NHS
West Essex
Clinical Commissioning Group

CONSENT TO EXAMINATION OR TREATMENT CLINICAL POLICY

West Essex CCG Policy Reference:
WECCG28

Target Audience	All staff employed by WECCG and GP practice members who make up the CCG
Brief Description (max 50 words)	This policy outlines the approach and process to be followed by any clinician prior to examination or clinical treatment. **Acknowledgement:** This policy has been produced using the original document *Consent to examination or treatment clinical guideline* written by SEPT. The CCG has the permission of SEPT.

Document Information

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Amendment History

Version	Date	Reviewer Name(s)	Comments
Revised final draft	5th Feb 2014	Josephine Smit	Amendments incorporated
Final draft	Jan 14	Josephine Smit	Discussed at Jan Policy Review Group and amendments agreed.
1.1	Jan 2017	Melanie Mavers	

Consent To Examination Or Treatment

1.0 INTRODUCTION

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is 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.

The Department of Health has issued a range of guidance documents on consent (see *Appendix A Reference guide to consent for examination or treatment 2009* and *Guidance on consent*). These should be consulted for details of the law and good practice requirements on consent. This clinical policy sets out the standards and procedures in the CCG, which will ensure that health professionals are able to comply with the guidance.

The policy relates to the seeking of consent for children (0-15 years olds), young people (16 and 17 year olds) and adults (aged 18 years and over)

2.0 SCOPE

This clinical policy is applicable to all permanent and temporary healthcare/social care staff working within all clinical services and locations in the CCG.

3.0 DEFINITION

'Consent' is a patient's agreement for a health or social care professional to provide care. Patients may indicate consent in the following formats:

- Written consent
- Verbal consent
- Implied consent (e.g. by presenting their arm for their pulse to be taken*)*

The circumstances in which written consent is best practice is covered in this policy

3.1 For consent to be valid, it must be:

- given voluntarily
- by an appropriately informed person
- who has the capacity to consent to the intervention in question
    - this will be the patient or
    - someone with parental responsibility for a patient under the age of 18
    - someone authorised to do so under a Lasting Power of Attorney (LPA) or
    - someone who has the authority to make treatment decisions as a court appointed deputy.

Acquiescence where the person does not know what the intervention entails is not 'consent'.

3.2 Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves**,** in relation to the specific decision, **no-one else can give consent on their behalf**. Guidance with reference to the *Mental Capacity Act 2005* and *Deprivation of Liberty* will be considered.

3.3 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 decision. For further details on advance decisions see the Department of Health's *Reference guide to consent for examination or treatment 2009 (chapter 1, paragraph 19)* and section XXXX

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. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making' i.e. 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.

4.0 RESPONSIBILITIES (individuals)

4.1 The Chief Officer is responsible for:

- Ensuring that the principles of this clinical policy, and other associated policies are implemented across the organisation

4.2 The Director of Nursing and Quality and the Medical Director will ensure:

- the policy is embedded into clinical practice as well as best practice framework and in ensuring these are updated regularly
- any identification and implementation of training and educational needs arising from any relevant documentation are adhered to
- that any clinical risk issues are addressed with the relevant line manager

4.3 Managers and other persons in charge will ensure:

- the procedures and principles detailed within this clinical policy are followed, to meet with all relevant guidance
- that any incidents related to consent are recorded
- staff receive appropriate and correct training
- that managers will make their staff aware of the consent to examination or treatment clinical policy and their adherence to it, and monitor its use

4.4 Health Staff

- The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to the treatment/procedure as it is they who will be held responsible in law if this is challenged later. It is the duty of the professional to inform their managers of any concerns.

- Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the health professional responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

- The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins. The task of seeking consent may be delegated to another person, as long either they are capable of

carrying out the procedure themselves or they have been specifically trained and are competent to take consent for that specific procedure.

- It is a healthcare professional's own responsibility to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent.

- It is the responsibility of all staff to work within their own competence and not to agree to perform tasks which exceed that competence.

- if you feel pressurised to seek consent when you do not feel competent to do so you must contact your line manager immediately for advice.

5.0 Procedures To Follow When Patients Lack Capacity To Give Or Withhold Consent

5.1 The Mental Capacity Act 2005 defines a person who lacks capacity, as a person who is unable to make a particular decision for themselves, at a time it needs to be made or take a particular action at a time it needs to be taken, because of an impairment of or disturbance in the functioning of their mind or brain. This guidance needs to be read together with Mental Capacity Act 2005 code of practice at www.dca.gov.uk

5.2 Where an adult patient or young person aged of 16yrs-17yrs does not have the capacity to give or withhold consent to a significant intervention, the guidance from the Mental Capacity Act must be followed, and this fact should be documented in Form 4 (form for adults who are unable to consent to investigation or treatment), 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 close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves.

5.3 For more minor interventions, such as routine nursing care, bathing, feeding and skin care, information relating to this decision making and that the patient lacks capacity should be entered in the patient's notes. In these cases it should be recorded that care is being provided in the patients 'best interests'. If the patients carer and/or relative has been involved in decision making discussions this should also be recorded along with any decisions or information discussed by the Multi-Disciplinary Team (MDT).

5.3.1 An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. Appropriate colleagues should be involved in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, 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. All verbal and written communication must be clearly documented in the patient's records.

5.3.2 Occasionally there will not be a consensus on whether a particular treatment is in the best interests of an adult's who lacks capacity. Where the consequences of having, or not having, the treatments are potentially serious, a court declaration may be sought. See Appendix D for details of how to do this.

5.4 **Availability of forms**
Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix B and can be printed as when required.

There are four versions of the standard consent form listed in Appendix B as follows:

- Form 1 Patient agreement to investigation
- Form 2 Parental agreements to Investigation or Treatment for a child or young person
- Form 3 Patient/Parental agreements to investigation or treatment where consciousness is not impaired and patient will be alert throughout the procedure.
- Form 4 Form for adults who are unable to consent to investigation or treatment

6.0 When Should Consent Be Sought
6.1 The seeking and giving of consent is usually a process, rather than a one-off event. To give valid consent, the patient needs to understand the nature and purpose of the procedure. For major interventions, it is good practice where possible to seek the person's consent to the proposed procedure well in advance, when there is time to respond to the patient's questions and provide adequate information. Clinicians should then check, before the procedure starts that the patient still consents.

6.2 Evidence must be provided to show discussion and decision-making processes clearly within the patients notes as part of 'seeking consent'. This process may occur at one time or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

6.3 **Single stage process**

6.3.1 It may be appropriate for a health professional to initiate a procedure immediately following discussion with the patient. For example, during an on-going episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be implemented they should then give their consent and the procedure can be undertaken. In such cases, consent will be given orally and documented accordingly in patient records.

6.3.2 When a proposed procedure carries significant risk, it is appropriate to gain written consent. The health professional must take into consideration whether the patient has had sufficient opportunity to absorb and understand 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. The documented discussion must show that the specific and relevant risks have been discussed and that the patient has understood the information given.

