

**EXPLANATORY MEMORANDUM TO**  
**THE MENTAL CAPACITY ACT 2005 (INDEPENDENT MENTAL**  
**CAPACITY ADVOCATES) (EXPANSION OF ROLE)**  
**REGULATIONS 2006**

**2006 No. 2883**

**1.** This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

This memorandum contains information for the Joint Committee on Statutory Instruments.

**2. Description**

2.1 Sections 35 to 40 of the Mental Capacity Act 2005 (the Act) provide that independent mental capacity advocates (IMCAs) must be instructed by NHS bodies and local authorities to represent and support people who lack capacity in the circumstances specified in those sections.

2.2 Section 35(1) also imposes an obligation on the appropriate authority – in relation to England, the Secretary of State – to make such arrangements as she considers reasonable to enable IMCAs to be available in the circumstances set out in sections 37 to 39. Section 35(1) therefore gives the Secretary of State authority to provide funding for the statutory IMCA service.

2.3 This statutory instrument is to be made under section 41 of the Act and is subject to the affirmative parliamentary procedure.

2.4 Section 41 provides a power to make regulations expanding the role of the independent mental capacity advocate (IMCA) in relation to people who lack capacity. Section 41 provides that such regulations may in particular set out the circumstances, additional to those set out in sections 37 and 39, in which IMCAs must or may be instructed.

2.5 Section 41 also provides a power to adjust the obligation to make arrangements imposed by section 35.

2.6 These Regulations provide that NHS bodies and local authorities may instruct IMCAs to represent people who lack capacity in the circumstances set out in Regulations 3 and 4. They provide that where an IMCA is instructed in these circumstances, the NHS body or local authority must take into account information given by or submissions made by the IMCA in making any relevant decision in relation to the person without capacity.

2.7 'NHS body' is defined in Regulation 1(4) and 1(5).

2.8 These Regulations also provide that the Secretary of State may make such arrangements as she considers reasonable to enable IMCAs to be available to represent and support people without capacity in the circumstances set out in Regulations 3 and 4. The Regulations therefore give the Secretary of State authority to provide funding for the IMCA service provided under these Regulations.

2.9 These Regulations are drafted to come into force on 1 November 2006 for the purposes of enabling the Secretary of State to make the arrangements provided for in the Regulations and on 1 April 2007 for all other purposes.

### **3. Matters of Special Interest to the Joint Committee on Statutory Instruments**

3.1 This is the first use of the powers contained in section 41 of the Act.

3.2 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, laid before Parliament on 13 July 2006 and subject to the negative parliamentary procedure, have been made under powers in sections 35 to 39 of the Act. These make provision, among other things, as to the appointment and approval of IMCAs instructed by virtue of these affirmative Regulations and as to the functions of IMCAs so instructed.

### **4. Legislative background**

4.1 The Mental Capacity Bill introduced to Parliament in June 2004 included provision for an "independent consultee" in response to concerns about a lack of safeguards for particularly serious health and welfare decisions in the draft Mental Incapacity Bill published in June 2003. The name of the independent consultee service and the functions were changed during the passage of the Bill, to reflect concerns that independent advocacy was key to both empowering and protecting the most vulnerable people who lack capacity to make decisions about their health and social care.

4.2 During the passage of the Bill Ministers committed to consulting with stakeholders on how the regulation making powers in s41 would be used and whether there were other decisions outside of long-term care and medical care and treatment, on which the IMCA might be consulted. (Hansard 2 November 2004 col 321).

4.3 Sections 35 to 41 of the Mental Capacity Act 2005 provide for IMCAs to be available in specified circumstances to support and represent particularly vulnerable people who lack capacity to make certain important decisions.

4.4 Sections 37 to 39 of the Act set out the circumstances in which an IMCA must be appointed. These are:

- where it is proposed to provide, withdraw or withhold serious medical treatment in relation to P (serious medical treatment is defined in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates)(General) Regulations 2006 using the power in section 37(6) of the Act);
- where it is proposed to make certain arrangements as to P's accommodation in a hospital or care home or in residential accommodation provided in accordance with sections 21 or 29 of the National Assistance Act 1948 (c.29) or section 117 of the Mental Health Act 1983.

4.5 However, an IMCA need not be appointed under these provisions unless there is no one (other than a paid carer) whom it would be appropriate to consult in determining what would be in P's best interests. Further, section 40 provides that no IMCA need be appointed where P has nominated someone who should be consulted or where he has created an Enduring Power of Attorney, a Lasting Power of Attorney (LPA) or the Court has appointed a deputy for him.

