

I sent some observations about the ReSPECT Form to the Care Quality Commission, asking if the CQC considers that the ReSPECT Form is properly compliant with the Mental Capacity Act: in particular, I consider that if the ReSPECT Form records a best-interests decision which was made by a Welfare Attorney or Court Deputy and the attorney or deputy possessed legal authority over the decision-making, it should be the attorney or deputy who signs the ReSPECT Form [and not the senior clinician].

The CQC appears to disagree with me – which I find ‘illogical and ‘disturbing” - and in this e-mail from the CQC, there is a very peculiar assertion about the nature of the Tracey court ruling.

I show the e-mail from the CQC in black, and my comments [which follow the text my comment relates to] are in brown.

Dear Mr. Stone

Thank you for contacting CQC in your original email of 2 October 2017 and subsequent more recent email of the 21 December 2017 with your concerns about the ReSPECT forms, and affording us the opportunity to respond.

Please accept our sincere apologies for the time it has taken to respond to your query. There was an administrative error which led to your query not being allocated to the right person within CQC in a timely manner. We have been reviewing our system of allocating queries and are putting in place an amended system that will address this.

You kindly shared with us a letter you had written to Alan Eccles of the Office of the Public Guardian dated 4 September 2017 in which you set out helpfully in some detail your concerns with legal reference points, and in your subsequent emails you provided some additional comments. CQC would understand then that your main concern is whether as a regulator we consider that the ReSPECT form and process is fully Mental Capacity Act compliant, and in particular whether the sign-off by a clinician is legally correct, for example if a Lasting Power of Attorney for Health and Wellbeing or other legal proxy is in place.

Yes – put simply, why isn't an attorney signing the form, if the recorded decision is legally within the authority of the attorney (ditto with Court Deputies).

As you are probably aware, although the work to produce the ReSPECT forms was led by the Resuscitation Council (UK), it was developed by a large working group that included clinical staff (adult and paediatric, as well as primary and secondary care), the royal colleges, social care, patient organisations and representatives and CQC as the regulator, as well as representatives from all four UK countries. Senior and authoritative legal advice was accessed by the working group who devised the form and process.

Yes, I am aware of that huge group of 'contributors' and it perplexes me that with such a collection of brain-power, nobody 'inside ReSPECT' seems to have properly understood the Mental Capacity Act.

As for 'Senior and authoritative legal advice was accessed by the working group who devised the form and process' well, it took an age for its FAQs to be improved where they covered legal proxies, and I have got my own [if 'off-the-record'] 'senior legal advice'

[https://twitter.com/MikeStone2\\_EoL/status/906073527236907009](https://twitter.com/MikeStone2_EoL/status/906073527236907009)

and – as the Montgomery and Briggs rulings proved - 'authoritative legal advice' is an interesting phrase.

The overall purpose of the ReSPECT process is to move clinical practice, within all venues of care, away from a binary decision about 'for' versus 'not for' CPR and more towards a positive discussion between clinicians, patients and their representatives about the medical realities, with consideration for the patient's circumstances.

Firstly – our law for Advance Decisions is very clear: a patient can forbid attempted CPR either 'absolutely' or with a conditionality (a circumstance which must be present, for the refusal to apply).

The ReSPECT Form is something to do with best-interests decision-making, and we simply should not be trying to promote best-interests decision-making 'during clinical 'emergencies'' about things such as CPR: we should be promoting the making of Advance Decisions by patients, and the following of those ADRTs by clinicians [and by other carers].

The form was designed as a general purpose form and the signing of it by a clinician is to be taken as an indication by the clinician that the provisions of the Mental Capacity Act have been followed. By signing the form, the clinician is making it implicit that they have taken account of the patients view, if they had capacity at the time the form was completed. If the patient lacked capacity at the time the form was completed, the clinician confirms by signing that relatives, carers and any Lasting Power of Attorney for Health and Wellbeing or other legal proxy as appropriate was consulted.

The form is 'too general purpose' in the sense that it covers countries with different legal frameworks, and both adults and children for whom the laws differ: it is too restricted (not sufficiently 'general purpose') in that it specifically cannot also serve as an Advance Decision if the patient wished it to do that.

And – AS I HAVE POINTED OUT – the clinician CANNOT attest that 'the provisions of the 'provisions of the Mental Capacity Act have been followed' because THE CLINICIAN IS ONLY AWARE OF WHAT THE CLINICIAN HAS HIM/HERSELF DONE OR BEEN TOLD OF.

Also – there is NO CONCEPT WITHIN THE MCA of any person who isn't a Judge 'validating compliance with the MCA's best-interests requirements'. There is the concept of 'challenge' - which applies to anyone's best-interests decision-making, but the concept of 'challenge' is VERY RESTRICTED INDEED if the decision-maker is an empowered attorney or deputy: sections 6(6) and 6(7) of the Act, or section 7.29 of the Code of Practice:

7.29 Attorneys must always follow the Act's principles and make decisions in the donor's best interests. If healthcare staff disagree with the attorney's assessment of best interests, they should discuss the case with other medical experts and/or get a formal second opinion. Then they should discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection (see paragraphs 7.45–7.49 below). While the court is coming to a decision, healthcare staff can give life-sustaining treatment to prolong the donor's life or stop their condition getting worse.

