



Capacity to Consent Policy

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The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

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Subject to the Written Ministerial Statement HCWS202 made on 30 October 2017, announcing the publication of the Government's final response to the Law Commission's report on mental capacity and Deprivation of Liberty Safeguards (DoLS), the publication of the Law Commission's report, the Government is committed to take action to reform mental health, and transform care for people with learning difficulties and / or autism. Taking action to reform the current DoLS regime is an important contribution towards achieving these aims and providing greater protection for some of the most vulnerable people in our society. As a result the Government broadly agree with the Liberty Protection Safeguards model. Therefore the Government has commissioned a review into the Mental Health Act, proposals that relate to the interface between the Mental Health Act and Mental Capacity Act will be considered as part of that review. This is to ensure that Liberty Protection Safeguards fit with the conditions and future direction of the health and social care sector.

The Government are committed to continue to work through the detail of the recommendations and engage further with stakeholders particularly on implementation. The government will bring forward legislation to implement the model when parliamentary time allows. Currently the timeframe is unknown but it has been indicate to likely to occur after BREXIT (April 2019 onwards).

1. Introduction

Following the introduction of the Mental Capacity Act 2005 (MCA) and Revised Mental Health Act 2007 introducing Deprivation of Liberty Safeguards this Capacity to Consent Policy has been developed to cover the legal responsibilities of the East of England Ambulance Service NHS Trust (EEAST) within this policy identified as the Trust within text. This policy also covers all commissioned services working on behalf of the Trust and accessing people in their line of work for the Trust.

This document will ensure all staff (refer to 4.2 for definition of staff) working within EEAST undertake Capacity assessments. Such assessments will be in keeping with the Code of Practice within the MCA and all staff must act at all times in the best interests of the person who is assessed as lacking capacity at time of the assessment.

Decisions made in the best interests of a person must not permanently deprive a person of their liberty or breach the person's Human Rights.

2. Purpose

The suite of documents contained within the policy aims to provide clear operational Trust guidance for staff to follow when undertaking Mental Capacity assessments.

The policy aims to promote all forms of awareness around the importance of ensuring that persons are able to give valid consent (written or verbal) to any procedure, treatment or intervention undertaken by EEAST staff.

Where appropriate, Mental Capacity assessments will be undertaken for those persons who are unable to give valid consent to any procedure, treatment and intervention. Such assessments will provide the required legal evidence for staff to then act in the "Best Interests" of the person.

This document outlines when and how safer holding (restraint) may be used under the Mental Capacity Act which all EEAST staff must follow.

EEAST, POL018 - Capacity to Consent Policy, V4.0 (extended)

This Capacity to Consent Policy should be read in conjunction with the Trust's Safeguarding Children and Young People, Safeguarding Vulnerable Adults policies along with the new Trust safer holding policy.

This policy sets out the standards and guidance for the Trust, which aim to ensure that health professionals are able to comply with the law and Department of Health Guidance with regards to the principles of consent and also mental capacity assessment.

3. Duties

The Trust has a legal responsibility to ensure that the implementation of the Mental Capacity Act 2005 and Mental Health Act 2007 is in keeping with the respective Code of Practices.

3.1 Chief Executive Officer

The Chief Executive Officer (CEO) is ultimately responsible for ensuring that the Trust is compliant with all aspects of the MCA and Code of practice. Accountability for ensuring the Trust fulfils its legal requirement rests with the Trusts CEO who may delegate to a nominated officer within the organisation.

3.2 All Staff

All staff have a responsibility to read, understand and adhere to the requirements of this policy and its appendices and maintains an up to date knowledge of current practice in relation to assessing a person's capacity to give consent.

All staff must ensure that when persons refuse to consent to any proposed treatment, intervention or conveyance that a capacity assessment is undertaken and if necessary staff are to act and record in the best interests of the person if the person has been assessed as lacking capacity. Best interest decisions should always promote being the less restrictive decision.

3.3 All Operational Staff

All operational staff within the Trust have a responsibility to ensure they are familiar and understand the Consent to Capacity policy and apply it when assessing, supporting and managing any person they may be treating (as indicated in section 3.2).

3.4 Health Professional / Carer

The health professional or carer examining or treating a person is ultimately responsible for ensuring the person is genuinely consenting to what is being done: it is the health professional that will be held responsible in law if this is challenged later.

In addition, it is a health professional's or carer's own responsibility:

- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so.
- To work within their own competence and not to agree to perform tasks which exceed their competence.

3.5 Consultation and Communications with Stakeholders

- All Trust A&E/EOC/NES/ Staff
- All A&E/EOC and NES Managers
- All OOH Staff and Managers
- All commissioned services working on behalf of the EEAST and accessing the public
- All Trust Staff with regular access to the Public
- NHS England (Midlands and East covering East of England)
- Acute and Mental Health Hospitals in East of England
- Any other relevant stakeholders, volunteers or third party providers accessing the public on behalf of EEAST

4. Definitions

4.1 Trust

Trust is used to identify the East of England Ambulance Service NHS Trust

4.2 Staff

Staff is used to identify any person accessing the public on behalf of the Trust. It includes the following staff groups: Trust employed/paid staff, volunteers, commissioned service staff (including third party providers), primary care staff and any other relevant staff.

4.3 Person

Person is used to identify a person, patient or any member of the public accessed by a member of staff

5. Person Consent

5.1 Context

“A person has a fundamental legal and ethical right to determine what happens to their own body. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery.

Seeking consent is also a matter of common courtesy between health professionals and persons”

(Good Practice in Consent Implementation Guide: Consent to Examination or Treatment, Department of Health)

Self-determination and autonomy is paramount in any decision making under mental capacity and staff can help the individual decide on best interests by way of recommendation.

