Derby and Derbyshire Safeguarding Adults Boards

Guidance to Assessing Mental Capacity and Making Best Interests Decisions

November 2023

Foreword from Emily Freeman, Chair of the Mental Capacity Act Subgroup for Derby and Derbyshire Safeguarding Adults Boards

The MCA subgroup for Derby and Derbyshire Safeguarding Adults Board would like to extend their thanks and gratitude to Waltham Forest Safeguarding Adult Board for their permission to use the Guidance to Assessing Mental Capacity and Making Best Interests Decisions document that was produced by their Mental Capacity Subgroup in 2021. This guidance aims to "demystify the Mental Capacity Act and make key aspects workable in practice."

Appropriate interpretation and application of the Mental Capacity Act 2005 (MCA) continues to be a recurrent theme in Safeguarding Adult Reviews and multi-agency case file audit findings both locally and nationally. As such, Derby and Derbyshire MCA Subgroup have reviewed the Waltham Forest guidance document, to align it with local practice and case examples, and are pleased to be able to share this updated guidance document for use.

I would like to thank members of the Derby and Derbyshire Safeguarding Adults Boards joint MCA Subgroup for their expertise, hard work and support in reviewing and updating this guidance. We hope that the guidance is useful to anyone seeking to apply the MCA in practice.

For more information on Safeguarding Adults Board, please see

https://www.derbyshiresab.org.uk/home.aspx and https://www.derbysab.org.uk/

Contents

This guidance is adapted by Derby and Derbyshire Safeguarding Adults Boards from Waltham Forest Safeguarding Adults Board 's Guidance to Assessing Mental Capacity and Making Best Interests Decisions (June 2021).

1.0. Introduction

The aim of this document is to provide guidance in relation to assessing mental capacity and making best interests decisions in accordance with the Mental Capacity Act 2005 (MCA). It is not our intention to cover the many other provisions within the legislation. Further information is available from your organisations' policies, process and practice guidance.

The MCA and its associated Code of Practice provide a statutory framework to empower and protect those who may lack capacity to make decisions because of mental impairment. The MCA Code of Practice sets out who can take decisions, in what circumstances, and how they should do this. The MCA also enables adults to plan for a time in the future when they might lack capacity, by giving them the opportunity to appoint a Lasting Power of Attorney (for property and finance and/or health and welfare) and make Advanced Decisions or Statements.

The MCA Code of Practice places a duty on all staff (e.g. health, social care, care providers, police, housing, ambulance and fire services and volunteers) to support people to make their own decisions wherever possible, to assess mental capacity and make best interests decisions on their behalf, as required.

The MCA applies to those aged 16 years and over, however some provisions are reserved for those aged 18 years and above e.g. the making of a Lasting Power of Attorney, the ability to act as someone's Attorney, the ability to make an Advance Decision to Refuse Treatment and the Deprivation of Liberty Safeguards (DOLS).

The DOLS were introduced, as an amendment to the MCA, on the 1st April 2009. They provide lawful authority to detain people in care homes and hospitals for the purpose of providing necessary care and treatment in their best interests. The DOLS do not authorise the care and treatment.

There is no legal definition of a Deprivation of Liberty but the Supreme Court 2014 provides us with the "Acid test" which helps to determine whether a person is objectively deprived of their liberty.

1) The person lack capacity to make a decision about where they are accommodated for care and treatment; and
2) The person is under continuous supervision and control; and
3) The person is not free to leave.

2.0. Explanations of terms and definitions:

ADRT or Advance Decision to Refuse Treatment	A refusal of a treatment that may be required in the future, made by someone who had mental capacity to make that decision at the time the decision was made. It is legally binding if it is valid and applicable. (Exceptions will apply in circumstances where the Mental Health Act is applicable.)
Advance Statement	This is a statement of wishes, preferences, values and beliefs. It is not legally binding but should be considered when making a best-interests decision for someone who lacks capacity to make that decision for themselves.
Court Appointed Deputies	Individuals appointed by the Court of Protection to act on behalf of adults who lack capacity and make decisions on their behalf about health and welfare and/or property and finance.
Deprivation of liberty Safeguards	The Deprivation of Liberty Safeguards (DOLS) is the procedure prescribed in law when it is necessary to deprive of their liberty, a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.
Human Rights Act 1998	The Act sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic law.
IMCA Independent Mental Capacity Advocates	Independent Mental Capacity Advocates were introduced as part of the MCA. This gives people who lack capacity to make certain decisions for themselves, the right to receive independent support and representation. Please see the MCA Code for full details on when an IMCA might be required.