4.6 These Regulations provide for additional circumstances in which IMCAs may (not must) be instructed by an NHS body or local authority. These are:

- where 'qualifying arrangements' have been made by an NHS body or local authority as to the accommodation of a person ('P') who lacks capacity and a review of the arrangements is proposed or in progress;
- an NHS body or local authority propose to take protective measures in relation to P, in accordance with guidance issued by the Secretary of State under section 7 of the Local Government Social Services Act 1979 (c.42), following allegations of abuse or neglect of P or abuse of another on the part of P. A copy of the guidance ("No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse".) can be obtained from the Department of Health website at:  
<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyandGuidance>

4.7 'Qualifying arrangements' are arrangements for accommodation, for a continuous period of 12 weeks or more, in a care home or hospital or in residential accommodation provided under section 21 or 29 of the National Assistance Act 1948 (c.29) or section 117 of the Mental Health Act 1983. As for sections 38 and 39 of the Act, accommodation provided as a result of an obligation imposed on P under the Mental Health Act 1983 does not count. In practice, this means that where the person concerned is to be detained or otherwise required to live in the accommodation in question under the Mental Health Act 1983, the IMCA does not need to be consulted. This is because the Mental Health Act contains its own safeguards and rights of appeal.

4.8 In relation to accommodation decisions, these Regulations do not provide for IMCAs to be instructed where P has nominated someone to be consulted, where he

has created a lasting or enduring power of attorney or where the Court has appointed a deputy for him. Nor do these Regulations make provisions for IMCAs in ‘qualifying accommodation’ review cases where there is someone (other than a paid carer) whom it is appropriate to consult. But in adult protection cases an IMCA may be appointed under these Regulations even where there is someone else appropriate to consult.

4.9 The provisions on appointment specified in Regulation 5 of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006, also apply where an IMCA is instructed under these Regulations made under section 41 of the Act.

4.10 Regulation 2 of these Regulations provides a power (not obligation) for the Secretary of State to make such arrangements as she considers reasonable to enable IMCAs to be available in the circumstances specified in Regulations 3 and 4.

4.11 Regulation 5 provides that (although there is no obligation on an NHS body or local authority to instruct an IMCA in the circumstances specified in Regulations 3 and 4) they may do so where they are satisfied that it would be of particular benefit to P. Regulation 5 also provides that where they do instruct an IMCA in these circumstances, they must take account of what he says.

4.12 These Regulations do not prevent an NHS body or local authority from instructing an IMCA in other circumstances. However, the Regulations only provide authority for the Secretary of State to make arrangements for IMCAs to be available in the circumstances set out in the Regulations.

## **5. Extent**

5.1 This instrument applies in relation to England only,

## **6. European Convention on Human Rights**

6.1 The Minister for State, Rosie Winterton has made the following statement about human rights:

“In my view the provisions of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 are compatible with Convention rights.”

## **7. Policy Background**

7.1 The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions, for example because of a learning disability, an illness such as dementia or brain injury or mental health problems. The clauses covering IMCAs were introduced into the Mental Capacity Bill in June 2004, in response to concerns about a lack of safeguards for the most vulnerable people in society, when facing particularly serious health and social care decisions.

7.2 The duty to involve an IMCA under sections 37 to 40 of the Act only applies to people who lack capacity to make certain decisions and who have no one whom it is appropriate to consult as to their best interest. Under those sections of the Act, people who have the support of family or friends or those who have a power of attorney or a deputy under the Act will not have access to an IMCA.

### Consultation

7.3 The Government consulted between 5 July and 30 September 2005 on the details of the IMCA service, about how the regulation making powers should be used and about the operation and implementation of the service and about whether the service should be extended to other groups of people and situations.

7.4 The consultation exercise asked for views on six options for extending the service to other vulnerable people who lack capacity who may benefit from an IMCA or other circumstances where the IMCA should be appointed. The six options were: (i) no extension; (ii) a more intensive service to the most vulnerable; (iii) provide an IMCA in cases of dispute; (iv) provide an IMCA where requested by one of the parties; (v) extra care housing; (vi) allowing LAs and/or NHS bodies to determine priorities. The consultation paper also asked whether the IMCA should be involved in care reviews.

7.5 Responses were varied with contrasting opinions set out – none of the six options received unqualified support. There were 176 written responses to the consultation. In addition, some 450 people attended events to publicise the consultation. A summary of consultation responses and the Government's response to the consultation was published on 19 April 2006 and can be found at [www.dh.gov.uk/consultations/closedconsultations](http://www.dh.gov.uk/consultations/closedconsultations)

7.6 The Government's main priority, set out in the consultation response, is to introduce safeguards to protect the rights of individuals who do not have family or friends to advocate on their behalf. The Government is also mindful of concerns about introducing a good quality service for this group before looking to extend it further. There were concerns expressed in the consultation responses about the average time allowed for IMCAs for each decision as set out in the original planning assumptions. These have therefore been revised along the lines of option (ii) to provide a more intensive service for those who have no family or friends.

7.7 In addition, responses to the consultation were concerned that there may be other situations, beyond those listed in the Act, where a person who lacks capacity may be particularly vulnerable. In particular, respondents raised concerns that IMCAs should be involved in adult protection cases where it was likely that family or friends were abusing the vulnerable person.

