Capacity to Consent Policy

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Summary	This document sets out the policy for the standards and guidance for Primary Care 24 which enables health professionals to comply with law and guidance with regards to consent and the processes for managing consent.

Version	Date	Control Reason	Title of Accountable Person for this Version
V3.0	13.02.2017	Significant changes made to include: 1 Title change to incorporate capacity to consent. 2 Duties and Responsibilities. 3 Mental Capacity section incorporated into the Consent Policy. 4 Equality & Health Inequalities Statement added 5 Personal Information Statement added	Associate Director of Quality & Patient Safety
V4.0	31.01.2018	1 Changes made to reflect service change 2 Title changes of Senior Nursing staff 3 Best interest assessments additional information with regard to communication tools applied in learning disabilities 4 Reference document added: North West Regional Capacity act Joint Protocol	Associate Director of Nursing

V4.1	14.10.2020	1. Addition of 'North West Regional Mental Capacity Act Joint Protocol' to appendices.	Deputy Director of Nursing

Reference Documents	Electronic Locations (Controlled Copy)	Location for Hard Copies
See section 17 for full list of references.	Primary Care 24 Intranet / Policies/Governance & Risk	Policy File, Wavertree Headquarters

Consultation: Committees / Groups / Individual	Date
SMT, Policy Group, Quality & Workforce Committee, Board. March 2017 Associate Director of Nursing	**Mar 2017** **Feb 2018**

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1 INTRODUCTION

Why is consent crucial?

"Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients."

Good Practice in Consent Implementation Guide: Consent to Examination or Treatment, Department of Health. 2002

2 PURPOSE

This policy sets out the standards and guidance for Primary Care 24, which aim to ensure that health professionals are able to comply with the law and Department of Health (DoH) Guidance with regard to the principles of consent and also mental capacity assessment. The policy outlines Primary Care 24 processes and procedures for managing consent and the roles and responsibilities within it these processes and procedures.

The following Standard Operating Procedure should be read and applied within the framework of this policy by those staff working within NHS 111:

- NHS 111 Standard Operating Procedure section Capacity to Consent for all staff within the NHS 111 service.

3 SCOPE

The Capacity to Consent Policy applies to staff either directly or indirectly employed by Primary Care 24. This includes GPs, Nurses, Paramedics, and any other Primary Care 24 staff who are required to seek valid consent.

4 DUTIES AND RESPONSIBILITIES

The Chief Executive has overall responsibility for Primary Care 24 having systems in place to ensure its employees are able to comply with the law and DoH Guidance with regard to the principles of consent.

The Medical Director has responsibility as the executive lead for consent and mental capacity. The Medical Director for Primary Care 24 will be responsible for providing assurance to the Board of Directors that the policy is being complied with.

The Director of Quality and Patient Safety is responsible for the corporate management of the Capacity to Consent Policy, including the provision of clinical advice to staff across the whole organisation

The Associate Director of Quality and Patient Safety is responsible for the development and implementation of the Capacity to Consent Policy, including monitoring and the provision of policy compliance assurance across the organisation.

The Medical/Clinical Leads of the Service Delivery Units for Primary Care 24 will be responsible for supporting local implementation of the policy and the provision of advice to staff and will have responsibility, locally, for ensuring the effective implementation and monitoring of the policy.

The Service Delivery Unit (SDU) Managers and Heads of Services for Primary Care 24 are responsible for ensuring they have a comprehensive understanding of their own remit within this policy and any associated procedures or guidance documentation. They will lead by example and adopt good practice at all times to

ensure the implementation of effective mental capacity testing and application of best interest decisions if deemed relevant.

Duties include:

- Ensuring the staff they are responsible for regulating, are familiar with this policy and any associated procedures.
- Ensure that staff members responsibilities for adhering to the Mental Capacity Act (2005) are reflected in personal development plans or appraisals.

The Quality and Safety Team will have responsibility for supporting local implementation and monitoring of the policy.

Medical staff and Senior Clinical Nursing and are responsible for providing clinical advice to staff and supporting any audit or monitoring processes.

All Clinical Staff have a responsibility to ensure they are familiar and understand the policy and apply it when managing all patients.

The health care professional or examining, treating or consulting the patient is ultimately responsible for ensuring the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

All health care professionals are to work within their own competence and not to agree to perform tasks which exceed their competence.

If you feel pressurised to seek consent when you do not feel competent to do so, contact your **Medical/Clinical Lead** for the service you work in. If you are working out of 9-5 hours you should contact the shift lead and request contact with the Director on call. In these circumstances it may be necessary for the healthcare professional to be counselled and to undertake a debrief of the particular incident to ensure a full understanding of the principles of consent.

5.0 BACKGROUND TO CONSENT ISSUES

Why consent is crucial:

5.1. The Department of Health has issued a range of guidance documents on consent. This policy sets out the standards and procedures in Primary Care 24, which aim to ensure that health professionals are able to comply with current guidance. See section 17 for a full list of references.

5.2 What consent is...and isn't

5.2.1 'Consent is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- Be competent to take the particular decision;
- Have received sufficient information to take it; and
- Not be acting under duress.

5.2.2 The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice.

In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. This is better described as 'joint decision making'. The patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's

clinical knowledge. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **no one else can give consent on their behalf.** However, treatment may be given if it is in 'their best interests', as long as it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment.*

5.3 Guidance to Consent For Information

5.3.1 The Department of Health's *Reference guide to consent for examination or treatment* provides a comprehensive summary of the current law on consent and includes requirements of regulatory bodies such as, the General Medical Council where these are more stringent.

5.3.2 *Key points on consent: the law in England* has been distributed widely to health professionals working in England (See Appendix 1). This document summarises those aspects of the law on consent which arise on a daily basis.

5.3.3 Specific guidance incorporating both the law and good practice advice is available for health professionals working with children, with people with learning disabilities and with older people. Details can be found by following the link below.

https://www.health-ni.gov.uk/publications/consent-guides-healthcare-professionals

5.4 The Process for Obtaining Consent

5.4.1 When should consent be sought?

When a patient formally gives their consent to a particular intervention, this is only the ***endpoint*** of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'.

5.4.2 Valid Consent.

For consent to be valid it must be given voluntarily by an appropriately informed person, (the patient or where relevant someone with parental responsibility for the patient under the age of 18) who has the capacity to consent to the intervention in question. If the person does not know what the intervention entails, then this is not consent. Consent can be written, oral or non–verbal, an example of non-verbal Consent would be where a patient, after receiving appropriate information, holds out an arm for their blood pressure to be taken, this is 'implied consent'. Staff must bear in mind that the patient is entitled to withdraw consent at any time. For the purpose of Primary Care 24, there are no procedures which are likely to require written consent.

5.4.3 Giving Consent

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment.

Health Care Professionals should be alerted to the possibility of pressure under influence and where appropriate should arrange to see the patient or speak to the patient on their own to establish that the decision is truly that of the patient.

To give valid consent the patient needs to understand in broad terms the nature and purpose of the procedure. Any misrepresentation of these elements will invalidate consent.

Although informing patients of the nature and purpose of procedures enables valid consent to be given as far as any claim of battery (physical assault or handling of a patient without consent) is concerned, this is not sufficient to fulfil the legal duty of care to the patient. Failure to provide other relevant information may render the professional liable to action for negligence if a patient subsequently suffers harm as a result of the treatment received.

5.4.4 Duration of Consent

When a patient gives valid consent to an intervention, or until its completion in general that consent remains valid for an indefinite duration unless the patient withdraws it.

5.4.5 Withdrawal of Consent

A patient with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a patient does object during an examination/procedure, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the patient's concerns and explain the consequences of not completing the procedure.

At times an apparent objection may reflect a cry of pain rather than withdrawal of consent and appropriate reassurance may enable the practitioner to continue with the patient's consent. If stopping the procedure at that point would genuinely put the life of the patient at risk, the practitioner may be entitled to continue until the risk no longer applies.

Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The practitioner should try to establish whether at that time, the patient has the capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the patient's best interests, although this should not be used as an excuse to ignore distress.

5.4.6 When Consent is refused

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected, except in circumstances defined by the Mental Health Act 1983. This is the case even where this may result in the death

of the patient and/or the death of an unborn child, whatever the stage of pregnancy.

Refusal of treatment by those under the age of 18 is covered in further sections of this policy.

5.4.7 Exceptions to the Principles of Consent

Certain statutes set out specific exceptions to the principles noted within this policy. These are briefly described below:

- The 2007 Mental Health Act (MHA) made several key changes to the 1983 Mental Health Act, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales.

  Whereas the 1983 MHA focused on strengthening patients' rights to seek independent reviews of their treatment, the 2007 MHA is largely focused on public protection and risk management. The amended legislation extends the powers of compulsion and introduces compulsory community treatment orders, making patients' compliance with treatment a statutory requirement

- The Public Health (Control of Disease) Act 1984 provides that, on an order made by a magistrate, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in a hospital without their consent, such regulations have not been made and thus the treatment of such persons must be based on the common law principles.

- Section 47 of the National Assistance Act 1948 provides for the removal to suitable premises of persons in need of care and attention without their consent. Such persons must either be suffering from grave chronic disease or be aged, infirm or physically incapacitated and living in insanitary conditions. In either case, they must be unable to devote to themselves (and are not

receiving from others) proper care and attention. The Act does not give a power to treat such persons

6 CHILDREN AND YOUNG PEOPLE

6.1 Children Under 16

Any child under the age of 16 who has sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will have the capacity to consent to that intervention. However, this would be based on the complexity of the proposed treatment and if the level of the child's capacity extends to understanding that treatment. As the understanding required for different interventions will vary considerably, a child under 16 may therefore have capacity to consent to some interventions but not others.