6.3 Two or more stage process

6.3.1 When written consent is required, treatment options will be discussed in advance of the procedure. This may be undertaken at one consultation (either within primary care or in a hospital out-patient clinic), or over a series of consultations with different health professionals. The consent process will have at least two stages as follows:

a) Provision of information via discussions and options with a verbal decision being offered

b) Confirmation that the patient has consented to proceed.

The consent form will be completed as evidence of all stages and confirmation to proceed.

6.3.2 Patients receiving elective treatment or investigations, for which written consent is appropriate, should be familiar with the contents of their consent form before arriving for the procedure and should have received a copy of the page documenting the decision making process. The patient will be invited to sign the form, to confirm their consent to proceed. This may be signed at the out-patient clinic, pre-admission clinic or on arrival for the appointment for treatment. However, if the form is signed before the appointment, the health care team **must** confirm and discuss with the patient their understanding of the proposed procedure and allow for concerns to be discussed including whether their condition has changed. All of this must be documented in the patient's notes at each consultation. This is particularly important when there has been a time lapse between the consent being given and the appointment. It is essential use open ended questions that require more than 'yes', or 'no' answers; for example, "tell me what you're expecting to happen" rather than "is everything all right?"

6.3.3 While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. Therefore, it is not best practice and will, in most cases, be inappropriate to ask a patient to sign the consent form on the morning of surgery or after they have begun to be prepared for treatment (for example, by changing into a hospital gown) unless this is unavoidable because of the urgency of the patient's condition.

6.4 Duration of consent

6.4.1 When a person gives valid consent to an intervention, generally that consent will remain valid for an indefinite duration of time unless it is withdrawn by the person. However, health professionals need to consider that the circumstances of an individual may change; for example, their state of health and/or their understanding and perceptions may alter quite quickly. Therefore, health professionals should ensure consent is obtained each time where necessary.

6.5 Seeking consent for anaesthesia

6.5.1 Where an anaesthetist is involved in a patient's care it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, after having discussed the risk and benefits.

6.5.2 In elective treatment a patient MUST have received information about anaesthesia BEFORE their pre-operative visit from the anaesthetist, as it is considered too late at this stage for a patient to be in position to generally make a decision about whether or not to undergo anaesthesia.

6.5.3 Patients will have received general information leaflets regarding anaesthesia at a prior meeting with the opportunity to have discussed concerns. This information will be recorded in the patient's notes and made available to the anaesthetist.

6.5.4 When the clinician providing care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

6.6 Emergencies

6.6.1 In emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.
In the case of children where a life-threatening emergency arises it may not be possible to seek the consent of the person with parental responsibility for the child, or the person with parental responsibility may refuse consent. 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.

6.7 Parental Responsibility and Treatment of Children and Young People

6.7.1 Only people with 'parental responsibility' are entitled to give consent on behalf of their children unless the child/young person is on a specific care order. It is important to be aware that not all parents have parental responsibility for their children (for example, following amendment of the *Children Act 1989* by the *Adoption & Children Act 2002*, an unmarried father has parental responsibility if his name is registered on the birth certificate of a child born after 1st December 2003, but may not always do so where the birth occurred before that).
Others who may hold PR for a child are:

- the child's legally appointed guardian including Special Guardianship
- a person in whose favour the court has made a residence order concerning the child

- a local authority designated in a care order in respect of the child
- a local authority or other authorised person who holds an emergency protection order in respect of the child.

If you are in **any doubt** regarding parental responsibility this **must** be verified before proceeding. Further guidance can be accessed on the internet at. https://www.gov.uk/government/uploads/.../dh_103653__1_.pdf

6.7.2 Looked After Children

Children or young people who are 'Looked After' by a local authority are accommodated with carer's who do not hold parental responsibility for the child or young person and therefore cannot give legal and valid consent to treatment or interventions. These include local authority appointed or Independent Fostering Agency (IFA's) foster carers, residential care staff and family members such as grandparents, aunts/uncles or siblings with whom a child may be placed. In such circumstances provision may be made for the local authority to seek to arrange for authority to consent to be delegated to the child's identified carer/s. Carers must provide written evidence to the prescribing health professional of the authority delegated to them to consent to a particular intervention, i.e. immunisation.

6.7.3 Responsibilities of Health Professionals providing Healthcare to a Looked after child

Health professionals providing healthcare to a child should always assure themselves that the person agreeing to the treatment or procedure has the authority to do so and understands the associated risks and benefits. If there is any doubt the health professional is duty bound to seek clarity and confirmation of agreement from the child's social worker and, if necessary, from the person with PR via the social worker unless to delay would increase the pain or suffering of the child.

The health professional is also responsible for providing to the person with PR, via the social worker, sufficient information for and informed decision to be made about the prescribed treatment.

The intervention must be recorded in the child's PCHR as well as in the NHS health record.

6.74 Gillick Competency

Children who have 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. This is described as being 'Gillick competent'. A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent. Additional consent from the person who holds parental responsibility will not be required however it is best practice to involve them in the decision making process.

Decisions of competent children to consent to an intervention cannot be over-ruled by a person who holds parental responsibility for the child. However, should a competent child refuse consent the person with parental responsibility may consent on their behalf. However, it would be appropriate to seek the decision of a court before proceeding. Even where a child lacks capacity to consent on their own behalf, it is good practice to involve the child as much as possible in the decision making process.

7.0 Assessing Capacity To Give Or Withhold Consent

7.1 The *Mental Capacity Act* sets out a two stage test and assessment for capacity in an adult patient:

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

Stage 2: Does the impairment or disturbance prevent the person from making a particular decision?

7.2 It is a 'decision-specific' and time specific test. The Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance or behaviour.

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

- Understand the relevant information
- Retain that information
- Use the information as part of the decision making process

Decision making where the person does not have capacity

7.4 The Act supported by the *Mental Capacity Act 2005* code of practice provides a non-exhaustive checklist of factors that decision makers must work through in deciding what is in a person's best interests. People caring for the person lacking capacity gain the right to be consulted concerning a person's best interest.

Where a person lacks the capacity to make a decision for themselves, any decision must be made in that person's best interests. The Mental Capacity Act introduced a duty on NHS bodies to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks the capacity to make a decision has no one who can speak for them, other than paid staff. The Act allows people to plan ahead for a time when they may not have the capacity to make their own decisions: it allows them to appoint a personal welfare attorney to make health and social care decisions, including medical treatment, on their behalf or to make an advance decision to refuse medical treatment.

Advance decision making

7.5 Since the implementation of the *Mental Capacity Act* competent adults (aged 18 and over) can make decisions about what treatment they may not wish to receive in the event that they subsequently become incapable, by means of an Advance Decision to refuse treatment. This decision may be expressed verbally or in writing, however this expression should be clearly documented in patient's health records. For further information see the Lord Chancellor's *Mental Capacity Act 2005 Code of Practice* on www.dca.gov.uk

Independent Mental Capacity Advocate (IMCA)

7.7 Where the patient has no friends or family to consult, decision makers will instruct a local IMCA in situations where:

- The decision is about providing, withholding or stopping '**serious medical'** treatment provided by the NHS

- Proposal by the organisation that the person be into long-term care of more than
- 28 days in a hospital or 8 weeks in a care home
- A proposed long-term move (8 weeks or more) to different accommodation

The only exception to the requirement to consult an IMCA before taking such a decision can be in situations where an urgent decision is needed.