### Expansion of Role

7.8 Following consultation on a number of options proposed for expanding the IMCA service, the Government decided to allow local authorities and NHS bodies to determine priorities for providing IMCAs, in addition to those provided under sections 37 to 39 of the Act, to the most vulnerable people within their localities and

to commission services accordingly, within the funding available. Regulations 3 and 4 specify the additional circumstances where an IMCA may be instructed at the discretion of the local authority or NHS body.

### Expansion of Role

7.9 The Regulations specify those other circumstances in which LAs and NHS bodies may provide the IMCA service on a discretionary basis along the lines of option (vi). These include involving the IMCA in a care review following a change of accommodation and in adult protection cases. Policy on care reviews is already good practice under Section 7 of the Local Authority Social Services Act 1970 and statutory guidance, including Fair Access to Care Services

7.10 The policy intention is not to prevent independent advocates and IMCAs being used in other circumstances but to put their use and functions on a statutory footing for certain important decisions.

## **8. Impact**

8.1 A Regulatory Impact Assessment and Race and Equality Impact Assessment have been prepared for this instrument and are attached. They also cover the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006. Overall there will be no significant impact on businesses or the voluntary and charitable sector as a result of these Regulations.

8.2 The cost of instructing an IMCA in the circumstances specified by this statutory instrument will be met from the £6.5m per annum allocated for the whole IMCA scheme and devolved to local authorities for local commissioning. This will be new funding from the Department of Health.

## **9. Contact**

Sheila Evans at the Department of Health Tel: 020 7972 4332 or e-mail: sheila.evans@dh.gsi.gov.uk can answer any queries regarding the instrument.

## **REGULATORY IMPACT ASSESSMENT**

### **1. Title**

Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006

and

Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006

### **2. Purpose**

2.1 The Mental Capacity Act 2005 (the Act) provided the statutory framework for a new service, the Independent Mental Capacity Advocate (IMCA) service. Its

purpose is to help particularly vulnerable people who have no family or friends and who lack capacity to make important decisions about serious medical treatment and changes of residence, for example, moving to a hospital or a care home. The provisions in the Act are intended to come into force from April 2007.

2.2 The Act set out the basic framework for the IMCA service. These two instruments are the first use of the powers contained in sections 35 to 41 of the Act. The 'General' Regulations are covered in paragraph 5 below and the Regulations relating to 'Expansion of Role' of the IMCA service are covered in paragraph 6 below.

2.3 The purpose of the regulations is to set out the detail on how the IMCA service will be set up, in particular they:

- set out how the IMCA will be appointed under the powers in sections 35(2) and (3),
- set out the functions and role of the IMCA and how the IMCA can challenge decisions,
- define 'serious medical treatment' under the powers in section 37(6)
- define the term "NHS body" under the powers in section 37(7), and
- set out how the powers to expand the IMCA service to other groups and situations will be used under the powers in section 41.

2.4 This regulatory impact assessment (RIA) and race and equality impact assessment (REIA) - see Appendix A - apply in relation to England only. The RIA and REIA cover the two sets of regulations.

### **3. Background**

3.1 The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions for example because of a learning disability, an illness such as dementia or brain injury or mental health problems. The Act sets out who can take decisions, in which situations, and how they should go about this.

3.2 The clauses on the IMCA service were introduced into the Mental Capacity Bill in June 2004 in response to concerns about a lack of safeguards for particularly serious health and welfare decisions for the most vulnerable people, in the draft Mental Incapacity Bill published in June 2003.

3.3 The duty to involve an IMCA only applies to people who lack capacity to make certain important decisions and who have no family or friends. Under the Act, people who have the support of family or friends or those who have an Enduring Power of Attorney, a Lasting Power of Attorney (LPA) or a deputy under the Act will not have access to the IMCA service.

3.4 The Act includes regulation making powers to extend the service to other groups and situations and the regulations covering Expansion of Role use these powers.

#### **4. Consultation**

4.1 During the Parliamentary passage of the Act, the Government committed to consulting with interested parties about how the regulation making powers relating to the IMCA should be used.

##### Consultation within Government

4.2 Consultation within Government on the regulations largely involved the Department of Health (with responsibility for health and social care issues), the Department for Constitutional Affairs (DCA) (with responsibility for mental capacity issues), the Wales Office, the Home Office, the Department for Communities and Local Government and the National Assembly for Wales.

4.3 Implementation of the Mental Capacity Act is led by the Department for Constitutional Affairs, but the Department of Health is leading on the policy on the IMCA service.

##### Public Consultation

4.4 The Government consulted between 5 July and 30 September 2005 on regulations to be made on the IMCA service. These included:

- the operation of the IMCA service, including issues such as funding, commissioning the service, standards, training and skills needed,
- how to ensure the independence of the IMCA,
- monitoring and accountability,
- the main functions the IMCA will carry out,
- definitions of serious medical treatment, and
- whether to extend the IMCA service beyond people who have no families or friends and to situations other than serious medical treatment and accommodation.