6.1.2 In the case of children, only people with 'parental responsibility' are entitled to give consent on behalf of their children, if they are perceived not to have sufficient understanding and intelligence to enable them to understand what is involved. Not all parents have parental responsibility for their children and if in doubt check before accepting consent on behalf of the child.

If the child is competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However, where the decision will have on-going implications, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child's best interests to do so. Although a child or young person may have the capacity to give consent, valid consent must be given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parents, other carers, or a potential sexual partner, and it is important to establish that the decision is that of the individual him or herself.

6.1.3 As with adults, assumptions that a child with a learning disability may not be able to understand the issues should never be made automatically.

The health practitioner must be aware that not all parents have parental responsibility for their children, for example, unmarried fathers do not automatically have such responsibility although they can acquire it if:

- They are registered as the child's father
- There is an agreement made with the child's mother providing for him to have a parental responsibility for the child
- There is successful application to the court by the father for parental responsibility

6.2 Under Section 8 of the Family Law Reform Act 1969, people aged 16 or 17 are entitled to consent to their own medical treatment and any ancillary procedures involved in their treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention; the same criteria as for adults should be used. If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to that of the young person. It is however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them.

6.2.1 Child or young person with capacity refusing treatment

Where a person of 16 or 17 who does not consent to treatment in accordance with

section 8 of the Family Law Reform Act, or a child under 16 but competent, refuses treatment, such a refusal can be over-ruled either by a person with parental responsibility for the child or by the court. If more than one person has parental responsibility for the young person, consent by any one such person is sufficient, irrespective of the refusal of any other individual.

This power to over-rule must be exercised on the basis that the welfare of the child/young person is paramount. As with the concept of best interests, "welfare" does not just mean physical health. The psychological effect of having the decision over-ruled must also be considered. While no definitive guidance has been given as to when it is appropriate to over-rule a competent young person's refusal, it has been suggested that it should be restricted to occasions where the child is at risk of suffering "grave and irreversible mental or physical harm".

For parents to be in a position to over-rule a competent child's refusal, they must inevitably be provided with sufficient information about their child's condition, which the child may not be willing for them to receive. While this will constitute a breach of confidence on the part of the clinician treating the child, this may be justifiable where it is in the children's best interests. Such a justification may only apply where the child is at serious risk as a result of their refusal of treatment.

A life-threatening emergency may arise when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of the child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

7 SINGLE STAGE PROCESS OF OBTAINING CONSENT

7.1 In many cases it will be appropriate for a health professional to initiate a procedure

immediately after discussing it with the patient. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately, consent will be taken verbally. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed. In the case of Primary Care 24 it is unlikely that any procedure undertaken within the out of hour's period would be subject to significant risk and require written consent.

8 PROVISION OF INFORMATION

8.1 The provision of information is central to the consent process. Before a patient can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits, including the risk/benefits of doing nothing. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen next.

8.2 Patients and those close to them will vary in how much information they want, from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgment in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

8.3 Provision for patients whose first language is not English

Primary Care 24 is committed to ensure that patient's whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is **not** appropriate to use children to interpret for family members who do not speak English. In this event, the Health Care Professional should use Language Line Interpretation services.

8.4 Access to more detail or specialist information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. Patients will be directed to the most appropriate websites and information leaflets.

9 WHO IS RESPONSIBLE FOR SEEKING CONSENT

9.1 The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. It is they who will be held responsible in law if this is challenged later. Any staff member who conducts any level of assessment over the telephone or face to face maybe required to obtain consent. e.g. in the case of telephone triage and third party callers, a person must consent to having a third party caller speak about them and for the staff member to share information with them.

9.2 Where oral or non-verbal consent is being sought at the point of the procedure / consultation, this will naturally be done by the healthcare professional or member of staff responsible.

9.3 Responsibility of health professionals

It is always best for the person actually treating the patient to seek the patient's consent. With this in mind, the position within Primary Care 24 is as follows:

There are no services or departments in Primary Care 24 in which consent will be sought by a third party who is not capable of performing the procedure.

- Primary Care 24 do not undertake complex treatments which involve

significant risk

- providing clinical assessment and treatment is the primary purpose of the procedures undertaken by Primary Care 24
- there is no requirement to consent any consequences for the patient's employment, social or personal life

9.4 Procedures to follow when patients lack capacity to give or withhold consent

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented within the clinical record along with the assessment of the patient's capacity:

- why the health professional believes the treatment to be in the patient's best interests,
- And the involvement of people closest to the patient.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The health professional should involve appropriate colleagues in making such assessments of incapacity, such as specialist teams, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatments are potentially serious, a court declaration may be sought.

10 REFUSAL OF TREATMENT

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the M*ental Health Act 2007*. The situation for children and young people is more complex, this is set out in section 6.0 of this policy.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their clinical notes.

Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the Intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

11 MENTAL CAPACITY

11.1 Having mental capacity means that a person is able to make their own decisions. A person is unable to make a particular decision if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

11.2 The Mental Capacity Act

The Mental Capacity Act 2005 (MCA) is specifically designed to cover situations where someone is unable to make a decision because the way their mind or brain works is affected, for instance, by illness or disability, or the effects of drugs or alcohol A lack of mental capacity could be due to:

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or the treatment for it.
- Substance misuse

The type of decisions that are covered by the MCA range from day-to-day decisions such as what to wear or eat, through to more serious decisions about where to live, having an operation or what to do with a person's finances and property.

It is very important to remember at all times that lack of capacity may not be a permanent condition.

11.3 Assessments of capacity

Assessments of capacity should be time and decision specific. The MCA applies in England and Wales to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves.

It 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.

It puts the individual who lacks capacity at the heart of decision making and places a strong emphasis on supporting and enabling the individual to make his/her own decisions. If they are unable to do this it emphasizes that they should be involved in the decision making process as far as possible.

It provides new safeguards for people who lack capacity and the people who work with, support or care for them.
It is underpinned by five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity. See section 11.8 for the five principles of the MCA.

11.4 The MCA – Children & Young People

Where the MCA applies to young people aged 16 – 17

- There is an overlap between the MCA and the Children Act for 16 and 17 year olds and most of the provisions of the MCA apply to young people and the Code of Practice for the MCA will give guidance on how to proceed.
- Any decisions relating to the treatment of young people aged 16 or 17 years old must be made in their best interests and in accordance with the principles of the MCA. As with all such decisions, the decision-maker must, where practicable and appropriate, consult the person's family and friends, especially those with parental responsibilities, as part of the best interest's decision making process.

11.5 Where the MCA does not apply to young people aged 16 – 17

There are certain parts of the MCA that will not apply to young people aged 16-17 years old, as the MCA requires a person to be 18 or over. These are:

- Making a Lasting Power of Attorney (Appendix 2)
- The MCA interface with the legislative Policy and Procedure (Appendix 1)

- Making a will. The law generally does not allow people under 18 to make a will and the MCA confirms that the Court of Protection has no power to make a will on behalf of anyone under 18.

11.6 Where the MCA applies to children under the age of 16

In most situations the care and welfare of children under 16 will be dealt with under the Children's Act 1989.

There are two parts of the MCA that will apply to children under 16:

- The Court of Protection's powers to make decisions concerning the property and affairs of a child under the age of 16. The Court can make these decisions where the Court considers it likely that the child will lack capacity to make decisions about their property and affairs even when they are 16.
- The criminal offence of ill treatment or wilful neglect also applies to children under 16 who lack capacity as no lower age limit is specified for the victim. The Code of Practice explains in more detail about legal proceedings for young people and the relationship with other relevant laws such as the Children Act 1989.

11.7 Key Provisions of the MCA

- There must always be the presumption that people you provide care or treatment for have capacity to make decisions for themselves.
- A single clear test for assessing whether a person lacks capacity to make a decision.
- A check list of key factors which provides a starting point to help you determine what is in the 'best interests' of a person lacking capacity.
- Several ways that people can influence what happens to them if they are unable to make particular decisions in the future, including advance decisions.

- To refuse medical treatment, statements of wishes and feelings, and creating a Lasting Power of Attorney (LPA) (See Appendix 2).
- Clarification about the actions you can take if someone does lack capacity, and the legal safeguards that will govern this.
- An obligation for you to consult, where practical and appropriate, people who are involved in caring for the person who lacks capacity and anyone interested in their welfare (for example family members, friends, partners and carers) about decisions affecting that person.
- A new advocacy service called the Independent Mental Capacity Advocate (IMCA) service.
- A new criminal offence of ill-treatment or wilful neglect of people who lack capacity.

11.8 The Five Principles of the MCA

The MCA has five key principles which emphasize the fundamental concepts and core values of the MCA.

These must be considered and applied when you are working with, or providing care or treatment for people who lack capacity.

The five principles are:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

2. People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means that you should make every effort to encourage and support the person to make the decision for themselves. If a lack of capacity is established, it is still

important that you involve the person as far as possible in making decisions.

3. People have the right to make what others might regard an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.

4 Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

5 Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity you must choose the option that is in their best interests and you must consider whether you could do this in a way that interferes less with their rights and freedom of action.

11.9 Helping people to make decisions for themselves

When a person in your care needs to make a decision you must start from the assumption that the person has capacity to make the decision in question (Principle1).

You should make every effort to encourage and support the person to make the decision themselves (Principle 2) and you will have to consider a number of factors to assist in the decision making. These could include:

- Does the person have all the relevant information needed to make the decision? If there is a choice, has information been given on the alternatives?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Help should be given to communicate information wherever necessary. For example, a person with a learning disability might find it easier to communicate using pictures, photographs, videos, tapes or sign language.
- Are there particular times of the day when a person's understanding is better or is there a particular place where they feel more at ease and able to make a

decision? For example, if a person becomes drowsy soon after they have taken their medication this would not be a good time for them to make a decision.