5.2 What is Consent

‘Consent’ in the context of EEAST and its day to day work is a person’s agreement for a health care professional to provide care. A person may indicate consent non-verbally (for example by presenting an arm for a pulse to be taken), verbally or in writing.

For the consent to be valid, the person must comply with all the following:

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

The context of consent can take many different forms, ranging from the active request by a person for a particular treatment (which may recommend 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 or any recommendation offered, the person 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 person to understand the options available to them for health care and to decide between them the appropriate pathway of care. Seeking consent should also be viewed as 'joint decision making' where the person requiring help and the health worker need to agree on the best course of action to be taken based upon the person's values, wishes, beliefs and preferences and the health professional's clinical knowledge. It should also be communicated in a way that the person is able to understand.

5.3 Valid Consent

For consent to be valid it must be given voluntarily by an appropriately informed person, (the person or where relevant someone with parental responsibility for the person under the age of 18) who has the capacity to consent to the recommended intervention in question. If the person does not know what the intervention entails then this is not 'consent'

In addition, the person giving consent must be able to;

- Understand the information being given to them.
- Be able to respond or make their response known

This is particularly important where English may not be the first language of the person. In circumstances where the health professional considers further assistance from translator services is required they should contact Language Line via the EOC.

It is important to remember that the 'interest of the child' should always take precedence. One view cannot veto another.

5.4 Giving Consent

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

Such pressure can come from partners or family members as well as health or care professionals. Staff should be alert to this possibility and where appropriate should arrange to see the person on their own to establish that the decision is truly that of the person and not of others.

To give valid consent the person needs to understand in broad terms the nature and purpose of what they are giving consent for. Any misrepresentation of treatment and/or proposed procedures will invalidate the consent given.

In addition, failure to provide other relevant information to the person regarding the proposed treatment or procedure may not fulfil the legal duty the health professional has to the person and any subsequent detrimental affect suffered by the person may be identified within law as a failing in the health professional's treatment within the consultation under the provision of wilful neglect.

5.5 Duration of Consent

When a person gives valid consent to a recommended intervention, in general that consent remains valid for an indefinite duration unless the person withdraws it or there is a change in their circumstances and they no-longer have the capacity to give consent.

5.6 Withdrawal of Consent

A person with capacity is entitled to withdraw consent at any time, including during the time a procedure is being undertaken. Where a person does object during treatment, it is good practice for the health care professional, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure.

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

Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The health care professional should try to establish whether at that time the person has the capacity to withdraw. If capacity is lacking, it may sometimes be justified to continue in the person's best interests, although this should not be used as an excuse to ignore distress. Any best interest decision should always be the less restrictive option appropriate to the circumstances faced with at the time.

5.7 When Consent is Refused

If an adult or young person (16-17) with capacity makes a voluntary and appropriately valid decision to refuse treatment, their decision **must** be respected, except in circumstances defined by the Mental Health Act 1983, the Children Act 1989 or the Family Reform Act of 1969. This is the case even where this may result in the death of the person and/or the death of an unborn child, whatever the stage of pregnancy.

It must be remembered that adults and young people detained under the MHA may only be given treatment for their mental disorder without giving consent. If any medical care or treatment or investigation is required for a person detained under the Mental Health Act they must give consent or be assessed as to whether they are competent to give consent for such medical treatment, care or interventions.

5.8 Form of Consent

The validity of consent does not depend on the form in which it is given. The elements of voluntariness, appropriate information (valid) and capacity must be satisfied for consent to be valid.

5.9 Duty of Care and Consent

Duty of Care may be defined as:

'The absolute responsibility of a healthcare professional to treat and care for a person with a reasonable degree of skill and care'

Negligence arises when that duty of care is breached and 'reasonably foreseeable harm' arises as a result and falls under the new Criminal Justice and Courts Act 2015. A lack of valid consent does not automatically absolve the healthcare professional of their duty of care or risk of negligence. This means any health care professional who does not treat a needy person because valid consent was not gained could be deemed to be negligent if a genuine effort was not made to gain such consent or if it cannot be demonstrated that the person had the capacity to provide such consent.

For people who lack the capacity to consent, once the Trust accepts a "duty of care" for a person e.g. a health care professional either responds to a call out or provides a service to the person. The health care professional is then required to provide whatever recommendation of care, treatment and/or intervention the person requires that is considered to be in the persons best interests. In situations which relate to life-sustaining treatment, the death of a person would not be seen to be in the person's best interest.

People who have a long term lack of capacity will often have an advanced directive in place. An advanced directive is a legal process agreed within the court for a person, who is known to the individual lacking capacity. This person defined by the court is known as the advocate and the advocate is then given the legal right to make decisions on behalf of the person lacking capacity. This process is called an advanced directive and is defined as a protective measure to protect the person's interests. It is important to remember that the advance directive or advocate would not come into effect if the patient currently has capacity at the time of the assessment.

6. Children and Young People

The legal position regarding consent and refusal of treatment by those under the age of 18 is different for that of adults, in particular when treatment is refused.

6.1 Young People Aged 16-17

People aged 16 years and older are considered to have capacity to consent to their own medical treatment unless it is established that the young person lacks capacity. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-riden by either a person with parental responsibility or a court. This is to ensure that the best interests of the child are considered at all times.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed recommended intervention; the same criteria as for adults should be used.

If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person. It is however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them.

6.2 Children Under 16 – The Concept of Competence

There is no statutory legislation governing consent in children under the age of 16, but there is clear case law established by *Gillick v West Norfolk AHA* [1986] where the presiding Judge Lord Fraser ruled:

If a child has sufficient intelligence and understanding to enable him/her to understand the treatment and implications of treatment then he/she can consent to that treatment.

This is frequently the guidance used for determining whether to treat a young person with or without the consent of the parents.