4.5 There were 176 written responses to the consultation including individuals, the NHS and local authorities, organisations representing healthcare, independent advocacy organisations, regulatory bodies (including the Commission for Social Care Inspection and Ombudsman), and other regional and national independent sector providers and stakeholder organisations representing people who lack capacity. In addition, some 450 people attended events to publicise the consultation.

4.6 A summary of consultation responses and the Government's response to the consultation was published on 18 April 2006 and can be found at [www.dh.gov.uk/consultations/closedconsultations](http://www.dh.gov.uk/consultations/closedconsultations) . The Executive Summary and the Government response have been made available in an accessible version, and in Arabic, Bengali, Chinese, Gujarati, Punjabi and Somali. CD-Rom and braille versions are also available on request. Details of the consultation issues and the Government's response can be found at Annex A.

## **5. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates)(General) Regulations 2006**

5.1 This statutory instrument is made under sections 35-40 of the Act and sets out:

- the definition of serious medical treatment,
- the appointment criteria for independent mental capacity advocates (IMCAs),
- the detail of the role of the IMCA and how the IMCA can challenge decisions,
- a definition of the meaning of ‘NHS body’ for the purposes of sections 37 and 38 of the Act.

### Serious Medical Treatment (SMT)

5.2 Section 37(6) of the Act defines ‘serious medical treatment’ as ‘treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations’. Respondents to the consultation were clear that it would be impossible to provide a definitive list of such treatments and any list setting out particular treatments would be subject to change over time. The regulations therefore set out the characteristics of treatments where an IMCA should be involved and where providing, withholding or withdrawing treatment is to be considered serious. Factors include the risk or burdens versus perceived benefit of the treatment or where the choice between treatments is unclear; or where the treatment would have serious consequences for the person. Examples of medical treatments that might be considered serious will be included in the Code of Practice.

5.3 Decision makers will only consult with an IMCA where ‘serious medical treatment’ is proposed to be provided or arranged by NHS bodies where the person lacks capacity to make the decision and there is no one appropriate to consult. This should not therefore impose a significant additional burden on decision makers. Information provided by the IMCA may serve to clarify a decision. Furthermore, decision makers would consult family or friends, in cases where it was not appropriate for an IMCA to be instructed, when treating someone who lacked capacity and serious medical treatment was proposed.

### Appointment

5.4 The intention is to commission the IMCA service locally with funding devolved through local authorities. £6.5m per annum has been agreed to meet the running costs of the IMCA service. Commissioning arrangements will be made administratively with commissioning guidance developed centrally. We want to encourage local authorities within one area to work flexibly and in partnership to commission the IMCA service across boundaries. This could maximise use of the resources in some areas if, for example, local authorities were to make ‘lead commissioner’ arrangements.

5.5 The intention is that existing independent advocacy organisations will provide the service and many will already have administrative arrangements and standards of good practice in place. The additional burden imposed by these regulations will be minimal and encourage good practice and raise standards.

5.6 Regulation 5 on the appointment of independent advocates providing the IMCA service, set out the minimum standards that they have to meet. These include checking that a person is of good integrity and character by undertaking criminal records bureau type checks prior to appointment and taking up references. The cost of these checks will be met from running costs.

#### Independence

5.8 The regulations specify that the IMCA must be able to act independently of any person responsible for instructing him to act as an IMCA. This will form a part of the contracting process and will not represent an additional burden on local authority commissioners.

#### Training

5.7 The regulations provide that all IMCA advocates should have appropriate training and experience or a combination of training and experience. The intention is that all IMCAs receive appropriate training to help ensure a common standard of skills and knowledge. The cost of developing a national advocacy qualification will be met through Department of Health funding (see paragraph 7.4 below) together with induction training for those IMCAs appointed before the full training has been approved and accredited. This regulation does not impose any additional burdens.

#### Functions

5.10 The regulations sets out the detailed steps that the IMCA must follow when they have been instructed to represent a vulnerable person, to fulfil the functions set out in section 36(2) of the Act. Regulation 6 describes the duties of the IMCA but does not impose additional responsibilities beyond those set out in the Act.

#### Challenging decisions

5.11 IMCAs will use existing complaints mechanisms to resolve disputes locally as far as possible when these arise about a decision made by an NHS body or local authority, or about the process that has been followed in reaching a decision, in relation to a person who lacks capacity. Additional funding has been made available to meet the cost of complex cases including disputed cases as well as the situation where an IMCA takes a case to Court (see table of costs at paragraph 7.4 below).