Lasting Power of Attorney (LPA)	This allows an adult to appoint a person(s) to make decisions on their behalf in case they lack capacity to make a decision for themselves at some time in the future. There are two types of LPAs: 1. Health and Welfare 2. Property and Financial Affairs
Life-sustaining Treatment	This is any medical intervention, technology, procedure, or medication which a person providing healthcare regards as necessary at the time in question to sustain life.
Safeguarding Adult Review (SAR)	This is a multi-agency process that considers whether serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

3.0. Mental capacity: some key issues to consider

The MCA sets out five core principles which must be followed:

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes a decision that others believe to be unwise.
4. An act done or decision made, for or on behalf of a person who lacks capacity must be done so, or made in his or her best interests.
5. Before such an act is done, or decision 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.

4.0. What is a mental capacity assessment?

Principle 1 of the MCA is the presumption of mental capacity. However, if a person's mental capacity to make a decision is in doubt, professionals **MUST** apply the Mental Capacity Act 2005 (MCA). The ethos of the MCA, along with all effective Human Rights-based practice, is to work with people and empower where possible, rather than do things for people. This

reflects a strengths-based approach, where the focus is on a person's abilities, knowledge and capacity rather than their deficits.

- **A mental capacity assessment is, in many ways, an attempt to have a real conversation with the person on their own terms, applying their own values and beliefs.** For example, it is essential to recognise and explore the importance of culture or religion to a person and how this may influence their decision making.
- **Mental capacity assessments are time and decision specific: the person's ability to make a specific decision at the time it needs to be made.** This means that it is essential that the decision is clearly defined and that the assessment of a person's ability to make a decision may need to be revisited, as their capacity may change over a period of time.

When assessing a person's capacity, the focus should always be on ensuring that the assessment is relevant to the person circumstances and the decision in question. It is important to make attempts to inform the person before assessing their mental capacity and explain the reasons for this in way that the person can understand. Every effort should be made to share relevant information with the person in an accessible way, recognising the individuals' specific communication needs and diversity, to support participation in the assessment.

The assessment process may be seen as intrusive to the person and can interfere with their right 'to respect for private and family life' (Article 8 Human Rights Act). Therefore, you must always have grounds to consider an assessment necessary. Conversely, you must also be prepared to justify a decision not to carry out an assessment, where there appears to be a reason to consider that the person could not take the relevant decision(s).

The MCA Code of Practice does not define who should undertake a mental capacity assessment. It identifies different people may be appropriate depending on the decision. For example, if the decision is about the delivery of care or the support required by a person to access the community, a social care worker may be best placed to be the assessor and decision maker. Whereas a decision relating to medication administration and non-compliance would be best considered by a health professional.

It is important to recognise that professionals have skills and expertise relating to different decisions and that identifying the most appropriate professional for the decision in question is essential.

5.0. Fluctuating and temporary capacity

Some people have 'fluctuating capacity' or 'temporary capacity' and it is important to distinguish between the two, see below:

What is fluctuating capacity?
A person with fluctuating mental capacity, such as a person with bi-polar disorder, is someone whose mental impairment may lessen or become more severe over time which means that they may have periods when they are perfectly capable of making decisions and other times when they are not. The fluctuation in someone's mental capacity can take place over a matter of days or weeks, or even over the course of each day. For example, for some people with dementia may be significantly less impaired at the start of the day than they are towards the end. This must be considered when assessing their mental capacity and supporting them to make a decision.
How to address fluctuating capacity?
Consider whether the decision is one that can wait. If it can, then delay it until the person may be able to be supported to make their own decision. If the decision(s) cannot wait, then assess the person's mental capacity and follow the best interests decision making process as normal. However, remember that further and regular assessments may be required if the person's mental capacity fluctuates.
What is temporary capacity?
A person who has a temporary impairment of the mind or brain that affects their ability to make decisions e.g. a person suffering from a severe urinary tract infection and experiencing confusion, unconsciousness, severe head injury or even the effects of alcohol or drugs.
How to address temporary capacity?
Where the decision cannot be delayed, then assess mental capacity and follow the best interests decision making process as normal. It would be sensible to keep the mental capacity assessment under review and be prepared to re-assess when there are indicators that the person's condition has improved, and they may have regained capacity. It is of note that all mental capacity assessments must be kept under review, and even more important for those people whose mental capacity fluctuates, or their loss of mental capacity is thought to be of a temporary nature.
Executive dysfunction
Another common area of difficulty is when the person seems to say one thing but does another, this may be a result of executive dysfunction. Where executive dysfunction may be a factor, the capacity assessment should include conversations with those who know the person best; getting a full picture of the person's real-world experience; conversations with the person and considering whether a medical review may be necessary. A person-centred robust capacity assessment will be necessary to understand whether the person is making an 'unwise' decision (has capacity) or is unable to understand the risk/consequences because of a mental impairment (lacks capacity).

6.0. How to establish consent?

Consent is a person's agreement to someone e.g. a volunteer, carer, health and / or social care professional, to provide support, care or treatment. A person may indicate consent non-verbally (for example by presenting their arm for their pulse or blood pressure to be taken), verbally, or in writing.

It is important to recognise that a person may have capacity to agree or disagree with a course of action. If the person disagrees, it does not necessarily indicate that the person lacks capacity to make a specific decision.

For the consent to be valid, the person must:

- Have the mental capacity (understand, retain, weigh up and communicate) to make the particular decision
- Have received sufficient information to inform the decision they are making
- Not be acting under duress of others

If there is any indication that the person lacks mental capacity to give informed consent, a mental capacity assessment must be carried out. Please refer to the Mental Capacity Assessment flowchart on page 9.

7.0. Recording and documentation for professionals

Simple Decisions: It is required practice to make reference to mental capacity/best interests in care records even for simple everyday care decisions, although detailed recording is not usually expected.