If the child is considered competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However, where the decision will have on-going implications, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child's best interests to do so. Health care professionals have a duty of care and can breach confidence if this is in the best interests of the child. One view cannot veto the other.

Although a child or young person may have the capacity to give consent, valid consent must be given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parents, other carers, or a potential partner through sexual encounter or coercion, and it is important to establish that the decision is that of the individual him or herself. Safeguarding the child's best interests is paramount in any decision making and should not be underestimated.

In addition, as the understanding required for different interventions will vary considerably, a child under 16 may have the capacity to consent to some interventions but not others. All health care professionals must demonstrate clear communication skills when interacting with children and young people and ensure that the child or young person understands and has the capacity to consent to each aspect of the recommended treatment being provided. As with adults, assumptions that a child with a learning disability may not understand the issues should never be made automatically.

6.3 Child or Young Person With Capacity Refusing Treatment

In cases where a young person aged 16-17 or a child aged under 16 who is assessed as being competent to provide consent, choose to refuse treatment, the refusal for treatment can be over-ruled either by a person with parental responsibility or by the court. If more than one person has parental responsibility for the young person, consent by any one such person is sufficient, irrespective of the refusal of any other individual.

This power to over-rule must be exercised on the basis that the welfare of the child/young person is paramount. Whilst no definitive guidance has been given as to when it is appropriate to over-rule a competent young person's refusal to accept treatment, it will be in the scenario where refusal to

consent would be likely to result in significant harm, death or permanent disability of the child or young person.

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

As in the case where persons are giving consent for themselves, those giving consent on behalf of young persons must;

- Have the capacity to understand the intervention in question.
- Be acting voluntarily.
- Be appropriately informed.
- Be acting in the best interests of the child.

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

7. Exceptions to the Principles of Consent

Certain statutes set out specific exceptions to the principles of consent contained within this policy. These are:

- Part IV of the Mental Health Act 1983 sets out circumstances in which persons detained under the Act may be treated without consent for their mental disorder. It has no application to treatment for physical disorders unrelated to the mental disorder.
- Neither the existence of mental disorder nor the fact of detention under the 1983 Act should give rise to an assumption of incapacity. The person's capacity must be assessed in every case in relation to the particular decision being made as the capacity of a person with a mental disorder may fluctuate.
- The Public Health (Control of Disease) Act 1984 provides that, on an order made by a magistrate, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in a hospital without their consent.
- Section 47 of the National Assistance Act 1948 provides for the removal to suitable premises of persons in need of care and attention without their consent. Such persons must either be suffering from grave chronic disease or be aged, infirm or physically incapacitated and living in insanitary conditions. In either case, they must be unable to devote to themselves (and are not receiving from others) proper care and attention. The Act does not give a power to treat such persons without their consent and therefore their treatment is dependent on common law principles. Actions taken by staff under this section should be taken in conjunction with Local Authority colleagues.

8. Mental Capacity Act 2005 (MCA) and Code of Practice

The following section provides guidance for staff when operating within the framework of the Mental Capacity Act. Such guidance will require staff to follow the principals of the Act when providing care, treatment or interventions to the person.

In emergency situations urgent decisions may have to be made and immediate action taken in the person's best interests. In these situations it may not be practicable or appropriate to delay treatment or care while trying to help the person make their own decisions. In an emergency situation staff will always act to preserve life and act in the best interests of the person. . This is sometimes known as the pre-cautionary principle and applies to the emergency setting.

8.1 What is Mental Capacity?

Having mental capacity means a person has the ability, competence and insight to make their own decisions about any given situation or requirement. When making a decision a person with capacity can:

- Understand the information which requires a decision
- Retain the information to enable a decision to be made
- Weigh up the information to enable a decision to be made
- Communicate their decision

8.2 The Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) covering England and Wales provides a statutory framework for people aged over 16 who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can make decisions, in which situations and how they should go about this. The Act applies to everyone who works in health or social care and puts the individual who lacks capacity at the heart of decision making. The Act is underpinned by five key principals which **MUST** inform actions taken by staff when recommending in providing care or treatment for a person who lacks capacity or is considered to lack capacity.

8.3 Key provisions of the Act

- There must always be the presumption that people you provide care or treatment for have capacity to make decisions for themselves
- A single clear test for assessing whether a person lacks capacity to make a decision
- A check list of key factors which provides a starting point to help you determine what is in the 'best interests' of a person lacking capacity
- Several ways that people can influence what happens to them if they are unable to make particular decisions in the future, including advance decisions to refuse medical treatment, statements of wishes and feelings, and creating a Lasting Power of Attorney (LPA)
- Clarification about the actions you can take if someone does lack capacity, and the legal safeguards that will govern this

- An obligation for you to consult, where practical and appropriate, people who are involved in caring for the person who lacks capacity and anyone interested in their welfare (for example family members, friends, partners and carers) about decisions affecting that person
- A new advocacy service called the Independent Mental Capacity Advocate (IMCA) service
- A new criminal offence of ill-treatment or wilful neglect of people who lack capacity

8.4 The Code of Practice for the Mental Capacity Act 2005

The Code of Practice provides guidance for a range of people and professionals with different functions and duties under the Act, and has statutory force.

This means that certain categories of people have a legal duty to have regard to it when working with or caring for individuals who lack the capacity to act or make decisions for themselves. In particular the Code of Practice focuses on those who have a duty of care to someone who lacks the capacity to consent to the care that is being provided and that duty of care requires the worker to act in the best interests of the person at all times.

8.5 Legal Duty

Whilst there is no legal duty for anyone to comply with the Code of Practice for the Mental Capacity Act, the Trust requires all staff to comply with it. However, the MCA would always override the Code of Practice in the legal perspective.

