Our Ref: NG/RM/25269
Date: 3rd September 2025

Nicola Griffiths
Deputy Director of Governance
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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 31st July 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:
Compassion in Dying is a national charity. To ensure that we provide the right information to the people we support and to inform our policy work I am writing to kindly request the below information under the Freedom of Information Act 2000.

For context, we support people to make informed decisions, start honest conversations about death and dying with loved ones, and record and revisit their wishes whenever they want to. We also support healthcare professionals to discuss, record and implement advance care plans with a particular focus on Advance Decisions to Refuse Treatment, Advance Statements and Lasting Powers of Attorney for Health and Welfare.

We receive over 4,000 contacts to our free nurse-led information line each year and are committed not just to supporting individuals to consider and record their treatment wishes, but to ensuring those wishes are known and respected when it matters most. The people we support consistently experience two particular challenges in hospital settings:

1) Advance Decisions to Refuse Treatment not being followed.
2) Health and Welfare Attorneys being excluded from the decision-making process when someone lacks capacity.

These experiences, which we hear through our nurse-led information service, are also reflected in a recent Court of Protection case (AB, Re (ADRT: Validity and Applicability) [2025] EWCOP 20 (T3) (10 June 2025) which examined how Advance Decisions to Refuse Treatment should be acted upon by NHS Trusts.

Link to judgment: https://caselaw.nationalarchives.gov.uk/ewcop/t3/2025/20

1. Do you have a policy (or policies) which outlines the responsibilities of health and care professionals and the Trust towards a patient who has an Advance Decision to Refuse Treatment (ADRT) or Lasting Power of Attorney (LPA) for Health and Welfare?
   This document might include:

- How an ADRT/LPA should be used in decisions about a person's treatment,
- What to do if there are doubts about the validity and/or applicability of the document,
- How to involve Health and Welfare Attorneys when making treatment decisions
- How or when decisions will be referred to the Court of Protection

If yes, please share a copy with us in any available format.

Please see Appendices 1 and 2 attached. Both policies are currently under review/ update.

2. In the event that a patient or family member, or someone using the Trust's services has a concern about the implementation of an Advance Decision to Refuse Treatment (ADRT) or a Lasting Power of Attorney (LPA) for Health and Welfare, does the Trust have a documented process or course of action that would be provided to the person to allow them to resolve their concerns?
   If yes, please share a copy with us.
   If this information is covered within a policy you have included in the response above, please leave blank.

3. Do you have a named individual who is responsible for overseeing the Trust's compliance with the Mental Capacity Act 2005?
   If yes, please share their contact details.
   The Trust's Chief Medical Officer, Dr Dennis Okolo

   Staff email addresses are exempt as they constitute personal data and would contravene the principles of the Data Protection Act 2018 (in accordance with qualified exemption S40 (2)(a) of the FOI Act).

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

Document level: Policy
Code: MHA 16
Issue number: _____

Mental Capacity Act Policy

Lead executive	Dr O Adeyemo
Authors details	Mental Health Law Team Manager

Type of document	Policy
Target audience	Everyone working with and caring for a person, who may lack capacity to make decisions for themselves, needs to be aware of and behave in accordance with the Act and follow its Code of Practice
Document purpose	Guidance for all staff members who may be required to assess capacity and make best interests decisions on behalf of a person who lacks capacity. The policy: • Focuses on the processes and recording of assessment / decision making under the Mental Capacity Act. • Provides guidance on when to use the Mental Capacity Act and when it may be appropriate to consider the Mental Health Act or Deprivation of Liberty Safeguards. • Outlines the different authorities for making decisions on behalf of a person who lacks capacity – advance decisions, lasting power of attorneys and court appointed deputies. • Provides guidance around referrals for Independent Mental Capacity Advocates (IMCA) and the Court of Protection.

Approving meeting	Quality Committee / Trust Board	Meeting date	9 August 2018 26th September 2018
Implementation date	30 September 2018	Review date	31st October 2024

Trust documents to be read in conjunction with	

Document change history		Version	Date
What is different?			
Appendices / electronic forms			
What is the impact of change?			

Training requirements	E-learning.

Document consultation

Directorates	
Corporate services	Trust Mental Health Law Governance Group, membership has representatives from each Directorate.
External agencies	

Financial resource implications	None.

External references
Mental Capacity Act Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice **Law Society (2015) Deprivation of Liberty a practical guide -** http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Monitoring compliance with the processes outlined within this document	The Mental Health Law Governance Group will, on behalf of the hospital managers, monitor compliance with this procedure and will routinely commission an MCA audit of compliance.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people)	Yes	Less favourable
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people		

with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Mental Capacity Act 2005 only applies to over 16's.		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	~~Yes~~ / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	~~Yes /~~ No	
What is the level of impact?	Low / ~~medium / high~~	

Contents

1. Introduction

1.1 The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals, aged 16 or over who lack the mental capacity to make particular decisions for themselves. Everyone working with and caring for a person, who may lack capacity to make decisions for themselves, needs to be aware of and behave in accordance with the Act and follow its Code of Practice.

1.2 The Mental Capacity Act (MCA) covers a wide range of decisions made and actions taken, on behalf of people who may lack capacity to make decisions for themselves. These can be decisions about day to day matters – like what to wear or life changing events such as whether the person should move into a care home or undergo a major surgical operation. The Mental Capacity Act also covers some decisions about care and treatment for mental disorder that are not within the scope of the Mental Health Act.

1.3 This policy provides guidance for all staff members who may be required to assess capacity and make best interests decisions on behalf of a person who lacks capacity.

The policy focuses on the processes and recording of assessment / decision making under the Mental Capacity Act.

The policy provides guidance on when to use the Mental Capacity Act and when it may be appropriate to consider the Mental Health Act or Deprivation of Liberty Safeguards.

The policy also outlines the different authorities for making decisions on behalf of a person who lacks capacity – advance decisions, lasting power of attorneys and court appointed deputies.

The policy also provides guidance around referrals for Independent Mental Capacity Advocates (IMCA) and the Court of Protection.

The policy should also be used by staff members as a resource to offer advice and guidance to relatives and carers who may be making informal decisions on behalf of someone who lacks capacity.

2. Principles

The MCA is underpinned by a set of five key principles

2.1 **Presumption of capacity** – A person must be assumed to have capacity unless it has been established that they lack capacity.

2.2 **Supporting decisions –** A person is not to be treated as unable to make a decision unless all practicable steps to help them make decisions have been taken without success.

2.3 **Unwise decisions** – A person is not to be treated as unable to make a decision merely because they make an unwise decision.

2.4 **Best interests** – an act done or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity, must be done or made in their best interests.

2.5 **Least restriction** – 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.

3. Assessing Capacity

3.1 The assessment of capacity is of fundamental importance to everyone affected by the provisions of the Act. It is important that anyone called upon to assess another person's capacity must understand what they are being asked to do and to be prepared to justify their findings. The starting point should be the presumption of capacity. The individual / member of staff responsible for assessing a person's capacity (**the assessor**) will usually be the individual who is proposing to make a decision / take some form of action in connection with that persons care or treatment.

3.2 Any assessment of a person's capacity must be 'decision-specific', this means that:

- The assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions.
- If someone cannot make complex decisions this does not mean that they cannot make simple decisions.
- A decision about capacity cannot be based upon their age, appearance, condition or behaviour alone.

3.3 Before deciding that someone lacks capacity, it is important to take all practical steps to enable them to make the decision themselves.

Providing relevant information – Does the person have all the relevant information, if they have a choice to they have information on all the alternatives.

Communicating in an appropriate way – When supporting a person to communicate their decision it may help to consult with carer's, family and friends about how the person best communicates. Interpreters may be required, or pictorial aids may assist. Could the information be explained or presented in a way that is easier to understand (e.g. sign language, visual aids, non-verbal communication, interpreter)? Could anyone else assist with communication (e.g. family member, speech therapist, and advocate)?

Making the person feel at ease – Choosing particular times when the persons understanding is better, locations where the person is more comfortable, could the decision be delayed until a time where the person can make their own decision. It is unlikely that an individual will feel comfortable expressing themselves within a multidisciplinary meeting and efforts should be made to use comfortable and familiar surroundings or involve someone that the person feels comfortable with.

Supporting the person – can anyone else support the person to make choices or express a view e.g. family member, advocate or member of staff the person feels comfortable with.

3.4 Refusal of capacity assessment

There may be circumstances in which a person whose capacity is in doubt refuses to undergo the assessment or refuses to be examined by a doctor. It is usually possible to persuade someone to agree to an assessment if the consequences of refusal are explained carefully and fully. In the face of an outright refusal, in most circumstances, no one can be forced to undergo an assessment of capacity unless required to do so by a court in legal proceedings.

4. The Capacity Test

The Mental Capacity Act sets out a clear two stage test of capacity:

4.1 The Diagnostic Test – A person is unable to make a decision in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

This is a very broad definition that includes long term psychiatric conditions such as dementia, schizophrenia, learning disability or brain injury, but may also include temporary conditions such as intoxication with alcohol or drugs, concussion, unconsciousness or the effects of extreme pain or medication.

A formal diagnosis is not required; however the assessor would need to clearly justify their opinion. However, if there is no reasonable evidence for an impairment or disturbance the person cannot be considered to lack capacity.

4.2 The Functional Test - The person will be unable to make the particular decision if after all appropriate help and support, they cannot do one or more of the following:

- understand the information relevant to the decision;
- retain that information;
- use or weigh that information as part of the process of making the decision;
- Communicate their decision (whether by talking, using sign language or any other means).

4.3 Additional guidance

Understand - The information relevant to a decision includes information about the reasonably foreseeable consequences of: (a) deciding one way or another; or (b) failing to make the decision. It may often help the person to understand if information is provided in small chunks or through visual aids prompts or through use of interpreters if appropriate

Retain - The fact that a person is able to retain information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision. It may help to write things down or use picture, ask the person to explain it in their own words, repeat the information in a follow up visit.

Use or Weigh up - When supporting a person to weigh up information, it may help to get the person to identify the positive and negative aspects of making a particular decision, if they are unable to identify the potential issues themselves, present the information to them, then explore the reasons behind their choice.

Communicate - This element of the test has a very low threshold, for example a person who can only communicate by means of nodding, blinking etc. would pass this element of the test.

4.4 There must be a causal relationship between the diagnostic and functional elements of the test e.g. Mr A was unable to retain information relating to treatment because of the effects of his dementia.

4.5 The threshold for decisions is on the balance of probabilities. In borderline cases, or where there is an element of doubt, the person doing the assessment should seek a second opinion from a colleague.

5 Best Interests Decisions

5.1 The process of deciding what is the best interest of a person who lacks capacity to make specific decisions for themselves, is a fundamental part of the Mental Capacity Act and should be given as much consideration as an assessment of capacity. The person / member of staff responsible for making a best interest decision is called the 'decision maker'.

5.2 The Best Interests Checklist

There are some common factors when working out what is in persons' best interests.