## **6. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006**

#### Options for extending the IMCA service

6.7 The RIA for the IMCA consultation exercise set out the options for extending the IMCA service. These are set out at Annex A. The response to the consultation, including the Government response was published on 19 April 2006 and can be found on the DH website at:

[www.dh.gov.uk/consultations/closedconsultations](http://www.dh.gov.uk/consultations/closedconsultations)

#### Increasing time from 4 to 8 hours per decision

6.1 Following consultation, the Government decided to look again at the planning assumptions underlying provision of the service and to increase the time allowed for each decision from four to eight hours. This meets the concerns of many who responded that the service should aim to provide an effective service for those covered already without seeking to extend statutory provision to other groups and situations (option ii in the consultation – see Annex B). The cost of this measure will be met from existing funding. The table at paragraph 7.4 below sets out the implications.

#### Extending service

6.2 Section 41 of the Act provides that the IMCA role can be expanded, by regulations, to other sets of circumstances. This statutory instrument gives local authorities and NHS bodies the power to extend the IMCA role to specified groups and situations (option vi in the consultation – see Annex B). They specify the circumstances in which local authorities may provide the IMCA service on a discretionary basis. These include involving the IMCA in a care review following a change of accommodation and in adult protection cases.

6.3 The regulations allow that, when accommodation arrangements have been made for a person who lacks capacity to agree to the arrangements, and a review of the arrangements is proposed, then the NHS body or local authority may instruct an IMCA to be available to represent and support the person. Statutory guidance under Section 7 of the Local Authority Social Services Act 1970 sets out current requirements for care reviews. Involving an IMCA should not place a significant additional burden on local authorities since reviews will already be undertaken and an IMCA only instructed in certain cases.

6.4 The regulations specify that an IMCA may be made available to represent and support a person, where an NHS body or local authority proposes to take, or has taken, protective measures, including measures to minimise risk. The regulation applies in relation to the person who lacks capacity to agree to one or more of the measures. An IMCA will only be instructed in adult protection cases where proceedings following guidance issued under Section 7 of the Local Authority Social Services Act 1970 have already been instigated. The IMCA involvement will not increase the number of cases and may serve to clarify a situation and avoid lengthy proceedings.

6.5 In using these discretionary powers, the NHS body or local authority must be satisfied that it would be in the benefit of the person who lacks capacity to be represented by an IMCA and they must take into account any information or report made by the IMCA in making a decision.

6.6 The Government will evaluate the IMCA service after the first year of implementation to determine if it sufficiently addressed the advocacy needs of the unbefriended. At that time, it may be possible to consider using regulation-making powers to extend access to other groups or situations if resources allow.

## **7. Set up and running costs**

### Set up costs for IMCA service

7.1 Set up costs for the IMCA service have been estimated at £6.5m for 2006/2007. £2.2m will be made available to local authorities to tender for and commission the IMCA service to enable independent advocacy organisations to employ people to act as IMCAs from January 2007. A further £500k will be used to develop and rollout a data base for collection of information about the IMCA service. £500k has been allowed to fund 7 organisations to run the IMCA service on a pilot basis between January 2006 and December 2007. These costs do not represent any additional burdens on local authorities or NHS bodies.

Training for IMCAs

7.2 The regulations require that all IMCAs receive ‘appropriate’ training. Overall IMCA training costs have been estimated at £2.6m for 2006/7. This includes costs for developing the IMCA training qualification and for developing an additional induction training package for IMCAs recruited in advance of the full training being available. None of these costs represent additional burdens on NHS bodies or local authorities and will be met by the Department of Health.

Costs for awareness raising and developing training

7.3 A programme for raising awareness and educating and training an estimated three million health and social care staff in the Mental Capacity Act generally, at a cost of over £12m is being developed. These costs are included in the set up costs for the Mental Capacity Act 2005 itself. As many staff as possible will receive a cascaded presentation before April 2007.

Ongoing running costs

7.4 Running costs are estimated at £6.5m per annum from April 2007. The table below shows the breakdown of expenditure adopting options (ii) and (vi) with no increase in the allocated annual budget of £6.5m. The Department of Health is providing annual running costs of £6.5m devolved to local authority commissioners for the IMCA service which should result in no additional costs to the frontline.

<b>Original estimates - £6.5m</b>	
providing the IMCA to around 16,000 people who have no family or friends, at 4 hours per decision: 16,000 x £100	<b>£2.6m per annum</b>
dealing with 2,270 (14%) more complex cases (at an additional 4hours per decision) 2,270 x £100	<b>£227k per annum</b>
Any disputes arising on these cases, including taking the cases to Court	<b>£273k per annum</b>
extending the service to other groups and situations	<b>Up to £3.4m</b>

<b>Revised estimates - £6.5m - options (ii) and (vi)</b>	
providing the IMCA to around 16,000 people who have no family or friends, at 8 hours per decision: 16,000 x £200 (option ii)	<b>£3.2m per annum</b>
dealing with 4,000 (25%) more complex cases and any disputes arising on these cases, at an additional 8 hours	<b>£800k per annum</b>

per case: 4,000 x £200	
Giving local authorities discretion as to when to involve an IMCA* (option vi). Up to 12,500 extra cases at 8 hours per case: 12,500 x £200	<b>£2.5m per annum</b>
* This may include bringing in an IMCA in care Reviews or adult protection case where appropriate.	