Certain categories of people are legally required to “have regard” to relevant guidance in the Code of Practice. This means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and **they should be able to explain how they have had regard to the Code when acting or making decisions on behalf of someone who is assessed as lacking capacity.**

There are a number of categories of professionals that are required to have a regard to the Code of Practice and this includes:

- **“A variety of healthcare staff (doctors, nurses, therapists, radiologists, paramedics)”**
- **“Others who may be involved in the care of people who lack capacity including ambulance crew, housing workers and the Police”**

8.6 The five guiding principles of the Mental Capacity Act

The Mental Capacity Act (MCA) has five key principals which emphasise the fundamental concepts and core values of the MCA. These **MUST** be borne in mind when working with or providing care or treatment for people who lack capacity.

The five principals are:

1. Every patient who is 16 or older has the right to make his or her own decisions and must be assumed to have the capacity to do so unless it is proved otherwise. This means it cannot be assumed that an individual lacks capacity just because they have a particular medical condition or disability.

2. An individual must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means every effort should be made to support and encourage the person to make their own decisions (this includes using all steps to ensure they patient understands (i.e. consideration of language line or pre hospital communication booklet)
3. An individual has the right to make what others might regard as unwise or eccentric decisions. This means individuals have their own values, beliefs and preferences which may differ from other people, and they should not be seen as lacking capacity because of this
4. Anything done for on behalf of a person who lacks capacity must be done in their **best interest and ne the less restrictive method**. An explanation of the term “best interest” is not specifically defined in the MCA, although the principal is set out in the Act as “An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interest”. The person who has to make the decision on behalf of the person who lacks capacity is known as the ‘decision-maker’.

The Act gives a checklist of key factors which must be considered when determining what is in the best interests of a person who lacks capacity.

These include:

- Assumptions about best interest cannot be made merely on the basis of the person’s age or appearance, condition or any aspect of their behaviour.
- The decision-maker must consider all the relevant circumstances relating to the decision in question.
- The decision maker must consider whether the person is likely to regain capacity e.g. after receiving medical treatment). If so can the decision or act wait until then.
- The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.
- If the decision concerns the provision or withdrawal of life sustaining treatment the decision-maker must not be motivated by a desire to bring about the person’s death.

The decision-maker must in particular consider:

- The person’s past and present wishes and feelings (in particular if they have been written down).
- Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors.

As far as possible the decision-maker must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

- Anyone previously named by the person lacking capacity as someone to be consulted if you are aware of such a person.
- Carers, close relatives or close friends or anyone else interested in the person’s welfare.
- Any attorney appointed under a Lasting Power of Attorney.
- Any deputy appointed by the Court of protection to make decisions for the person.

Any decision taken regarding capacity under the Act requires the above steps to be taken in order to determine what is in the person’s best interest and is time and issue specific.

5. Anything done for, or on behalf of an individual without capacity should be less restrictive of their basic rights and freedoms.

9. Equality Impact Assessment

The Executive Summary of the Equality Impact Assessment can be found in Appendix G

10. Dissemination

All staff via email, intranet and through Line Managers for staff who do not have access to IT.

11. References and further reading

- Reference guide to consent for examination or treatment. (DH 2009)
- Good Practice in Consent Implementation Guide. Consent to examination or treatment. (DH 2001)
- 12 Key Points on Consent – the Law in England. (DH 2009)
- Mental Capacity Act (2005)
- Mental Health Act (revised 2007)
- Deprivation of Liberty (Safeguards to the MCA) (introduced in the revised MHA 2007)
- Mental Capacity Act Code of Practice 2013
- Criminal Justice and Courts Act (2015)
- Children Act (1989)
- Family Reform Act (1969)
- Care Act (2014)

Appendices

Appendix A Assessing Capacity

Appendix B Guidance for Staff Assessing Capacity

Appendix C The Use of Restraint

Appendix D Checklists for staff to protections from liability under the Mental Capacity Act 2005

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Appendix A Assessing Capacity

It **MUST** always be assumed the person has capacity to make the decision in question, and an assessment of capacity will need to be undertaken **BEFORE** carrying out any care or treatment.

1. The Code of Practice refers to a person's capacity (or lack of capacity) specifically in relation to their capacity to make a particular decision about a specific care/treatment option at the time it needs to be made. This means a person may lack capacity to make some decisions but not others at any particular time. It also implies capacity may fluctuate depending upon the person's medical condition and disability. Capacity therefore needs to be assessed at the time a particular decision is being made for the specific care or treatment requirement and the person undertaking the assessment needs to have a "reasonable belief" that the person lacks capacity if this is the decision arrived at.

To help determine if a person lacks capacity to make particular decisions, the Act sets out a two-stage test of capacity (part of the five guiding principles):

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

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

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

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

The Act defines a person as unable to make a decision if they cannot:

- Understand information about the decision to be made (the Act calls this “relevant information”)
- Retain the 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)
- On the balance of probability if the person cannot do one or more of the following they will be deemed as lacking capacity for that decision..
The communication point only applies in situations where people cannot communicate their decision in any way.

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

2. Helping the person to make decisions for themselves

The Mental Capacity Act requires that every effort is made to help a person make a decision for themselves. This will require staff taking the following steps to ensure the person is given as much assistance as possible to make a decision:

- Ensuring a person has all the relevant information needed to make the decision including any information on alternatives.
- Ensuring that information is provided in a way that makes it easier for a person to understand.
- Establishing whether anyone else can help or support a person to understand information or make a choice, for example a relative, friend or carer.
- Attempting to establish whether there are particular times of the day or a particular place where a person may feel more at ease and consequently more able to make a decision.

3. Emergency situations (Doctrine of Emergency)

Clearly in emergency medical situations, urgent decisions will have to be made and immediate action taken in a person’s best interest. In these situations it may not be practicable or appropriate to delay treatment or care while trying to help the person make their own decisions. This is often the situation faced by EEAST staff.