- Best Interests Decisions cannot be based on a person's age, appearance, condition or behaviour.
- Every effort should be made to encourage and enable the person to take part in making the decision.
- If there is a possibility that the person may regain the capacity to make the decision for them, can the decision be delayed until that time.
- The persons past and present wishes and feelings, beliefs and values should be taken into account.
- The views of others who are close to the person should be considered as well as the views of an attorney or deputy.
- All of the relevant circumstances should be considered, including those most relevant to the person and the particular decision.
- In cases where decisions are required involving life sustaining treatment, the Best Interests Decision cannot be motivated by the desire to bring about a persons' death.

5.3 When making best interests decisions staff should also consider the medical, emotional, psychological and social consequences of making / not making a decision on the person. Where the decision is complex staff should consider adopting a balance sheet approach listing the benefits and burdens of the options available.

5.4 A person's past and present wishes are of **primary importance** when making a best interests decision.

5.5 Consultation

The Mental Capacity Act places a duty on the decision maker to consult other people close to a person who lacks capacity, where practical and appropriate, what they think is in the person's best interests and information relating to the persons wishes, feelings values and beliefs. These include:

- Anyone the person has named as someone they want to be consulted.
- Anyone involved in caring for the person.
- Anyone interested in the persons welfare (family carers, foster carers, other close relatives or an advocate already working with the person).
- An attorney appointed under an Lasting Power of Attorney (LPA).
- A deputy appointed by the court of protection.
- If there is no one to consult an IMCA should be appointed (See below section 21).

Individuals who are consulted may also have conflicting views or may been previously considered not to be acting in the persons best interest, this is no reasons not to consult them.

However there may be occasions where the process of consultation with a particular individual could cause the person distress or put them at risk of harm. In this situation reasons for not consulting an individual should be clearly recorded by the decision maker.

5.6 Additional Guidance

The Decision Maker should consider the persons past and present wishes and feelings, including any relevant written statements, how beliefs and values would influence the person's decision if they had capacity and any other factors the person would consider if they were able to do so.

Current wishes and feelings may be expressed through non-verbal communication and behaviour.

The decision maker should make every effort to maximise the persons participation in making the decision following the steps outlined in 3.3 – providing clear information about the decision, communicating appropriately, making the person feel at ease and offering support.
Less restrictive alternatives of care and treatment should always be considered as part of the Best Interests Decisions.

If restriction or restraint will be a factor in care and treatment of the person, then the decision maker needs to justify why it is in the persons best interests, that is necessary and a proportionate and response to any risk of harm to the person.

5.7 Although the views of the person who lacks capacity and their close carers and family members are important, the final Best Interests Decision rests with the decision maker. The decision should be made on the balance of probabilities

5.8 Best Interests decisions should always focus on the person the decision is about and not on the interests of individuals who care for the person or the organisation's that are providing care and treatment. Some best interests' decisions may have resource implications for the organisation involved in providing care and treatment, in these situations decision makers should include their own manager or the manager of the service provider in the process.

6. Who assesses capacity and makes best interest decisions

6.1 The identity of the person responsible for undertaking the capacity assessment and making the best interest decision will often be based on the nature and complexity of the decision, their knowledge of the proposed care and treatment and their knowledge of and relationship with the person.

6.2 **Assessors / Decision Makers can include:**
Carers, family members, volunteers, Health Care Support Workers, STR Workers and unqualified clinical staff who may all be involved in assessing capacity and making day to day decisions when offering choices such as food, shopping, attending appointments etc.

Doctors – There are some situations where doctors will assess mental capacity as part of a lawful procedure. They may also be involved to diagnose an individual to support a capacity assessment. They should also act as assessors / decision makers in relation to treatment decisions e.g. prescription of medication, surgery.

Named Nurses / Care Co-ordinators – may be required to act as the assessor /decision maker for a person who lacks capacity as part of developing their care plan and co-ordinate specialist assessments if required.

Psychologists may provide specialist mental capacity assessments.

Social Workers and specified Nurses may act as assessors / decision makers for accommodation placements and moves.

Occupational Therapists may also assess capacity and make best interests decisions when considering activities of daily living.

6.3 Assessments and best interest decisions should be undertaken by the same individual. Formal assessment of capacity and best interests' decisions should only be undertaken by qualified members of staff.

6.4 Sometimes assessments of capacity and best interests' decisions will involve more than one professional or the multidisciplinary team. However **the final decision as to whether someone has or lacks capacity or if care and treatment is in their best interests must be taken by the assessor / decision maker**.

6.5 Where Trust staff are involved with carer's / family members making decisions on behalf of a person who may lack capacity, they should provide support and

guidance around the process of capacity assessment and making best interests decisions.

6.6 Where unqualified workers are involved in making day to day decisions on a regular basis, qualified workers should provide support and guidance.

7. Types of decisions and recording

7.1 Deciding on what decision / action is required should be the starting point of any capacity assessment / best interest decision. However the processes involved may be different depending on the complexity of the assessment / decision required.

7.2 Informal Assessments / Decisions
Informal assessments and decisions around day to day activities must safeguard the rights and interests of the incapacitated person, Although informal assessments and decisions do not need to be formally recorded, staff members should be able to justify the reason why the person lacks capacity and why the decision / care is in the persons best interests.

7.3 Named Nurses / Care Co-ordinators should also consider a person's capacity and best interests in relation to day to day care as part of the care planning process recording likes / dislikes / wishes; carer other professionals views are already part of good care planning practice. If unqualified staff has to make informal assessments / decisions about a person's care on a regular basis e.g. dressing / choice of food this also needs to be included in the care plan.

7.4 Formal Assessment / Decisions
Formal capacity assessments and best interest decisions **should only be undertaken by qualified staff members**.

7.5 Formal assessments / decisions may be required where:

- The decision has long term implications for the person.
- Where there are concerns about risk of harm to the person.
- The decision is around accommodation in a care home or a hospital admission over 28 days.
- Where the person is expressing different views to different people, such as saying one thing to their family and another to care staff, or where the person's capacity to make a particular decision may be subject to challenge, either at the time the decision is made or in the future.
- A decision is required around significant mental health care or treatments (including decisions that fall within the definition of **serious medical treatment**) that are not within the scope of the Mental Capacity Act. This could include: - Admission to hospital, the prescription of medication.

7.6 Formal Capacity Assessments and Best Interest Decisions should be clearly recorded on the person's electronic patient record, using NSCHT Consent Form or NSCHT Consent Form Under 16's.

7.7 **Serious Medical Treatment** is defined as treatment which involves giving new treatment, stopping current treatment, or withholding treatment that could be offered in circumstances where:

- if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved;
- a decision between a choice of treatments is finely balanced;
- what is proposed is likely to have serious consequences for the patient;

Serious consequences are those which could have a serious impact on the patient, either from the effects of the treatment itself or its wider implications. This may include treatments which cause serious and prolonged pain, distress or side effects

7.8 IMCA's must be consulted about decisions involving serious medical treatment (see below section 21).

7.9 Other Formal Assessment required by law. In some cases it is a requirement of the law that a formal assessment of capacity be carried out. This includes the following situations:

- Where a doctor or other expert witness certifies that in their professional opinion a person who has signed a legal document (such as a Will) has capacity to do so but whose capacity could be challenged.
- To establish that a particular person who is or likely to be involved in litigation requires the assistance of the Official Solicitor or other litigation friend.
- Where the Court of Protection is required to make a decision as to whether a person has or lacks capacity in relation to a particular matter.
- Where the court is required to make a decision as to a person's capacity.
- Where there may be legal consequences of finding of capacity, for example in a settlement of damages following a claim for personal injury.
- Where legal proceedings are contemplated (for example divorce proceedings) and there is doubt about the person's capacity to instruct a solicitor or take part in the proceedings.

In these situations formal reports or certificates of capacity may be required.

7.10 **Emergency Assessments / Decisions**

In emergency situations that are life threatening or where there is significant risk of harm to the person, members of staff are unlikely to be able to formally assess capacity or consult carer's / relatives about what may be in the person best interests. In emergency situation it will almost always be in a person's best interests to give care / treatment without delay, unless it conflicts with a valid advance decision. Staff members should record the reason why the person lacked capacity and why the emergency decision / care was in the persons best interests as soon as possible after any emergency intervention.

7.11 **Complex Assessments / Decisions**

Complex capacity assessments may involve a situation where the person or carer challenges a capacity assessment, there is a disagreement between professionals or the assessment of capacity / incapacity is borderline. Assessors should have discussion with the person / carer / professionals to resolve any

disagreements. Borderline capacity / incapacity assessment may be resolved by asking a colleague to undertake a further assessment

Complex Best Interests Decisions - Where the decision is more complex or involving significant risk (e.g. Adult Protection or Serious Medical Treatment cases) and / or where there may be a lack of consensus or a dispute about what is in the person best interests, a formal Best Interests Decision Meeting should be arranged (see below section 8).

8. Best Interests Meetings

8.1 The decision maker may decide to hold a Best Interests meeting where, for example:

- Complex and far reaching decisions on social care or health treatment are to be made.
- There is a degree of uncertainty about what would be in the person's best interests.
- There is a significant degree of risk to the person concerned.
- There is a dispute about what is in the persons Best Interests.

8.2 Purpose of Best Interest Decision Meetings

- To enable all parties who have been or are to be consulted, to hear the views of others, rather than give their opinions in isolation.
- To help resolve any areas of uncertainty, conflict or disagreement.
- The decision maker should encourage the person lacking capacity to attend and participate in the meeting where this is practicable.

8.3 The decision maker might decide to hold a meeting either before or after consulting people individually. The decision maker is responsible for arranging the meeting. Meetings should be recorded fully, if the meeting is formal or is needed because of a dispute, minutes should be taken.

Where possible and appropriate the person the decision is about and / or an advocate should be involved in the meeting.

See suggested Best Interest Meeting Agenda – Appendix 2

9. Disputes

9.1 Disputes may occur about issues covered in the Mental Capacity Act such as:

- a person's capacity to make a decision;
- their best interests;
- a decision someone is making on their behalf; or
- An action someone is taking on their behalf.

9.2 It is in everybody's interests to settle disagreements and disputes quickly and effectively, with minimal stress and cost.

9.3 If someone wants to challenge an assessor / decision-maker's conclusions, consider:

- Involving an advocate to act on behalf of the person who lacks capacity to make the decision;
- Getting a second opinion;
- Holding a formal or informal best interests meeting;
- Attempting some form of mediation;
- Pursue a complaint through the Trust's formal procedures (see Trust Complaints procedure).

9.4 If all other attempts to resolve the dispute fail the matter may need to be referred to the Court of Protection. In this case the issue should initially be directed to the Mental Health Law Team at Harplands Hospital.

10. Advance Decisions

10.1 When considering making a decision on behalf of someone who lacks capacity, the decision maker should identify if the person has made an advance decision. An Advance Decision enables someone aged 18 and over, whilst still capable, to **refuse** specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

10.2 An advance decision to refuse treatment must be valid and applicable to current circumstances. If so, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision.

10.3 Health and social care professionals will be protected from liability if they:

- Stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable;
- Treat a person because, having taken all practicable and appropriate steps to find out is the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.

10.4 Where people are detained under a Section of the Mental Health Act 1983 (MHA) that authorises treatment e.g. Section 2, 3, 37 Hospital Order, they can be given treatment despite having an advance decision to refuse it. In such situations Responsible Clinicians should clearly justify why they are overriding an advance decision

10.5 **Life Sustaining Treatment** - Advance decisions to refuse life sustaining treatment must be in writing it must be signed by the person making the advance decision or by some other individual in their presence by their direction. A witness must also sign it or acknowledge the persons signature. It can be in any format and might be in the person's medical notes. People cannot make advance decisions to ask for their life to be ended.