8.0 REFUSAL OF TREATMENT

8.1 If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. Health professionals must ensure refusal of treatment is offered to a patient as one of the patients options. All competent adults are entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see www.dh.gov.uk/consent chapter 3 para. 13-20.

(The following paragraphs apply primarily to adults)

8.2 If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their health record. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

8.3 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 wish to do so. Where delay may affect their treatment choices, they should be advised accordingly and documented in health records.

8.4 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 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.

8.5 If a patient is refusing treatment that is essential for their welfare and you have any concerns about their mental state at the time of refusal, you should try to establish whether at that time the patient has the capacity to withdraw consent. See www.dca.gov.uk.

9.0 Provision Of Information

9.1 Before patients can come to a decision about treatment, they need comprehensible information about:

- their condition
- about possible treatments/ investigations
- their risks and benefits (including the risks/ benefits of doing nothing).

They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example the removal of particular tissue. Once a decision to have a particular treatment/ investigation has been made, patients need information about what will happen; where to go, how they will feel afterwards and so on.

9.2 Information disclosed will vary for each patient, relative and carer; some require comprehensive information, including rare risks, to some who ask health professional to make decisions on their behalf. Sound clinical judgment is required in determining the information given. However, the presumption must be that all patients will be treated with the utmost respect and all information will be imparted, allowing the patient to make an

informed decision. When the patient gives a clear indication (either verbally or non-verbally) that they do not wish to be given this level of information, this must be documented.

Local Arrangements
9.3 All written information can be translated on request, or made available in large print, braille or recorded onto tape or CD. PALS (Patient Advice and Liaison Service) will advise all local advocacy services.

Provision for patients whose first language is not English
9.4 This organisation is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff.
For interpreting and translation services contact:
*Essex Interpreting Service on 01206 822080

It is not permitted to use children to interpret for family members who do not speak English.

Access to health professionals between formal appointments
9.7 Following an appointment with a health professional in primary care or in the out-patient department, patients may have further concerns they wish to discuss and would like answering before making a decision. It will be conducive for patients to have telephone contact numbers for doctor's secretaries, care co-ordinators and key workers. This allows for direct telephone contact with the healthcare team, preventing further delays or the need to make other appointments, thus allaying anxieties.

Local Arrangements
9.8 All outpatient clinics will provide patients with information about their treatment and any investigation. Contact details where patient can obtain further information (including out-of-hours) must be provided.

10.0 Completing Consent Forms

10.1 When a patient formally gives consent to a particular intervention, documented evidence must be provided to show discussion and decision making process clearly within the patients notes as part of seeking consent.

10.2 Consent must be obtained by the health care professional prior to any treatment. This can be documented either through the use of a consent form completed by the health care professional or through documentation within the patient's notes.

10.3 Completed consent forms must be kept with the patients notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

10.4 When a proposed procedure carries significant risk, it is appropriate to gain written consent. The health professional must take into consideration whether the patient has sufficient opportunity to understand and consent to the information and allows a decision to proceed.

The patient must be given a copy of their completed consent from for their records

10.5 The health professional completing the consent form will do so in one of the following instances:

- Will be undertaking the procedure
- Will have received specialist training regarding the procedure
- Has been assessed competent to do so
- Is aware of their own knowledge and limitations
- Be aware this is subject to audit

10.6 The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person's care will remain ultimately responsible for the quality of medical care provided. The task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified and with sufficient knowledge of the proposed investigation or treatment.

10.7 It is the healthcare professional's responsibility:

- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent
- To work within their own competence and not to agree to perform tasks which exceed that competence
- Take action to contact their line manager for advice if it any time they feel pressurised into seeking consent and do not feel competent to do so

10.8 Health professionals confirming the patients consent will have genuine access to appropriate colleagues when they are personally not able to answer any remaining questions. Contact will be via hospital telephone if necessary.

11.0 Tissue

11.1 The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing). At present, this Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes. This should be clearly documented in the patient's notes, making provision for patients to record their consent or objection to the use of tissue and for this to be notified to the laboratory. Patients must also be able to record objections to particular uses or use of particular tissues. No tissue/organs should be retained post mortem without the appropriate consent.

11.2 Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.

11.3 This organisation does not have an active policy on tissue samples, as procedures for taking tissue samples are not performed in the organisation.

11.4 The Human tissue Act 2004 lists the purpose for which consent is required in schedule 1, and they are referred to as 'scheduled purposes'. The consent required under the Act is called 'appropriate consent'. Full details on the requirements of the Human Tissue Act and the HTA's codes of practice are on the HTA's website at www.hta.gov.uk. These should be consulted to ensure compliance.

12.0 Clinical Photography And Conventional Or Digital Video Recordings

12.1 Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

12.2 Consent form (*Appendix F*) to be completed. One photograph to be taken by CCG staff by digital camera which will be transferred and printed from the Trust shared drive. Following this action, the image will be deleted from the system.

12.3 Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. If such a recording is required for education, publication or research purposes, consent must be sought in writing, ensuring that the person given consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

12.4 Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

12.5 All photography must be taken in line with policy and procedures in order to ensure patients dignity and respect are maintained and adhered to.

12.6 Photographs/videos taken must be shown to service users before being used in any promotional leaflets promoting the organisation's services and full consent must be given. Once a photograph has gone into the public domain, consent cannot be withdrawn as the CCG may have no control over where the photograph may be used again; however, it does agree to not use the photograph for the purpose other than specifically agreed for.

13.0 TRAINING

13.1 Seeking consent for care and/or treatment is a fundamental aspect of clinical practice and all clinicians who are registered practitioners will have both undergone some degree of education about consent and associated issues during their professional training and have received information from their professional body. However, registered practitioners must also ensure that they understand the local approach to seeking consent and that they have completed any local/ departmental induction.

13.2 Line managers will ensure that non-registered practitioners receive training about the local approach to seeking valid consent for care and/ or treatment from a registered practitioner as part of local induction.

13.3 All healthcare professionals will need to attend all relevant training where necessary in line with this clinical policy.

14.0 Dissemination, Implementation and Access

14.1 All line managers are responsible for ensuring this practice and the associated clinical policy is implemented in their area of clinical responsibility.
14.2 This clinical policy and associated documents can be found on the CCG's Intranet site.

14.4 Any amendments to this Clinical Guideline will be submitted for approval to the CCG Policy Review Group.

14.5 A Trust-wide audit co-ordinated by the Central Referral Service will be undertaken annually which will review the practice and procedure outlined in this Clinical Guideline. Outcomes of audit will be reviewed at the CRS Clinical Performance group.