4. Who should assess capacity

The Health Professional who assesses an individual’s capacity to make a decision will usually be the Health Professional who is directly concerned with the individual at the time the decision needs to be made. This means different Health Professionals will be involved in assessing someone’s capacity to make different decisions at different times.

As an example, if a person is assessed as lacking capacity and needs conveying to hospital in their “best interests” for treatment or investigation, the decision to convey the person will be taken by the Trust staff member and therefore the legal duty is upon the Trust staff member to undertake the capacity assessment. A professional opinion on the person’s capacity can be sought for example from a psychiatrist, social worker or GP. However the final decision about a person’s capacity must and can only be made by the Trust staff

member intending to make the decision or carry out the action on behalf of the person who lacks capacity- not the professional who is there to give advice, sometimes remotely. In this example the Trust staff member who will be conveying the person to hospital must make the decision about the person's capacity to consent to transfer to the hospital **NOT** the Doctor or any other professional providing advice or instruction.

Where a crew are attending the person, the crew member who is in a position of treating or caring for the person will undertake the capacity assessment. Where a paramedic is available it will be their responsibility to carry out the capacity assessment. However, the legal duty falls to all staff who are undertaking treatment and / or transport of any individual either in an emergency setting or non-emergency setting.

The Health Professional undertaking a capacity assessment does not need to be an expert in assessing capacity. They must however have a 'reasonable belief' that the person lacks capacity to make the decision or consent to an act at the time that the decision or consent is needed and be able to demonstrate clearly how that the decision of a lack of capacity has been reached. The Trust has documentation (Capacity to Consent Assessment Form) for all staff to follow when undertaking a capacity assessment. The documentation will guide any member of staff through an appropriate assessment.

The only time a specific professional who is trained and qualified to undertake specialist capacity assessments is required, is when they are conducting a formal "Best Interest" assessment under Deprivation of Liberty (DoL). This process identifies a long term care package such as a residential order. In such cases the assessment will be undertaken by either an Approved Mental Health Practitioner (AMHP) or Psychiatrist who has received the appropriate training.

The Trust Capacity to Consent policy **must** be used by any and all staff be they front line, volunteer, private or support service. This includes those supporting emergency operations, scheduled transport and primary care services. Any completed forms must be retained as per contractual agreements with the Trust.

5. What is 'reasonable belief' of lack of capacity

In order to have protection from liability under the Act when providing care or treatment the worker must have a 'reasonable belief' that the person in question lacks capacity to make relevant decisions about their care and treatment. To have this reasonable belief, they must have taken 'reasonable' steps to establish that the person lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. They must also establish that the act or decision is in the person's best interest. If someone challenges their assessment they must be able to describe the steps they have taken, and also have objective reasons for believing the person lacked capacity to make the decision in question.

Professional staff, who are qualified in a particular field, are normally expected to undertake a more in-depth assessment than carers or untrained care workers, reflecting their higher degree of knowledge and experience in their area of work.

Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent situations. In emergency situations it will almost always be in the person's best interests to give urgent treatment without delay this is known as the Doctrine of Emergency and set out within the law, is the identified sanction appropriate to saving a person's life.

An exception to this will be when the healthcare professional giving treatment is satisfied that an advance decision to refuse medical treatment exists.

All assessment and decisions should be recorded in line with the Trust Capacity to Consent Assessment form.

6. Who should keep a record of capacity assessments?

The Trust requires all staff to undertake an appropriate assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records (Capacity to Consent Form)/ person care record.

Written records should clearly indicate what decision or consent to an act the person was assessed for and how the decision was made that the person lack capacity. This should include the steps taken to establish 'reasonable belief'.

- a. All Trust records for Capacity to Consent should be retained within the Trust and must be collected and stored by the Clinical Governance Team.

7. Protection from liability

The MCA provides protection for actions carried out in connection with care or treatment, when those actions are carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in the person's best interest. The Act does not define 'care and treatment' but within the Act treatment includes diagnostic or other procedures.

Healthcare and treatment actions covered by the Act include:

- Giving medication
- Taking someone to hospital for assessment or treatment
- Providing care in an emergency

These actions only receive protection from the liability if the person is reasonably believed to lack capacity to give permission for the action. The action must also be in the person's best interest and follow the principals of the Act.

8. Limits on Protection from Liability

The key areas where acts might not be protected from liability under the Act are where there is inappropriate use of restraint or where a person who lacks capacity is deprived of their liberty in the absence of formal authorisation issued by the designated supervisory body.

9. Use of restraint

The Trust has a policy of **no restraint** being used when attending to persons except under exceptional circumstances under common law. However, under the Mental Capacity Act restraint may be used by staff when it is considered to be in the Best Interests of a person who lacks capacity but then **ONLY** restraint that is proportionate and reasonable may be used.

Under the Mental Capacity Act, a person is defined as using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not, in law this can be identified as a physical or verbal act.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two recommendations are met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it takes must be a proportionate response to the likelihood and seriousness of harm and only last as long as required

In addition, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviours, or is in the acute stages of an illness causing them to act in a way that may cause harm to others, staff may under common law, take appropriate and necessary action to restrain or remove the person in order to prevent harm both to the person concerned and anyone else. Acts under common law would not provide sufficient grounds to deprive someone of their liberty.

Any use of restraint should be reported through DATIX and reviewed by the Safeguarding Lead to determine if appropriate.

Restraint under MCA should not be confused with safer holding, all Trust staff should familiarise themselves with the Trust safer holding policy and ensure that their training is current and up to date in line with the policy.