10.6 For full guidance on advance decisions see the Trust Procedure on Advance Decisions and Advance Statements to Refuse Treatment. (Clinical 1.55).

10.7 Statements of wishes, feelings and beliefs

Statements of wishes feelings and beliefs are a more informal mechanism which can be used by a person to let family, friends, and professionals who will be involved in their care of their wishes should they lose capacity to make their own decisions in this respect at some point in the future. Statements can also include what the person would **like** to happen in the event that they lose capacity.

Those making a best interest decision on a person's behalf will have a legal duty to have regard to such a statement in considering that person's best interests. Not complying with the statement must be for reasonable and rational reasons.

Statements of wishes, feelings and beliefs need not be in writing, but those that are written down and given to family, friends and health and social care professionals are more likely to be followed. Such statements should be encouraged as part of the care planning process.

10.8 Where staff are involved with a person who wishes to plan for the future, they should give advice, support and assistance to the person wishes to make a statement / advance decision.

11. Lasting Power of Attorney

11.1 The Mental Capacity Act replaces the current system for appointing Enduring Power of Attorney (EPA) in relation to financial decisions with the Lasting Power of Attorney (LPA). In addition to property and affairs (financial matters), LPAs can also cover personal welfare (including healthcare and consent to medical treatment) for people who lack capacity to make such decisions for themselves.

11.2 A person (donor) over the age of 18 can formally appoint one or more people (attorneys or donees) to look after their health, welfare and/or financial decisions, if at some time in the future; they lack capacity to make these decisions for themselves. At the time of making an LPA, the person must have the capacity to understand the importance of the document and the power that they are granting to the attorney.

11.3 An LPA must be registered with the Office of the Public Guardian (OPG) (before it can be used) Further information and guidance is available from the Mental Health Law Team at Harplands Hospital or the Office of the Public Guardian website http://www.guardianship.gov.uk/index.html

11.4 An LPA for property and affairs can be used when the donor still has capacity unless the donor specifies otherwise. However, an LPA for personal welfare will have no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision.

11.5 Donor's may restrict the extent of the powers granted to the attorney but personal welfare LPAs may include decisions about:

- where the donor should live and who they should live with;
- the donor's day-to-day care, including diet and dress;
- who the donor may have contact with;
- consenting to or refusing medical examination and treatment on the donor's behalf;

- arrangements for medical, dental or optical treatment;
- assessments for and provision of community care services;
- social activities, leisure activities, education or training;
- personal correspondence and papers;
- rights of access to personal information;
- Complaints about the donor's care or treatment.

11.6 Attorneys can consent to treatment for mental disorder on the individual's behalf; however they cannot consent to the person being deprived of their liberty for the purpose of mental health treatment. Attorneys cannot consent to treatment under Section 58 of the Mental Health Act.

11.7 Attorney's do not have the right to consent to or refuse treatment in situations where:

- the donor has the capacity to make the particular healthcare decision;
- the donor has made an advance decision to refuse the proposed treatment and has not authorized the donee to over-ride this decision in their LPA;
- the decision relates to life-sustaining treatment (unless the LPA has specifically authorized this).

11.8 Attorneys must follow the statutory principles set out in the Act and make decisions in the best interests of the person who lacks capacity. If there are concerns that an Attorney is not making decisions in the best interests of the person, staff should initially discuss this with the attorney, consider a safeguarding referral if there are concerns around risk and approach the Office of the Public Guardian (OPG) / Court of Protection if necessary.

Staff should request a copy of the registered order as evidence that the person has an appointed LPA. If this is not available, for any reason, staff can request confirmation of the LPA from the OPG by completing form 100 which is available on the www.gov.uk OPG website, refer to section 20.1

12. Court Appointed Deputy

12.1 In the absence of a Power of Attorney, the Court of Protection can appoint a deputy to act and make decisions about property and affairs or to make personal decisions on behalf of a person who lacks capacity. The court order from the Court of Protection will specify what powers the deputy is granted and will be as limited in scope and duration as possible.

12.2 If a person who lacks capacity to make decisions about property and affairs does not have an attorney, applications to the court are necessary:

- for dealing with cash assets over a specified amount that remain after any debts have been paid;
- for selling a person's property; or
- Where the person has a level of income or capital that the court thinks a deputy needs to manage.

12.3 Where the only income of a person who lacks capacity is social security benefits and they have no property or savings there will usually be no need for a deputy

to be appointed. People's benefits can be managed by an appointee, appointed by the Department for Work and Pensions.

12.4 Applications to the Court of Protection to consider financial matters are usually made by the Local Authority.

For Stoke on Trent Local Authority:
Julie Simpkins - Financial Assessments Manager - Stoke on Trent City Council
Floor 1, Civic Centre, Glebe Street, Stoke. ST4 1HH
Telephone: 01782 235973

For Staffordshire Local Authority:
Deputyship & Deprivation of Liberty Safeguards Team - Staffordshire County Council
Block A , 4th Floor, Wedgwood Building, Tipping Street, Stafford, ST16 2DH
Telephone : 01785 895665

12.5 Deputies for personal welfare decisions will only be required in the most difficult cases where:

- important and necessary actions cannot be carried out without the court's authority; or
- There is no other way of settling the matter in the best interests of the person who lacks capacity to make particular welfare decisions.

The Local Authority is usually the applicant for welfare decisions for people who live in the community; however the Trust may be the applicant if the person is an inpatient. The court may appoint an organisation as the deputy with individual staff members being nominated by the organisation as decision makers.

12.6 The court will usually specify the decision(s) that a deputy can make on behalf of the incapacitated person. A deputy has no authority to refuse the provision of or continuation of Life-sustaining treatment for a person who lacks capacity – such decisions must be taken by the court.

13. The Court of Protection

13.1 The Court of Protection is a specialist court which deals with all issues related to the Act. It will deal with decisions concerning both the property and welfare of people who lack capacity. The Court has the power to:

- Make declarations about whether or not a person has capacity to make a particular decision.
- Make decisions on serious issues about healthcare and treatment.
- Make decisions about the property and financial affairs of a person who lacks capacity.
- Appoint deputies to have ongoing authority to make decisions.
- Make decision in relation to LPAs and EPAs.
- Make decisions about deprivation of liberty.

13.2 Applications to the Court of Protection

- Where medical treatment is the issue, the Trust will be the most likely applicants, unless the medical treatment is to be undertaken by healthcare professionals from another trust e.g. the person requires surgical intervention

at University Hospital North Midland (UHNM) and in this situation UHNM would be the applicants. Where a particular decision relates to care or treatment for mental disorder and comes within the scope of the mental health act, it is unlikely that an application to the court would be required.

- Where personal welfare or financial issues are concerned, the Local Authority is likely to be the applicant.
- Where there is a dispute between family members/ informal carer's and the care team in relation to a particular decision which cannot be resolved, the Trust should consider application to the court in relation to healthcare / medical treatment issues. The local authority should consider application in relation to matters of welfare and financial affairs.
- If there is a dispute solely between family members / carers (i.e. the care team do not take a position on the disagreement) the family members / carers will have to decide themselves if they wish to apply. However if this sort of dispute has a negative impact on the care / treatment of an individual, the Trust or Local Authority may wish to consider making an application.

13.3 Process of applying to the Court of Protection

In almost all cases permission will first have to be sought from the Court to allow an application to the Court to be made. The Court must consider the reasons for the application, the benefit to the person lacking capacity and whether it could be achieved in any other way e.g. through negotiation, local complaints procedures, dispute resolution or mediation systems.

Where the care team are considering an application to the court of protection they should contact the Mental Health Law Team to obtain legal advice.

Emergency Applications – In emergency situations the court can be contacted to make an **emergency interim order.**

You must fill in an application notice (COP9) and send the original and one copy to the court. Include 2 copies of any relevant evidence, e.g. accounts, an invoice from a nursing home.

If you haven't applied to become a deputy yet, include your interim application with your main application.

There's no fee for an interim application.

Court of Protection
PO Box 70185
First Avenue House
42-49 High Holborn
London
WC1A 9JA

You can also take your application in person to the public counter of the Court of Protection.

Apply for an emergency order

You can make an emergency application if you need a court order for a decision in a very serious situation, e.g. to stop someone who lacks mental capacity from being removed from where they live or to give them treatment for a serious medical problem.

Apply by contacting the Court of Protection. Ask to speak to the urgent business officer when you call. They will discuss the matter with you and arrange to receive your application so it can be considered by a judge.

Emergency applications
Telephone: 0300 456 4600
Monday to Friday, 10am to 4pm
Find out about call charges

Out-of-hours emergency applications
Telephone: 020 7947 6000
Find out about call charges

In situations where an individual's social care needs would be met by the Trust under a Section 75 agreement with the Local Authority, the Local Authority (via its legal team) would still be expected to make a welfare application to the Court with the support and information from Trust workers.

14. Providing Care and Treatment under the Mental Capacity Act (Section 5)

14.1 The Act provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity provided that:

- the principles of the Act are observed (see above);
- an assessment of capacity has been carried out and there is a reasonable belief that the **person lacks capacity** in relation to the matter in question; and
- There is a reasonable belief that the action taken is in the **best interests** of the person.

14.2 Acts that might be covered include:

- help with washing, dressing or personal hygiene;
- help with eating and drinking;
- help with communication;
- help with mobility;
- domiciliary care and other services;
- arranging residence;
- help in maintaining the person's safety and/or associated with adult protection procedures;
- diagnostic examinations and tests;
- assessments;
- medical and dental treatment;
- surgical procedures;
- nursing care;

- Emergency procedures (such as cardiopulmonary resuscitation) – (provided no valid advance refusal in place).
- Admission to hospital for assessment and treatment of a mental disorder may be authorised by Section 5 in some situations.

14.3 Section 5 cannot be used to provide care and treatment for a person who lacks capacity where it conflicts with an advance decision, court appointed deputy, or lasting power of attorney. However, if staff members are concerned that a deputy or attorney may not be acting in the best interests of a person they could seek guidance from the Office of the Public Guardian.

15. Decisions exempt from the scope of the Mental Capacity Act

15.1 Certain decisions can never be made on behalf of a person, or are governed by other legislation:

- consent to sex;
- consent to marriage/civil partnership/divorce;
- discharging parental responsibility / consent to adoption of a child
- decisions on voting;
- Decisions to give, or consent to treatment for mental disorder of people who are liable for detention and treatment in accordance with Part IV of the Mental Health Act 1983.

16. Restraint

16.1 Restraint covers a wide range of actions, including the use or threat of force to make a person do something they are resisting or to restrict a person's movement whether they are resisting or not. Types of restraint can include:

- Actions to limit personal freedom of movement e.g. use of MAPPA holding techniques, continuous periods of observation;
- Actions that limit a person's movement in their environment e.g. refusal to allow the person to leave a ward / hospital, restriction in a particular area of the ward;
- Actions that limit a person's social contact / family life e.g. restrictions around contact with family members / carers.