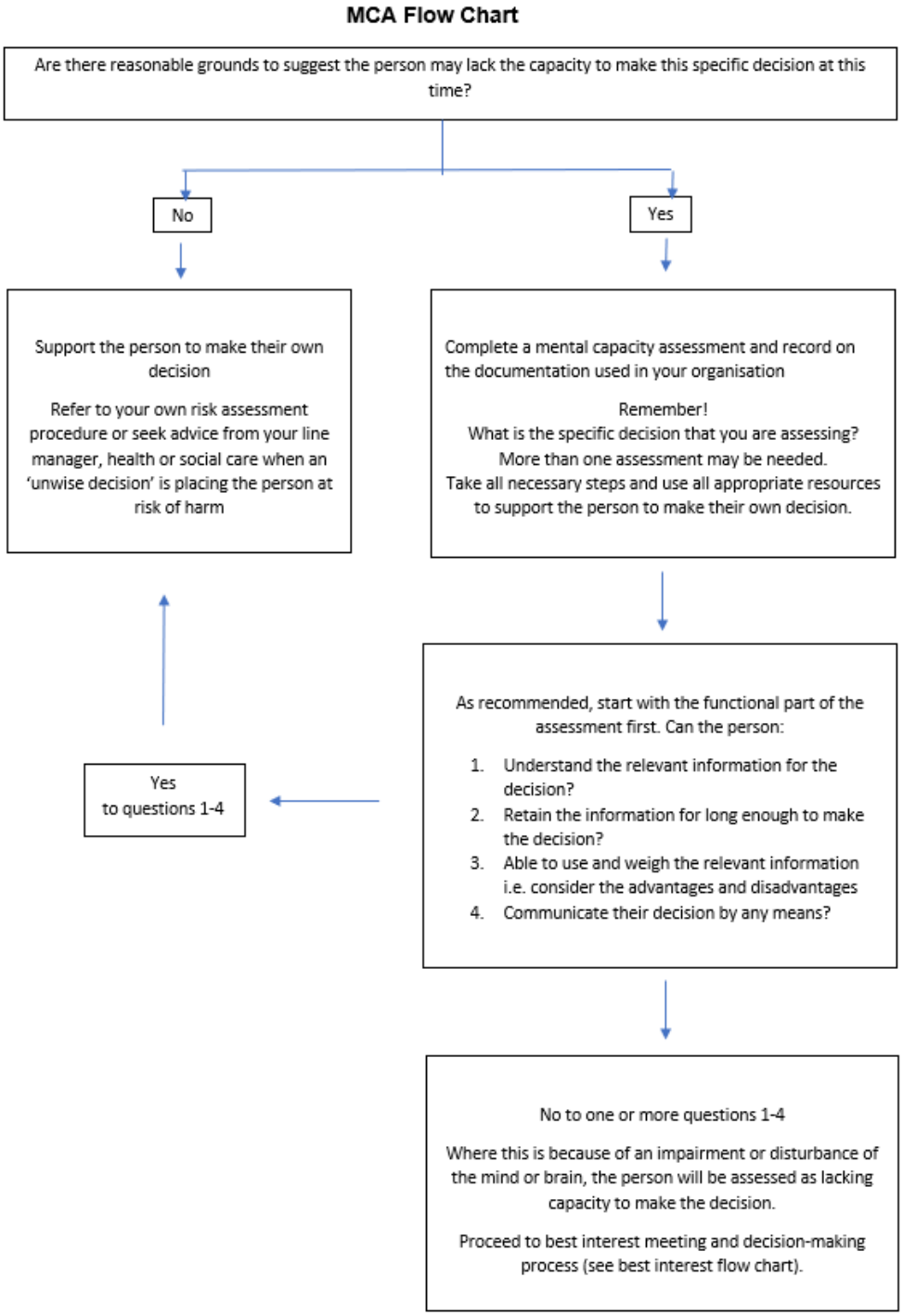
Intermediate or Complex Decisions: Recording for these decisions is required to be more in-depth and demonstrate how a particular conclusion was reached during the mental capacity assessment, as well as best interest considerations as outlined in the 'Best Interests' checklist.

A balance sheet approach i.e. listing the available options and highlighting the pros and cons of each is also helpful for analysing each option to reach a decision about the least restrictive option, that is in the person's best interests.