15.0 References

National References

Reference Guide to Consent for Examination or Treatment (2009) Pub: DOH

Mental Capacity Act 2005 code of practice: www.dca.gov.uk

Human Tissue Act 2004 www.hta.gov.uk

Mental Capacity Act and Deprivation of Liberty Safeguards Guidance October 2016 Southend Safeguarding Adults Board, Essex Safeguarding Adults Board,Thurrock Safeguarding Adults Board

APPENDIX A

12 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 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, some-one 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 specially trained to seek 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.

Is the patient's consent voluntary?
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. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusals of treatment

10. Competent adult patients are entitled to refuse treatment, even where 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 well-being 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 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment,* available from the NHS Response Line 0541 555 455 and at www.doh.gov.uk/consent.

APPENDIX B

List of Consent Forms

Consent Form 1 Patient Agreement to Investigation or Treatment
Consent Form 2 Parental Agreement to Investigation or Treatment for a Child or Young Person
Consent Form 3 Patient/Parental Agreement to Investigation or Treatment Where Consciousness Not Impaired
Consent Form 4 Form for Adults who are Unable to Consent to Investigation or Treatment

Consent Form 1 Patient Agreement to Investigation or Treatment

PATIENT AGREEMENT TO INVESTIGATION OR TREATMENT

Patient details (or pre-printed label)

Patient's surname/family name..…….

Patient's first names …….

Date of birth …….

Responsible health professional.……

Job title …….

NHS number (or other identifier)……..

□ Male □ Female

Special requirements ……
(e.g. other language/other communication method)

To be retained in patient's note

Patient identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

……..
……
……

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits ……..……
……
……..……..……
Serious or frequently occurring risks ……...……
..……
……..……
Any extra procedures which may become necessary during the procedure
 blood transfusion……..……
 other procedure (please specify) ……..……..……..……..
……...……..…..

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

 The following leaflet/tape has been provided ……..……..……..…

This procedure will involve:
 general and/or regional anaesthesia local anaesthesia sedation

Signed:…… Date .. ……..……
Name (PRINT) ……..……..…… Job title ……...……..…

Contact details (if patient wishes to discuss options later) …..……..……

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ……..……. Date ……..……
Name (PRINT) ……..……

Top copy accepted by patient: yes/no (please ring)

Statement of patient **Patient identifier/label**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures, which may become necessary during my treatment. I have listed below any procedures, which **I do not wish to be carried out** without further discussion. ……
……
……
……

Patient's signature ……..… Date……...…….
Name (PRINT)

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature ……..……..……. Date …….
Name (PRINT) …….

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed:…….……..…….. Date .. ……
Name (PRINT) ……..……. Job title …...…….…….

Important notes: (tick if applicable)

□ See also advance directive/living will (e.g. Jehovah's Witness form)
□ Patient has withdrawn consent (ask patient to sign /date here)..……...……

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an *aide-memoir* to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- They are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain

kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

CONSENT FORM 2

PARENTAL AGREEMENT TO INVESTIGATION OR TREATMENT FOR A CHILD OR YOUNG PERSON

Patient details (or pre-printed label)

Patient's surname/family name..…….

Patient's first names …….

Date of birth …….

Age …….

Responsible health professional.……

Job title …….

NHS number (or other identifier)……..

□ Male □ Female

Special requirements ……
(e.g. other language/other communication method)

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)
……
……

Statement of health professional **(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)**

I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits
……
……
Serious or frequently occurring risks
……
……

Any extra procedures, which may become necessary during the procedure
□ Blood transfusion……
□ Other procedure (please specify)
……
……

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient and his or her parents.

□ The following leaflet/tape has been provided
……

This procedure will involve:
□ General and/or regional anaesthesia □ local anaesthesia
□ Sedation

Signed:…… Date .. ……..
Name (PRINT) …… …… Job title …….. ……

Contact details (if child/parent wish to discuss options later)
……..

Statement of interpreter (where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed …… Date ……
Name (PRINT) ……

Top copy accepted by patient: yes/no (please ring)

Statement of parent Patient identifier/label

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 2, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form and **I confirm** that I have 'parental responsibility' for this child.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I have been told about additional procedures, which may become necessary during my child's treatment. I have listed below any **procedures, which I do not wish to be carried out** without further discussion.

……
……
……
……

Signature …… Date……...
Name (PRINT) ……. Relationship to child…….

Child's agreement to treatment (if child wishes to sign)

I agree to have the treatment I have been told about.

Name …… Signature ……..……...
Date …….

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child have signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish the procedure to go ahead.

Signed:…… Date .. ……..……..
Name (PRINT) ……. …… Job title …….. ……..…….

Important notes: (tick if applicable)

 See also advance directive/living will (e.g. Jehovah's Witness form)

 Parent has withdrawn consent (ask parent to sign /date here)

……..……...

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as a shorthand for 'person with parental responsibility'. Where children are legally competent to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a competent child wishes them to do so.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance *Seeking consent: working with children.* Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child's mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement (although this may change in the future).

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks, which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent

See the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Consent Form 3 Patient/Parental Agreement to Investigation or Treatment Where Consciousness Not Impaired

PATIENT/PARENTAL AGREEMENT TO INVESTIGATION OR TREATMENT
(WHERE CONSCIOUSNESS NOT IMPAIRED)

Patient details (or pre-printed label)

Patient's surname/family name..…….

Patient's first names …….

Date of birth ……..

Responsible health professional.……

Job title ……..

NHS number (or other identifier)……..

□ Male □ Female

Special requirements ……
(e.g. other language/other communication method)

To be retained in patient's notes

Patient identifier/label

Name of procedure (include brief explanation if medical term not clear)
……
Statement of health professional **(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)**

I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits
……
……
Serious or frequently occurring risks:
……

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

 The following leaflet/tape has been provided……..

Signed:…… Date ……..
Name (PRINT) …… Job title …….

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed ……..…… Date…….……..
Name (PRINT)……..……..

Statement of patient/person with parental responsibility for patient

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature …… Date…...……..…….
Name (PRINT) …….. Relationship to patient ……

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.
Signed: …… Date …….. ……
Name (PRINT) ……..…… Job title ……...

Top copy accepted by patient: yes/no (please ring)

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed**. It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form (see also 'This form' above)

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- They are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated

that patients should be told about ‘significant risks which would affect the judgement of a reasonable

patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Consent Form 4 Form for Adults who are Unable to Consent to Investigation or Treatment

MCA2 - SET Capacity Assessment Form

This form must be used for significant decisions

PART 1: Individual's Details and Assessment of Capacity (Compulsory)

1.1 Details of the Individual

First Name:		**Surname:**	
Electronic Database No. (& System)		**Date and Time of Assessment**	
Date of Birth		**Gender:**	
Permanent Address (incl post code)			
Home Phone Number			

Temporary Address (incl. post code) if not at home			
Name of Contact Person		**Phone Number**	
Nature of this Address			

Ethnicity: If the individual's ethnicity has not been self defined, detail here on the source of this information:

☐ White British	☐ Any other Mixed Background	☐ Black African
☐ White Irish	☐ Indian	☐ Any other Black Background
☐ Any other White Background	☐ Pakistani	☐ Chinese
☐ White and Black Caribbean	☐ Bangladeshi	☐ Any other Ethnic Group
☐ White and Black African	☐ Any other Asian Background	☐ Unknown
☐ White and Black Asian	☐ Black Caribbean	☐ Not stated

1.2 Family and / or Friends

Please give names, addresses, contact details and nature of relationship for known family or friends who *may* be appropriate to consult if the individual is found to lack capacity, and a decision needs to be made in their best interests.