16.2 Restraint can only be justified under Section 5 of the Mental Capacity Act if the following two conditions are met:

- it must reasonably be believed that it is restraint is necessary to prevent harm to the person who lacks capacity; and
- The amount or type of restraint must be a proportionate (least intrusive and minimum amount) response to the likelihood and seriousness of harm.

16.3 Where restraint is cumulative, frequent and ongoing the person may be deprived of their liberty. The person will also be deprived of their liberty if they are subject to continuous supervision and control and are not free to leave. (See MHA18 Deprivation of Liberty Safeguards Policy and Procedure for further information)

16.4 Section 5 of the Mental Capacity Act **cannot** be used in situations where a person is being deprived of their liberty. Section 5 of the Mental Capacity can be used to restrain an individual in an emergency circumstances however where

staff use continuous hands on restraint or seclusion it is likely that the degree and intensity of restraint will meet the deprivation of liberty threshold.

16.5 Where a person is deprived of their liberty for purposes of care or treatment of their mental disorder (including learning disability) staff should consider detention is authorised under either the Mental Health Act, DOLS or in some rare cases by the Court of Protection (See MHA18 Deprivation of Liberty Safeguards Policy and Procedures).

17 Admission to hospital under the Mental Capacity Act

17.1 Where a person lacks the capacity to consent to admission to a psychiatric hospital for care and treatment of a mental disorder, it is likely that they be will deprived of their liberty during their admission (Law Society 2015). Where the person is not within the scope of the Mental Health Act and application for DoLS is not possible, the member of staff responsible for admission could use Section 5 of the Mental Capacity Act to admit the person to hospital.

17.2 A formal assessment of capacity and best interests' decision should be completed prior to any Section 5 admission. Otherwise a formal assessment of capacity and best interest decision should be undertaken by the Ward team as soon as possible after the patient arrives on the Ward all recorded on the persons electronic patient record. On completion of the consent form / capacity assessment / best interest decision electronic forms, staff will be guided to complete the Deprivation of liberty checklist electronically in the patients electronic patient record (Previously Form L32). (See MHA18 Deprivation of Liberty Safeguards Policy and Procedures).

17.3 Where carer's or family members oppose an admission, further advice should be sought from the Mental Health Law Team.

18. Care and Treatment of Mental Disorder

18.1

- If someone is detained under the Mental Health Act (MHA), decision-makers cannot normally rely on the Mental Capacity Act to give treatment for mental disorder;
- People detained under the MHA can be given treatments **for their mental disorder** even if this goes against an advance decision to refuse that treatment
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live;
- IMCAs do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

18.2 An Attorney can consent to mental health treatment on behalf of an individual who lacks capacity; however they cannot consent to a deprivation of liberty.

18.3 Where an individual's detention is authorised by DoLS and they do not object to any aspect of their care and treatment of their mental disorder, treatment should be authorised by Section 5 of the Mental Capacity Act.

19. Care and Treatment of physical disorder

19.1 Section 5 of the Mental Capacity Act can be used to treat physical conditions that are unrelated to an individual's mental disorder e.g. treatment of a heart condition even when the person is detained under the Mental Health Act.

20. Office of the Public Guardian

20.1 The role of the Public Guardian is intended to protect people who lack capacity from abuse. The Public Guardian is supported by the Office of the Public Guardian (http://www.guardianship.gov.uk/index.html) whose remit is to:

- Maintain a register of LPAs and EPAs.
- Maintain a register of orders appointing deputies.
- Supervise deputies appointed by the Court.
- Direct Court of Protection Visitors to visit people lacking capacity.
- Receive reports from attorneys acting under LPAs and from deputies.
- Provide reports to the court as requested.
- Deal with representatives (including complaints) about the way in which attorneys or deputies exercise their powers.
- Provide general information about the Act.

20.2 Where there are concerns about the way in which Attorneys (LPA) and Court Appointed Deputies exercise their powers staff should contact the Office of the Public Guardian to investigate their concerns. Consideration should also be given to initiation of Safeguarding Procedures as per Trust Policy.

21. Independent Mental Capacity Advocates (IMCA's)

21.1 Role of the IMCA

The Independent Mental Capacity Advocate's role is to represent and support the person so that the 'decision-maker' can reach a decision and take action that is in the person's best interest. The IMCAs role therefore is:

- to gather information from the person him/herself as far as is possible;
- to gather information about the person from the decision-maker, all health and social care records, paid carers, family and friends and any other relevant records;
- to engage with the decision-maker in order to understand the nature of the decision to be made;
- to present (in the form of a final report) and discuss the information gathered in order to ensure that the decision-maker can make best interests decisions;
- to challenge decisions where the decision-maker has not given adequate consideration to the information provided;
- To obtain a further medical opinion if necessary.

The IMCA can be involved in meetings and reviews where it is in the person's best interest that they participate. Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person's best interests.

21.2 Staff should consider referral to an IMCA when:

- A person not have the capacity to make the decision required at the time the decision needs to be made, **AND**
- They do not have family and friends who are suitable to be contacted to represent them, **AND**
- A decision to be made must be in relation to a serious medical treatment, **OR**
- The NHS or Local Authority is proposing a change in long-term accommodation (a stay in hospital likely to be greater than 28 days or a stay in a care home of more than 8 weeks, or a move between such accommodation).

21.3 Circumstances where it is deemed to be 'not practicable or appropriate to consult family and friends 'are:

- Where the family member or friend lives a great distance away and there are difficulties making contact
- Where family and friends have little interest or knowledge of the person
- Where family and friends are unwilling to be consulted.
- Where family and friends are too frail (mentally or physically)
- Where actual or potential abuse of the person by family members or friends is suspected
- Where family members or friends can be seen to materially gain e.g. a conflict of interests.

21.4 The referral for the IMCA service should be made by the person (the decision–maker), who wishes to take some action in connection with the person's care. Referral for an IMCA will be made by filling in the IMCA Referral Form, either on the Staff Information Desk or by contacting the Mental Health Law Manager at Harplands Hospital.

22. Children and Young People

22.1 Section 2(5) states that the Act does not generally apply to people under the age of 16, however there are two exceptions:

- The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity and is likely to still lack capacity to make financial decisions when they reach the age of 18.
- Offences of ill-treatment or wilful neglect of a person who lacks capacity.

22.2 Most of the Mental Capacity Act applies to young people aged 16-17 years who may lack capacity to make specific decisions. There are three exceptions:

- Only people aged 18 and older can make a LPA.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of protection may only make a statutory will for a person aged 18 and over.

23. Confidentiality

23.1 Carrying out an assessment of capacity requires the sharing of information about the personal circumstances of the person being assessed. It is important that information concerning the person being assessed which is directly relevant to the decision in question is made available to ensure that an accurate and focussed assessment can take place. As a general principle, personal information may only be disclosed with the person's consent, even to close relatives or 'next of kin'. However there are circumstances when disclosure is permitted in the absence of consent. Legal advice should be sought in such circumstances.

23.2 Personal information on any individual should not be disclosed unless:

- the person agrees; or
- there is a legal obligation to do so; or
- There is an overriding public interest.

23.3 Where a person lacks capacity, the test of 'best interests' may also justify disclosure.

23.4 An assessment of capacity may require the sharing of information amongst health and social care workers. Only as much information as necessary should be divulged.

23.5 Where a LPA has been appointed for welfare issues, they will determine if information can be shared and they must normally be consulted prior to the disclosure. Where it is not possible to consult, e.g. if urgent treatment is necessary, then action must be taken in the person's best interests and the LPA advised as soon as practicable after.

23.6 For full guidance on sharing and disclosure of information please see the One Staffordshire Information Sharing Protocol (Policy Number 7.5).

24. Payment for goods and services

24.1 Carers may have to spend money on behalf of a person who lacks capacity. The Act does not give a carer access to a person's income or assets – this would require a Lasting Power of Attorney, or an order from the Court of Protection. However, a carer can purchase necessary goods and services by:

- spending any available cash of a person lacking capacity;
- promising that the incapacitated person will pay (though the supplier may not be happy with this, or the carer might worry that they would be held liable for any debts);
- Using their own money and then seeking permission from the Court to reclaim that money from the incapacitated person's bank account.

24.2 'Necessary' means something that is suitable to the person's condition in life (their place in society, rather than any mental or physical condition) and their actual requirements when the goods or services are provided. The aim is to ensure that a person lacking capacity can enjoy a similar standard of living to that prior to them losing capacity.

Goods are not necessary if a person already has a sufficient supply – two pairs of shoes could be necessary, but a dozen pairs probably would not be necessary.

24.3 Carers should keep bills, receipts and other proof of payment when paying for necessary goods and services.

25. Offence of Ill Treatment / Neglect

25.1 The Act introduces a criminal offence of ill treatment or wilful neglect of a person who lacks capacity.

25.2 This offence could potentially cover restraining someone unreasonably against their will (see 13 above), failure to provide adequate care, financial, sexual, physical and psychological abuse.

25.3 This offence applies to any person who:

- Has the care of a person who lacks capacity;
- Is an attorney appointed under an LPA or EPA;
- Is a deputy appointed for the person by the court?

25.4 Any suspected abuse must be handled in accordance with the Trust Safeguarding procedures.

26. Research

26.1 The Act sets out a clear framework for a wide range of research including clinical, health and social care research, but not clinical trials which are covered by separate legislation.

26.2 Safeguards to protect people who lack capacity taking part in research include:

- Relatives/unpaid carers must be consulted and agree to the person taking part;
- If the person without capacity shows any signs that they are not happy to be involved, research must not continue;
- Research must be necessary, safe and appropriate, and cannot be carried out as effectively using people who have capacity to consent to it.

26.3 Further information on the process for implementing/taking part in research can be found in the Trust Research Governance Guidance document.

27. Monitoring

27.1 Day to day implementation will be the responsibility of, ward/unit/team managers, consultants, modern matrons and lead / senior clinicians as part of their supervision responsibilities.

27.2 Monitoring of staff attendance at mental health law training will take place by attendance being recorded into the core required spread sheet, which will enable

us to quarterly monitor our progress against our predicted targets, realigning and amending as required.

27.3 The Mental Health Law Governance Group will, on behalf of the hospital managers, monitor compliance with this procedure and will routinely commission an MCA audit of compliance.

28. Policy Review

28.1 This procedure will be reviewed within three years of the implementation date unless there are any changes which require the procedure to be amended prior to the review date.

29. References

29.1 Mental Capacity Act Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Law Society (2015) Deprivation of Liberty a practical guide -
http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

All these documents and copies of the DOLS forms are available on SID under Resources / Mental Health Law Page.

Glossary / Definitions

Acts in connection with care or treatment.	Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity. This could cover actions that might otherwise attract criminal prosecution or civil liability if someone has to interfere with the person's body or property in the course of providing care or treatment.
Advance Decision	A decision to refuse specified treatment made in advance by a person who has capacity to do so.
Appointee	Person appointed under Social Security Regulations to claim and collect social security benefits or pensions on behalf of a person who lacks capacity to manage their own benefits.
Assessing Lack of Capacity	The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" and "time specific" test. No one can be labelled 'incapable' simply as a result of a particular medical condition or diagnosis. Section 2 of the Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.
Best Interests	An act done or decision made for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a non-exhaustive checklist of factors that decision makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement Past and present wishes are of central importance when making best interests decisions. Also, people involved in caring for the person lacking capacity gain a right to be consulted concerning a person's best interests.
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made.
Carer	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability.
Court Appointed Deputy	A person appointed by the Court of Protection to deal with a specific issue or range of issues to help a person who lacks capacity and has not got an attorney.
Court of Protection	Specialist court that deals with all issues relating to people who lack capacity to make specific decisions.

