Northern Ireland Assembly

Research and Information Service Briefing Paper

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Public Finance Scrutiny Unit

Mental Capacity Bill: Training Costs

Paper 2 of 5

On 8 June 2015 the Mental Capacity Bill (the Bill) was introduced in the Assembly. To facilitate Assembly consideration of the costs arising from the Bill, this Briefing Paper is the second in a five-part series produced by RaISe's Public Finance Scrutiny Unit (PFSU). The Paper examines the costs that the Department of Health Social Services and Public Safety (DHSSPS) and the Department of Justice (DoJ) have estimated for staff training relating to the Bill.

Introduction

As introduced by the Department of Health Social Services and Public Safety (DHSSPS) on 8 June 2015, the Mental Capacity Bill (the Bill) fuses together mental health and mental capacity law. It introduces a single statutory framework governing all situations where a decision needs to be made in relation to the care, treatment, or personal welfare of persons aged 16 or over who lack capacity to make such decisions for themselves. The Bill removes the ability of those persons to be treated for a mental health condition against their wishes, if they retain the capacity to refuse treatment. This means that those with a mental health illness will be treated equally to those with physical illnesses.[1]

The Bill's Explanatory and Financial Memorandum (EFM) states:

> *The introduction of the legislation will be a very significant change to practice and culture across the health and social care (HSC) and justice sectors.* ***The estimated costs therefore take account of the costs of training the entire*** **[Health and Social Care]** ***HSC workforce.***[2] [emphasis added]

The DHSSPS' undertaking to train the entire workforce is reasonably expected to have logistical, as well as financial implications.

This Briefing Paper is part 2 in a series produced by RaISe's Public Finance Scrutiny Unit (PFSU) to facilitate the Assembly's scrutiny of the departmental training cost estimates relating to the Bill.

The Paper is structured in the following way:

- Section 1 provides a comparative context given the current lack of detail about subordinate legislation, which was highlighted in Paper 1 of this series. It presents information on the training process associated with the Mental Capacity Act in England and Wales, which may help to inform similar training that is to be delivered as a result of this Bill;
- Section 2 assesses the DHSSPS' and DoJ's estimates for the provision of training to support implementation of the Bill in Northern Ireland; and,
- Section 3 provides brief concluding remarks.

Scrutiny points are noted throughout.

[1] See RaISe paper NIAR 420-14 for more information

[2] http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2014-2015/mental-capacity/mental-capacity-bill---efm---as-introduced.pdf (page 82)

1. Mental capacity training in England and Wales

It is acknowledged at the outset that the regime under the Bill will differ from comparable prevailing legislation in England and Wales, i.e. the *Mental Capacity Act 2005*. Having said this, staff working in the Northern Ireland (NI) Health and Social Care (HSC) and beyond will need to understand how the Bill and subsequent subordinate legislation will impact upon them: for example, how the deprivation of liberty safeguards apply to those under their care.

HSC staff will therefore, require training that is likely to be similar to the training provided to their equivalents in England and Wales. For this reason, it may be useful for the Assembly to learn from the experiences there; this important contextual information is likely to be of some value when considering the projected costs of training in NI.

1.1. House of Lords

On 13 March 2014, the House of Lords Select Committee on the *Mental Capacity Act 2005* published its report on its post-legislative scrutiny of that Act. The report made significant recommendations regarding training and awareness amongst healthcare professionals:[3]

Training and oversight of professionals: the role of professional regulators and medical Royal Colleges

17. The Act needs a higher profile among professionals in order to be properly understood and effectively implemented. The medical Royal Colleges and professional regulators have a responsibility to play their part in promoting best practice through standard setting, training, awareness-raising and enforcement. (paragraph 137)

18. **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. In future, we would expect the responsibility for this to sit with the independent oversight body. (paragraph 138)**

19. **Recommendation 7: In particular, 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. (paragraph 139)**

20. **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. (paragraph 140)**

21. Consistency in training and oversight of professionals is essential. Whatever body is given responsibility for the implementation of the Act will have a vital role in co-ordinating the response of the medical Royal Colleges and professional regulators to ensure a shared understanding of legal obligations under the Act is used by all. (paragraph 141)

22. We expect that the existence of an independent oversight body with responsibility for implementation of the Act will act as a spur to the medical Royal Colleges and the professional regulators in taking forward work to raise the profile of the Mental Capacity Act and ensure compliance. (paragraph 142)

[3] http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf (page 10)

In summary, it is clear from the recommendations that the Select Committee found training provision less than perfect in terms of the Act's profile amongst healthcare professionals. The training recommendations formed part of the Select Committee's recommendations for addressing the Act's poor implementation.[4]

