

“The best and most compassionate services are rooted in a conversation of equals”

“Patients must be involved and given their say at every level of the system”

“Care and support for people with mental health challenges, should offer access to interventions and approaches that give people the greatest choice and control over their lives, in the least restrictive environment, and should ensure that people’s human rights are protected”

10.13 In addressing the actions of *Hard Truths*, the health and social care system must ensure that the needs of individuals lacking capacity are given appropriate prominence.

10.14 One example of work underway is the consultation on the CQC’s fundamental standards – one of which covers person-centred care and the need to act in the best interests of someone who lacks capacity.

10.15 The Government for its part shall firmly align and integrate its continuing response to Mid-Staffordshire with its response to the House of Lords Mental Capacity Act Inquiry.

D: Transforming Care – the Government response to Winterbourne View

10.16 The abuse at Winterbourne View brought to light a series of systemic failures – included in which was a disregard for the Mental Capacity Act. Treatment was unnecessarily restrictive, individuals were not supported to make decisions, mental capacity and best interests assessments were neglected. Residents were unlawfully detained.

10.17 A key recommendation from the Serious Case Review was that “*adults with learning disabilities and autism, who are currently placed in assessment and treatment units, should have the full protection of the Mental Capacity Act*”. We could not agree more.

10.18 *Transforming Care* set out the Government response to Winterbourne View. The Mental Capacity Act and its message of empowerment underpin this response. Specific (though clearly not exhaustive) actions from *Transforming Care* with direct relevance to the MCA are listed below.

Valuing every voice, respecting every right:

- “Health and care commissioners should put plans into action..... all individuals should be receiving personalised care and support in appropriate community settings”. The MCA demands that individuals who may lack capacity are provided with a care package that is in their best interests, not – as occurred at Winterbourne View – in the interests of the system. An assessment of mental capacity is a vital first step in the production of a care plan.
- “CQC will make unannounced inspections of providers of learning disability and mental health services.... and take enforcement action”. Compliance against the MCA will be a key part of these unannounced inspections. The Government considers serious non-compliance with the MCA to be a fundamental block to providers receiving CQC registration.
- “NHS England will hold Clinical Commissioning Groups (CCGs) to account for their progress in transforming the way they commission services for people with learning disabilities/ autism and challenging behaviours”. Included in this, NHS England will hold CCGs to account for commissioning MCA-compliant care. A service that does not embrace the principles of the MCA is a service that will not meet our expectations regarding quality and safety.
- “The National Institute for Health and Care Excellence (NICE) will publish quality standards and clinical guidelines on mental health and learning disability”. MCA principles should feature at the heart of these guidelines and we will work with NICE, as appropriate, to support their development.

10.19 The above is just a “snap shot” of actions in *Transforming Care* supported by the MCA. Anyone familiar with the Mental Capacity Act will be struck by the familiarity of the culture change envisaged post-Winterbourne. The recognition of the need to listen to “challenging” individuals, to consult their friends and family, to protect individuals from harm whilst allowing the freedom to take risks: these are fundamental tenets of the MCA.

10.20 The Government will seek to align its *Transforming Care* and MCA programmes to the mutual benefit of both: we encourage system partners to do the same.

E: Closing the Gap: Priorities for essential change in mental health

10.21 The Government’s approach to mental health aims to ensure that mental health has equal priority with physical health, that discrimination associated with mental health problems ends and that everyone who needs mental health care should get the right support, at the right time. The Government’s approach to mental capacity stands squarely alongside these ambitions.

10.22 One myth that must be addressed is that which says mental health and mental capacity are one in the same thing. Certainly they are closely related but an individual with a mental disorder is not necessarily an individual who lacks capacity to make a certain decision. Indeed, a founding principle of the MCA is that individuals must be presumed to have capacity unless proved otherwise.

10.23 Closing the Gap identifies 25 aspects of mental health care and support where we expect to see tangible changes in the next couple of years: changes that will directly affect millions of lives for the better. Many of these people will also experience a lack of some degree of

mental capacity. The Government has identified the following action areas where alignment of our mental capacity and mental health strategies can realise significant rewards.