Court of Protection Visitor	Person sent by the Court or Public Guardian to visit people who have deputies or attorneys acting for them to make general welfare checks or investigate suspected problems.
Decision Maker	Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code, as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.
Donor	A person who appoints an attorney (by making an EPA or LPA) Enduring power of Attorney (EPA).
Enduring Power of Attorney (EPA)	When someone (a donor) appoints someone else (an attorney) to act for them with regard to their property and financial affairs. New EPAs cannot be made after 1 October 2007 but existing ones remain valid.
Independent Mental Capacity Advocate (IMCA)	An IMCA will be appointed to look at the best interest issues where a person lacking capacity has no one to speak for them (friend/family/LPA/Deputy) and there is a major decision to be made about serious medical treatment or a long-term care move. May also be appointed in adult protection cases.
Lasting Power Attorney (LPA)	When someone (a donor) appoints someone else (an attorney) to make decisions about certain things for them in the future. There are two types of LPA: • Personal welfare LPAs which can only be used when the donor lacks capacity to make relevant personal welfare or health decisions; • A property and affairs LPA which can be used whether the person has or lacks capacity to make decisions for themselves unless they have specified otherwise in their LPA.
Public Guardian / Office of the Public Guardian (OPG)	Monitors court appointed deputies, keeps registers of and investigates complaints about attorneys and deputies.
Receiver	Person appointed by the Court of Protection prior to 1 April 2007 to manage the financial interests of someone who lacks capacity.

Appendix 2

Best Interests Meeting Agenda and brief guidance

Name of Relevant Person: Date of Meeting:

- Confidentiality / Best Interests Statement
- Record people in Attendance
- Record of apologies and contributions received
- Purpose of the meeting - what is the decision to be made
- Identify who is the Decision Maker
- Following the Best Interests Checklist
- Encourage participation – is the person attending the meeting, if not who has conversed with them to gain their views, wishes and opinions to ensure they are able to participate.
- Avoid discrimination – no assumptions should be simply based on a person's age, gender, appearance, culture, condition or behaviour.
- Assess if the person might regain capacity – if this is a possibility could the decision that need to be made wait.
- Consult the person – identify their past and present wishes, views and opinions. (Case law states that the further we deviate from the persons views and wishes the rational for doing so has to be clearly evident.
- Consult others including:-
  - Anyone the person has named as someone they want to be consulted.
  - Anyone involved in caring for the person.
  - Anyone interested in the persons welfare (family carers, foster carers, other close relatives or an advocate already working with the person).
  - An attorney appointed under an Lasting Power of Attorney (LPA).
  - A deputy appointed by the court of protection.
  - If there is no one to consult an IMCA should be appointed (See below section 21).
- Record any differences of opinion
- Consider all relevant circumstances - Try to identify all the aspects the person would take into account if if they were making the decision for themselves.
- Avoid restricting the person's rights - Identify what is necessary and proportionate with in the available options and what will be least restrictive for the person's health and safety Consider the medical, emotional, psychological and social impact on the person.
- Record the outcome.

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents
Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required- link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	Once every 3 years	e-learning	✓
Training Grade Doctor	✓	Once every 3 years	e-learning	✓
Locum medical staff	✓	Once every 3 years	e-learning	✓
Inpatient Registered Nurse	✓	Once every 3 years	e-learning	✓
Inpatient Non-registered Nurse	✓	Once every 3 years	e-learning	✓
Community Registered Nurse	✓	Once every 3 years	e-learning	✓
Community Non Registered Nurse / Care Assistant	✓	Once every 3 years	e-learning	✓
Psychologist / Pharmacist	✓	Once every 3 years	e-learning	✓
Therapist	✓	Once every 3 years	e-learning	✓
Clinical bank staff regular worker	✓	Once every 3 years	e-learning	✓
Clinical bank staff infrequent worker	✓	Once every 3 years	e-learning	✓
Non-clinical patient contact	-	-	-	-
Non-clinical non patient contact	-	-	-	-

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc. Locally agreed as a minimum for mental health law training.

Any other additional information

Completed by		Date:	18.07.2018

North Staffordshire Combined Healthcare NHS Trust

Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment

CATEGORY:	Policy
THEME:	Clinical
DOCUMENT REFERENCE:	1.55
POLICY LEAD:	Executive Medical Director
APPROVAL DATE:	10th January 2019
APPROVAL BODY:	Quality Committee
BOARD RATIFICATION DATE:	24th January 2019
FINAL REVIEW DATE:	31st October 2024

This information will be completed by the Trust Secretary

Contents

1 POLICY STATEMENT

The Trust is committed, as far as possible, to enabling service users to make decisions and express preferences regarding their own care.

The policy enshrines this principle, giving service users the formal opportunity to take an active part in planning their care thus contributing to the development of a balanced partnership between individuals and health and social care professionals, as well as aiming to improve the experience and potential outcomes for all involved.

Advance Decisions and Advance Statements allow service users to make important decisions about their future care and treatment and the incorporation of Advance Decisions and Advance Statements into Trust policy and practice will continue to develop this partnership approach.

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

The Act includes many important provisions to protect the rights of those who lose capacity to make decisions and provides several ways that people can influence what happens to them should they be unable to make particular decisions in the future, including; **Advance Decisions** to refuse medical treatment; written statements of wishes and feelings (often called **Advance Statements**); the introduction of a **Independent Mental Capacity Advocate (IMCA)** in very specific situations; two forms of **Lasting Power of attorney (LPA),** a personal welfare and a property and affairs LPA. The system is overseen by two public bodies, the **Court of Protection** and its deputies and the **Public Guardian.** (See 1.3)

The Act is based on existing best practice and creates a single, coherent framework for dealing with mental capacity issues and an improved system for settling disputes, dealing with personal welfare issues and the property and affairs of people who lack capacity.

The Act‟s starting point is to confirm in legislation, that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as **the presumption of capacity.** The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process. The presumption of capacity applies also to any existing advance statement or advance decision. The provisions of the Act are that an individual must be 18 or over to make an advance decision.

Clear recording and the appropriate circulation and regular review / update of any known advance statements or advance decision is then crucial to enable the service user‟s wishes and feelings to be appropriately considered and acted upon.

An **Advance Statement or Advance Decision** to refuse treatment is written to assist in future treatment rather than written at a time of crisis. Reflection at an appropriate time after a crisis has occurred may provide an opportunity to identify the treatment that an Advance Statement or Advance Decision to refuse treatment needs to cover.

As the legal status of Advance Decisions and Advance Statements differ, it is important for staff to be clear of the distinction when working with service users.

1.1. Assessing Capacity

The Act makes clear that any assessment of a person"s capacity must be „decision-specific". This means that:

- The assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions.
- If someone cannot make complex decisions, this does not mean that they cannot make simple decisions.
- You cannot decide that someone lacks capacity based upon their age, appearance, condition or behaviour alone.

It may be appropriate to involve family, friends and/or carers when undertaking an assessment of capacity. This will depend upon the situation and the decision that needs to be made.

1.2. The Functional Test of Capacity

In order to decide whether an individual has the mental capacity to make a particular decision a two-part test must be applied:

Decide whether there is an impairment of, or disturbance in, the functioning of the person"s mind or brain (it does not matter if this is permanent or temporary)

if so, the second question you must answer is:

Does the impairment or disturbance make the person unable to make the particular decision in question at the time it needs to be made?

The individual lacks capacity if, after all appropriate help and support to make the decision they are unable to:

- Understand the information relevant to that decision.
- Retain that information
- Use or weigh up that information as part of the decision making process.
- Communicate their decision (whether by talking, using sign language or any other means).

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone.

An assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity to make a particular decision at the time that it needs to be made? You should be able to show in your records why you have reached the conclusion that the person lacks capacity.

1.3. Lasting Power of Attorney

Sometimes a person with capacity will want to give another individual the authority to make a decision on their behalf. A Lasting Power of Attorney (LPA) is a legal document that allows them to do so. Under a personal welfare LPA, the chosen individual can make decisions that are as valid as those made by the person themselves, once that person has lost the capacity to do so.

LPA"s can be used to appoint attorneys to make decisions about personal welfare, which can include healthcare and medical treatment decisions. In contrast, property and affairs attorneys can make decisions whilst the person still has capacity.

Personal welfare attorneys under a LPA might be able to make decisions about:

- Where the person should live and who they should live with.
- The person"s day to day care, including diet and dress.
- Who the person may have contact with.
- Consenting to or refusing medical examination and treatment on the person"s behalf.
- Arrangements needed for the person to be given medical, dental or optical treatment.
- Assessments for and provision of community care services.
- Whether the person should participate in social activities, leisure activities, education or training.
- The person"s personal correspondence and papers.
- Rights of access to personal information about the person, or complaints about the person"s care or treatment.

The standard form for personal welfare LPA"s allows attorneys to make decisions about anything that relates to the person"s personal welfare. The person can add restrictions or conditions to areas where they would not wish the attorney to have the power to act. For example, a person may only want the attorney to make decisions about their social care and not their healthcare.

To be valid, an LPA needs to be registered with the Office of the Public Guardian. It must be on the prescribed statutory form, detail the nature and effect of the LPA and be signed and witnessed. Where there is more than one attorney appointed, the person can specify whether they are to act jointly or independently. It could be that certain, more significant, decisions need full agreement by all attorneys whilst other more routine decisions could be taken by an individual. Once registered each page of the LPA will bear a hologram. It is possible to ask the Office of the Public Guardian to search their database (free of charge) to double check that an LPA is registered. The contact telephone number is 0845 330 2900. If it is not registered the attorney has no authority to act.

A general personal welfare LPA gives the attorney the right to make all of the decisions set out above although this is not a full list of the actions that they can take or decisions that

they can make. However, a personal welfare LPA can only be used at a time when the person lacks capacity to make a specific welfare decision.

An Advance Decision to refuse treatment supersedes an LPA unless the LPA was made after the Advance Decision and allows the attorney to consent to or refuse treatment.

If a service user presents an LPA, clinicians are advised to contact the Head of Corporate and Legal Affairs.

Information leaflets for service users, including leaflets in an accessible format, about Advance Statements and Advance Decisions to refuse treatment will be readily available across the Trust and on the Trust intranet.

2 SCOPE

Part 1 of this policy relates to **Advance Decisions** and applies to all service users of North Staffordshire Combined Healthcare NHS Trust aged 18 or over, as only those within this age bracket can make an advance decision to refuse medical treatment within the legislative framework.

Part 2 of this policy relates to **Advance Statements** and will apply to all service users over the age of 16 years.

In the context of this policy, a service user is a current user of the Trust‟s services or a former user who is not currently in receipt of a service but who wishes to make a statement or decision about any future care that they may receive from the Trust.

3 DUTIES

Advance Statements and **Advance Decisions** allow service users to make important decisions about their future care and treatment; the Trust will encourage and assist service users in this respect and work to facilitate the process.