1.2. Care Quality Commission

The Care Quality Commission (CQC) has a significant role in monitoring the implementation of the Act in England and Wales. In its report *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13,* the CQC stated:

> *In last year's report, we committed to improving the knowledge and confidence of our inspectors regarding the MCA, including the Deprivation of Liberty Safeguards.*
>
> *The following actions have been taken since then to improve staff understanding:*
>
> - *An e-learning package, setting the Deprivation of Liberty Safeguards within their essential context of the MCA, is available to staff including Registration Assessors and Compliance Inspectors, and is being updated.*
> - *We revised our general MCA guidance to reflect amended regulations (Regulation 18) that require a best interests process to be carried out when people are assessed as lacking capacity to consent to proposed interventions. This was produced as separate editions for our staff and providers.*
> - *All new inspectors receive specific MCA induction training, including the Deprivation of Liberty Safeguards. The content has been significantly expanded on what was previously available.*
> - *Staff with MCA expertise have attended a number of staff events to speak about the MCA over the last 12 months.*
> - *MCA issues and developments are now included as a permanent agenda item in monthly meetings attended by regional leads from across country.*[5]

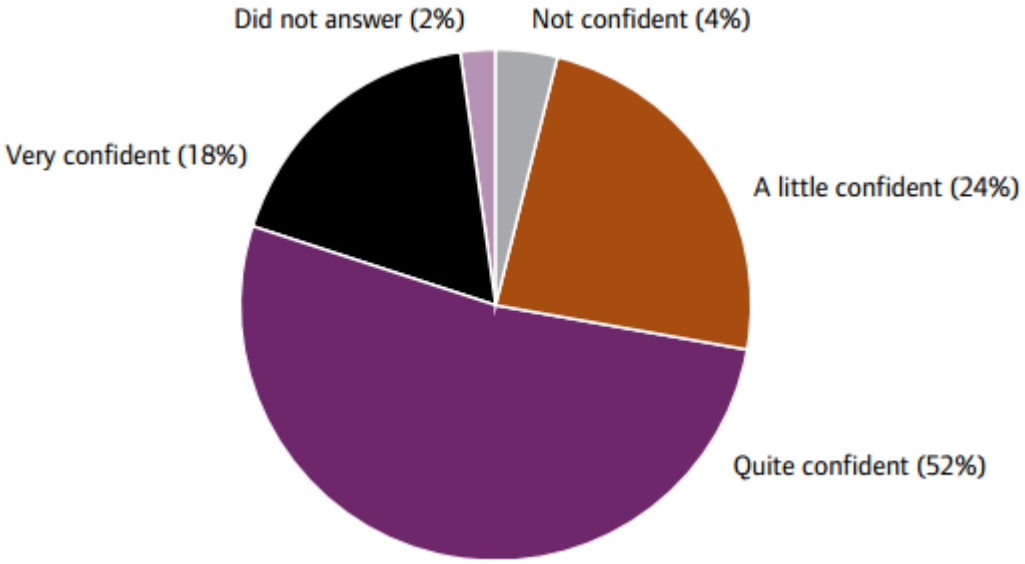
The cited passage shows that concerns about implementation of the Act *predated* the House Lords Select Committee report. Indeed, in that same report, the CQC showed that awareness of the Act amongst its own staff was less than perfect – see overleaf.

The chart below shows the results of a skills audit of CQC's frontline operations staff - including compliance inspectors, compliance managers, registration assessors,

[4] See Chapter 4 of http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf
[5] http://www.cqc.org.uk/sites/default/files/documents/dols_2014.pdf (page 4)

registration managers and heads of function. It found that a quarter (24%) were only "*a little confident*" in their understanding of the Act, as reflected in the below Figure 1. [6]

Figure 1: Results of the CQC's skills audit



1.3. Other interested parties

A number of other interested parties have published reports that have in some way considered the issue of training and the implementation of the Act.

For example, on 22 January 2015, the Community Care website reported analysis of the CQC reports:

> *Inspection reports published under the new inspection framework introduced by the regulator last October show that 29 of the 34 care homes and nursing homes rated 'inadequate' had failed to properly apply elements of the Mental Capacity Act 2005 (MCA) or the associated Deprivation of Liberty Safeguards (Dols). The most common concerns surrounded providers imposing restrictions on people's care without legal authorisation,* ***a lack of training and awareness of the legislation among staff – including some senior managers*** *– and failures to make referrals to local authorities for Dols authorisations.*[7] [emphasis added]

Perhaps worryingly, this report illustrates that at the start of this current year, concerns around training of care staff persist.