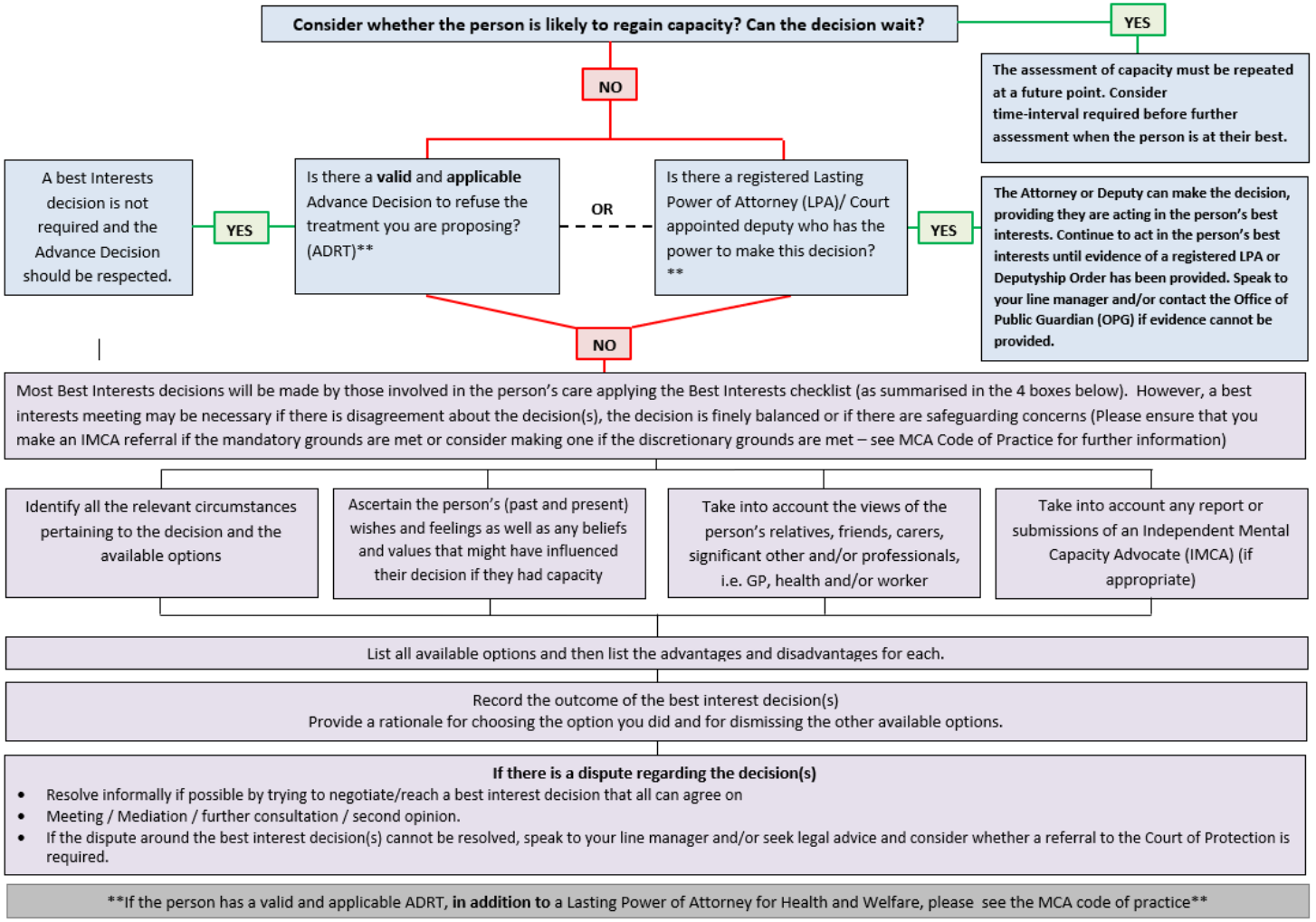
N.B. Please follow your own agency's protocol for recording capacity assessments and best interest decisions.

8.0. Mental capacity assessment flowchart (a)

This flowchart provides practical steps to support people to assess mental capacity. It is not intended to be definitive guidance - please refer to your own organisation's MCA policy and procedures, as well as the MCA Code of Practice for further information.



9.0. Best interests decision flowchart (b)



10.0.Safeguarding and mental capacity

Where an adult who has care and support needs is actually, or potentially, at risk of harm/abuse the Local Authority has a statutory duty under the Care Act 2014 to offer to safeguard the person.

If there is some concern that the adult may lack mental capacity with regard to any decision(s) that needs to be made throughout the safeguarding process, then the MCA must be applied as highlighted throughout this document i.e. the adult's mental capacity should be assessed and the best interests decision-making process followed.

Where the Local Authority feel that the adult would have 'substantial difficulty' participating in the safeguarding process and does not have an appropriate person (other than a paid professional) to support them, then the adult has a right to an advocate under the Care Act 2014.

Alternatively, there are discretionary powers for the Local Authority or NHS provider to instruct an Independent Mental Capacity Advocate (IMCA) for the purpose of decision(s) around the safeguarding process or any measures/services that might be offered to protect the adult. This might include significant matters such as a change of accommodation or contact with a family member or friend.

An IMCA can be instructed under safeguarding even if the adult has family or friends who are involved in their life if it is thought that this would be of benefit to the person.

In terms of safeguarding, the MCA also created two criminal offences of ill-treatment and wilful neglect of someone who lacks capacity in relation to at least some aspects of their care provision. These offences can be committed by anyone responsible for the person's care and support (paid and informal carers) and can result in a custodial sentence in some instances.

If you have safeguarding concerns for adults or children, please contact the Derby City or Derbyshire social care teams via the contact details listed.