Staff working for service users have a duty to assist them with regard to making decisions about their care, where asked to do so.

Advance Statements and Advance Decisions to refuse treatment should be understood as an aid to, rather than a substitute for, open dialogue between service users, carers and health and social care professionals. Open attitudes and a willingness to discuss the advantages and disadvantages of particular options can do much to establish trust and mutual understanding between all of those involved.

Staff should, at all times, follow the advice within the Code of Practice to the Mental Capacity Act 2005. Where there is any doubt concerning the applicability or validity of an Advance Decision, the professional involved should contact the Trust Head of Corporate and Legal Affairs who can seek advice from the Trust‟s solicitors if necessary.

4. FRAMEWORK

4.1. Part 1: Advance Decisions to Refuse Treatment

An Advance Decision to refuse treatment can be verbal or written, there is no legal requirement regarding the format unless it relates to life sustaining treatment. It is however, preferable if the Advance Decision is a written document, completed when the individual had capacity to make decisions.

To be valid, an Advance Decision must anticipate the circumstances that will exist when it is to be used. The consequences of any refusal to accept treatment in an Advance Decision must have been clearly understood by the service user when they made it. Service users should be encouraged to discuss their Advance Decision with appropriate health professionals when making it. They should also be encouraged to discuss their Advance Decision with their carers and relatives so that they are aware of the service users wishes.

An advance decision does not give an individual the right to demand specific treatment at the time of making it or in advance.

If a verbal advance decision is thought to have been made, please refer to the Mental Capacity Act Code of Practice 9.38 to 9.44 with regards to validity and applicability. This should be documented by those involved with the service user at the earliest opportunity.

An Advance Decision that refuses life sustaining treatment must be in a written document (it can be written by someone else or recorded in health care notes), signed and witnessed and must contain the words “this to apply even if my life is at risk”.

Advance Decisions are sometimes referred to as „**Advance Directives or Living Wills‟.**

An Advance Decision to Refuse Treatment:

- Must state precisely what treatment is to be refused – a statement expressing a general desire not to be treated is not enough. (See paragraph 9.13 of the Code of Practice).

- Should set out the circumstances when the refusal should apply. It is helpful to include as much detail as possible including the reasons for refusing treatment e.g. particular side effects as this will support the validity of the decision.

- Will only apply at a time when the person lacks capacity to consent to / or refuse the specific treatment.

Specific rules apply to life-sustaining treatment (set out at 9.24 to 9.28 of the Code of Practice).

The provisions of an advance decision to refuse treatment will reflect the expressed wishes of the individual in terms of refusing specific medical treatment and relapse management. In the General Medical Council‟s booklet, „Seeking Patient Consent; The Ethical Considerations‟, it is advised that in obtaining valid consent for treatment, any associated serious or frequently occurring risk should be discussed. The Medical Defence Union recommends that these discussions be formally documented.

Patients treated under the provisions of part IV of the Mental Health Act 1983 may be treated for their mental disorder, despite an advance decision to refuse treatment. In these circumstances it would be considered to be good practice to take full account of the person"s advance decision to refuse treatment, and to balance this with their duty to provide care.

Witnessing the person"s signature is not essential, except in cases where the person is making an advance decision to refuse life-sustaining treatment. However, if there is a witness, they are witnessing the signature and the fact that it confirms the wishes set out in the advance decision. It may be helpful to give a description of the relationship between the witness and the person making the advance decision. The role of the witness is to witness the person"s signature; it is not to certify that the person has the capacity to make the advance decision – even if the witness is a healthcare professional or knows that person.

Trust staff are advised NOT to witness documents, as this may imply that they have undertaken an assessment of capacity.

An Advance Decision cannot refuse the provision of „basic care" which health professionals **always** have a duty to provide. Basic care includes such things as warmth, shelter, actions to keep a person clean and the offer of food and drink by mouth. An Advance Decision however, can refuse artificial nutrition and hydration.

4.1.1. MAKING an Advance Decision to Refuse Treatment

- An Advance Decision enables someone aged 18 years and over, while still capable, to refuse specified medical treatment at a time in the future when they will lack the capacity to consent or to refuse that treatment.

- It is up to individuals to decide whether they want to refuse treatment in advance. They are entitles to do so if they wish, but there is no obligation.

- An Advance Decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision made by a person with capacity: It is binding on health care professionals who must follow the decision.

- Health care professionals will be protected from liability if:

  - They stop or withhold treatment because they reasonably believe that an Advance Decision exists, and that it is valid and applicable.

  - They treat a person because, having been told that an Advance Decision exists and having taken all practical and appropriate steps to find out if the person has made an Advance Decision to refuse treatment, they do not know or are not satisfied that a valid and applicable Advance Decision exists.

- It is important that an Advance Decision to refuse treatment is completed when an individual feels best able to represent their wishes clearly and to record them / have them recorded formally after capacity has been assessed by health care professionals (See pro forma – appendix 2)

- Some people choose to make Advance Decisions whilst they are still healthy, even if there is no prospect of illness. This might be because they want to keep some control over what might happen to them in the future. Others may think of an

Advance Decision as part of their preparations for growing older (similar to making a will). Or they might make an Advance Decision after having been told that they have a specific disease or condition e.g. degenerative cognitive impairment.

- An Advance Decision to refuse treatment needs to be written as clearly and unambiguously as possible in order to avoid misinterpretation. It can be expressed in either medical terms or layman‟s language i.e. written so that the service user understands it as well as anyone else who reads it.

- Assistance in recording an Advance Decision will always be offered to those individuals who have sensory impairments or who lack confidence in completing written forms. The provision of interpreter services will also be provided as required.

- A capable individual has the right to make an Advance Decision to refuse treatment when they feel it to be appropriate and to withdraw from it or negotiate a new or modified version at any time whilst they still have the capacity to do so. It is the service user‟s responsibility to ensure that any withdrawal or amendment is made known to relevant health professionals. The opportunity to discuss whether any changes have been made or are necessary should be taken at least at each care plan review.

4.1.2. REQUIREMENT TO ACT on an Advance Decision to Refuse Medical Treatment

Before acting on an Advance Decision staff must satisfy themselves that the Advance Decision is valid and applicable to the current situation by checking that:

- The service user has lost capacity
- The service user was at least 18 years of age and had capacity when the Advance Decision was made, (there should always be a presumption of capacity).
- The Advance Decision has not been withdrawn or amended when the service user had capacity to do so.
- The service user has not drawn up a **Lasting Power of Attorney** authorising a personal welfare attorney to refuse or consent to the treatment to which the Advance Decision relates on their behalf
- The service user has not done something that is clearly inconsistent with the details of the Advance Decision
- The proposed treatment is one specified in the Advance Decision and the circumstances pertaining are those envisaged by the service user when making the advance Decision.
- There are no reasonable grounds for believing that there has been a change in circumstances which, if the service user had known about, would have affected their decision.

Professionals should also consider:

- The length of time that has passed since the Advance Decision was made and whether there have been relevant developments in medical treatment that the service user could not anticipate.

- Whether there have been any significant changes to the service user"s circumstances that might affect the validity or applicability of the Advance Decision (e.g. a pregnancy that was not anticipated when the Advance Decision was made).

- If the Advance Decision is considered valid and applicable it must be followed.

- Even if the Advance Decision is not considered valid, the professionals should take it into consideration in their assessment of best interests for the service user.

- Emergency treatment should not be delayed if there is no clear indication that an Advance Decision exists. Where it is believed that the person has made an Advance Decision but it is not immediately available, professionals should assess the situation and, if urgent, treat whilst the position is clarified.

4.2. Part 2: Advance Statements

An Advance Statement identifies the individual"s wishes or preferences regarding their care and treatment and how the provision of that care may be provided should they become mentally unwell and incapacitated. It is therefore, aimed towards planning for a crisis / relapse / acute episode when the individual is unable to make their preference known.

Ideally this should be a written document, the content of which has been agreed through negotiation between the individual and the mental health care worker(s), which has been completed during a period of recovery / stability for the individual when they had capacity to make decisions. However, Advance Statements can be verbal or written by the person without the help of a health care professional.

An Advance Statement may cover numerous elements of care and treatment. Additionally it will identify those trusted relatives, carers and advocates who may be contacted in an emergency and/or provide information for health professionals. The Advance Statement may also indicate what practical arrangements the individual may wish to have addressed if admitted to hospital, e.g. care of dependents, safeguarding their home etc.

An Advance Statement is not legally binding (so staff do not need to follow it). However, professionals should take the service users wishes into account when making decisions about medical treatment and care management. If a decision is made which disregards the service user"s Advance Statement the reasons for this must be documented in their record by the clinician making the decision.

If a service user wants to include an expressed wish not to receive a particular treatment, or not to be treated at all, **the Mental Capacity Act 2005** provides the statutory basis for *refusal of treatment.*

4.2.1. Making an Advance Statement

- A service user must be at least 16 years old and have capacity in order to make a valid Advance Statement. A child under the age of 16 years may be able to consent to treatment if it is concluded that they have the capacity to make the decision, and is of sufficient understanding and intelligence to be capable of making up their own mind. This is referred to as „**Gillick competence".** It would also be possible for someone with parental responsibility to record their wishes in an Advance Statement, which need to be in the child"s best interests.

- Advance Statements offer the potential to enhance the collaborative approach of CPA/care planning by placing an emphasis on establishing an accepted agreement between an individual, other important people involved in their lives and the health and social care professionals. Information regarding Advance Statements should be given to service users when their care plans are being devised and reviewed.

- It is up to individuals to decide whether or not they want to make an Advance Statement – there is no obligation.

- A capable individual has the right to make an Advance Statement when they feel it to be appropriate and to withdraw from it or negotiate a new or modified version at any time.

- It is important that Advance Statements are completed when an individual feels best able to represent their wishes clearly and to record them / have them recorded formally. Staff should facilitate the recording of an Advance Statement if the service user has capacity to make the statement but is unable to write themselves. Although an Advance Statement may contain a refusal for treatment, legally this is not binding.

- An Advance Statement may be viewed as part of a person"s preparation for growing older (similar to making a will), or made as a consequence of a specific disease or condition. Advance Statements need to be written as clearly and unambiguously as possible to avoid misinterpretation. Responsibilities should be understood by everyone referred to and should not be imposed on third parties where they have not given their agreement. If a statement made is unclear in any way this should be discussed with the service user, who should be asked to clarify the meaning.

- A service user may use an Advance Statement to nominate another person who should be consulted at a time when a decision needs to be made on their behalf. This does not however, give that nominee the power to give consent on behalf of the service user – it means that the nominee should be consulted and their views taken into account when a decision is being made.

4.2.2. REQUIREMENTS to act on an Advance Statement

- Where an Advance Statement has been placed in the clinical records, or where staff are advised that one exists but it is not in the records, staff should make an entry into the records (electronic and paper) recognising that one exists. Staff should take all reasonable steps to secure a copy and file it in the notes.

- As an Advance Statement is not legally binding, emergency treatment should not be withheld whilst a copy is sought.

- All those who are likely to be involved in the care of the individual should be advised that the Advance Statement exists.