I would highlight 'While the court is coming to a decision'.

A decision to provide treatment is a clinical one of course, irrespective of whether the patient does or does not have capacity.

I prefer 'offer' to 'provide' - the general concept is that clinicians are not required to offer a treatment which would be clinically ineffective, but for CPR there is also section 4(5) of the MCA to be considered.

Clearly, a patient with capacity may refuse treatment even if that did not seem sensible in terms of the clinical outcomes.

You will know that the Court of Appeal judgement in R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors (2014) clarified that emergency treatment decisions are to be based on clinical judgement, hence the form being ultimately signed by a clinician, but information around treatment options must be given to the patient under duties of consultation and involvement.

No – I didn't 'know' that.

So far as I'm aware, Tracey was about the communication to patients and relatives of opinions held by clinicians that attempted CPR 'could not be clinically successful', when the clinicians have decided to not attempt CPR based on their opinion that attempted CPR would not be successful.

Which IS NOT 'emergency treatment decisions are to be based on clinical judgement'.

FURTHERMORE that sentence in the e-mail from the CQC is NOT CONSISTENT WITH the revised ReSPECT FAQs, which do make it clear that 'best interests' still applies during emergencies – the relevant section of the FAQs is:

'Where emergency treatment has been started as a result of a recommendation, then as part of the continuing review of the person's care and updating of the ReSPECT recommendations, the attorney should be consulted as soon as practicable to confirm whether they agree that the treatment should continue. If the attorney does not agree, then, again save in exceptional circumstances, the treatment must stop (including life-sustaining treatment if the power of attorney specifically contains the power to refuse such treatment).'

I fully support the idea that any record of 'in my opinion attempted CPR could never be successful irrespective of why this patient arrests' should be signed by the clinician

whose opinion that it – that ISN'T 'emergency treatment decisions are to be based on clinical judgement'!

If a patient lacks capacity then by extension such consultation must take place under the framework of s.4 of the Mental Capacity Act, hence involving any legal representatives and/or family where relevant.

This is so legally-flawed in terms of its lack of clarity and ambiguity, that I'm wondering if it was written by the RC(UK) – it most definitely would NOT have been penned by the CQC's former MCA Lead. Section 4 of the MCA, along with 6(6) and 6(7) certainly explain the 'rules' - but that sentence is NOT a useful and unambiguous description of s4 and 6(6/7).

Respect forms are not legally binding, nor are they consent forms or Advance Decisions to Refuse Treatment, rather they are recommendations to guide immediate decision-making. You are aware of the "What is a legal proxy and what is their role?" and "Why is there no section on the ReSPECT form for the signature of the person or their relatives/legal proxy?" responses to the FAQ at <http://www.respectprocess.org.uk/faqs.php>.

Yes, I've read the ReSPECT FAQs. The FAQs covering legal proxies have been belatedly improved significantly (see above, as an example of that improvement).

The explanation as to why patients, legal proxies and 'relatives' are being prevented from signing the ReSPECT Form is, however, 'deeply unsatisfactory' - and very obviously so for empowered legal proxies [the argument for 'relatives' is more intricate – but I believe still compelling].

CQC do not seek to vary from this position.

Yes, I've gathered that from this reply to me – however, I would rephrase that as 'the CQC intends to support a 'legally-perverse absence of non-clinical signatures on the ReSPECT Form'.

As you are aware, and reference in your most recent email to CQC dated 21 December, the guidance around legal proxy has recently been updated to clarify "If the attorney has the power to consent to or refuse life-sustaining treatment, and makes clear that they would exercise that power on behalf of the person to refuse treatment in particular circumstances, then in general no recommendation should be

made for such treatment to be administered in those circumstances.” This would appear to satisfy your concerns with respect to decision-making but we would note this applies only where Legal Power of Attorney’s are specifically so authorised.

That doesn’t address an issue I pointed out to the CQC via my Letter to the OPG:

<https://www.dignityincare.org.uk/Discuss-and-debate/download/283/>

‘More importantly, because of 6(6) if the attorney signs the ReSPECT form, the ‘recommendation’ about what is likely to be in the patient’s best interests directly carries the legal authority of the attorney ‘to the reader’s eye’: there is no genuine ‘legal authority’ over best-interests decision-making, carried by the signature of a clinician.’

Section 6 subsections (6) and (7) of the Mental Capacity Act clearly describe the provisions and limitations of any person authorised through Lasting Power of Attorney – ie nothing stops a person providing life sustaining treatment while a decision for any relevant issue is sought from the court. This is further explained in the following paragraphs of the Mental Capacity Act Code of Practice:

7.30 An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if, when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority.

7.31 As with all decisions, an attorney must act in the donor’s best interests when making decisions about such treatment. This will involve applying the best interests checklist (see chapter 5) and consulting with carers, family members and others interested in the donor’s welfare. In particular, the attorney must not be motivated in any way by the desire to bring about the donor’s death (see paragraphs 5.29–5.36). Anyone who doubts that the attorney is acting in the donor’s best interests can apply to the Court of Protection for a decision.