- Can anyone else help or support the person to understand information or make a choice? For example, a relative, friend or advocate.
- You must remember that if a person makes a decision which you think is eccentric or unwise; this does not necessarily mean that the person lacks capacity to make the decision (Principle 3).
- When there is reason to believe that a person lacks capacity to make a decision you will be expected to consider the following:

Has everything been done to help and support the person to make a decision? Does this decision need to be made without delay? If not, is it possible to wait until the person does have the capacity to make the decision for him/herself?

If the person's ability to make a decision still seems questionable, then you will need to move onto the next phase of assessing capacity as set out in section 13.

12 ASSESSING CAPACITY

- You should always start from the assumption that the person has capacity to make the decision in question (Principle 1).
- You should always bear in mind that just because someone lacks capacity to make a decision on one occasion that does not mean that they will never have capacity to make a decision in the future, or about a different matter.
- There are two questions to be asked if you are assessing a person's capacity. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

If so:

- Is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision at the relevant time

This two-stage test must be used and you must be able to demonstrate that it has been used. Remember that an unwise decision made by the person does not of itself indicate a lack of capacity. Most people will be able to make most decisions, even when they have a label or diagnosis that may seem to imply that they cannot. This is a general principle that cannot be over-emphasised.

12.1 When should capacity be assessed?

The MCA 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. For example, it is possible that someone with learning disabilities could make decisions about what to wear or eat but not about whether or not they need to live in a care home.
- You cannot decide that someone lacks capacity based upon their age, appearance, condition or behaviour alone.

12.2 The Test to Assess Capacity

It is good practice to involve, where possible, family friends and/or carers when assessing a person's capacity. However, it is recognised that this may not always be possible due to the urgent nature of incidents attended by the ambulance service.

You should never express an opinion, without first conducting a proper assessment of the person's capacity to make a decision.

An assessment that a person lacks capacity to make a decision must never be based simply on:

- Their age
- Their appearance
- Assumptions about their condition, or
- Any aspect of their behaviour

The Act deliberately uses the word ‘appearance’ because it covers all aspects of the way people look. So for example, it includes the physical characteristics of certain conditions, for example, scars, features linked to Down’s syndrome or muscle spasms caused by cerebral palsy) as well as aspects of appearance like skin colour, tattoos and body piercings, or the way people dress (including religious dress).

The word ‘condition’ is also wide-ranging. It includes physical disabilities, learning difficulties and disabilities, illness related to age, and temporary conditions (for example, drunkenness or unconsciousness). Aspects of behaviour might include extrovert (for example, shouting or gesticulating) and withdrawn behaviour (for example, talking to yourself or avoiding eye contact).

12.3 The Two Stage Test of Capacity

To help determine if a person lacks capacity to make particular decisions, the Act sets out a two-stage test of capacity.

Stage 1: Diagnostic – Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act. Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and;
- The symptoms of alcohol or drug use.

Stage 2: Functional – Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves.

Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed. In order to decide whether an individual has the mental capacity to make a particular decision, you must first 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?

The person will be unable to make the particular decision if after all appropriate help and support to make the decision has been given to them (Principle 2) they cannot:

1 Understand the information relevant to that decision, including,

understanding the likely consequences of making, or not making the decision

2 Retain that information

3 Use of weigh that information as part of the process of making the decision

Every effort should be made to find ways of communicating with someone before deciding that they lack the capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone. Those who do might include people who are unconscious or in a coma. In many other cases such simple actions as blinking or squeezing a hand may be enough to communicate a decision.

An assessment must be made on the balance of probabilities - is it more likely than not that the person lacks capacity? You must record fully, on the clinical record, why you have come to the conclusion that the person lacks capacity to make the particular decision.

13 BEST INTERESTS

If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in their best interests (Principle 4). The person who has to make the decision is known as the 'decision-maker'. This may be an ambulance service clinician, the carer responsible for the day to day care, or another professional such as a doctor, nurse or social worker.

13.1 What is 'Best Interests'?

The law gives a checklist of key factors which you must consider when working out what is in the best interests of a person who lacks capacity (The MCA Code of Practice can provide more information in relation to this):

- Avoid Discrimination

It is important not to make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.

- Identify all relevant circumstances

The decision-maker must identify all the things the person would take into account if they were making the decision or acting for themselves.

- Assess whether the person might regain capacity

The decision-maker must consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision or act wait until then?

- Encourage participation

The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.

- If the decision concerns life sustaining treatment

The decision-maker must not be motivated by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

13.2 The decision maker must, where possible, consider:

- The person's past and present wishes and feelings (in particular if they have been written down).
- Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors.
- As far as possible the decision-maker must consult other people if it is

appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially: anyone previously named by the person lacking capacity as someone to be consulted carers, close relatives or close friends or anyone else interested in the person's welfare any attorney appointed under a Lasting Power of Attorney

- Any deputy appointed by the Court of Protection to make decisions for the person.
- When making a best interest decision, every effort should be made to ascertain as much information in relation to the person in conjunction with the carers, relatives, e.g. check summary care record, which may include information with regard to how the person likes to be treated, who can be contacted for further information, communication tools which maybe in place for persons e.g. Disability Distress Assessment Tools, which will help describe how people communicate pain, distress. For further reading refer to www.disdat.co.uk

If you are making the decision you must take the above steps, amongst others and weigh up the above factors in order to determine what is in the person's best interests.

13.3 What do I do if there is a dispute about 'Best Interests'?

Family and friends will not always agree about what is in the best interests of an individual.

If you are the decision-maker you will need to clearly demonstrate in your record keeping that you have made a decision based on all available evidence and taken into account all the conflicting views.

If there is a dispute, the following things might assist you in determining what is in the person's best interests:

- Involve an advocate who is independent of all the parties involved.

PC24 will support staff that follow this policy providing you have complied with this policy in assessing a person's capacity and have acted in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example:

- Diagnostic examinations and tests
- Assessments
- Medical treatment
- Admission to hospital for assessment or treatment (except for people who are liable to be detained under the Mental Health Act 1983. See appendix 3 for information on the difference between the MCA and the Mental Health Act 1983).
- Emergency procedures (such as IV cannulation, administration of drugs or cardio pulmonary resuscitation).

13.4 A practitioner will have acted in the best interests of an incapable patient where the treatment she/he gave (or refrained from giving) was in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in the form of treatment.

It will be important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity, reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person's best interests.

It is the practitioner in charge of a patient's care and treatment who must decide what is in his/her best interests. The patient's spouse or his/her family, friends or colleagues cannot give or withhold consent to treatment on the patient's behalf. However, what they have to say may be useful in deciding where his/her best

interests lie.

14 IMPLEMENTATION

14.1 This policy will be implemented via the document owner with the support of the head of each Service Delivery Unit and Departmental Heads and Senior Medical and Nursing/ Paramedics.

14.2 The document owner will outline the plan for implementation in conjunction with the policy (See Appendix 3). Training needs should be assessed and identified. See Appendix 4 for the Training Needs Analysis.

14.3 Dissemination will be once the policy has been approved by the Primary Care 24 Board. It will be uploaded onto the staff intranet, this will be supported by a message through the newsletter, NEWS24. The Quality & Patient Safety team will be responsible for this action.

14.4 Policy Review. This policy will be reviewed within one year of release by the author then at least every three years thereafter. However, should national guidance, legislation or a there is a change in services then the policy may be reviewed earlier.

As part of the policy review process, the effectiveness of the policy and its application will be assessed. Information and results from audit systems, adverse incidents, user feedback and external audits/reviews will be used to inform this assessment.

14.5 Monitoring Compliance

Capacity to Consent Audit appears on the Urgent Care Clinical Audit Plan. The compliance to following capacity to consent procedures is audited on an annual basis. Feedback and quality improvement is led by the Clinical Leadership structure with support from the Quality & Patient Safety team.

Element	Lead	Tool	Frequency	Reporting Arrangements
Policy is in date	Quality & Patient Safety Team	100% of new employees have access and have read the policy.	yearly	Quality & Workforce Committee

15 EQUALITY & HEALTH INEQUALITIES STATEMENT

PC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

16 PERSONAL INFORMATION STATEMENT

PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

This policy complies with the Data Protection Act 1998, therefore no Privacy Impact Assessment is necessary.

17 REFERENCES AND BIBLIOGRAPHY

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- The Department of Health Good Practice Consent Implementation Guide (Department of Health 2002). Available at: *http://www.health.wa.gov.au/mhareview/resources/documents/UK_DOH_implementation_guide.pdf*

- The Department of Health's Reference Guide to Consent for Examination or Treatment. Available at: *https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition*

- Seeking Consent: Working with Children. Available at: *https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/seeking-consent-guide-children.pdf*

- Seeking Consent: Working with Older People. Available at: *https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/seeking-consent-guide-older-people.pdf*

- Seeking consent: Working with people with learning disabilities. Available at: *https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/seeking-consent-learning-disabilities.pdf*

- Mental Capacity Act: Code of Practice: Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf*

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- Section 47 of the National Assistance Act 1948. Available at: http://www.legislation.gov.uk/ukpga/Geo6/11-12/29/section/47

- Section 8, Family Law Reform Act 1969. Available at: http://www.legislation.gov.uk/ukpga/1969/46

- Better Health for People with Learning Disabilities National Development Team for Inclusion, March 2017

- http:disdact.co.uk/

- North West Regional Mental Capacity Act Joint Protocol NW Regional Mental Capacity Act Joint Protocol Policy

18 APPENDICES

Appendix 1 Key points on consent: The law in England

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is "can this patient understand and weigh up the information needed to make this decision? Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5 Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6 It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specifically trained to see consent for that procedure.

What information should be provided?

7 Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8 Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9 No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. This information could also be recorded electronically on the practice clinical system.