Similarly, on 9 January 2015, a lack of awareness amongst nurses was reported in *Nursing Times*:

[6] http://www.cqc.org.uk/sites/default/files/documents/dols_2014.pdf (page 22)
[7] http://www.communitycare.co.uk/2015/01/22/mental-capacity-act-failings-prominent-inadequate-rated-care-providers/

> *Lack of awareness among nurses about legislation on whether a patient is able to consent to treatment, as well as insufficient recruitment checks on new staff, are among issues exposed at GP surgeries by regulators.*[8]

Finally, it also appears from the United Kingdom Government's response to the House of Lords Select Committee Report that the Office of the Public Guardian (OPG) for England and Wales has identified training needs in relation to the Act:

> *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.*[9]

The information outlined throughout the above sub-sections highlights difficulties around training when new regimes are implemented. Lessons should be learned from the English and Welsh experience so that the NI departments ensure its HSC does not have similar problems. Getting it right in the first instance is cost effective; a particularly important consideration given current budgetary constraints.

[8] http://www.nursingtimes.net/nursing-practice/specialisms/practice-nursing/some-practice-nurses-lack-training-in-mental-capacity-laws-finds-cqc/5078062.article

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/318730/cm8884-valuing-every-voice.pdf (page 5

2. Departmental estimated staff training costs in NI

In its report on consultation responses, the DHSSPS noted that "*more than half of the responses in relation to implementation commented on the need for training*."[10]

According to DHSSPS' analysis, issues raised included:

- the need for those involved in caring for persons that lack capacity to receive tailored training;
- the need for high-quality training;
- the need for training to continue beyond the initial implementation period; and,
- the importance of learning from the training regime in England and Wales.[11]

Relying on information provided to the PFSU by the DHSSPS and the DoJ, the below sub-sections address: estimated staff training costs for the HSC and the DoJ.

2.1. DHSSPS training costs

2.1.1. The costing basis

The DHSSPS explained to the PFSU that its training cost estimate is based upon consultation with HSC bodies, reflecting their opinion on the level and detail required in the training to facilitate implementation of the Bill. Staff members were grouped according to the training level they would require; the groupings were then matched to staff survey data.[12]

The training levels are shown in Table 1 below:

[10] http://www.dhsspsni.gov.uk/mental-capacity-bill-consultation-summary-report.pdf (page 117)
[11] http://www.dhsspsni.gov.uk/mental-capacity-bill-consultation-summary-report.pdf (page 117)
[12] Letter from DHSSPS to RalSe, 3 June

Table 1: Proposed levels of training[13]

Training Level	Detail
Level 0	General awareness training: -All HSC and Independent sector frontline staff; and, -Public awareness campaign
Level 1	1/2 Day - Staff with limited patient interaction and direct medical involvement (environmental support).
Level 2	1 day - Staff with direct patient interaction and medical involvement. Staff with specific functions under the Bill, advocates and Trust Panels.
Level 3	2-3 days - Professional Staff with direct medical decision making responsibilities. Senior staff with specific functions under the Bill, advocates and Trust Panels including the requirement to exercise expert opinions or operate a challenge or decision support function.
Level 4	(Profession Centred) - Up to 5 days - Professional Staff with direct medical decision making responsibilities. Senior staff with specialised responsibilities and functions under the Bill, advocates and Trust Panels including the requirement to exercise expert opinions or operate a challenge or decision support function.
Level 5	Profession Centred) - up to 12 days - Professional Social Work Staff with specific decision making responsibilities.

The DHSSPS further stated that the "*requirement to sustain operational service was a primary factor in the costing process.*"[14] It is inarguable that such a requirement should be considered in a costing process. The DHSSPS statement gives rise however, to a relatively obvious question: what else was considered?

Scrutiny point:

The Assembly may wish to establish what other factors were taken into account by the DHSSPS during the costing process, i.e. what factors beyond the requirement to sustain operational service?

2.1.2. Two costs for training

The DHSSPS has provided two costs for training. These are presented as a choice between running a stand-alone training programme and subsuming the new mental capacity regime training into existing training provision, as stated in Table 2 below:

Table 2: Two costs for training

Training costs		
	New Legislation Training Programme (million)	Training subsumed into existing provision (million)
Costs	£21.58	£4.08
Difference		£17.50

[13]Letter from DHSSPS to RalSe, 3 June
[14]Letter from DHSSPS to RalSe, 3 June

It should be noted that these costs are <u>not</u> presented as a range of estimates. Rather, there is simply a choice between two sets of estimates, which are based on different methods of delivery. Therefore, the estimate is not from £4.08 million (m) to £21.58m. It is **<u>either</u>** £4.08m **<u>or</u>** £21.58m. This means the presentation of costs as a range in the EFM is somewhat misleading, because a range suggests that costs may fall at any point along a continuum, rather just than at either end.