## **8. Social impact (including Health Impact)**

8.1 The regulations allow NHS bodies or local authorities discretion to involve an IMCA in care reviews and in adult protection cases. Involving an IMCA in care reviews will help to provide people with the most appropriate living conditions with the best use of resources for treatment and care. This has the potential to increase choice and well-being of vulnerable adults.

8.2 Involving an IMCA in adult protection cases, may help prevent and minimise the risk of abuse for particularly vulnerable adults.

8.3 The number of additional decisions where an IMCA may be involved as a result of the regulations could increase by up to 12,500. This would not mean an increase in running costs which remain at £6.5m per annum.

## **9. Equity and fairness**

9.1 The Mental Capacity Act 2005 already provides for IMCAs for people who lack capacity who have no family or friends. The regulations on Expansion of Role extend the service to more people who lack capacity. People with learning disabilities, older people, people with mental health problems and those with brain injuries and degenerative conditions are all likely to benefit.

## **10. Rural proofing**

10.1 There is no reason to believe that the distribution of people affected will differ in any significant way between urban and rural areas, and also no reason to suppose that the regulations will impact on rural areas any differently from the way they affect other areas.

## **11. Environmental impacts**

11.1 There is no environment impact arising as a result of these regulations.

## **12. Consultation with small business: the Small Firms' Impact Test**

12.1 The regulations may impact on small businesses. The “small businesses” most likely to be affected are independent hospitals, care homes and independent advocacy organisations. The impact upon them is uncertain at this stage but we

anticipate that the impact of the introduction of the IMCA service generally may be to drive up standards although it may also result in some additional bureaucracy for independent advocacy organisations as they appoint and train IMCAs and receive referrals from NHS bodies and local authorities. Any additional costs should be included in the commissioning tender.

### **13. Competition Assessment**

13.1 The introduction of the IMCA service and the measures introduced through these regulations are not expected to have a significant effect on competition as most of the resource implications are anticipated to impact on NHS bodies and local authorities. It is possible though that the proposals could have different effects on different independent hospitals and care homes, and thus affect their charges differently. They may also affect competition among independent advocacy organisations.

### **14. Enforcement and Sanctions**

How will the proposal be enforced? Who will enforce this legislation?

14.1 The IMCA service already has a legislative base in the Mental Capacity Act 2005. The extension of the service through these regulations introduces a legal requirement to adhere to those arrangements. People who lack capacity, or others acting on their behalf, will have recourse to the courts, including the European Court of Human Rights.

Will the legislation impose criminal sanctions for non-compliance?

14.2 The legislation will not impose criminal sanctions for non-compliance.

### **15. Monitoring and Review**

15.1 The Government believes that compliance with standards should primarily be part of contract monitoring, validated by performance assessment and service inspection evidence gathered by commissioners and by CSCI or HC. All contracts or engagement protocols between the commissioner and IMCA service provider will include agreed complaints procedures. All IMCA advocacy services will have a clear and accessible complaints procedure and be required to report complaints about them to their commissioning body.

15.2 The Department will produce an annual report on the IMCA service for the first three years following implementation. The Department with the DCA will also review any regulations made after three years.

## **16. Summary and Recommendations**

Summary

16.1 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 are made under sections 35-40 of the Act. In summary they cover the appointment of IMCAs, training, independent, functions the challenging role of IMCAs and a definition of NHS body. Annual funding of £6.5m is being provided to fund the service with additional set up and training costs during 2006/7.

16.2 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 are made under section 41 of the Act. They give local authorities flexibility to extend the IMCA service within the resources available to other vulnerable groups and situations.

16.3 In summary, there are no significant additional costs or burdens imposed on local authorities, NHS bodies, small businesses or the charity and voluntary sector as a result of these regulations. Any additional burdens, such as appointing and training IMCAs that result will be balanced by annual funding provided.

#### Recommendation

16.4 The recommendation is that both sets of Regulations are accepted as set out in this RIA.

### **17. Declaration**

To be completed when Regulations are laid.

**I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs**

*Signed Rosie Winterton*

**Date 7<sup>th</sup> July 2006**

**Rosie WINTERTON, Minister of State for Health Services, Department of Health**

#### **Contact point**

Pam Nixon at the Department of Health Tel: 020 7972 4332 or e-mail:  
Pam.Nixon@dh.gsi.gov.uk

## Summary of consultation on Independent Mental Capacity Advocate (IMCA) Service

### General Regulations

#### Serious Medical Treatment (SMT)

Nearly all respondents thought that it would be impossible to have a definitive list of treatments that covered all serious medical treatment decisions relevant for the IMCA service and that the best approach was to define the characteristics of the decision that made it serious. The regulations therefore set out the characteristics of treatments where an IMCA should be involved, including the risk or burdens versus perceived benefit and choices between treatments. Examples of medical treatments that might be considered serious are to be included in the Code of Practice.