1		**2**	
Name		**Name**	
Address incl. post code		**Address incl. post code**	
Phone Number		**Phone Number**	
Relationship with Individual		**Relationship with Individual**	
Appropriate to Consult? If not, you MUST record the reason here		**Appropriate to Consult? If not, you MUST record the reason here**	

If this is a SOVA Investigation, Give the name of the Safeguarding Lead	

1.3 Decision Maker and Assessor Details

Assessor 1: The Decision Maker		**Assessor 2**	
Name		**Name**	
Sign below to confirm that you have read and understood the five key principles of the Mental Capacity Act (written below) and will adhere to them whilst carrying out this assessment			

Signature		**Signature**	
Designation		**Designation**	
Address incl. post code		**Address incl. post code**	
Phone Number		**Phone Number**	
Mobile		**Mobile**	
Fax		**Fax**	
Email		**Email**	
Established Relationship with Individual?		**Established Relationship with Individual?**	

1.4 This MCA assessment must adhere to the Act's 5 key principles:

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Does the Service user have an impairment of, or a disturbance in the functioning of, their mind or brain?	☐ Yes	☐ No

What is the individual's presenting condition?		
☐ Unconsciousness ☐ Autistic Spectrum Disorder ☐ Mental Health Issues ☐ Other Cognitive Impairment e.g. stroke	☐ Dementia ☐ Learning Difficulties ☐ Acquired Brain Injury	☐ Other (please state)

1.5 The Capacity Assessment

What prompted this assessment?		
☐ Serious medical treatment ☐ Care Review	☐ Change of accommodation ☐ Safeguarding Adults Procedures	☐ Finances ☐ Other – please state

What is the exact decision to be made, or action to be taken?

Explain to the individual the purpose of this assessment, including all necessary information and all available options to help them make a decision (for example the pro's and con's, the consequences of taking, or not taking an action).

Do they understand the information given to them?	☐ Yes	☐ No
Can they retain the information long enough to make a decision?	☐ Yes	☐ No
Can they weigh up and discuss the pros and cons of the decision or action?	☐ Yes	☐ No
Can they communicate a decision (by any means)?	☐ Yes	☐ No

Does the individual have capacity in respect of the specific issue?	☐ Yes	☐ No
Write below the details of the discussion YOU MUST PROVIDE SUFFICIENT EVIDENCE TO EXPLAIN YOUR ANSWERS TO THE ABOVE QUESTIONS (continue on a blank sheet of paper if necessary)		

If the answer to ONE OR MORE of the above questions is 'No' then the person lacks capacity in regard to this issue. If the answer to all of the questions is 'Yes', then the person has capacity.

1.6. Does the Individual Require an IMCA?

- **If the individual is unbefriended and the decision is about a change of accommodation, or serious medical treatment, you MUST involve an IMCA.**
- **If a friend or family member exists, but they may not act in the individual's best interests (for example because they are the alleged victim or abuser in a Safeguarding Adults investigation) you MAY involve an IMCA.**
- **If the individual is unbefriended and a health or social care review is being carried out, you MAY CONSIDER involving an IMCA as good practice.**

Does the individual require an IMCA?	☐ Yes ☐ No
If not, please give reasons	
Date of referral to the IMCA service	

If the individual requires an IMCA, use Part 3 to make the referral and STOP HERE until the IMCA report has been received. If not, complete part 2.

PART 2 – Best Interests (compulsory if the person lacks capacity)

2.1 In order to make sure that the final decision is the least restrictive option, and is in the person's best interests, consider the following factors. Have you:

Involved the individual as far as is practically possible?	☐ Yes	☐ No
Consulted all relevant records?	☐ Yes	☐ No
Consulted all appropriate friends / family?	☐ Yes	☐ No
Consulted with the person's generic advocate?	☐ Yes	☐ No
Consulted with other staff?	☐ Yes	☐ No
Considered evidence of the person's past wishes and feelings (including advance decisions/directives)?	☐ Yes	☐ No
Take into account the IMCA's report (if applicable)?	☐ Yes	☐ No
Consulted with any legal representatives (e.g. Donees of LPA, Court of Protection Deputies)?	☐ Yes	☐ No

What is your best interests' decision, after consideration of all the relevant factors? YOU MUST PROVIDE SUFFICIENT EVIDENCE TO EXPLAIN YOUR ANSWERS TO THE ABOVE QUESTIONS

ASSESSOR 1: DECISION MAKER		**ASSESSOR 2**	
Name (print)		**Name (print)**	
Signature		**Signature**	
Date		**Date**	

PART 3: Referral for an IMCA (Compulsory if IMCA is required)

This section must be attached to Part 1 of the MCA2 form. It identifies whether an IMCA is required & records the decision-maker's instructions to the IMCA provider.

Why is an IMCA required?	This is a safeguarding adults investigation	☐
	The decision is about a change of accommodation (provided by NHS or local authority)	☐
	A health or social care review is being planned	☐
	The decision is about serious medical treatment	☐

Is the individual aware of the advocacy referral?	
Is the individual able to make his/her wishes known on the referral issue?	
Risks/precautions to be taken when meeting individual:	

Communication needs/preferences:	

Does the individual have:	☐ Registered Enduring Power of Attorney ☐ Enduring Power of Attorney ☐ Lasting Power of Attorney (health & welfare) ☐ Lasting Power of Attorney (property & affairs) ☐ Other – such as Ordinary Power of Attorney or Appointeeship ☐ Court Appointed Deputy (property & affairs) ☐ Court Appointed Deputy (personal welfare) ☐ Advocate already involved ☐ Advance Decision ☐ Advance Directive / Living Will

Any further information? Including copies of relevant information, contact details etc	

MCA15 – MCA2 Quality Checklist Form

To be used by ECC & NEPFT Staff only

This checklist MUST be completed before sending it for Quality Checking

Section 1.1 – Details of the individual			
1.1.1	Is the full name of Service User recorded?	Yes ☐	No ☐
1.1.2	Is the electronic database number recorded?	Yes ☐	No ☐
1.1.3	Are the date and time of the assessment recorded?	Yes ☐	No ☐
1.1.4	Is the date of birth recorded?	Yes ☐	No ☐
1.1.5	Is the gender recorded?	Yes ☐	No ☐
1.1.6	Are the permanent address and phone number recorded?	Yes ☐	No ☐
1.1.7	Are the temporary address and phone number recorded? (If applicable)	Yes ☐	No ☐
1.1.8	Is the name of the contact person of the temporary address recorded? (If applicable)	Yes ☐	No ☐