- Providing the Advance Statement is clear and unambiguous it should be taken into account when making decisions about the care and treatment of the service user. Statements that express preferences or requests should be followed where possible but the clinical team"s final decision should always be based on the person"s best interests as defined by the current circumstances.

- Treatment or care does not have to be provided where it has been requested in an Advance Statement if not judged to be in that person"s best interests. For information on „Best Interests" consult chapter 5 of the Code of Practice to the Mental capacity Act 2005.

- An Advance Statement cannot be used to demand a particular treatment or to require anyone to do anything that is unlawful.

4.3. PROCEDURE for Advance Statements and Advance Decisions to Refuse Treatment

- As part of the assessment and care planning process with an individual, the assessor or care coordinator will ensure that the individual is aware of, and if appropriate, discuss the process of making an Advance Statement or Advance Decision to refuse treatment with the individual (and carer where appropriate), including identifying if there is an existing document or verbal Advance Decision. An information leaflet will be provided and the individual can then decide if or when they might want to make or update an Advance Statement or Advance Decision to refuse treatment.

- An existing written Advance Statement or Advance Decision that the service user does not want to rescind or update does not need to be transferred onto the Trust pro forma (see Appendix 1) however, staff should make an entry into the service user"s records (electronic and paper) recognising that one exists.

- If the individual has an existing verbal Advance Statement or Advance Decision to refuse treatment this should be recorded in their notes using the Trust pro forma and be identified as outlined below.

- Individuals can discuss and decide what treatment they want to refuse with their care coordinator, consultant, member of their care team, their advocate or by accessing support through a user group.

- A multi-disciplinary / CPA review provides an opportunity to discuss and review the Advance Decision to refuse treatment. This process should enable the individual to express their wishes and allow for family, carers or advocates to take a role in supporting the service user as well as bringing their unique understanding of the individuals needs to this process.

- There may be occasions where the patient in the care of our Trust has made an Advance Statement or Advance Decision to refuse treatment for a physical condition, the management and care of which is outside the mental health care team"s area of expertise. In this event the most appropriate health care professional should be contacted to provide advice on the situation.

- When an Advance Statement or Advance Decision to refuse treatment has been made this should be indicated on the Care Programme Approach (CPA) documentation.

- The service user will retain the original Advance Statement or Advance Decision to refuse treatment and a copy will be circulated to all members of the care coordination / multidisciplinary team, including the G.P.

- The process of identifying the existence of an Advance Statement or Advance Decision to refuse treatment through electronic patient"s records / care planning process will facilitate the alerting of health and social care professionals who may not have current involvement with the service users care e.g. Crisis Resolution and Home Treatment Services.

- An Advance Statement or Advance Decision to refuse treatment should be reviewed with the individual and the multidisciplinary /CPA team every 6 months. However, an individual can request a review of the Advance Decision to refuse treatment at any time whilst they have capacity. If the review results in changes, the updates document must be circulated as indicated above.

- If any concerns arise as to the legal effect of the Advance Statement or Advance Decision to refuse treatment, initial advice should be sought from the Trust Head of Corporate and Legal Affairs.

4.4. Records and Record Keeping

The existence of an Advance Statement or Advance Decision to refuse medical treatment should be clearly and prominently noted in the service user"s records where it will be easily seen. Any subsequent change or withdrawal should also be fully recorded.

An Advance Statement or Advance Decision should be shared with the service user"s G.P. together with any other person"s who need to be aware of the position in the event of a crisis or emergency.

When a service user is assessed as having lost capacity and an Advance Statement or Advance Decision is judged to have come into force an entry should be made to this effect in the service user"s records detailing the full circumstances and reasons for any decisions made. If the service user regains capacity to act and make their own decisions then this should similarly be recorded.

Any action taken by a service user that contradicts their expressed wishes in an Advance Statement or Advance Decision should be clearly noted in their records for future reference.

Any decision made that an Advance Statement or Advance Decision is not valid or applicable should be fully recorded with full reasons as to why that decision was reached.

Any actions inadvertently taken that contravene wishes expressed in a valid and applicable Advance Statement or Advance Decision should be recorded with full reasons and details of who has been informed.

4.5. Advice and Support

Staff should at all times follow the advice contained in the Code of Practice to the Mental Capacity Act 2005.

Where there is any doubt of the applicability or validity of an Advance Statement or Advance Decision, the professional involved should establish as much information as possible about the service user"s wishes and contact the Trust Head of Corporate and Legal Affairs.

If there is serious disagreement between any of the parties involved as to the applicability or validity of an Advance Statement or Advance Decision, it may be necessary to seek a ruling from the Court of protection. If this is considered likely, early notification should be made to the Head of Corporate and Legal Affairs, who will alert and take advice from the Trust"s solicitors.

Individuals who feel that their Advance Decision to refuse treatment or Advance Statement has not been taken account of, or it has been overridden without explanation, may take up their concerns with individual health or social care professionals. Should this fail to provide an acceptable explanation; the Trust has an agreed complaints procedure. Leaflets are available across the Trust in this regard.

Flowcharts to aid decision making regarding Advance Statements and Advance Decisions are shown as appendices 3 and 4.

5. Implementation and Monitoring

Training in the use of Advance Statements and Advance Decisions to refuse treatment will be provided to staff as part of the training in the Mental Capacity Act 2005.

Auditing and evaluation will be established to provide guidance on the likely benefits of the approach and to inform any adjustments which need to be made to it"s operation as outlined in this policy.

6 References

- Mental Capacity Act Code of Practice 2005:

http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf

Appendix 1

ADVANCE STATEMENT

I (name) _____

of (address) _____

_____

_____

_____

D.O.B_____ **NHS Number** _____

If I am unable to make decisions for myself due to incapacity, I wish and intend that the views expressed below are taken into account when decisions are being taken about my care and treatment:

_____

_____

_____

_____

_____

I will keep this Advance Statement under review when planning care.

I may withdraw this decision at any time by notifying the Trust in writing

Signed:_____ **Date:** _____

I can confirm that this form has been completed by the above named person and I act as witness to their signature.

Witness name: _____

Witness Address: _____

_____

Signed:_____ **Date:** _____

Care **Coordinator:**

Consultant: _____

General **Practitioner** **is**

Address _____

_____

He/she has/has not been given a copy of this document

Appendix 2

ADVANCE DECISION

I (name) _____

of (address) _____

_____

_____

D.O.B_____ **NHS Number** _____

If I am unable to make decisions for myself due to incapacity I wish and intend that the views expressed below are followed when decisions are being made about the care and treatment I receive from the Trust

Under the following circumstances I do not want the specific treatments:

_____
_____
_____
_____
_____

The reasons for refusing the treatment(s) are:

_____
_____
_____

_____

I would also wish to refuse life sustaining treatment, "even if my life is at risk" such as:

Cardio-Pulmonary Resuscitation (restarting my heart) ☐

Assisted Ventilation (breathing) including use of a machine ☐

Artificial Nutrition and Hydration ☐

(the giving food or water by route other than mouth)

Other (please state)_____ ☐

I have marked the boxes to show that these are the specific treatments that I do not want. I am aware that I will be provided with basic care, support and comfort.

Signature: _____ Date: _____

Witness Name: _____

Witness Address: _____

Witness Signature:_____ Date: _____

Should there be a change of circumstances then:……

……

……

Review date: _____

Assessment of capacity (this must be completed on each occasion).

Name and grade (printed) _____ Signature: _____

(Person assessing capacity)

Name (printed):_____Signature: _____

(person making decision)

Witness Name:_____Signature: _____

I have retracted / modified this Advance Decision to refuse treatment

(delete as appropriate)

Name (print): _____ Signature: _____

Date: _____

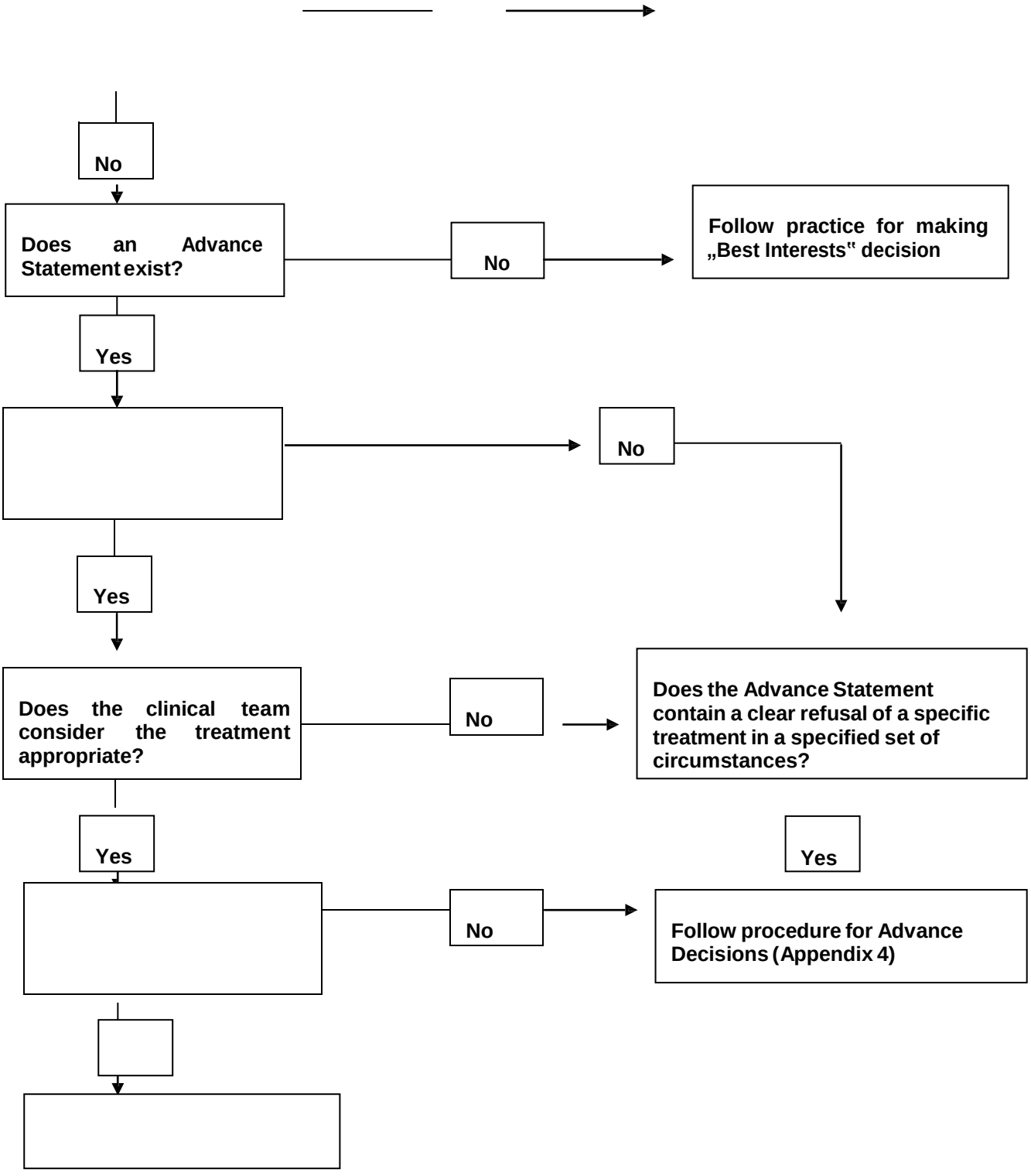
Appendix 3

Implementing an Advance Statement

Does the Service User have the necessary capacity?