#### Commissioning

The majority of respondents to the consultation were in favour of IMCAs being appointed locally. The intention is to commission the IMCA service locally with funding devolved through local authorities. Local authorities will commission independent advocacy organisations in partnership with PCTs to provide the IMCA service for NHS bodies and local authorities in their locality, although the IMCAs will have the flexibility to work across boundaries if required. The regulations do not specify the local authority commissioning role but separate guidance on commissioning is being developed.

#### Independence of IMCAs

Most respondents thought that maintaining the independence of the IMCA from service providers was vital to the success of the service, and that this should be achieved through commissioning contracting arrangements with independent advocacy organisations. The Government agreed that it was important that;

- (a) they must be completely independent of any person responsible for instructing the IMCA; and
- (b) IMCA must not have any professional or paid involvement with the provision of care or treatment for any vulnerable person for whom they may be appointed to act;

The original intention was to put this in the code of practice but to make this even more clear, regulation 4(2) sets out the independence criteria (a) while (b) will be included in the Code of Practice.

#### Training for IMCAs

Most respondents agreed that IMCAs should have specific training and that this should be provided by local colleges or universities. The regulations provide that all IMCA advocates should receive appropriate training to help ensure a common standard of skills and knowledge. It is planned to develop a national advocacy qualification, which may be accredited by Qualifications and Curriculum Authority (QCA) and provided by an awarding body such as the Open College Network (OCN). However, this qualification will not be available before April 2007. The intention is therefore to provide all those appointed to act as IMCAs with induction training.

Regulation 4 therefore refers to appropriate training and experience rather than referring to a specific qualification.

### Standards

Nearly all respondents (97%) thought that there should be national standards for both individual advocates and for the independent advocacy organisations commissioned to provide the service. The Government response stated that regulations on the appointment of independent advocates providing the IMCA service should set out the minimum standards that they should have to meet. This should include requiring individual advocates to undergo Criminal Records Bureau checks prior to employment. Where relevant disclosures under those checks are made, the advocate should not be able to work as an IMCA. Independent advocacy organisations who will be commissioned to provide the IMCA service should also have to meet appropriate organisational standards as part of the commissioning/contract arrangements. This is covered under regulations 4.

### Functions of IMCAs

Respondents were content with the functions listed in s36(2). Regulation 6 sets out the detailed steps that the IMCA must follow to fulfil these functions, to the extent that it is practicable and appropriate to do so, when they have been instructed to represent a vulnerable person. IMCAs will be required to submit a report of their findings.

### Challenging decisions

Respondents to the consultation saw challenging as a key element of the IMCA's role. There will be situations where disputes arise about the decision made by an NHS body or local authority or about the process that has been followed in relation to a person who lacks capacity. In such cases, the IMCA will use existing complaints mechanisms to resolve cases locally as far as possible. Respondents were divided on the question of whether IMCAs should be able to bring simple cases to Court as a last resort where there is no other way of resolving a dispute. Some thought IMCAs should have this function if they had training to do so while others felt this was outside the IMCA role or could only be done with legal support.

Regulation 7 set out the circumstances in which the IMCA can challenge or assist in challenging the decision maker and specify that an IMCA will be able to apply direct to the Court of Protection for a decision. Regulation 7 provides that an IMCA will be in the same position as an 'ordinary friend' or relative of the person who lacks capacity and will therefore need to seek permission of the Court of Protection to make an application. Challenges can include the decision that the person lacks capacity.

## **Expansion of Role Regulations**

### Extending the IMCA service

The consultation exercise asked for views on six options for extending the service to other vulnerable people who lack capacity who may benefit from an IMCA or other circumstances where the IMCA should be appointed. The six options were: (i) no

extension; (ii) a more intensive service to the most vulnerable; (iii) provide an IMCA in cases of dispute; (iv) provide an IMCA where requested by one of the parties; (v) extra care housing; (vi) allowing LAs and/or NHS bodies to determine priorities.

### Options

Responses were varied with no clear preference for one option. The Government's main priority, set out in the consultation response, is to introduce safeguards to protect the rights of individuals who do not have family or friends to advocate on their behalf. The Government is also mindful of concerns about introducing a good quality service for this group before looking to extend it further. There were concerns expressed in the consultation responses about the average time allowed for IMCAs as set out in the planning assumptions. These have therefore been revised along the lines of option (ii) to provide a more intensive service for those who have no family or friends.

In addition, responses to the consultation were concerned that there may be other situations, beyond those listed in the Act, where a person who lacks capacity may be particularly vulnerable. The regulations therefore allow LA commissioners flexibility to extend the IMCA service within the resources available to other vulnerable groups and situations. The regulations specify those other circumstances in which LAs and NHS bodies may provide the IMCA service on a discretionary basis along the lines of option (vi). These include involving the IMCA in a care review following a change of accommodation and in adult protection cases. Policy on care reviews is already good practice under statutory guidance issued under Section 7 of the Local Authority Social Services Act 1970.