1.1.9	Is the nature of temporary address recorded?	Yes ☐	No ☐
1.1.10	Is the ethnicity recorded?	Yes ☐	No ☐
Section 1.2 – Family and/or Friends			
1.2.1	Are the names of family and friends recorded?	Yes ☐	No ☐
1.2.2	Are the addresses and phone numbers of family and/or friends recorded?	Yes ☐	No ☐
1.2.3	Is the relationship with the individual recorded?	Yes ☐	No ☐
1.2.4	Is the reason why the family and/or friend is appropriate to consult recorded?	Yes ☐	No ☐
1.2.5	Is the name of the Safeguarding Lead recorded? *(Only if SOVA Investigation)*	Yes ☐	No ☐
Section 1.3 – Decision Maker and Assessor Details			
1.3.1	Are the names of the Decision Maker and 2nd assessor recorded?	Yes ☐	No ☐
1.3.2	Have the Decision Maker and the 2nd Assessor signed the form?	Yes ☐	No ☐
1.3.3	Are the designation of the Decision Maker and 2nd Assessor recorded?	Yes ☐	No ☐
1.3.4	Are the addresses and phone numbers (inc mobile, fax) of the Decision Maker and 2nd Assessor recorded?	Yes ☐	No ☐
1.3.5	Are the e-mail addresses of the Decision Maker and 2nd Assessor recorded?	Yes ☐	No ☐
1.3.6	Has the relationship between the Decision Maker/2nd Assessor and the Individual been established?	Yes ☐	No ☐
Section 1.4 – Condition of the Individual			
1.4.1	Is it recorded if the Service user has an impairment of, or a disturbance in the functioning of, their mind or brain?	Yes ☐	No ☐
1.4.2	Is the presenting condition recorded?	Yes ☐	No ☐
Section 1.5 – The Capacity Assessment			
1.5.1	Is the basis of the referral recorded?	Yes ☐	No ☐
1.5.2	Has the exact decision that needs to be been made recorded?	Yes ☐	No ☐
1.5.3	Have the boxes regarding the purpose of the assessment been ticked? (4 boxes)	Yes ☐	No ☐
1.5.4	Is it recorded that the individual has or has not got the capacity to make the decision?	Yes ☐	No ☐
1.5.5	Is sufficient evidence recorded?	Yes ☐	No ☐
Section 1.6 - IMCA			
1.6.1	Is an IMCA required?	Yes ☐	No ☐
1.6.2	If not, are the reasons why recorded?	Yes ☐	No ☐
1.6.3	Is the date of referral to the IMCA service provided?	Yes ☐	No ☐
Section 2 – Best Interests Decision			

2.1	Is the Best Interests Checklist completed?	Yes ☐	No ☐
2.2	Is the Best Interests decision recorded?	Yes ☐	No ☐
2.3	Are the names of the Decision Maker and 2nd assessor recorded?	Yes ☐	No ☐
2.4	Have the Decision Maker and the 2nd Assessor signed and dated the form?	Yes ☐	No ☐
Section 3 – Referral for an IMCA (Only if Applicable)			
3.1	Is the reason why an IMCA is required recorded?	Yes ☐	No ☐
3.2	Is all other information regarding the individual recorded?	Yes ☐	No ☐
Other (Please record anything relevant)			
Comments:			

Where do I send my MCA2 Form?

- In **Southend Local Authority**, copies of *ALL* completed MCA2 forms should be sent electronically to: sarahrange@southend.gov.uk. Telephone: 01702 534404.
- In **Essex Local Authority**, copies of MCA2 forms completed by Essex County Council Teams should be sent electronically to: SafeguardingEssex@essex.gov.uk or faxed to 01245 550355 (confidential fax). If you require guidance or need some advice, please ring 01245 434804.
- In **Thurrock Local Authority**, copies of ALL completed MCA2 forms should be sent electronically to: safeguardingadults@thurrock.gov.uk
- In **All NHS Trusts**, copies of MCA2 forms should be sent to the appropriate MCA Lead.
- **All IMCA Requests** (Essex Local Authority or All NHS Trusts) must be sent either electronically to

SafeguardingEssex@essex.gov.uk by fax 01245 550355 (confidential fax) or by post to the Adult Safeguards Unit, County Hall, Chelmsford, Essex, CM1 1YS.

Guidance for Completing the MCA2 Form

All adults (16 and over) are presumed to have capacity.

Therefore assessments of capacity must only be conducted where there are doubts about an individual's ability to make a specific decision, or consent to a specific action.

The only way to prove a lack of capacity is by carrying out a capacity assessment.

Assessments of capacity for significant decisions should be conducted by two people:

- **One assessor must be the decision maker**
- **One assessor must be a registered qualified professional (this can be the same person)**

Wherever possible, one person must also have an established relationship with the individual. However if a decision needs to be made urgently, the assessment can be made solely by the decision maker.

Assessments must be done as soon as possible, unless you can evidence that it is in the individual's best interests to wait (if for example, the decision isn't an emergency, and you believe that they may be more receptive to information at a later time of the day).

This form will assist you in carrying out the assessment of capacity. If you need further information, visit www.essex.gov.uk or call the Essex County Council Adult Safeguards Unit on 01245 434 861.

MCA2 assessments of capacity are entirely separate to either discharge care planning or decisions that an adult is medically fit for discharge.

Assessments of capacity must be recorded immediately on the MCA2 form, signed and dated by both people who have jointly undertaken the assessment.

Assessing Capacity

Care should be taken to ensure that all practicable (do-able) steps are taken to facilitate an individual's optimum performance in this assessment; including provision of communication aides. Where an interpreter is required, this should be a professional interpreter.

Remember that you must **evidence** your findings in each question – for example, how did you *know* that the individual could / couldn't understand the information you gave them? What did they say / do to make you reach that conclusion?

A positive answer must be achieved for all parts of question 1.5 to conclude that the individual has capacity. If a conclusion about an individual's capacity in respect of a specific decision can not be reached, assessors working within Essex Local Authority Boundaries can request a consultation (second opinion) through the Adult Safeguards Unit. Assessors from other Local Authorities should consult their line manager or seek legal advice.

For more technical guidance concerning assessing capacity, see MCA19.

Making a Best Interests Decision

If the individual does not have capacity, they cannot consent; therefore decisions about proceeding will need to be made on the basis of the individual's best interests. Consultation must occur where appropriate with any person holding Lasting Power of Attorney; Enduring Power of Attorney, Court Appointed Deputy, IMCA, Family & friends.

Decisions made by the Decision Maker in an individual's **best interests** must be the **least restrictive** possible.

It is legally the sole responsibility of the Decision Maker to determine if the individual has capacity in respect of the specific question detailed in section 6 "Reason for Capacity Assessment above" (*Note a positive answer must have been achieved for all parts of question 8*). If a conclusion about an individual's capacity in respect of a specific decision can not be reached, assessors working within Essex Local Authority Boundaries can request a consultation (second opinion) through the Adult Safeguards Unit. Assessors from other Local Authorities should consult their line manager or seek legal advice.