10. Deprivation of Liberty and Safeguards for the Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS) was introduced as legislation within the Mental Capacity Act when rewritten in 2007. The Mental Capacity Act and DoL came about following a ruling by the European Court of Human Rights that it was illegal to deprive a person who lacked capacity of their liberty without the specific authorisation of a supervisory body following a detailed best interest assessment undertaken by a specially trained and qualified professional.

DoL is most likely to apply to people within hospital or nursing/care homes and it is unlikely that the ambulance crew will have any direct involvement unless a person subject to an authorisation is transferred from one establishment to another. In such cases staff should ensure that they adhere to and follow the type of deprivation authorised, and satisfy themselves that any action taken by them complies with the specified authorisation. A written copy of such authorisation should be kept with the person records.

Currently all journeys provided by an ambulance service are classed as emergency journeys and would not fall under DoLS but under the Doctrine of Emergency and acting in someone's best interest.

11. Ill treatment and Wilful Neglect

The Mental Capacity Act created an offence of ill-treatment or wilful neglect by any person who has the care of another, who lacks, or who the first person reasonably believed to lack capacity – or by any deputy or person with lasting powers of attorney under the 2005 Act. The offence is now included in the new Criminal Justice and Court Act 2015.

The code of practice states that the offence of ill-treatment and wilful neglect are separate.

Ill treatment - involves deliberation or recklessness and it does not matter whether the behaviour was likely to cause, or actually caused harm or damage to the victim's health.

Wilful neglect - in general means that a person had deliberately failed to do something he or she knows was a duty.

In situations where ambulance staff have assessed a person as lacking capacity they then must act in the person's best interest advocating the less restrictive solution. For example a person assessed as lacking capacity refuses to transfer to hospital for further investigation and treatment which the staff believe would be in the person's best interests. If the ambulance staff elect not to take the person to hospital even though such action is considered to be in the person's best interests then the ambulance staff could be held liable to wilful neglect if any harm came to the incapacitated person as a result.

However, documenting and discharging care to another service that enables further support in the less restrictive manner would support the staff member under the act. Using the example above, asking for a GP to attend the location to offer further support and treatment would be a less restrictive solution.

12. Other aspects of the Mental Capacity Act

The Mental Capacity Act introduced revisions for the following:

Court of Protection

The Court of protection has been given new powers under the MCA and extended their role in cases relevant to protecting and safeguarding vulnerable adults. The Court of Protection has the power to make declarations about whether or not a person has capacity and about lawfulness of any act done or proposed to be done in relation to the person. They also have the power to appoint deputies to act on behalf of the person (for personal welfare and/or property and affairs) or make decisions (orders) about the best interest for the person.

Advance Statements

Under the Mental Capacity Act a person can make an advanced statement about their preferences for the care and treatment they may require in the future at a time when they may lack the capacity to provide the consent for themselves. Advance statements are usually a general statement of the person's wishes and views, and though they must be considered by staff treating the person in the future at a time when that person may lack capacity staff are not legally bound to follow them. Advance statements can include the wish for the person's 'attorney' or 'deputy' to be consulted on all health and welfare decisions when the person lacks capacity. Examples of advance statements would include specifying the type of diet or personal care regime a person would want.

Advanced Decisions to Refuse Treatment (ADRTs)

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

An advance decision does not need to be in writing; except for decisions relating to life-sustaining treatment.

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

The following list gives a very brief summary of some of the main requirements for advance decisions to refuse treatment:

- It must be valid. The person must not have withdrawn it, or overridden it by making a Lasting Power of Attorney that relates to the treatment in the advance decision, or acted in a way that is clearly inconsistent with the advance decision.
- Please note: if you appoint a Lasting Power of Attorney (LPA) for personal welfare after making an ADRT, then the LPA can override your decision in your ADRT. It must not be witnessed by someone who is likely to benefit from the person's death, i.e. family members
- It must be applicable to the treatment in question. It should clearly refer to the treatment in question (detailed medical terms do not have to be used) and it should explain which circumstances the refusal refers to. If there have been changes in circumstances which there are reasonable grounds for believing would have affected a person's advance decision when they made it, then it may not be applicable.

Where people are detained under the Mental Health Act 1983 and can therefore be treated for mental disorder without their consent, they can also be given such treatment despite having an advance decision to refuse the treatment.

People cannot make an advance decision to ask for medical treatment - they can only say what types of treatment they would refuse.

People cannot make an advance decision to ask for their life to be ended.

- If you are satisfied that the decision is both valid and applicable then staff will have to abide by that decision. If you are unable to determine the decision is valid under English law the term 'precautionary principle' can be applied that enables you to act in the patients best interest until a point you can reassess your actions are still valid in supporting the patient.

Advance decisions to refuse life-sustaining treatment

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

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

Lasting Power of Attorney (LPA)

The Mental Capacity Act introduces a new form of power of attorney which will allow people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person making an LPA will be called the donor. The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person(s) appointed will be known as an attorney(s). The LPA will give the attorney authority to make decisions on behalf of the donor and the attorney will have a duty to act or make decisions in the best interests (Principle 4 of the MCA) of the person who has made the LPA.

There are two different types of LPA:

- A personal welfare LPA is for decisions about both health and personal welfare
- A property and affairs LPA is for decision about financial matters

When a person makes an LPA they must have the capacity to understand the importance of the document and the power they are giving to another person. Before an LPA can be used it must be registered with the Office of the Public Guardian. This is vital, without registration an LPA cannot be used at all.

A personal welfare attorney will have no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision for him or herself. If the person in your care lacks capacity and has created a personal welfare LPA, the attorney will be the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the attorney's authority the attorney will have the authority to make personal welfare decisions and consent to or refuse treatment (*except life-sustaining treatment*) on the donor's behalf. The attorney must make these decisions in the best interests of the person lacking capacity (Principle 4).