- Adults will be given the right to make choices about the mental health care they receive. Fundamental to individual choice is the supply of information to individuals in a suitable format that they can understand. The MCA has enshrined in law the principle that individuals lacking capacity must be empowered to make their own decisions and should be free to make decisions that others may consider “unwise” should they have the capacity to do so. These legal rights will be reinforced by the extension from April 2014 to mental health, of the right (contained in the NHS Constitution Handbook) for individuals to choose the organisation that provides their NHS care.
- Carers will be better supported and more closely involved in decisions about mental health service provision. Where individuals who lack capacity cannot make a certain decision, the MCA says that the decision then taken must be made in their best interests (as opposed to the interests of the provider). Vital to determining what represents the best interests decision is the involvement of friends, family and carers: to build the picture of the likely preferences of the individual in question. The Government intends to seek the input of the Standing Commission on Carers as to how we might develop or raise awareness of tools and materials that can assist the carers (of those lacking mental capacity) to support best interests decision-making.
- We will radically reduce the use of all restrictive practices. The Government’s recent policy document “*Positive and Proactive Care*” sets out how we expect to see the use of restrictive practices minimised wherever possible. The MCA introduced into law the least restrictive principle and should be the reference point for all restrictive practices involving individuals who lack capacity. We will align the work of our mental capacity and mental health programmes ensuring that this principle is embedded throughout and, where a deprivation of liberty is unavoidable as part of an individual’s care plan, this is legally authorised (either via the Deprivation of Liberty Safeguards or the Court of Protection).

10.24 “*No health without mental health*” encapsulates the Government’s mental health approach. For those lacking capacity, their mental health needs will only be satisfactorily met if they, their families and those professionals caring for them having a thorough understanding of the MCA. The Government shall seek out opportunities to embed understanding of the MCA in the mental health community.

F. The UN Convention on the Rights of Persons with Disabilities (UNCRPD)

10.25 The UNCRPD came into force in the UK in July 2009. Its purpose is to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (Article 1). The UNCRPD incorporates what it terms as a ‘paradigm shift’ that considers persons with disabilities as holders of rights on an equal basis with others. The Committee’s report acknowledged the work that Government is undertaking as it continues to assess the compatibility of the Mental Capacity Act with the Convention. Our commitment in this Response to raising awareness of the Act will include focussing on non discrimination and equal treatment, accessibility and inclusion - themes which are central to the UN Convention.

ANNEX A:

Mental Capacity Act: Ambitions for the Health and Social Care System

Through a shared and complementary programme of work, the joint ambition of the member organisations of the Mental Capacity Act Steering Group is to foster and enable a health and social care system where:

- Individuals lacking the mental capacity to make their own decisions receive the same opportunities and same quality of care as those with mental capacity
- Individuals lacking mental capacity are supported to express their health and care preferences and exercise choice in the same manner as individuals with mental capacity
- Informal carers of those lacking capacity (such as close family and friends) are consulted in best interests decision making. Where appropriate, individuals lacking mental capacity will be supported by an IMCA.
- Assessments of mental capacity are undertaken whenever appropriate
- For individuals who lack the mental capacity to make their own decisions (even after all appropriate steps to support them to do so have been taken), decision-makers proceed with the best interests of the individual first and foremost in mind.

Such a system will mean that no longer will individuals, who may lack capacity with regards to certain decisions at certain times, simply be labelled as lacking the capacity to make decisions on any aspects of their care and treatment. Instead, we will see a health and social care system, with the five principles of the Mental Capacity Act firmly embedded from home to headquarters. A system where everyone is as empowered and engaged in their own care as possible, and as such, a system where individuals will more likely achieve good health outcomes, a positive patient experience and improved well-being.

The member organisations of the Mental Capacity Act Steering Group are:

Academy of Medical Royal Colleges
Association of Directors of Adult Social Services
Care Provider Alliance
Care Quality Commission
College of Social Work
Court of Protection
Department of Health
Health Education England
Local Government Association
Ministry of Justice
Monitor
NHS Confederation
NHS England
Office of the Public Guardian
Public Health England
Royal College of Psychiatrists
Social Care Institute for Excellence

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