What to do if you have concerns:

Check the details below and add email if appropriate

If you have safeguarding concerns for adults or children, please contact Derby or Derbyshire safeguarding teams to report any safeguarding concerns, or if advice and support is required:

Concerned about an adult?

Derby City Phone: 01332 642855

Website: Derby City Council – Safeguarding Adults

Derbyshire County Council Phone: 01629 533190

Website: Derbyshire County Council – Safeguarding Adults

Concerned about a child?

Derby City Phone: 01332 641172

Website: Derby City Council – Safeguarding Children

Derbyshire County Council Phone: 01629 533190

Website: Derbyshire County Council – Safeguarding Children

11.0. Considerations on the wider context of care provision

The person is at the centre of their care and support

- The person's views and wishes must always be valued and where appropriate in line with 'Making Safeguarding Personal'
- The person should be informed of every step of the process
- Listen to them and work towards the outcome they want

Don't walk away – walk alongside

- People who have a cognitive impairment may find it difficult to engage with agencies – continue to support, and take time to build a trusting relationship
- Present the information on the basis of their understanding when discussing the decision you need them to make. It is not necessary that the person understands every element of what is being explained to him. What is important is that the person can understand the 'salient' factors
- If the person has mental capacity, do not judge them when they make an 'unwise decision'. The key to a successful assessment is patience and empathy
- Work with them, provide and empower them to help themselves when possible
- Always apply the least restrictive option in the person's best interest

Multi-agency approach

- Include other agencies and organisations. Who else is involved? Who needs to be involved?
- What information is held by others and/or is required?
- Work collaboratively to share risk with your colleagues from across the partnership

Think family

- What impact is the person's behaviour having on the people around them?
- What impact are the other people in the family having on the person
- Is there anyone else at risk i.e. in a domestic abuse or elder abuse situation?
- Does the person have a statutory right to advocacy?

Think family, think community and wider than statutory services

- Engage the community, friends and family
- With informed consent (where that can be obtained) speak to neighbours or anyone else the individual may interact with
- Are there any voluntary/community organisations who could offer support?

Build trust

- Form a relationship, start conversations to get to know the person rather than immediately focus on the issues;
- Keep communication consistent
- Provide reassurance: the person may fear losing control. It is important to allay such fears.

- Agree to small steps
- If the person is known to have fluctuating mental capacity, please plan for a time to have a discussion with the person at their least impaired and make best interest decisions at a time when the person lacks mental capacity to make a decision(s)

Build trust

- Understand the person's background – incorporating their wishes
- Always treat the person with respect and dignity
- Be non-judgemental and anti-discriminatory

12.0.Case examples around mental capacity:

Case study on self-neglect: Joe

Joe is a 58-year-old man, who is diagnosed with paranoid schizophrenia. He lived in his own home in the community and valued his independence. He was supported by social care and the mental health team, who were involved in monitoring his wellbeing and providing intervention when his mental health deteriorates. His home environment was poor, and he was reported to be living in in squalor, despite him having some support.

His workers focused on supporting Joe to remain in his home to live independently but did not coordinate an approach to the delivery of support which resulted in his situation deteriorating further. Joe's condition worsened and his family raised concerns for him, recognising his significant weight loss. He was malnourished. He had no food in his home and his teeth were decayed. Those supporting Joe had failed to adequately assess his mental capacity to look after himself at home. The capacity assessment undertaken did not consider the key decisions to be made, which were Joe's ability to feed himself and care for himself.

The Mental Capacity Act 2005 states that a person should be presumed to have capacity unless it is established that they lack capacity.

This case was referred to the Ombudsman who stated:

"Health and social care professionals were so fixated on the man's wishes to live independently, that they failed to carry out a capacity assessment of his ability to look after himself, which would have revealed that he was unable to cope with everyday tasks like feeding himself and cleaning……While I have no doubt in this case that the care team was seeking to provide the best support, their presumption that the person affected had the mental capacity to make his own decisions resulted in him being malnourished. This was detrimental to his health and distressing for his family."

The Ombudsman also confirmed that there was sufficient information for professionals to challenge the presumption that the man had capacity to make this decision.