If the decision is about life-sustaining treatment, the attorney will only have the authority to make the decision if the LPA specifies this. **In an emergency situation staff will always act to preserve life (the precautionary principle) and in the best interest of the person, unless the Attorney is present, an LPA is immediately available and clearly specifies that the Attorney can make an appropriate decision as part of that LPA.**

It is important to read the LPA if it is available to understand the extent of the attorney's power. If unsure and where time allows, staff should always seek advice from one of the Named Professionals or the Clinical Advice Line (CAL). All LPAs are filed with the Office of Public Guardian.

13. Complaints and Concerns raised with the Trust in relation to capacity assessments and actions taken in the person Best Interests.

The Trust may receive complaints in relation to the findings of capacity assessments undertaken and subsequent actions taken by staff in the persons best interests. Any complaints or concerns will be dealt with in line with Trust complaint procedures and any subsequent Trust policy as appropriate.

Any complaint received from the person will be logged by the Trust complaints team as a capacity complaint, investigated by operational staff and overseen by the Trust Safeguarding Team.

Where a complaint is received from a person's advocate, written consent must be provided by the person before the complaint can be investigated. Where the complaint is received from a person's nominated attorney or deputy under a Lasting Power of Attorney no written consent from the person for information sharing is required but staff should satisfy themselves that the Lasting Power of Attorney provides the deputy with powers to act in relation to the health and wellbeing of the person.

Concerns raised about capacity assessments or actions taken in the persons best interests (from another organisation) will be logged by the Trust complaints team as a Capacity issue, investigated by operational staff and overseen by the Safeguarding Lead.

The management of complaints or concerns raised to the Trust on Capacity Assessments undertaken and actions taken in the persons best interests, will be dealt with in line with existing time frames for the management of complaints with the Trust.

If necessary the Trust Safeguarding Lead will recommend further investigation of the complaint or concern raised under the Trusts Managing Performance Policy where concerns regarding clinical practice are identified during the course of any investigation.

14. Sharing information

People making decisions on behalf of people who lack capacity will often need to share personal information about the person lacking capacity. This information is required to ensure that decision makers are acting in the best interests of the person lacking capacity.

When releasing information, the following questions must be considered:

- Is the person asking for the information acting on behalf of the person who lacks capacity?
- Is disclosure in the best interests of the person who lacks capacity?
- What kind of information is being requested?

Access to personal information must be in accordance with the law. For example, the NHS Code of Practice on Confidentiality provides the following guidance:

“Where the person is incapacitated and unable to consent, information should only be disclosed in the person's best interests, and then only as much information as is needed to support their care.”

Disclosure of, and access to, information is regulated by:

- the Data Protection Act 1998 (Revised 2018)
- the common law duty of confidentiality
- professional codes of conduct
- the Human Rights Act 1998.

Attorneys with a Lasting Power of Attorney (LPA) are entitled to as much information as if they were the person lacking capacity. Court of Protection visitors have a right of access to records and independent mental capacity advocates have a right of access to that part of a person's records relevant to the decision in question. Court of Protection deputies may have access to a person's records if the Court gives them that power.

Appendix B Guidance for Staff Assessing Capacity

At all times staff have a duty of care to a person under their care whether the person has capacity or not. In those situations where the person does not have capacity to consent to recommended treatment and/or interventions, staff are then required to provide whatever care, treatment and/or interventions the person requires that is considered being in the person's best interests in the less restrictive manner. In situations which relate to life-sustaining treatment, the death of a person would not be seen to be in the person's best interest.

This section provides guidance for staff when assessing a person's capacity to make decisions and any determination subsequently made for acting in the person's best interests. It also provides guidance on the use of restraint when used under the Mental Capacity Act. This is separate to the Trust policy on safer holding.

It will also provide guidance for staff when a person is assessed for capacity in private dwelling or public places and advise on what action to take

15. Assessing Capacity

“A person must be assumed to have capacity unless it is established that (s)he lacks capacity” (*Mental Capacity Act 2005*)

Ambulance staff frequently attend incidents where a person refuses examination, treatment and/or transport. Often this can cause problems with what subsequent actions are required to ensure that the person receives the most appropriate care.

Ambulance staff **must consider** the use of Trust Capacity Assessment process when:

- A person refuses examination/treatment and/or transport to hospital.
- Following initial clinical assessment, the person's capacity to consent to treatment is questionable.
- Person who is known Mental Health / Psychiatric history.
- Person who is known to have self-harmed or attempted suicide or a history of either or both such action.
- Any other person who lacks capacity (or is perceived to not have capacity) at the time of treatment or transport.

The Capacity Assessment process has been developed using a combination of the following:

- Initial clinical assessment process (Diagnostic Stage). A cognitive function test, based on components of the Mini Mental State Examination (part of Diagnostic Stage).
- The functional test of capacity using five key questions
- Clinical Practice Guidelines (JRCALC) assessment for Suicide and Self-Harm Risk Assessment Form

When undertaking the assessment staff must explain the process in a clear and understandable manner, appropriate to the individual. Any communication difficulties or requirements must be identified and considered prior to the assessment. It is important to remember that even a person with a mental illness can still have capacity.

Following a person's refusal of the recommended treatment and or transport there is a responsibility upon the clinician and Trust to ensure that the duty of care has been safely and appropriately delegated.

16. Capacity Assessment Process

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

This is a general principle that cannot be over-emphasised. The assessment process has to be clear, documented and accountable.

17. Diagnosis

The person must be clinically assessed appropriate to the presenting condition. Information gathered from the assessment should be used to decide if there is evidence of any impairment or disturbance in the functioning of the mind or brain.

The clinical assessment, including history and observations must be recorded on the person's patient care record. Any confirmed or suspected diagnosis should be logged on the Capacity Assessment form. The following questions must be asked and recorded in the appropriate section of the Patient Report Form as part of the initial diagnostic assessment.