The best interests' decision and the assessment as a whole should show that the decision maker has made a decision on the best available evidence and has taken into account conflicting views.

The MCA provides legal protection from liability for carrying out care if:

- The principles of the MCA have been observed
- The decision maker can demonstrate they assessed capacity
- The decision maker reasonably believes the person lacks capacity with regard to the decision
- The decision maker reasonably believes the action is in the best interests of the person

Ordinarily a person representing the interests of the person should be consulted before making a decision. However, in emergency situations it will be often in the best interests of the person to provide urgent care without delay.

If there is a dispute then it should be clearly identified. If there is a dispute then the following things can assist the decision maker:

- Involve an advocate who is independent of all parties involved
- Get a second opinion
- Hold a case conference
- Go to mediation
- An application can be made to the Court of Protection for a ruling

The IMCA Service

IMCAs are mental capacity advocates for people who do not have mental capacity to make the decision in question. They will represent the person when there is no-one else to do so, and after investigation, will make a recommendation to the decision maker detailing what they think should be done in the person's best interests.

APPENDIX C

INFORMATION TO ASSIST IN AMENDING CONSENT FORMS

The following suggestions may help Trusts who have not already done so to amend their consent forms in the light of legislative and other changes. This is not a comprehensive list of all changes that Trusts may wish to make, which will be a matter for local decision. Trusts may wish to consult their own legal Departments about the suitability of their forms.

There are some global changes that can be made to the wording of the forms to reflect the Mental Capacity Act (MCA), most significantly the use of 'capacity' or 'lack the capacity' in place of 'competent' and the term 'advance decision to refuse treatment' in place of 'advance directive' or 'living will'.

Trusts may also want to include a reference to consent for the use of human tissue under the Human Tissue Act on some of the forms as appropriate.

The completion of consent forms is of course only part of the consent process and should only be carried out in the context of an informed discussion with the person giving consent with more detailed explanation given where necessary.

Consent form 1 – Patient agreement to investigation or treatment

• This form deals with people who have the capacity to consent to treatment and therefore is largely unaffected by the MCA.

• In the section 'statement of health professional', the wording about risks could be amended to reflect the *Chester v Afshar* judgment (see introduction of revised Reference guide to consent),. so as to prompt health professionals to discuss "significant, unavoidable or frequently occurring risks" with the patient rather than simply recording "serious or frequently occurring risks" as at present.

• The information on page 4 could be updated to reflect the MCA, in particular the section on when the form would not be used, which could be amended in the following way:

"When NOT to use this form

If the patient is 18 or over and lacks the capacity to give consent, you should use form 4 (form for adults who lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

• understand information about the decision to be made
• retain that information in their mind
• use or weigh that information as part of the decision-making process, or
• communicate their decision (by talking, using sign language or any other means).

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to so under a Lasting Power of Attorney or as a court appointed deputy."

Consent form 2 - Parental agreement to investigation or treatment for a child or young person

• It may be useful to amend the title of the form and other reference to a parent to read 'parent (or person who has parental responsibility)'

• The section 'statement of health professional' – the wording about risks could be amended to reflect the *Chester v Afshar* judgment (see introduction of revised Reference guide to consent) for example to prompt health professionals to discuss "significant, unavoidable or frequently occurring risks" with the patient rather than simply recording "serious or frequently occurring risks" as at present.

• The information 'who can consent' on page 4 could be amended where it refers to young people who refuse consent (see 'Child or young person with capacity refusing treatment' in Chapter 3 of revised Reference guide to consent). The text could be amended along the following lines:

"Where a young person of 16 or 17 or a Gillick competent child under 16, refuses treatment, it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child."

Consent form 3 - Patient/parental agreement to investigation or treatment

• Comments on use of terms and amendments to reflect the *Chester v Afshar* judgment as for forms 1 and 2 would also apply to this form.

Consent form 4 - Form for adults who are unable to consent to investigation or treatment

• The MCA is of most relevance to this form and this is covered in chapter 2 of the revised Reference guide to consent.

• It may be useful to amend the title of the form to 'Form for adults who lack the capacity to consent to investigation or treatment'

• Section B will need to be amended to reflect the wording of the MCA, for example along the lines of:

"B Assessment of patient's capacity (in accordance with the Mental Capacity Act)

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

understand information about the procedure or course of treatment
retain that information in their mind
use or weigh that information as part of the decision-making process, or
communicate their decision (by talking, using sign language or any other means)

Further details: for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful."

• Section C will need to reflect the elements health professionals will need to consider as part of a best interests assessment, for example along the following lines:

"C Assessment of patient's best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient's best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

(Where the lack of capacity is likely to be temporary ……..)

The treatment cannot wait until the patient recovers capacity because: "

• Section D will need to reflect the fact that, unless the person has an attorney or deputy, the final responsibility for determining what is in a person's best interest will rest with the relevant health professional. However, the health professional must consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) as far as is practicable and as appropriate.

• Section D could also include a section on the involvement of an Independent Mental Capacity Advocate, for example along the lines of:

"Independent Mental Capacity Advocate (IMCA)

For decisions about serious medical treatment, where there is no one appropriate to consult other than paid staff, has an Independent Mental Capacity Advocate (IMCA) been instructed?

Yes No

Details:

Signature …….. Date……..."

• The form could include a new section E to cover patients who have an attorney or deputy, for example along the lines of:

E The patient has an attorney or deputy

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient's best interests. CLINICAL POLICY CLP16

Signature of attorney or deputy
I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section C) and believe the procedure to be in the patient's best interests.
Any other comments (including the circumstances considered in assessing the patient's best interests)
Signature:…… etc"
• The information on page 4 will need to be amended in line with the changes made to the form and the MCA. The information below is given as a guide of the areas this information could cover:
"Guidance to health professionals
This form should only be used where it would be usual to seek written consent but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment then you must abide by that refusal.. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.dh.gov.uk/consent).
When treatment can be given to a patient who lacks the capacity to consent
All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005. More information about the Act is given in the Code of Practice1
Treatment can be given to a patient who is unable to consent, only if :
• the patient lacks the capacity to give or withhold consent to this procedure AND
• the procedure is in the patient's best interests.
Capacity
A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:
• Understand the information given to them that is relevant to the decision.
• Retain that information long enough to be able to make the decision.
• Use or weigh up the information as part of the decision- making process.
1 1 Mental Capacity Act 2005 Code of Practice - www.publicguardian.gov.uk/mca/code-of-practice.htm

• Communicate their decision - this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity.

Best interests

The Mental Capacity Act requires that a health professional **must** consider all the relevant circumstances relating to the decision in question, including, as far as possible considering:

• 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

• the other factors that the person would be likely to consider if they were able to do so.

When determining what is in a person's best interests" a health professional must not 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. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.

The Act also requires that, as far as possible, health professionals must consult other people, if it is appropriate to do so, and take into account of 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 and anyone engaging in caring for patient and their family and friends.

Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are not decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the *Act*.