This case illustrates the need to undertake a Mental Capacity assessment relating to a specific decision, listening to the persons views as part of the assessment in addition to considering the evidence available from a variety of sources to decide on the person's ability to make the decision and their ability to enact their decision.

Joe has subsequently moved into a supported living service, where he is doing well. He is receiving support to meet his needs but also to continues to enjoy his independence.

Case study on hospital discharge concerns: Calvin

Calvin is a 48-year-old man who has had a cardiac arrest and as a result, sustained an anoxic brain injury. Prior to his cardiac arrest he lived at home with his wife and 4 children. He ran his own business, loved sports and being outdoors. He spent 3 months in hospital before a transfer to a rehabilitation ward to prepare him for discharge.

Calvin was very unsettled on the ward and sought to leave on daily basis, he required intervention from multiple security staff to keep him safe. His wife visited him each day spending time with him and providing him with support. He responded well to this support.

Calvin was assessed as lacking capacity to make a decision about his care and support to progress his rehabilitation. In planning his hospital discharge, the ward discharge team undertook a best interest meeting. It was agreed that Calvin would be moved to a rehabilitation placement over 30 miles away from his home. This was felt to be the most suitable service to progress his recovery.

As part of the Deprivation of Liberty Safeguards (DOLS) assessment work it became apparent that Calvin's wife objected to this plan. She identified the importance of her visits to Calvin and how difficult she would find to visit him, whilst caring for their 4 children. This decision was challenged, and a placement was identified closer to the Calvin's family home. This allowed Calvin to receive care and he also start visiting his home and family supported by his wife and care staff. This went so well that Calvin went home for a visit and did not want to return into care.

He remains at home supported by his wife, with care being commissioned to deliver care and provide ongoing rehabilitation. Calvin is able to spend time with his family and access the outdoors, two things that are very important to him. This has supported his mental wellbeing, in addition to his physical recovery.

Case study on revisiting decision: Raj

Raj is a 26-year-old woman with a learning disability. She lives in a supported living service. Raj accesses the community without support but will always tell staff where she is going and when she will be back.

Raj is able to use the internet and accesses social media platforms. She has been approached by person via the internet, who she views as her friend and has arranged to meet the person at their request. Raj did not talk with staff about this but mentioned her plans to her sister who raised concerns.

Those supporting her were worried about her plans and felt that she could be at risk of harm. They talked with Raj about her actions and her decisions to meet the person she considered to be her friend, despite not knowing them. She cannot see any problem with this. The manager of the service alerted Raj's Social Worker to the identified risk, who sought legal advice.

A capacity assessment was completed by the manager of the supported living service. It became clear that Raj was unaware of the possible risk of harm to her when communicating with people on the internet and planning to meet strangers. Raj held the view that the person is her friend and as a result she is not at risk of harm. Raj's Social Worker was updated on this and sought further legal advice on the actions that needed to be taken.

A plan was agreed for staff to support Raj access the internet, so they can identify possible risks to Raj and on this occasion, Raj agreed to cancel the meeting with the friend.

Those supporting her made a referral to the Community Learning Disability team. Workers in this team met with Raj on a number of occasions to provide information and education her on the safe use of the internet and the potential risks. They used simplified language, visual aids and practical examples recognising Raj's communication needs and to support her learning and understanding.

Raj's Social Worker visited her to review her care. Raj and the support staff have worked together to develop a plan to minimise risk. When revisiting Raj's ability to make a decision about accessing the internet, Raj was able to demonstrate a better understanding of the risk and made a decision to seek staff support when using the internet. The staff continue to support Raj to develop her knowledge and ensure an appropriate and proportionate level of support is available. This continues to be reviewed and monitored recognising the potential risk to Raj but also her wish to continue to use the internet and access the community unsupported.

Case study on advance decision: Georgia

Georgia is a 36-year-old woman who was diagnosed with Multiple Sclerosis, which she is aware is likely to start to impact on her ability to make decisions and care for herself in the future. Whilst she has capacity, she makes an advance decision. She stated that if she loses the ability to look after herself because of her memory problems, and couldn't communicate her decisions, she did not wish to be resuscitated if this became necessary.