Refusal of treatment

10 Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11 **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general wellbeing and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12 If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'adverse refusal'), and those circumstances arise, you must abide by that refusal.

Appendix 2 Lasting Powers of Attorney & Advance Directives

Providing care or treatment for people who have planned ahead

The MCA has far reaching effects for people who work in health and social care because it extends the ways in which people using services can plan ahead for the time when they may lack capacity. These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment, and written statements of wishes and feelings.

Lasting Powers of Attorney (LPAs)

The MCA introduces a new form of power of attorney which will allow people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person making an LPA will be called the donor. The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person(s) appointed will

be known as an attorney(s). The LPA will give the attorney authority to make decisions on behalf of the donor and the attorney will have a duty to act or make decisions in the best interests (Principle 4) of the person who has made the LPA.

There are two different types of LPA:

1. A personal welfare LPA is for decisions about both health and personal welfare relevant to PC24
2. A property and affairs LPA is for decision about financial matters (for information only)

Important facts about LPA's

- The introduction of the LPA for property and affairs will mean that no more Enduring Powers of Attorney (EPA) can be made from October 2007, but the MCA makes transitional provisions for existing EPAs to continue whether they are registered or not.
- This means that pre-existing EPAs can continue to be used post October 2007 (whether registered or not) and can continue to be registered post October 2007.
- When a person makes an LPA they must have the capacity to understand the importance of the document and the power they are giving to another person.
- Before an LPA can be used it must be registered with the Office of the Public
- Guardian. This is vital, without registration an LPA cannot be used at all.
- A personal welfare attorney 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 for him or herself.
- If the person in your care lacks capacity and has created a personal welfare LPA, the attorney will be the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the attorney's authority the attorney will have the authority to make personal welfare decisions and consent to or refuse treatment (*except life-sustaining treatment*) on the donor's behalf. The attorney must make these decisions in the best interests of the person lacking capacity (Principle 4).
- If the decision is about life-sustaining treatment, the attorney will only have the

authority to make the decision if the LPA specifies this.

- It is important to read the LPA if it is available to understand the extent of the attorney's power.

Advance decisions to refuse treatment

An advance decision is where a person aged 18 or over may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if it may result in the person's death and if it is valid and applicable it must be followed as it is legally binding and has the same force as when a person with capacity refuses treatment (see below for the requirements for advance decisions).

An advance decision does not need to be in writing; except for decisions relating to life-sustaining treatment (see below) but it is helpful if it is.

What are the requirements for advance decisions?

The MCA introduces a number of rules people must follow when making an advance decision. If you are making a decision about treatment for someone who is unable to consent to it, you must be satisfied that the advance decision exists, is valid and applicable to the particular treatment in question.

The following list gives a very brief summary of some of the main requirements for advance decisions (if you are involved in such a decision you should consult the Code of Practice):

- It must be valid. The person must not have withdrawn it, or overridden it by making an LPA that relates to the treatment in the advance decision, or acted in a way that is clearly inconsistent with the advance decision.
- It must be applicable to the treatment in question. It should clearly refer to the treatment in question (detailed medical terms do not have to be used) and it should explain which

circumstances the refusal refers to. If there have been changes in circumstances which there are reasonable grounds for believing would have affected a person's advance decision when they made it, then it may not be applicable.

You should also note that:

- Where people are detained under the Mental Health Act 1983 and can therefore be treated for mental disorder without their consent, they can also be given such treatment despite having an advance decision to refuse the treatment
- People cannot make an advance decision to ask for medical treatment - they can only say what types of treatment they would refuse
- People cannot make an advance decision to ask for their life to be ended.

If you are satisfied that the decision is both valid and applicable then you will have to abide by that decision.

Advance decisions to refuse life-sustaining treatment

The MCA sets out additional formalities for advance decisions that refuse life- sustaining treatment.

An advance decision to refuse life-sustaining treatment must fulfil the following additional requirements:

- It must be in writing, which includes being written on the person's behalf or recorded in their medical notes.
- It must be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are unable to sign it for themselves.
- It must be verified by a specific statement made by the make, either included in the document or a separate statement that says that the advance decision is to apply to

the specified treatment even if life is at risk.

- If there is a separate statement this must also be signed and witnessed.

Conscientious objection

You will not have to act on an advance decision if you object to it on religious or moral grounds.

You must make this known as soon as possible and arrangements must be made for the management of the patient's care to be transferred to another health professional.

Liability of people who work in health

You will not incur liability for providing treatment in a patient's best interests if, having taken reasonable steps, you do not know or are not satisfied that a valid and applicable advance decision exists. If you are satisfied that an advance decision exists which is valid and applicable, then not to abide by it could lead to a legal claim for damages or a criminal prosecution for assault.

If you reasonably believe that there is a valid and applicable advance decision then you will not be held liable for the consequences of abiding by it and not providing treatment. You should clearly record how you came to your conclusions.

Disputes and disagreements about advance decisions

You will have to form a view about whether or not an advance decision is valid and applicable and you should refer to the Code of Practice for more detailed guidance particularly if there is a disagreement. If there is a dispute or difficulty, then you should consider mediation or the matter could be referred to the Court of Protection by you or a relative, carer or a close friend of the patient.

Dealing with advance decisions that are made before October 2007

People can already make advance decisions sometimes known as a 'living will'. If any of the people you provide care or treatment for have already got an advance decision, you should suggest that they check that it meets the new rules that the MCA sets out to ensure that it is valid and applicable when the MCA comes into force. If the person has already lost capacity then the advance decision may still be binding.

The Mental Capacity Act and the Mental Health Act 1983

The MCA may be used to treat people for mental disorder when they cannot consent to the treatment because they lack capacity and where the treatment is in their best interests.

For most other purposes, the MCA will continue to apply to a patient detained under the Mental Health Act. This means, for example, that an advance decision to refuse treatment for any illness or condition other than mental disorder is not affected, nor is any power an attorney has to consent to such treatment. It also means that where a detained patient lacks capacity to consent to treatment other than treatment for mental disorder, the decision-maker will need to act in accordance with the MCA. For more detail on the interface between the MCA and the Mental Health Act 1983 you should read the Code of Practice.

Appendix 3 Implementation Plan

Question	Response	Additional resources If so identify	Timescale
Who does the policy affect	PC24 Health Care Professionals	Nil	Immediately following approval by the Board.
What additional Standard Operating Procedures or forms need to be included in the policy	As outlined in the appendices.	Nil	As above
			Next board after

What is the proposed date of implementation	March 2017	Nil	Quality & Workforce Committee
Is training required	Yes	Nil	Nil
If so what training is required (attach separate training outline)	Mandatory elearning	Nil	Nil
Who will facilitate the training	Training Leads		Nil
What audit processes have been identified	Monitoring Compliance – Section 14.5	Nil	Nil

Appendix 4 Training Needs Analysis

Training requirement	Frequency	Course length	Delivery method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Consent to examination or treatment principles are covered in Mental Capacity Act training as part of organisational induction and level 2 integrated Safeguarding training days. At induction, then every three years in line with Safeguarding training requirement	At induction, then three yearly in line with Safeguarding training Requirements and learning.		Various subject experts from Corporate Safeguarding Team	N/A	HR	Quality and Patient Safety Department
SDU	**Target Audience**					
Integrated Urgent Care Primary and Community Services	• All clinical staff will familiarise themselves with the Consent to Examination and Treatment Policy. • The principles in practice of gaining consent will be covered in the local induction procedure for all clinical staff e learning • Where staff are required to gain consent for procedures they do not themselves perform, services are responsible for ensuring they receive specialist training locally and have documented competency. • All staff will complete mandatory Safeguarding training which includes consent issues					
Corporate	Not required					

Equalities and Health Inequalities – Screening Tool

Name of Policy: Capacity to Consent Policy

Date of Ratification: March 2017

Version number: V1.0

First published: November 2016

To be read in conjunction with Equalities and Health Inequalities Analysis Guidance, Quality & Patient Safety Team, Primary Care 24, 2016.

Prepared by: Quality & Patient Safety Team.

1 Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Primary Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.Primarycare24.co.uk/

2 Equality and Health Inequalities: Screening Tool

A	General information
A1	Title: What is the title of the activity, project or programme? **Capacity to Consent Policy**
A2.	What are the intended outcomes of this work? Please outline why this work is being undertaken and the objectives. **The overall aim of the Capacity to Consent policy is to support healthcare staff to provide care and treatment with the patient's informed consent to do so and to assist**

	staff in appreciating how important it is that all patients understand the care and treatment being offered and can make an educated decision about what they want.		
A3.	Who will be affected by this project, programme or work? Please identify whether the project will affect staff, patients, service users, partner organisations or others. **The policy will directly affect healthcare professionals and indirectly affect patients/service users.**		
B	**The Public Sector Equality Duty**		
B1	Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?		
	Yes	No	Do not know
	Summary response and your reasons: **The policy is written to provide guidance to healthcare professionals based on law in relation to consent and capacity to consent. There may be request from patients to be examined by the same sex healthcare professional. We will positively respond to any requests to ensure privacy and dignity are maintained and any religious beliefs are respected. This may cause a negative impact as there maybe occasions when a same sex practitioner is not available within urgent community OOH, this will be monitored.**		
B2	Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **There may be request from patients to be examined by the same sex healthcare professional in any examination. We will positively respond to any requests to ensure privacy and dignity are maintained and religious beliefs are respected. This may cause a negative impact as there maybe occasions when a same sex practitioner is not available within urgent community OOH, alternative arrangements will always be provided and discussed with the patient and this will be monitored.**		
B3	Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons: **Because the policy is based on what the law says.**		
B4	Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **There may be request from patients to be examined by the same sex healthcare professional. We will positively respond to any**		

	requests to ensure privacy and dignity are maintained and religious beliefs are respected. This may cause a negative impact as there maybe occasions when a same sex practitioner is not available within urgent community OOH, alternative arrangements will always be provided and discussed with the patient and this will be monitored.		
B5	Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary reasons: **A patient requesting a same sex healthcare professional will always be offered an alternative way of receiving the care they need, this will be discussed with the patient at the time.**		
B6	Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons**: A patient requesting a same sex healthcare professional will always be offered an alternative way of receiving the care they need, this will be discussed with the patient at the time.**		
C	**The duty to have regard to reduce health inequalities**		
C1	Will the initiative contribute to the duties to reduce health inequalities?		
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?		
	Yes	**No**	Do not know
	Summary response and your reasons: **A patient requesting a same sex healthcare professional will always be offered an alternative way of receiving the care they need, this will be discussed with the patient at the time.**		
C2	Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?		
	Yes	No	Do not know
	Summary response and your reasons: **Patients who will not consent to examinations from different sex healthcare professionals will always be given alternative choices in receiving the appropriate healthcare they need.**		
D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?		
D1	Will a full EHIA be completed? Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. [1] Please place an X below in the correct box below. Please then complete part E of this form.		
	Yes	Cannot decide	**No**