### Option (i)

No additional costs beyond the estimated £3.1m for providing an IMCA for the 16,000 decisions involving people who are unbefriended. Additional costs for NHS and social care professionals were included in the Regulatory Impact Assessment for the Mental Capacity Act 2005. Additional costs were estimated at £8.2m for health care and £3.8m for social care per annum.

### Option (ii)

This option would provide a more intensive service for the most vulnerable group – those who have no family or friends. The Government has now decided to revise estimates to give IMCAs 8 hours per decision and per review, this will cost an estimated £3.2m. Costs for health and social care staff would be as per option (i).

### Option (iii)\*

Under this option, the IMCA would be available where there is a dispute between the individual, family and health or social services about the serious medical treatment or long term care to be provided.

Disputes between the decision maker and the person who lacks capacity or their family are already provided for by existing complaints mechanisms in both health and social care.

Costs would depend on starting assumptions about the likely number of complaints or disputes. If disputes formed 13% of cases and 1% of these went to court, the estimated costs would be an additional £2.5m on top of option (i). Costs to health and social care staff would be as per option (i).

Option (iv)\*

Providing an IMCA where requested. Additional public sector costs for England would range from an estimated additional £2.7m (assuming a take-up rate of 33%) to £6.8m (assuming a 75% take-up rate). Costs to health and social care staff would be as per option (i).

Option (v)\* - Extra care housing.

This option would seek to extend the IMCA safeguard to people who lack capacity who are supported in extra care housing. For example, when someone is threatened with eviction. Estimated additional costs would range from around £160,000 if this affected 10% of people who lacked capacity in extra care housing, to £530,000 if it affected 33% of the people who lack capacity.

\*These costs are based on allowing 4 hours per decision.

Option vi) -Allowing Local Authorities and/or NHS bodies to determine priorities

This option, covered by the regulations, will enable LAs, who commission the IMCA service in consultation with NHS bodies, to determine who are the most vulnerable people within their localities, within specified options, and to commission services accordingly.

## Annex B

### **Basis for costs**

#### Frequency of cases

The Department of Health has estimated that, at any point in time, 1.2 million people in England and Wales are likely to lack capacity to make decisions. Of these, around 155,000 have severe and profound learning disability, and around 350,000 have severe dementia.

Only a small proportion of these people are likely to face particularly significant decisions every year. We have estimated that there might be 39,000 decisions every year about serious medical treatment and 69,000 decisions about moves into or between long-term care.

Of these people facing particularly serious decisions we estimate that around 15% do not have friends or family to be consulted in the decision-making process. The figure was estimated using a number of different research reports about the different client groups who may lack capacity.

Therefore the planning assumptions have included estimates of about 16,000 decisions each year in England that would require the involvement of an IMCA. The 16,000 decisions covers around 6,000 decisions about serious medical treatment and 10,000 decisions about care moves. These estimates will be reviewed following the evaluation of the IMCA pilots.

#### Basis for costs

The estimated total cost of one advocate is £25 per hour. This figure includes all costs such as management salaries, training, and accommodation. This would allow for an advocate salary of around £25,000 and a manager's salary of around £30,000. These are consistent with the average salaries used by the IMCA pilot organisations. The intention is that IMCAs will be commissioned from existing advocacy providers rather than from new organisations set up for the purpose of providing the IMCA service.

Following the consultation, planning assumptions have now been changed so that each advocate session will now last approximately 8 hours, the average cost per session now estimated at £200 with an advocate completing an average of 4 sessions a week. The cost per session was estimated at £172 per advocate and £26 per manager – or £200 per session. Additional costs for complex cases or where cases were disputed were estimated at £200 per case.

Additional costs for NHS and social care professionals were included in the Regulatory Impact Assessment for the Mental Capacity Act 2005. The workforce and costing model to assess cost impacts for the Act identified decisions involving people who lack capacity about significant medical decisions and about where they lived as the key areas where additional costs might accrue. Such decisions would usually

involve activities or processes in which health and social care staff would be involved e.g. assessment, case conference and patient discussion.

By estimating the likely frequency of such activities or processes for each decision point before and after the Act it was then possible to estimate the annual staff cost in each case for health and social care professionals, such as doctors, nurses, social workers, care assistants. It was then possible to estimate the annual cost for each case. Allowance was made both for where processes might be quicker and for where there might not be best practice at the moment.

For the expected effects on cost of the IMCA see the Regulatory Impact Assessment for the Mental Capacity Act 2005 - available at:

<http://www.dca.gov.uk/menincap/legis.htm>

For the workforce requirements for the IMCA, including effects on health and social care professionals see the explanatory notes to the Mental Capacity Act - available at:

[www.opsi.gov.uk/acts/en2005/2005en09.htm](http://www.opsi.gov.uk/acts/en2005/2005en09.htm)