It seems appropriate to query the robustness of these estimates given the current lack of detail regarding subsequent subordinate legislation. Hence, arguably they convey a spurious degree of precision.

This point can be further illustrated by reference to the estimates provided in Table 3:

Table 3: Initial training costs for the HSC

Initial non recurrent costs		**New Legislation Training Programme**	**Training subsumed into existing provision**	**Difference**
	Staff No's	Detailed Summary Costings – **Estimated Costs (£'M)**	Detailed Summary Costings - **Estimated Costs (£'M)**	**Training Cost Reduction £'M)**
Level 0 awareness	65,700	0.30	0.30	-
Level 1 training	21,428	0.84	0.22	0.61
Level 2 training	36,275	6.13	0.83	5.31
Level 3 training	4,464	7.11	2.03	5.08
Level 4 training	4,186	6.22	0.65	5.57
Level 5 training	312	0.99	0.06	0.94
Total initial training costs		**21.58**	**4.08**	**17.50**

The estimates contained in the above table may imply robustness. However, it is unclear from the currently available information as to whether the DHSSPS has identified and specified its precise training needs, and tested the market for the cost to deliver training relating to the Bill.

Scrutiny points:

1. **The Assembly may wish to establish whether the DHSSPS has approached the market for training to be provided externally.**
2. **If not, does the DHSSPS intend that training will be provided internally?**

Further to Table 3, it raises a fundamental issue about the proposed training delivery model. As noted above, it appears there is a choice between the DHSSPS commissioning a stand-alone training programme and building the training into existing provision.

Clearly, the choice is significant from the perspective of sustaining operational service. But it also appears to be significant from a financial perspective. The estimated cost of building training into existing provision is **less than a fifth of a stand-alone training programme – £21.58m compared to £4.08m.**

A key question is whether this apparently attractive option would deliver the required outcome of an adequately trained HSC workforce in a reasonable timescale. This is particularly significant when considered in the context of the difficulties reported in Section 1 in relation to training in England and Wales.

Indeed, in a letter to the PFSU, the DHSSPS suggested that the existing provision approach is unsuitable: "*given the scope of the legislation, this baseline scenario is not realistic*".[15]

Scrutiny points:

1. The Assembly may wish to seek DHSSPS' view of the relative pros and cons of the two possible delivery models. In particular, what is DHSSPS' assessment of risks that may be associated with incorporating delivery into existing provision, including explanation of the reasons why this is "not realistic"?

2. The Assembly may also wish to ask the DHSSPS why it did not make it clearer in the EFM that the lower end of its cost range in part relies on an estimated cost that is "not realistic"? In other words, why present estimated costs in a range – as stated in the EFM - when the lower end cannot be effectively delivered?

2.2. DoJ training costs

In a letter to the PFSU, the DoJ provided its view of training costs associated with the criminal justice elements of this Bill. These are set out in Table 4:[16]

Table 4: DoJ training costs

Pre-implementation	Year 1	Year 2	Year 2
-	£75,000	£15,000	£15,000

It is immediately apparent that – by comparison – these DoJ estimated costs are strikingly low. It is acknowledged that the criminal justice system does not have anywhere near the same numbers of staff as the entire NI HSC workforce. But the Bill would introduce the same culture shift in the way that individuals are to be treated in the justice system, as it would in the HSC sector.

For example, it seems probable that police officers who may be responsible for removing individuals to a place of safety would need to be trained. One would also

[15] Letter from DHSSPS to RaISe, 20 June
[16] Letter from DHSSPS to RaISe, 20 June

expect those who would receive individuals into such places of safety (including police stations) would likewise need to be trained.

It is important to recall at this stage that the Office of the Public Guardian has undertaken to raise awareness, as noted in Section 1 of this Paper.

Scrutiny points:

1. **The Assembly may wish to seek an assessment from the DoJ of who within the criminal justice system will need to be trained?**
2. **The Assembly may wish to ask the DoJ to explain its rationale for the estimated staff training costs.**

3. Concluding remarks

Looking to another jurisdiction's experience with legislation training in this area, this Briefing Paper noted problems regarding staff training in England and Wales following the Mental Capacity Act 2005. Although this legislation is different, their experience usefully highlights the importance of training to implement the culture shift that would be required in NI under the Bill, if enacted.

The Paper also importantly highlights that the DHSSPS' estimated training costs should not be used as a range, despite what the EFM states; instead they are intended to represent two delivery options, as the DHSSPS has advised the PFSU. And, one of those options – existing provision - appears to be a baseline only estimate, which is not unrealistic by the DHSSPS. The Assembly may wish to address this issue with the DHSSPS.