E	Action required and next steps		
E1	If a full EHIA is planned: Please state when the EHIA will be completed and by whom. Name: Date:		
E2	If no decision is possible at this stage: If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made. Summary reasons: Additional information required: When will it be possible to make a decision about an EHIA?		
E3	If no EHIA is recommended: If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below. Summary reasons: This policy has been consulted on by the Quality & Patient Safety Team. There is no negative impact with respect to the characteristics as defined by the Equality Act.		

F	*Record Keeping*		
Lead originator:	Governance Administrator	Date:	13.02.2017
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NORTH WEST REGIONAL

MENTAL CAPACITY ACT

JOINT PROTOCOL

Approved by	North West Regional Mental Health Forum
Approval date	
Version number	2.0
Review date	July 2020
Responsible Police Lead	Chair of North West Regional Mental Health Forum
Responsible Ambulance Lead	Chief Consultant Paramedic
For use by	• Lancashire Constabulary • Greater Manchester Police • Merseyside Police • Cheshire Constabulary • Cumbria Constabulary • North West Ambulance Service NHS Trust

Change Form

Version	Date of change	Date of release	Changed by	Reason for change
0.4	January 2012		Steve Barnard	Feedback from NW Regional Mental Health Forum
0.5	February 2012		Steve Barnard	Formatting
0.6	February 2012		Steve Barnard	Feedback from Mersey and Greater Manchester Police
0.7	March 2012		Steve Barnard	Addition of Greater Manchester Police to protocol

1.0	March 2012		Steve Barnard	Final formatting for signature
1.1	October 2016			Reviewed & Amended by NWAS Mental Health Board
1.2	January 2017		Dan Smith	Reviewed by Regional Mental Health Forum
1.3	February 2017		Dan Smith	Amendments made following feedback from Regional Forum
1.4	May 2017		Dan Smith	NWAS logo Change
1.5	July 2017		Dan Smith	Minor amendments following feedback from Adele Owen GMP.
1.6	Sep 2017		Dan Smith	Further minor amendments following feedback from Adele Owen GMP.
1.7	May 2018		Dan Smith	Amendments following comments from Inspector R Spedding Cheshire Police.
2.0	Nov 2018		Dan Smith	Final Formatting for Signature and Sign off

NORTH WEST REGIONAL MENTAL CAPACITY ACT JOINT PROTOCOL

Contents

1 CHAPTER 1

INTRODUCTION

1a This protocol has been developed following consultation with the North West Region Police Forces and the North West Ambulance Service NHS Trust, and forms a memorandum of understanding, which all organisations have agreed to support and follow.

1b The protocol takes into account the Mental Capacity Act 2005 (MCA), Code of Practice 2007 and the National Policing Improvement Agency (NPIA) Briefing Note on Applying the Mental Capacity Act 2010.

1c The protocol provides a framework to support inter-agency working and appropriate use of resources to deliver safe patient care for those who lack capacity.

1d It is recognised that individual organisations will have their own policies, procedures and training relating to the MCA, which will specify how capacity is assessed, including specific roles and responsibilities.

2 CHAPTER 2

AIM

2a The aim of this protocol is to ensure organisations work together, to ensure patients who lack capacity receive appropriate treatment and care for their needs.

2b The protocol will ensure all organisations and staff comply fully with the legislative requirements of the MCA and follow the Code of Practice at all times.

2c The protocol will outline the actions required by staff from the partner organisations, to enable decisions to be taken on behalf of patients, who lack capacity.

2d The protocol will provide guidance to staff from the organisations to enable them to provide appropriate and proportionate care and treatment to patients lacking capacity, following best practice and proportionality guidelines, and in a manner that is the least restrictive possible.

3 CHAPTER 3

PROTOCOL STATEMENT

3a Staff working for or on behalf of the agencies who have agreed to sign and adopt this protocol will:

3b Have a formal duty of regard to the Act and the Code of Practice and will need to take active responsibility for equipping themselves to practice within the law. Staff should be able to explain how they have regard to the MCA and the Code of Practice when acting or making decisions on behalf of people who lack capacity to make decisions for themselves.

3c In every situation, assume that a person can make their own decisions unless it is proved that they are unable to do so. There will be a presumption of capacity.

3d Always act in the best interests of any person who lacks capacity and follow the relevant organisational policy or procedure.

4 CHAPTER 4

LEGAL CONTEXT

4a The Act applies only to people over 16yrs of age, who lack mental capacity or who are reasonably believed to lack mental capacity. It applies to public and private locations.

4b The MCA has five key principles which emphasise the fundamental concepts and core values of the MCA. These must be considered and applied when you are working with, or providing care or treatment for people who lack capacity.

4c The five principles are:

I. A person must be assumed to have capacity unless it is established that they lack capacity.
II. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
III. A person is not to be treated as being unable to make a decision merely because they appear to be making an unwise decision.
IV. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
V. 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.

4d A person lacks capacity regarding a matter, if at the material time they are unable to make a decision for themselves because of an impairment or, or disturbance in the functioning of the mind or brain.

4e The impairment or disturbance may be temporary or permanent.

4f A lack of capacity cannot be established merely by:

- A person's age or appearance
- A condition, or aspect of their behaviour, which may lead to an unjustified assumption about their capacity

4g Any power to restrain a person as a result of the MCA 2005 does not interfere with any existing powers of arrest for criminal offences or powers under the Mental Health Act (MHA).

4h Section 2.14 of the DoLS CoP;

Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency). Even when there is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that authorisation is needed before the journey commences.
In most cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in hospital or care home will be in their best interests.

5 CHAPTER 5

ASSUMPTION OF CAPACITY

5a When a person in your care needs to make a decision you must start from the assumption that the person has capacity to make the decision in question. You should make every effort to encourage and support the person to make the decision themselves

5b When a person is assessed as lacking capacity to make a decision for themselves, you will be expected to consider the following:

5c

- It should be remembered that in circumstances where the MHA applies, this should be used. The MCA does not replace authorities provided by the MHA.

5d

- Can the decision (care and treatment) be delayed until capacity can be restored?

5e

- Have all possible options been explored, in respect of alternative care and treatment which addresses the immediate needs of the patient? Does this decision need to be made without delay?

5f

- If not, is it possible to wait until the person does have the capacity to make the decision for themselves?

5g Further factors for consideration include:

5h

- Does the person have all the relevant information needed to make the decision? If there is a choice, has information been given on the alternatives?

5i Could the information be explained or presented in a way that is easier for the person to understand? Help should be given to communicate information wherever necessary. For example, a person with a learning disability might find it easier to communicate using pictures, photographs, videos, tapes or sign language and they may already have an enabling strategy for decision making and communication written in a plan.

5j Has the person's individual values, beliefs and preferences been considered? A person cannot be considered to lack capacity for this reason.

5k Are there particular times of the day when a person's understanding is better or is there a particular place where they feel more at ease and able to make a decision? For example, if a person becomes drowsy soon after they have taken their medication this would not be a good time for them to make a decision.

5l Can anyone else help or support the person to understand information or make a choice? For example, a relative, friend or advocate.

5m You must remember that if a person makes a decision which you think is eccentric or unwise; this does not necessarily mean that the person lacks capacity to make the decision.

6 CHAPTER 6

ASSESSING CAPACITY

6a You should always start from the assumption that the person has capacity to make the decision in question if the person has capacity and refuses treatment their wishes must be respected, even if the refusal may have drastic consequences.

6b There is a two stage test to consider if you are assessing a person's capacity:

I. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain? **If so:**

II. Is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision at the relevant time?

III.

6c The two-stage assessment in **Appendix C** must be used to assess an individual's ability to make decisions for themselves. Most people will be able to make most decisions, even when they have a presentation or diagnosis that seems to imply that they cannot. This is a general principle that cannot be over-emphasised.

6d Remember that an unwise decision made by the person does not in itself indicate a lack of capacity.

6e The North West Ambulance Service has procedures in place for the assessment and management of patients who are felt to lack capacity, which are in-line with the requirements of the MCA. Senior clinician support is also available to assist with the assessment and management of patients felt to lack capacity.

6f Police officers are not routinely trained in the assessment of mental capacity. Where police are the first service on scene it may be necessary to make an initial assessment, request assistance from the NWAS and/or local Mental Health Trust and act accordingly before other services arrive, where the seriousness or urgency of the situation dictates

6g Police should recognise the expertise of the ambulance service or other appropriate clinicians (such as doctors) regarding mental capacity assessments and work in co-operation; providing support as necessary.

7 CHAPTER 7

REGAINING CAPACITY

7a A patient lacking capacity must be provided every opportunity to regain capacity. This may include:

7b Instigating care and treatment that enable the patient to regain the capacity to make further decisions.