Shortly after Georgia was a passenger in a car and was involved in an accident. She sustained serious injuries and was taken to the Accident and Emergency (A&E) where staff assessed her condition. During this time, she lost consciousness and she had a cardiac arrest. The staff made the decision to resuscitate her.

In this case the staff were in an emergency situation and gave treatment to Georgia including resuscitating her. They had been made aware that there was an advanced decision but were unclear of the full detail and if it were applicable in this case.

At the time of the accident Georgia lived in her own home and was able to care for herself. After a lengthy hospital stay, she made a good recovery from her injuries and was able to return to her own home, with some initial support to meet her care needs.

Case study on hospital discharge: Graham

Graham is a 52-year-old gentleman, who has suffered an Intracerebral Haemorrhage, and required a craniotomy to remove a clot from his brain. Since this devasting incident he has received care and treatment on an acute Stroke ward for the last 3 months. Graham is now medically optimised but cannot walk and requires rotunda equipment and support from carers to transfer from bed to chair. Graham is experiencing aphasia, a communication difficulty that is affecting his ability to talk to people and understand what other people are saying.

Graham was fiercely independent prior to his Stroke and the affects have been highly distressing for Graham and his wife. The therapists on the ward have recommended that

Graham transfers to a neuro rehab with the aim of improving his communication, cognition, and mobility skills. However, Graham is indecisive, and is voicing that he wants to go both home and go to neuro rehab. Following thorough conversation with Graham, the therapists have picked up that Grahams memory problems have impacted his ability to recall and understand how his Stroke has affected his ability of daily living. Graham has also been observed trying to stand, forgetting that he required assistance from staff and a rotunda to transfer safely.

Professionals identified a reason to doubt Graham's capacity to make this specific decision himself. The Speech and Language therapist supported the Occupational Therapist to establish the best possible method of communication. A Mental capacity assessment was completed by the Occupational Therapist proposing transfer to the neuro rehab with support from the Speech and Language therapist. Graham was found to lack capacity to consent or refuse transfer to neuro rehab.

Graham continued to voice different wishes when this was discussed. A Best Interest Meeting was held which Graham, his wife, ward leader, doctor, Speech and Language Therapist, Occupational Therapist, Physiotherapist attended. These professionals were all relevant to the decision. The Neuro rehab ward leader attended by MS Teams. All the risks and benefits of transferring to neuro rehab and going home were discussed in the meeting. After attending the meeting, Graham voiced that he wanted to go to rehab, and his wife also agreed. Graham's wife had felt torn beforehand as Graham had been saying he wanted to go home sometimes, and this was highly emotive for her.

The Best Interest decision was made that Graham should transfer to Neuro rehab at the end of the week, but ward staff were required to monitor for any objections from Graham and his wife. Following the meeting there were no objections or concerns voiced and Graham transferred to rehab 5 days later. Graham had clearly voiced during the meeting that he wanted to take every available opportunity to get better as he will not get this chance again.

13.0.Further reading on mental capacity:

For further guidance see **https://www.39essex.com/sites/default/files/Mental-Capacity-Guidance-Note-Fluctuating-Capacity-in-Context-December-2021.pdf**

Additional information: **https://capacityguide.org.uk/flashpoints/the-person-seems-to-say-one-thing-and-to-do-another/** **Possible?**

This guidance should be read alongside:

Mental Capacity 2005	Mental Capacity Act Code of Practice	Care Act 2014
Derby and Derbyshire SABs Safeguarding Adults Policy and Procedures	DOLS Code of Practice	Making Safeguarding Personal (2014 Guide)
Derby and Derbyshire Safeguarding Adults Board: Adult Safeguarding Decision-Making Guidance		

14.0.Other useful links:

Age UK	SCIE MCA website	National MCA Forum
Alzheimer's Society	Office of the Public Guardian	Independent mental capacity advocate service
Mental Capacity Law and Policy	Essex Chambers resource on Mental Capacity law	National Autistic Society

With thanks to Waltham Forest Safeguarding Adults Board for permission to use their document.

Amended and adopted by partners of the Derby and Derbyshire Safeguarding Adults Board & voluntary organisations.