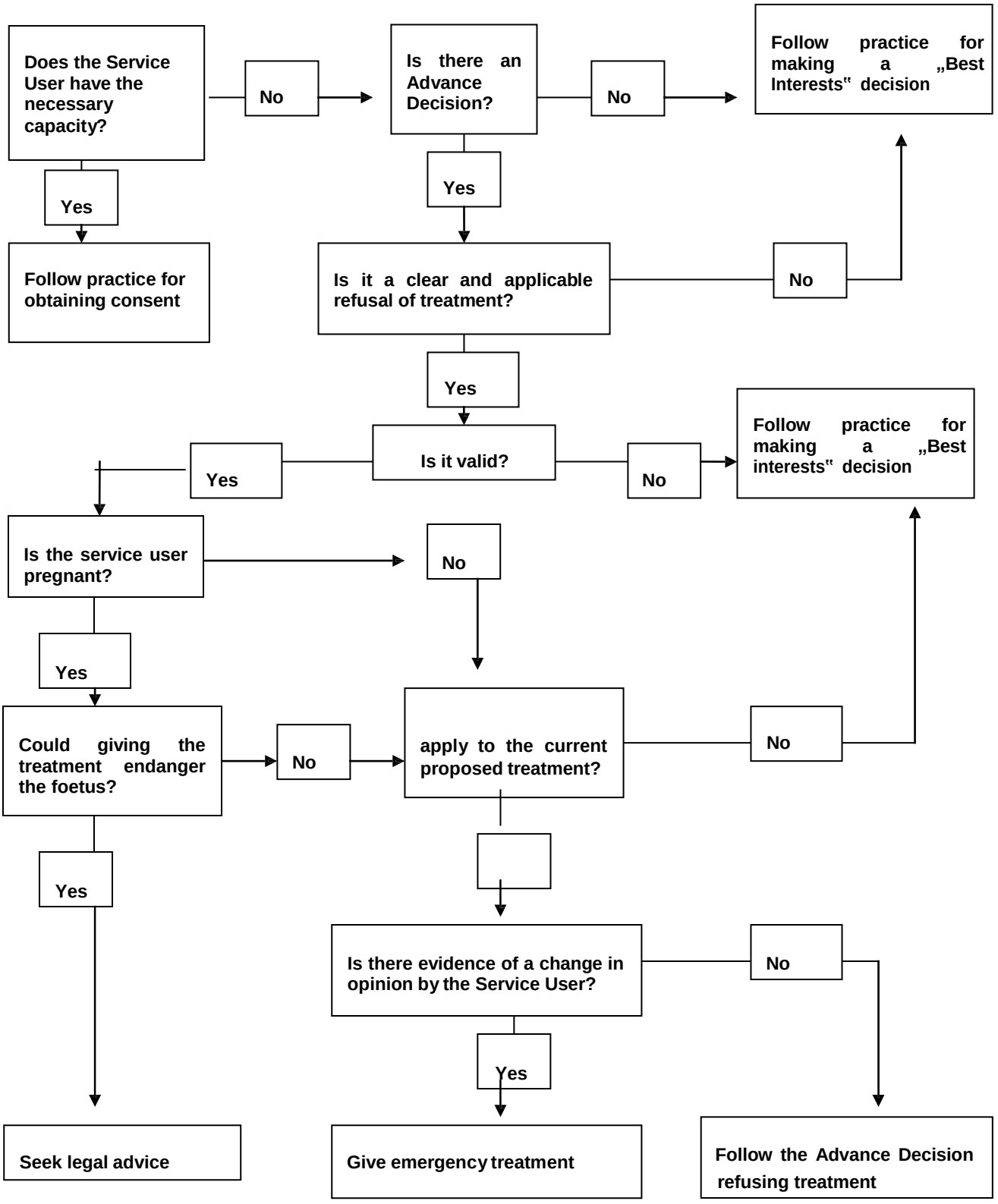
Yes

Follow practice / procedure for obtaining consent



Appendix 4

Implementing an Advance Decision to Refuse Treatment


Does the Service User have the necessary capacity?
No
Is there an Advance Decision?
No
Follow practice for making a „Best Interests" decision
Yes
Follow practice for obtaining consent
Yes
Is it a clear and applicable refusal of treatment?
No
Yes
Is it valid?
Yes
No
Follow practice for making a „Best interests" decision
Is the service user pregnant?
No
Yes
Could giving the treatment endanger the foetus?
No
apply to the current proposed treatment?
No
Yes
Is there evidence of a change in opinion by the Service User?
No
Yes
Seek legal advice
Give emergency treatment
Follow the Advance Decision refusing treatment

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Appendix 2

North Staffordshire Combined Healthca NHS

NHS TM1

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North Staffordshire Combined Healthcare Will

NHS Trust

An information Leaflet

Date issued:
Revised:
Review

What is an Advance Decision?

An advance decision is a decision you make or a document you complete if you want to refuse specific treatment should you lack the capacity to consent to treatment. It is made when you are well and are capable of understanding the implications of refusing the specific treatment. An advance decision, should clearly specify the future treatment that you are refusing, why you are refusing it and the specific circumstances when you will refuse the treatment.

Who can make an Advance Decision to refuse treatment?

Anyone over the age of 18 who has the capacity to decide how they don't want to be treated if they lack capacity in the future.

What is an Advance Statement?

An advance statement is a decision you make or a document that you complete when you are well regarding your wishes as to your care and treatment should you become unable to make decisions regarding your care. During a crisis you may be too ill to make an informed decision. This is a way of telling people what you want to happen, before that situation occurs.

Who can make an Advance Statement?

Anyone over the age of 16 who has the capacity to make decisions and would like to decide how their care will be managed if they lack the capacity to make decisions regarding their care.

Where can I get a copy of the Advance Decision or Advance Statement form?

You can obtain a copy from the following:-

If I require in-patient treatment can I insist on being admitted to a particular ward, or access to a particular service?

It may not be possible to specify an individual ward, department or hospital, but you may express a preference. This preference will be taken into account by the healthcare professional but they are not legally obliged to follow it.

Can Ichange/withdraw my Advance Decision or Advance Statement?

Yes you can change either document at any time whilst you still have capacity to make decisions about your healthcare, but please ensure that the healthcare professionals involved in your care and anyone else who has a copy of the document have a copy of the most up to date version. There is a form to help you inform people.

If you have an advance statement it will be reviewed as part of your care review meeting or Care Co-ordination review.

Why should I make an Advance Decision or Advance Statement?

During a crisis you may be too ill to make informed decisions or express what you want or arrangements that need to be made. This is a way of telling people what you do or don't want to happen, before that situation occurs

What type of things could be in this document?

Your advance decision can be written or verbal. There is no set format. It should specify the treatment you are refusing. If this is medication you should name the drug(s) you don't want and the specific circumstances in which this refusal applies. If your refusal relates to life sustaining treatment then the advance decision needs to be in writing and needs to include that the decision to refuse treatment applies even if your life is at risk.

Is an Advance Decision legally binding?

An advance decision is binding on healthcare professionals provided it is valid and applicable to the situation. If there is evidence that you changed your advance decision, appointed a Lasting Power of Attorney after making your advance decision or behaved in a way which was contrary to your advance decision then the healthcare professional is not under a legal duty to follow it. You must make it clear that when you made the decision you were properly informed about the implications and had capacity to make the decision.

An advance decision can be over-ridden by the Mental Health Act 1983. This only relates to treatment for your mental illness.

Does it need to be witnessed?

Yes. If your advance decision relates to life sustaining treatment it is a legal requirement for it to be witnessed. The trust pro-forma includes a witness signature and a section to be completed to show you have capacity at that time to make the decision(s) contained in the document.

Do I need to discuss the content of my Advance Statement document with family and friends?

If you have identified a member of your family or friend as being responsible for child care, care of pets, home security, etc., it is advisable that you discuss this with them prior to seeking their agreement. Failure to do so may result in your wishes not being followed.

Can I insist on certain medication and treatments?

You cannot insist on receiving certain medication or treatments, but you may express an opinion about treatments and identify which medication has worked for you in the past.

Is the document legally binding?

An advance statement sets out your wishes, and as far as possible the professionals will always take these into account. The advance statement is not legally binding

Could someone other than my Care Co-ordinator help me to complete the Advance Statement?

Anyone that you choose may help you to complete the Advance Statement. However, it is important to note that decisions regarding your care and treatment should reflect what is actually achievable and possible. You may wish to write the advance statement with a friend, colleague or user organisation, and then discuss this with your Care Co-ordinator.

Does the document need to be witnessed?

There are two spaces within the form that if people have helped with your advance statement they can sign. This is not a requirement

How do I make an Advance Decision?

An advance decision can be verbal or in writing. If the advance decision is in writing it can be a document that you write yourself, or you can write with help from your Care Co-ordinator, healthcare professional or with help from another person you ask to assist you. This may be a family member, friend or partner (carer). You may write it during a meeting with your care team or in a care coordination review, or at any other time you wish.

There is a special form for an advance decision that makes it easy, though a completed form is not compulsory.

Who should I discuss the content of my Advance Decision with?

If you are thinking about making an advance decision it is recommended that you get advice from the healthcare professional most closely involved with your current treatment or an organisation that can provide advice in relation to your specific condition or situation (this could Include your GP, consultants, social worker or district nurse). This will help you to have all the information you need to make an informed decision.

You are strongly advised to obtain independent advice from a Solicitor, Citizens Advice Bureau or an Advocate to make sure you express your decision clearly and accurately

What happens to the document when it is completed?

When you have written your Advance Decision, give it to your Care Co-ordinator/healthcare provider. They will ensure that, with your agreement, all members of your care team e.g. Consultant, CPN, Social Worker. GP etc. have a copy so they can look at it when they need to.

How do I make an Advance Statement?

Advance statements can be verbal or in writing. A written Advance Statement is a document that you write yourself, or you write with help from your Care Co-ordinator/healthcare professional or with help from another person you ask to assist you. You may write it during your care coordination review, or at any other time you wish. There is a special form that you may use which makes it easy to do. (Making My Wishes Known) Please note: if you feel particularly strongly about not receiving a particular treatment, the Trust recommends that you use its "advance decision" form.

What type of things could be in an Advance Statement?

The advance statement will set out your wishes about what you would like to happen if you become unwell.

The document sets out your wishes such as:

- Who people should contact if you become unwell.
- Your wishes regarding preferred medication.
- What treatment has worked well for you in the past and what has not been so helpful.
- Any special needs that you may have with regard to diet, health, religion, disability, etc.
- Arrangements that you wish to be made for your children/dependants or family pets.
- How you would like to make your home secure, and who should be responsible for this.

What happens to the document when it is completed?

When you have written your Advance Statement, give it to your Care Co-ordinator. They will ensure that, with your agreement, all members of your care team e.g. Consultant, CPN, Social Worker, GP etc. have a copy and can look at it when they need to.

It is also a good idea to give copies of the document, or at least the appropriate sections of it, to any of the people that you have named as being responsible for caring for dependants, pets, or who you have asked to look after the security of your home.