7c Delaying the decision, where possible, to enable actions to be taken which would assist the patient to make their own decision. This may include obtaining assistance from relatives, placing the patient in to a familiar environment, using tools to enable better communication.

7d Considering all potential options of care, which may not be considered optimum, but provide care and treatment which addresses immediate needs and allows an approach which is least restrictive.

7e A patient, initially deemed to be lacking capacity, should be continually assessed to ensure that decisions are not being made on behalf of a patient that has subsequently regained capacity.

7f A judgement should be made on what is a reasonable amount of time, to wait for capacity to be achieved. Consideration must be given to:

- The likelihood that the patient will regain capacity
- Urgency of the patient's condition
- Resources required to enable capacity

8 CHAPTER 8

BEST INTERESTS

8a If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in their best interests The person who has to make the decision is known as the 'decision-maker' . This may be an ambulance service clinician, police officer, the carer responsible for the day to day care, or another professional such as a doctor, nurse or social worker.

8b The law gives a checklist of key factors which you must consider when working out what is in the best interests of a person who lacks capacity (Appendix C can provide more information in relation to this).

8c In emergencies where there is limited or no information available, it will often be in a person's best interests for treatment to be provided without delay.

9 CHAPTER 9

RECORD KEEPING

9a When you act in someone's best interests, who you have assessed as not having mental capacity, you must record your actions and file it in accordance with local policy. In particular the following guide will help you ensure the right information is recorded.

I. The information you used to decide the person lacked capacity including questions you asked and their replies
II. How you reached your decision and why you acted
III. What other options you considered
IV. What you did, who was consulted and why
V. If you needed to act quickly without the time for consultation or questioning of the person an account as to why that was VI. Any other factors you took into account
VII. How you restrained the person, who was involved and for how long

9b It is essential that the full rationale behind a decision as to whether or not the person has capacity regarding a specific decision is documented.

9c Ambulance clinicians must ensure they document their decision making processes, assessment and care on the appropriate service documentation. It should include the rationale for the type of assessment undertaken. Where force has been used, an IRF is to be completed.

9d It is vital that when an assessment is not possible (or limited to a visual assessment of the patient's condition) the fact is recorded on the appropriate documentation with sufficient detail about why the assessment could not be completed. It is vital that all information relating to the patient's clinical condition, their behaviour and identified risks are recorded. All decisions, including a rational for them should also be recorded.

9e The Personal identification Numbers (PINs) of ambulance clinicians and police officer collar numbers should be recorded on all relevant documentation.

10 CHAPTER 10
USE OF RESTRAINT BY AMBULANCE SERVICE CLINICIANS

10a Ambulance clinicians are legally authorised and obliged under the MCA to act in the best interests of (and provide treatment for) patients who are lacking capacity - even where the patients refuse treatment or are abusive, threatening or violent.

10b The MCA also supports the use of proportionate force to ensure that patients lacking capacity receive care that is in their best interests or are protected from further harm.

10c Ambulance clinicians should complete a Dynamic Operational Risk Assessment (DORA) in all cases prior to the use of any form of minimal restraint; recording decisions and actions on appropriate forms.

10d Ambulance clinicians are trained to provide minimal restraint in cases where patients lac k capacity and there is no perceived risk of harm to them or the patient.

10e However, ambulance clinicians are neither trained nor expected to restrain patients who are acting in a threatening or violent manner.

10f Section 5 of the Mental Capacity Act 2005 gives Ambulance clinicians protection from liability when they use minimal restraint if they observe the following 2 conditions:

I. You must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity;

And;

II. The amount and type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm to the patient.

To be protected from liability one should bear in mind the statutory principles set out in section 1 of the MCA.

Any restraint which is used should be done so in accordance with the Nice Guidelines (NG10, 2015).

10g If restraint is deemed to be required, ambulance clinicians must ensure that the patient's dignity is maintained as far as is reasonably practicable.

11 CHAPTER 11

USE OF RESTRAINT BY POLICE OFFICERS

11a Police officers are legally authorised and obliged under the MCA to act in the best interests of persons to save life or prevent further harm to them.

11b The MCA also supports the use of reasonable force to ensure that patients lacking capacity receive care that is in their best interests or are protected from further harm.

11c Police officers will be protected from liability when they use restraint if they observe the following 2 conditions:

III. You must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity;

And;

IV. The amount and type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm to the patient.

12 CHAPTER 12

PROTOCOL FOR AMBULANCE SERVICE REQUESTING POLICE ASSISTANCE

12a Ambulance clinicians may request police assistance for patients who lack capacity under the following circumstances:

- Patients in need of treatment who require restraint due to their threatening or violent behaviour, identified through a Dynamic Operational Risk Assessment, and following appropriate risk mitigation techniques.
- Patients refusing emergency treatment and/or transport deemed to be in their best interests, where DORA has identified minimal restraint as being neither effective nor safe to be undertaken and where alternative avenues have been explored or cannot be provided by ambulance clinicians
- Patients who are at immediate risk of causing further harm to themselves or others

12b Where an immediate risk of violence or serious harm is identified, Police attendance can be requested using normal systems of escalation.

12c Ideally a senior clinician from NWAS should, where possible, be involved in decisions relating to Police attendance. If a senior clinician is on scene, they can request police attendance via EOC or the clinical support hub where appropriate.

12d Where a senior clinician is not in attendance, the clinician on scene should contact senior clinical advice via the clinical support hub.

12e In cases where Police attendance is required to assist with providing a patient with best interests care, the police should be contacted using the normal systems and the request should be made using the following terminology:
'Police attendance is required for an emergency Mental Capacity Act incident'. Significant risk information must also be communicated to EOC as per agreed procedure (Appendix D)

12f The police will respond to the incident as an emergency and grade the incident as a 1or 2. Calls to the police will be assessed, graded and responded to as per force policy.

12g Following arrival of the police at scene, the ambulance clinicians will provide the police officer(s) with the following:

- A brief history of the incident.

- Information relating to the clinical condition of the patient and the treatment/care required.
- A summary of the mental capacity assessment; highlighting the reasons why the patient is believed to lack capacity.
- A summary of what support is required by the police officer(s).

12h The ambulance clinicians and police officer(s) will then work together; completing a joint risk assessment and agreeing a plan on how to manage the patient in the safest, timeliest and least restrictive means possible.

12i A patient's mental capacity can change over relatively short periods of time. Therefore, it may be necessary for ambulance clinicians to re-assess patient's capacity at any time if there is a change in their behaviour or appearance. Assessments of capacity should be time and decision specific

12j Ambulance clinicians will have responsibility for all decisions relating to the clinical treatment of the patient, including the most appropriate destination hospital.

12k Ambulance clinicians will provide all available information to the police officers on scene, including clinical findings and impression. The attending police officers, using the information provided by the attending ambulance clinicians will decide on the appropriate type and level of restraint

13 CHAPTER 13

PROTOCOL FOR POLICE OFFICERS REQUESTING AMBULANCE ASSISTANCE

13a Police officers are often the first agency at the scene of an incident and may have to deal with patients who require immediate clinical assessment or treatment.

13b Police officers may contact a senior clinician to discuss any situation via the Clinical Support Hub. This must not delay an ambulance request in emergency situations which should be prioritised and requested using normal ambulance request procedures. If an ambulance request is not being made but police officers wish to discuss a case with a clinician, they are still able to contact the Clinical Support Hub. A copy of the diagnostic and functional assessment questions used by NWAS are included in the appendices. These may assist police officers in determining whether a patient has capacity. Contact with the senior clinician can be requested through police control, a contact number will be required for the call-back.

13c Police officers will request attendance of an emergency ambulance through Police Control as per normal procedures

13d Police will contact NWAS using the emergency 999 line and request assistance under the Mental Capacity Act. The NWAS response target for any incident will be clinically defined dependent on the condition of the patient. Prioritisation of calls will be based on clinical presentation and risk. It is imperative that deterioration or changes in condition are communicated to NWAS, as this may increase the priority of the incident.

13e NWAS EOC will confirm the dispatch of an emergency ambulance and advise if there are anticipated delays in responding to the incident (NB NWAS will endeavour to provide an immediate response for the majority of cases).

13f Where a significant delay in ambulance response is advised, NWAS EOC, through clinical support, may advise the police to consider transferring the patient to hospital in an appropriate police vehicle (subject to a dynamic risk assessment). This should not be for the purpose of moving a person who appears to be a mentally disordered patient to a place of safety, as such a scenario is provided for under s.135 and s.136 of the Mental Health Act.

13g Police Control will then advise the police officer(s) at the scene of whether an ambulance is responding or whether they need to consider transferring in a police vehicle because of anticipated delays.

13h Following arrival of the ambulance at scene, the police officer(s) will provide the ambulance clinicians with the following:

- A brief history of the incident.
- Information relating to their clinical concerns for the patient.
- A summary of the mental capacity assessment; highlighting the reasons why the patient is believed to lack capacity.
- A briefing on the risks/issues relating to the patient.

13i The police officer(s) and ambulance clinicians will then work together; reviewing the capacity assessment, completing a joint risk assessment and agreeing a plan on how to manage the patient in the safest, timeliest and least restrictive means possible.

13j A patient's mental capacity can change over relatively short periods of time. Therefore, it may be necessary for ambulance clinicians to re-assess patient's capacity at any time if there is a change in their behaviour or appearance. Assessments of capacity should be time and decision specific.

13k Ambulance clinicians will have responsibility for all decisions relating to the clinical treatment of the patient, including the most appropriate transport method and destination hospital.

13l Ambulance clinicians will provide information to the police, the police officer will then make a decision on whether restraint is required and what method of restraint should be used; taking into account the patient's condition/injuries and assessment or treatment required.