It isn’t obvious why there is a mixture of Act and Code being quoted here – however, if 7.30 and 7.31 were being quoted, then instead of sections 6(6) and 6(7) of the Act being mentioned, it would instead have made sense to use section 7.29 of the Code:

7.29 Attorneys must always follow the Act’s principles and make decisions in the donor’s best interests. If healthcare staff disagree with the attorney’s assessment of best interests, they should discuss the case with other medical experts and/or get a

formal second opinion. Then they should discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection (see paragraphs 7.45–7.49 below). While the court is coming to a decision, healthcare staff can give life-sustaining treatment to prolong the donor’s life or stop their condition getting worse.

In your email of 21 December 2017 you specifically asked “How can the senior clinician, confirm that an attorney or deputy has complied with the MCA: for example, compliance requires widespread consultation with many parties, to be carried out by a best-interests decision-maker - but how would the senior clinician, be aware of consultations which the clinician was not involved in?”. In response we would re-iterate that the clinician in signing is confirming that they are aware of any pertinent consultations. Sections 2 and 6 of the ReSPECT form outline the need to reference other documents that pertain to the completion of the ReSPECT form – in particular section 6 says “Record date, names and roles of those involved in decision making, and where records of discussions can be found”

This is a ‘complete logical mess’, and obvious issues include:

- 1) Why does the ReSPECT Form ‘reference Advance Decisions’ instead of stating in its Box 2 ‘if you have made an Advance Decision clip it to the front of this ReSPECT Form’ - a point I made in an e-mail to the new President of the RC(UK) just a few hours before I opened this response from the CQC;
- 2) ‘In response we would re-iterate that the clinician in signing is confirming that they are aware of any pertinent consultations.’ is such a ‘logically bonkers’ reply to ‘how would the clinician be aware of things the clinician was not involved in?’ that it defies a really concise analysis: however, I will be writing further about this issue separately.

We issued guidance to our inspectors in February 2017 directing them to consider not just the content of a ReSPECT form when assessing Mental Capacity Act compliance in relevant settings, but how the ReSPECT form fits with a planned process of care, good communication with appropriate persons (thereby including for example Legal Power of Attorney’s) and the wider provisions of the Mental Capacity Act.

Assuming that guidance is more than the sentence I have just read there, I WOULD LIKE TO READ IT.

We do not require providers to use the ReSPECT process, but expect that they would have an equivalent local policy and process in place if they are not currently using it. ReSPECT forms do not invalidate existing DNACPR instructions, nor other advance care planning. Whilst it is seen that over time ReSPECT forms will replace existing DNACPR instructions, CQC's position is not relative to the forms themselves, but rather ensuring the provisions of the Mental Capacity Act are being met and that good, effective care is being provided.

It seems to me that the CQC and I both share an objective:

'ensuring the provisions of the Mental Capacity Act are being met'

but that the CQC and I differ about what the Mental Capacity Act says.

#### CLOSING COMMENT

I will be asking the CQC for that guidance

'We issued guidance to our inspectors in February 2017 directing them to consider not just the content of a ReSPECT form when assessing Mental Capacity Act compliance in relevant settings, but how the ReSPECT form fits with a planned process of care, good communication with appropriate persons (thereby including for example Legal Power of Attorney's) and the wider provisions of the Mental Capacity Act.'

unless I can find it online.

We hope that you find this response helpful.

Kind regards

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#### COMMENTS ON THE FIRST E-MAIL END.

I sent an e-mail, asking where could I find the guidance for its inspectors which the CQC mentioned – the CQC replied that the guidance is 'private' and I do not consider that to be satisfactory: the CQC's guidance to its inspectors about the MCA will have an effect on patients and relatives, so I consider that we should all be able to read that guidance, to form a view about whether the guidance is legally correct.

I sent:

Dear Enquiries,

I would like to read the guidance you mentioned in your e-mail to me:

'We issued guidance to our inspectors in February 2017 directing them to consider not just the content of a ReSPECT form when assessing Mental Capacity Act compliance in relevant settings, but how the ReSPECT form fits with a planned process of care, good communication with appropriate persons (thereby including for example Legal Power of Attorney's) and the wider provisions of the Mental Capacity Act.'

If that guidance is available to read somewhere online, would you please send me the necessary URL.

If not, then do you require me send you an FOI requesting it, or will you simply send it to me?

Regards, Mike Stone

The Care Quality Commission replied:

Dear Mike,

Thank you for contacting the Care Quality Commission (CQC), your enquiry reference is ENQ1-4842866420.

In relation to your query, unfortunately, the document you are referring to is only available internally. However please see our [Right here, right now: Mental health crisis care review](#) webpage for information.

I hope that this helps. If you have any further queries please do not hesitate in contacting us again.

*We welcome feedback and your thoughts, comments and suggestions are very valuable to us. Please share your experience with us by clicking [here](#).*

Yours sincerely,