Lasting Power of Attorney and Court Appointed Deputy

A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment.

The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests.
The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no other way of settling the matter in the best interests of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather than the health professional who makes the treatment decision and the deputy must make decisions in the patient's best interests.

Second opinions and court involvement
Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court.
Cases involving:
• decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
• cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
• cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
• all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests (include cases involving ethical dilemmas in untested areas)
should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

Appendix D

HOW TO SEEK A COURT DECLARATION

Extract from the Court of Appeal's decision in St. George's Healthcare NHS Trust v S:25

"The case highlighted some major problems which could arise for hospital authorities when a pregnant woman presented at hospital, the possible need for Caesarean surgery was diagnosed, and there was serious doubt about the patient's capacity to accept or decline treatment. To avoid any recurrence of the unsatisfactory events recorded in this judgement, and after consultations with the President of the Family Division and the Official Solicitor, and in the light of the written submissions from Mr Havers and Mr Gordon, we shall attempt to repeat and expand the advice given in *Re MB [1997] 2 FCR 541, 38 BMLR 17*5. This advice also applies to any cases involving capacity when surgical or invasive treatment may be needed by a patient, whether female or male. References to 'she' and 'her' should be read accordingly. It also extends, where relevant, to medical practitioners and health professionals generally as well as to hospital authorities. The guidelines depend on basic legal principles, which we summarise.
i) They have no application where the patient is competent to accept or refuse treatment. In principle a patient may remain competent notwithstanding detention under the Mental Health Act.
ii) If the patient is competent and refuses consent to the treatment, an application to the High Court for a declaration would be pointless. In this situation the advice given to the patient should be recorded. For their own protection hospital authorities should seek unequivocal assurances from the patient (to be recorded in writing) that the refusal represents an informed decision: that is that she understands the nature of and reasons for the proposed treatment, and the risks and likely prognosis involved in the decision to refuse or accept it. If the patient is unwilling to sign a written indication of this refusal, this too should be noted in writing. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.
iii) If the patient is incapable of giving or refusing consent, either in the long term or temporarily (e.g. due to unconsciousness), the patient must
be cared for according to the authority's judgement of the patient's best interests. Where the patient has given an advance directive, before becoming incapable, treatment and care should normally be subject to the advance directive. However, if there is reason to doubt the reliability of the advance directive (e.g. it may sensibly be thought not to apply to the circumstances which have arisen), then an application for a declaration may be made. *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673

Concern over capacity
iv) The authority should identify as soon as possible whether there is concern about a patient's competence to consent to or refuse treatment.
v) If the capacity of the patient is seriously in doubt it should be assessed as a matter of priority. In many such cases the patient's general practitioner or other responsible doctor may be sufficiently qualified to make the necessary assessment, but in serious or complex cases involving difficult issues about the future health and well-being or even the life of the patient, the issue of capacity should be examined by an independent psychiatrist, ideally one approved under s12(2) of the Mental Health Act. If following this assessment there remains a serious doubt about the patient's competence, and the seriousness or complexity of the issues in the particular case may require the involvement of the court, the psychiatrist should further consider whether the patient is incapable by reason of mental disorder of managing her property or affairs. If so the patient may be unable to instruct a solicitor and will require a guardian *ad litem* in any court proceedings.
The authority should seek legal advice as quickly as possible. If a declaration is to be sought, the patient's solicitors should be informed immediately and if practicable they should have a proper opportunity to take instructions and apply for legal aid where necessary. Potential

witnesses for the authority should be made aware of the criteria laid down in *Re MB* and this case, together with any guidance issued by the Department of Health, and the British Medical Association.
vi) If the patient is unable to instruct solicitors, or is believed to be incapable of doing so, the authority or its legal advisers must notify the Official Solicitor and invite him to act as guardian *ad lite*m. If the Official Solicitor agrees he will no doubt wish, if possible, to arrange for the patient to be interviewed to ascertain her wishes and to explore the reasons for any refusal of treatment. The Official Solicitor can be
contacted through the Urgent Court Business Officer out of office hours on 020 7947 6000.

The hearing
vii) The hearing before the judge should be *inter parte*s. As the order made in her absence will not be binding on the patient unless she is represented either by a guardian *ad litem* (if incapable of giving instructions) or (if capable) by counsel or solicitor, a declaration granted *ex parte* is of no assistance to the authority. Although the Official Solicitor will not act for a patient if she is capable of instructing a solicitor, the court may in any event call on the Official Solicitor (who has considerable expertise in these matters) to assist as an *amicus curia*e.

viii) It is axiomatic that the judge must be provided with accurate and all the relevant information. This should include the reasons for the proposed treatment, the risks involved in the proposed treatment, and in not proceeding with it, whether any alternative treatment exists, and the reason, if ascertainable, why the patient is refusing the proposed treatment. The judge will need sufficient information to reach an informed conclusion about the patient's capacity, and, where it arises, the
issue of best interest.

ix) The precise terms of any order should be recorded and approved by the judge before its terms are transmitted to the authority. The patient should be accurately informed of the precise terms.

x) Applicants for emergency orders from the High Court made without first issuing and serving the relevant applications and evidence in support have a duty to comply with the procedural requirements (and pay the court fees) as soon as possible after the urgency hearing.

Conclusion

There may be occasions when, assuming a serious question arises about the competence of the patient, the situation facing the authority may be so urgent and the consequences so desperate that it is impracticable to attempt to comply with these guidelines. The guidelines should be approached for what they are, that is guidelines. Where delay may itself cause serious damage to the patient's health or put her life at risk then formulaic compliance with these guidelines would be inappropriate.

Appendix F Consent form for taking a photograph of a patient

CONSENT FORM FOR TAKING A PHOTOGRAPH OF A PATIENT

Patient details (or pre-printed label)

Patient's surname/family name..…….

Patient's first names …….

Date of birth …….

Age …….

Responsible health professional.……

Job title …….

NHS number (or other identifier)……..

□ Male □ Female

Special requirements ……
(e.g. other language/other communication method)

To be retained in patient's notes

In the event of a Patient being unable to consent due to a capacity issue, it may still be possible to take the photograph using the best interest principle (refer to Consent Form 4 Form for Adults who are Unable to Consent to Investigation or Treatment) but it is essential that a Mental Capacity Assessment is completed and attached to this form.

Statement of health professional
I have explained the purpose of the photograph to the Service User. I am confident the service user has the capacity to consent. In particular, I have explained that:

- 2 copies will be printed of the photograph.
- 1 copy will be placed inside the cover of the service user's notes.
- 1 copy will be attached to the service user's prescription chart
- The purpose of the photograph
- There is no obligation to agree to the photograph being taken

Signed:…… Date ……..
Name (PRINT) …… Job title …….

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed …… Date……..
Name (PRINT)……..

Statement of patient/person with parental responsibility for patient

I understand the reasons for a photograph to be taken and I agree for the photograph to be taken.

Signature …… Date…..……..…….
Name (PRINT) …….. Relationship to patient if applicable……

Top copy accepted by patient: yes/no (please ring)