14 CHAPTER 14

TRANSFER AND CONTINUING CARE OF PATIENT

14a It is always preferable to transport someone by ambulance. However, when there are identified risks, then measures may need to be taken to ensure the safety of the person, the public. ambulance clinicians and police officers. The safety of staff always needs to be a consideration in these circumstances. The other options to be considered are:

- Police Officer(s) to travel in the ambulance with patient and ambulance clinicians
- Police vehicle to follow ambulance
- Patient to be transported in a Police vehicle only in exceptional circumstances with ambulance clinicians observing in a safe position within the police vehicle.
- It should be noted that a patient who is capable of absconding from a vehicle, may not be safely transported within an ambulance, which can be easily unlocked form the inside. Patients considered highly likely to abscond from a moving vehicle may therefore be more safely transported in a police vehicle.

14b Ambulance clinicians are responsible for pre-alerting the destination hospital (via NWAS EOC) and providing them with information relating to the patient's condition, the presence of the police, the reason for their involvement and relevant risk information.

14c At handover NWAS clinicians should inform the destination hospital that the patient is attending the hospital under the MCA and not the MHA. There is often an assumption that because police are present the patient has been detained under sect 136 MHA. Police officers are not obliged to remain at the hospital and will leave following a risk assessment performed by the officers.

14d Ambulance clinicians are responsible for completing the appropriate paperwork with the normal clinical information including; full details of the capacity assessment, risk factors, actions agreed with police, police collar details, transport method and a description of any restraint applied by either ambulance clinicians or police officers. When police officers are involved and initially attend the hospital, then they should agree the appropriate paperwork details relating to their involvement before it is submitted to the hospital.

14e Ambulance clinicians are responsible for providing a full clinical handover at hospital and providing a copy of the completed appropriate paperwork to the hospital as per normal local procedures.

15 CHAPTER 15

FURTHER ADVICE/ESCALATION OF ISSUES

15a Where there are conflicting views at scene between police and ambulance clinicians with regard to how a patient should be managed, this will be resolved by formal escalation pathway involving negotiation between the relevant attending police officer's Supervisor or, if unavailable, the Police Duty Inspector and the Senior Clinician which was previously consulted.

15b Ambulance clinicians should also seek further clinical advice via the duty Advanced Paramedic where they have concerns over assessing capacity or are unsure about what the best interests/treatment options are for the patient.

15c Police officers should seek further guidance from their Force Incident Manager, Supervision or Divisional MH SPOC.

16 CHAPTER 16

HOW DOES THE MCA PROTECT PROFESSIONALS WORKING IN HEALTH AND SOCIAL CARE?

16a The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity to consent, provided that:

- you have observed the principles of the MCA
- you have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question
- you reasonably believe the action you have taken is in the best interests of the person.

16b Some decisions that you make could result in major life changes or have significant consequences for the person concerned and these will need particularly careful consideration.

16c The organisation will support staff who follow this protocol in conjunction with approved organisational policies and the principles of the MCA.

16d Providing you have complied with the MCA in assessing a person's capacity and have acted in the person's best interests healthcare professionals are able to examine and treat patients who do not have the capacity to give their consent. For example;

- diagnostic examinations and tests
- assessments
- medical treatment
- admission to hospital for assessment or treatment (except for people who are liable to be detained under the Mental Health Act 1983 emergency procedures (such as IV cannulation, administration of drugs or cardiopulmonary resuscitation).

16e A practitioner will have acted in the best interests of an incapable patient where the treatment she/he gave (or refrained from giving) was in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in the form of treatment.

16f It will be important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity, reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person's best interests.

16g It is the practitioner in charge of a patient's care and treatment who must decide what is in their best interests. The patient's spouse or their family, friends or colleagues cannot give or withhold consent to treatment on the patient's behalf. However, what they have to say may be useful in deciding where the patient's best interests lie.

17 CHAPTER 17

AUDITING, MONITORING AND REVIEW

17a All organisations included in this agreement will ensure that it is implemented in accordance with local procedures that will include provision for auditing the maintenance and the management of compliance with the terms of this document. The North West Regional Mental Health Forum will review compliance and monitor any difficulties encountered.

18 CHAPTER 18

SIGNATURES

18a Organisation: Lancashire Constabulary (on behalf of Cheshire, Cumbria, Lancashire, Merseyside and Greater Manchester Police Forces)

Name: T Woods

Role: ACC Operations

Signature

Organisation: North West Ambulance Service

Name: Mike Jackson

Role: Chief Consultant Paramedic

Signature

APPENDIX A

Capacity to Consent and Best Interests Decision form

The most senior clinician on scene should complete this assessment.

North West Ambulance Service NHS Trust

Incident Number	Date	Call Sign 1

Patient First Name / Patient Surname	Date of Birth

Does the Mental Capacity Act 2005 apply?	Y	N	2	
The patient is over 16 years of age?	☐	☐		If all three answers are Yes, continue. If you have selected 'No' to any question in Box 2, does the Mental Health Act 1983 apply?
Is there reason to doubt the patient's capacity?	☐	☐		
There is physical illness/injury requiring care/treatment?	☐	☐		

Please describe the decision you are asking the patient to make.		3
Please describe how the patient has a disturbance of the mind, indicating a potential lack of capacity.		4
Please identify, giving an explanation, why the patient is unable to make a decision.	*Unable to understand information* ☐ *Unable to retain information* ☐ *Unable to use information to form a decision* ☐ *Unable to communicate their decision* ☐	5
Please describe what actions you have taken to assist the patient to make their own decision and gain capacity.		6

Despite actions taken in Box 6, I reasonably believe the patient still lacks capacity because 7

Is the desired assessment or treatment time critical and would further delay cause immediate harm to the patient?	☐ YES (commence treatment) ☐ NO (continue to Box 9)	8

Best Interests Decision Options (Consider all options of care, giving consideration to expressed wishes of patient and family). 9

A	B
C	D

I believe option [ ] is the least restrictive, and offers the patient the appropriate care, which is proportionate to their condition and is in their best interests. 10

Clinical Grade: eCFR/UCS/EMT1/EMT2/Para/SP/AP/CP HCPC No. P A

Senior Clinician Signature: PIN No:

This form remains the the property of the issuing company; if found it should returned to the Clinical Records Manager, N.W. Ambulance Service NHS Trust, 449-451 Garstang Road, Broughton, PR3 5LN.

APPENDIX B

2.1 The Two Stage Test of Capacity

To help determine if a person lacks capacity to make particular decisions, the Act sets out a two stage test of capacity.

Stage 1: Diagnostic - Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain? It does not matter if this is temporary or permanent.

Stage 1requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Act.

Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury, and;
- The symptoms of alcohol or drug use.

Stage 2: Functional - Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves.

Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

2.2 Inability to make a decision

A person is unable to make a decision if they cannot:

I. Understand the information about the decision to be made.

II. Retain that information.

III. Use or weigh that information as part of the decision-making process, or process of making the decision

IV. Communicate their decision (whether by talking, using sign language or any other means).

The first three should be applied together. If a person cannot do any of these three things they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

Every effort should be made to find ways of communicating with someone before deciding that they lack the capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone. Those who do might include people who are unconscious or in a coma. In many other cases such simple actions as blinking or squeezing a hand may be enough to communicate a decision.

Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, *on the balance of probabilities*, that the individual lacks

capacity to make a particular decision, at the time it needs to be made. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

The Two Stage Test of Capacity

2.3 Stage 1 - Diagnosis

Cognitive Assessment

1. Is the patient orientated? Can they state what day it is, what their address is and where they are currently (if different)?

2. Is the patient able to identify/locate familiar objects? This might include; location of medicines at home, location and positioning of vehicles at an RTC or identification of a jacket or house keys.

3. Is the patient able to follow simple commands? (e.g. stand up, raise an arm to enable blood pressure to be taken)

Confirmation of whether the assessment indicates impairment or disturbance in the functioning of the mind must also be recorded.

If there is no evidence of impairment or disturbance then you must complete **Stage 2** to confirm questions 4 to 8. This will ensure the patient is fully informed and understands the decision(s) made.

If there is evidence of an impairment or disturbance then you must progress to **Stage 2** of the assessment process.

2.4 Stage 2 - Functional Assessment

The Stage 2 assessment questions are:

4. Does the person have a general understanding of what decision they need to make and why they need to make it?

5. Does the person have a general understanding of the likely consequences of making, or not making, the relevant decision,

6. Are they able to understand, retain, use and weigh up information relevant to the decision?

7. Can they use and retain the information as part of the decisionmaking process?

8. Can they communicate their decision?

If all the answers to the questions are yes, staff should consider that the patient has capacity and is able to make competent decisions relating to their care. It must be remembered however, that this is only a guide. If there are still concerns that a patient is not rational you may consider them to lack capacity.

If the answer to any of the questions is no, staff should consider that the patient *may* lack capacity and should explain the proposed examination, treatment or transport options further.

APPENDIX C

2.5 Best Interest

The best interests principle underpins the Mental Capacity Act. It is set out in section 1(5) of the Act.

'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.'

The concept has been developed by the courts in cases relating to people who lack capacity to make specific decisions for themselves, mainly decisions concerned with the provision of medical treatment or social care.

This principle covers all aspects of financial, personal welfare and healthcare decisionmaking and actions. It applies to anyone making decisions or acting under the provisions of the Act, including:

- family carers, other carers and care workers
- healthcare and social care staff
- attorneys appointed under a Lasting Power of Attorney or registered. Enduring Power of Attorney
- Deputies appointed by the court to make decisions on behalf of someone who lacks capacity, and
- The Court of Protection.

A person trying to work out the best interests of a person who lacks capacity to make a particular decision ('lacks capacity') should:

2.6 Encourage participation

- Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

2.7 Identify all relevant circumstances

- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

2.8 Find out the person's views

- Try to find out the views of the person who lacks capacity, including:

    - The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.

    - Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.

- Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

Avoid discrimination:

- Not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.

2.9 Assess whether the person might regain capacity

- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

2.10 If the decision concerns life-sustaining treatment

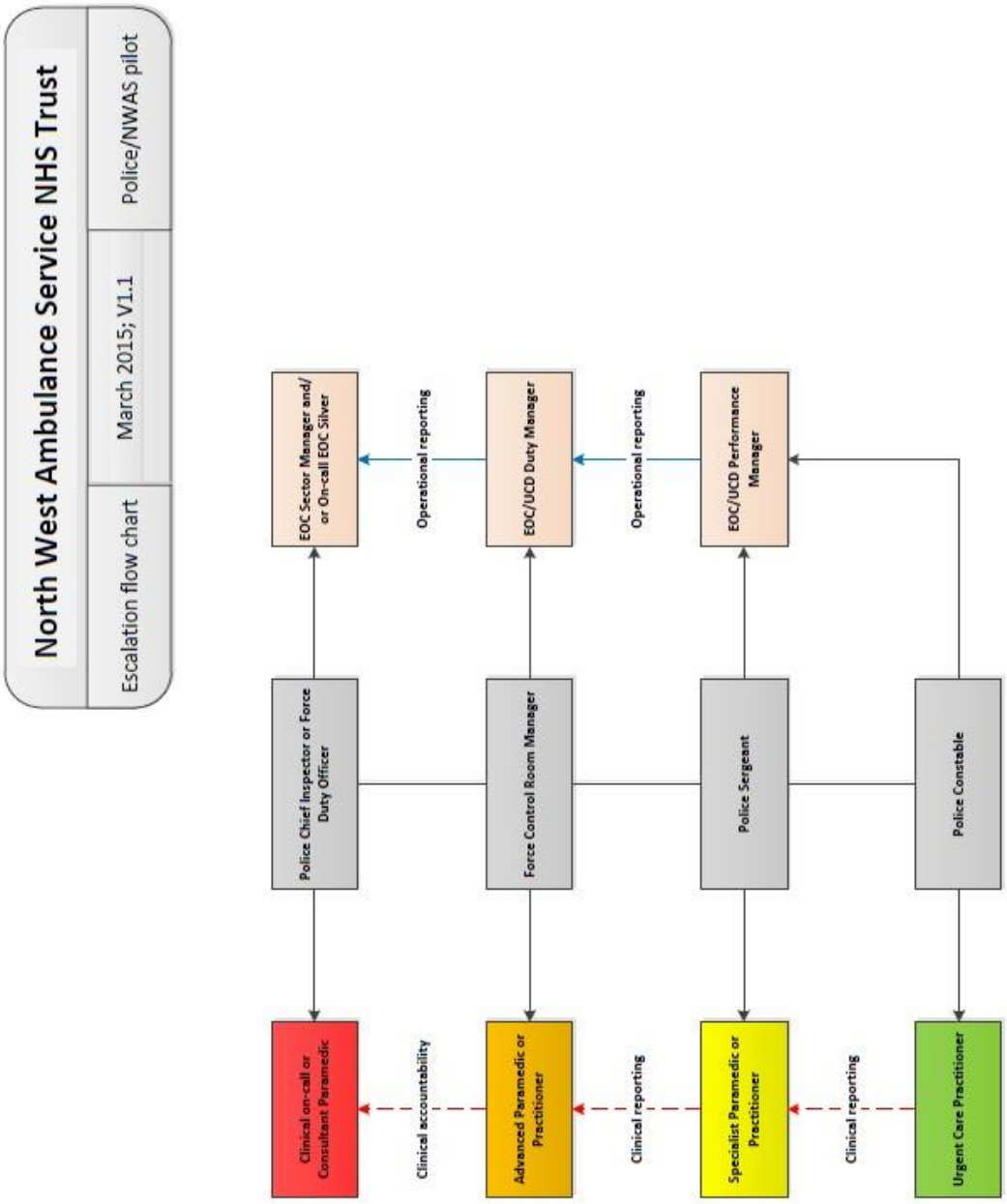
- Not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

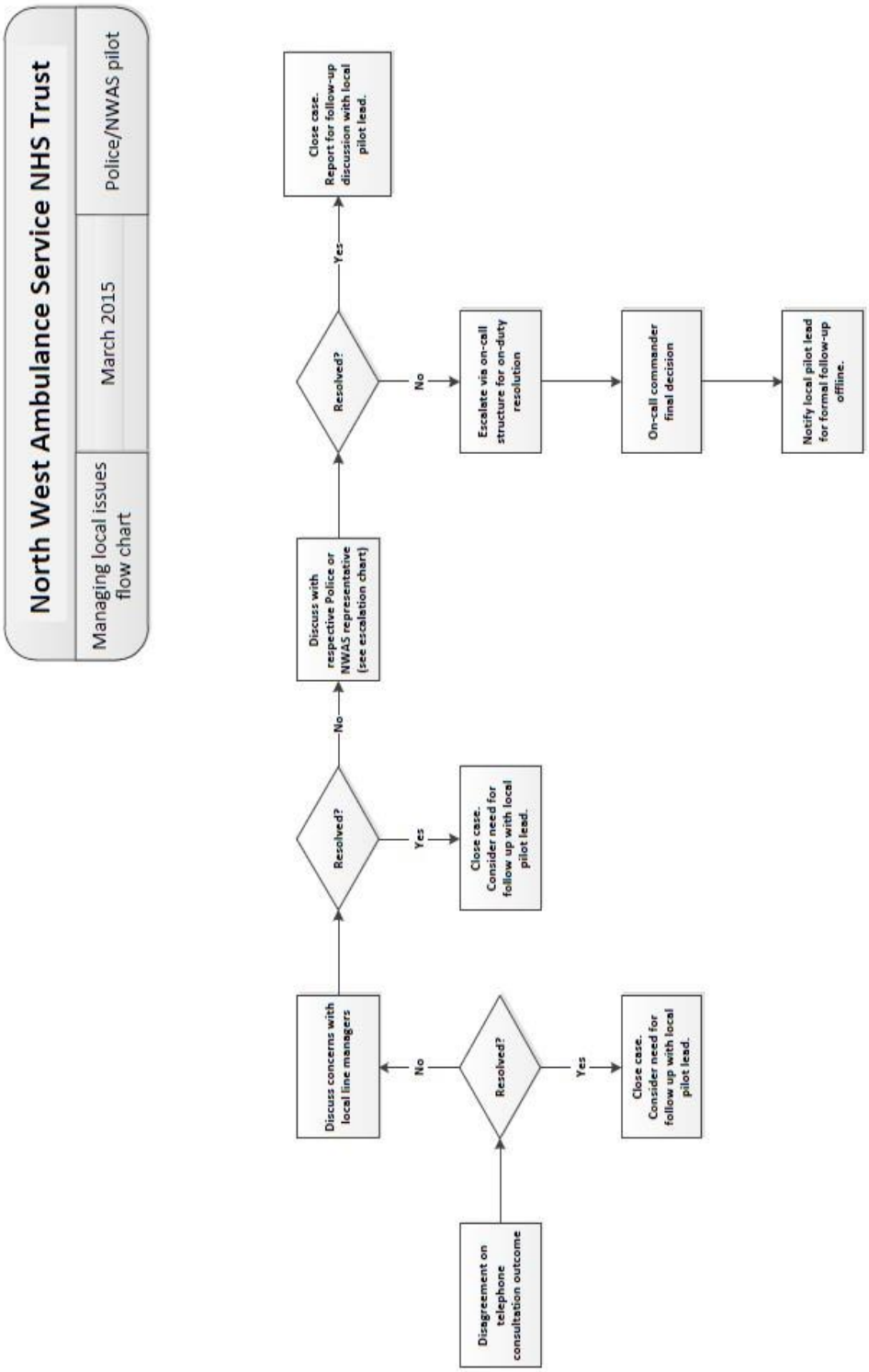
2.11 Consult others

- If it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.

APPENDIX D

PROCEDURE FOR CONTACTING POLICE FORCE


North West Ambulance Service NHS Trust
Escalation flow chart
March 2015; V1.1
Police/NWAS pilot
EOC Sector Manager and/ or On-call EOC Silver
Operational reporting
EOC/UCD Duty Manager
Operational reporting
EOC/UCD Performance Manager
Police Chief Inspector or Force Duty Officer
Force Control Room Manager
Police Sergeant
Police Constable
Clinical on-call or Consultant Paramedic
Clinical accountability
Advanced Paramedic or Practitioner
Clinical reporting
Specialist Paramedic or Practitioner
Clinical reporting
Urgent Care Practitioner


North West Ambulance Service NHS Trust
Managing local issues flow chart
March 2015
Police/NWAS pilot
Disagreement on telephone consultation outcome
Resolved?
Yes
Close case. Consider need for follow up with local pilot lead.
No
Discuss concerns with local line managers
Resolved?
Yes
Close case. Consider need for follow up with local pilot lead.
No
Discuss with respective Police or NWAS representative (see escalation chart)
Resolved?
Yes
Close case. Report for follow-up discussion with local pilot lead.
No
Escalate via on-call structure for on-duty resolution
On-call commander final decision
Notify local pilot lead for formal follow-up offline.

Legislation:

Mental Capacity Act 2005
Human Rights Act 1998

Guidance:

Mental Capacity Act 2005 – Code of Practice

Mental Capacity Act Reference Guide

Deprivation of Liberty Safeguards – Code of Practice

European Convention on Human Rights – Articles 2, 3, 5, 10, 14

NICE: NG10 2015 Violence and aggression: short-term management in mental health, health and community settings https://www.nice.org.uk/guidance/ng10

END OF POLICY