18. Cognitive Assessment

- Is the person orientated for time place and person?
- Is the person able to identify/locate familiar objects? This might include; location of medicines at home, location and positioning of vehicles at an RTA or identification of a jacket or house keys.
- Is the person able to follow simple commands? (stand up or sit down if appropriate or raise arm for BP taking)

19. Functional Assessment

- Does the person have a general understanding of what decision they need to make and why?
- Do they understand the consequences of making or not making the decision or of deciding way one or another?
- Are they able to understand and weigh up the importance of the information relevant to the decision?
- Can they retain the information as part of the decision making process?
- Can they communicate their decision?

The capacity assessment and findings should be recorded in the person's records on the designated Trust Capacity to Consent Assessment form. This should be completed accurately and comprehensively.

The only exception to this is when a child is in the care of a parent or guardian and they are making decisions about their treatment or care. In these instances the capacity assessment should be undertaken on the parent or guardian to ensure that they have capacity. In cases where the ambulance staff do not believe the parent or guardian has the capacity to make an informed decision about the care for a child, ambulance staff should act in the best interests of the child.

The Trust's Safeguarding Child and Young People Policy and reporting procedures should be considered in cases where there is concern over a parent or guardians capacity to make decisions for the treatment or care of a child. The refusal of treatment or care for a child by parents *with capacity* may also raise concerns that require reporting as a safeguarding issue via SPOC 0845 602 6856.

20. Refusal of Treatment in a Private Dwelling (For persons with capacity)

When a person has been identified as having capacity and they are in a private dwelling you must respect their wishes. Once you have completed the Trust Capacity to Consent Assessment and you are confident that the person has capacity you must ensure the following:

- That the clinical record including the Trust Capacity to Consent Assessment form is completed
- If the person consents, inform their GP of the situation (where possible), this can be done via the Trust SPOC 0345 602 6856
- A copy of the clinical record including the Trust Capacity to Consent Assessment form is sent to the GP (the top copy must be retained for Trust records)
- That the person has been advised that if they change their mind at any point they can request an ambulance to re-attend or contact their GP

Once these are complete you may leave the scene.

21. Refusal of Treatment in a Private Dwelling (For persons without capacity)

When a person has been identified as lacking capacity and they are in a private dwelling you have a duty to act in the person's best interests. Once you have completed the assessment and you are confident that the person lacks capacity you must ensure the following:

- If the person is physically aggressive urgent assistance from the Police should be requested as per Trust procedures for staff and person safety.
- Make every effort to provide the necessary treatment or care to the person.
- If appropriate, the use of restraint to ensure that the person receives treatment that is in their best interest (Doctrine of Emergency) and that advocates the less restrictive approach.
- Where this is not possible, contact the person's GP/Out of Hours service and request the urgent attendance of a GP for further assessment. In such cases an ETA must be obtained.
- The clinical record including the Trust Capacity to Consent Assessment form is completed. A copy of the Trust Capacity to Consent Assessment form is submitted with the PCR/Vehicle log sheet as per current Trust practice. These documents (PCR and Trust Capacity to Consent Assessment form) will be retained within the Clinical Quality Department as per Trust procedure.
- Correct duty of care discharge should be applied in all circumstances.

22. Refusal of Treatment in a Public Place (For persons assessed as having capacity)

When a person has been identified as having capacity and they are in a public place you must respect their wishes. Once you have completed the assessment and you are confident that the person has capacity you must ensure the following:

- The clinical record including the Trust Capacity to Consent Assessment form is completed.
- If the person consents, inform their GP of the situation (where possible), this can be done via the Trust SPOC 0345 602 6856

- A copy of the Trust Capacity to Consent Assessment form and Patient Report Form (PCR) are sent to the persons GP (the top copy must be retained for Trust records).
- The person does not pose a risk to themselves or other members of the public.
- The person has been advised that if they change their mind at any point they can request an ambulance to re-attend or contact their GP.

NB: If a person does pose a risk to themselves or other members of the public you must consider further support such as a request for the Police to attend.

23. Refusal of Treatment in a Public Place (For persons assessed as lacking capacity)

When a person has been identified as lacking capacity and they are in a public place you have a duty to act in their best interests (Doctrine of Emergency). Once you have completed the assessment and you are confident that the person lacks capacity you must ensure the following:

- Make every effort to provide the necessary treatment or care to the person.
- If appropriate use reasonable restraint to ensure that the person receives treatment that is in their best interests (Doctrine of Emergency).
- Consideration of further assistance from any agency (such as Police are requested to attend if further assistance is required). Where this is not possible, contact the person's GP/Out of Hours service and request the urgent attendance of a GP for further assessment. In such cases an ETA must be obtained.
- If the Police assist in the transfer of the person to an emergency department for further care or treatment, then the person must be transported in the ambulance with an appropriate and agreed level of support from the Police. This is completed as a dynamic Risk Assessment at the time of the incident.
- The clinical records and Trust Capacity to Consent Assessment form are completed. A copy of the Trust Capacity to Consent Assessment form must be submitted with the PCR as per current Trust practice.

Any concerns for a person's safety, vulnerability and further welfare should be considered and a referral to the Trust SPOC 0345 602 6856 should be completed.

Appendix C The Use of Restraint

Restraint can be:

- Physical – e.g. Held by one or more people
- Mechanical – e.g. Devices
- Chemical – e.g. Sedation
- Psychological – e.g. Objects taken away

Using restraint is the use or threatened use of force to make someone do something they are resisting. Restraint is a criminal offence if there is no justification for its use.

The Trust has a policy of **no restraint** being used when attending to persons except under exceptional circumstances under common law.

However, under the Mental Capacity Act restraint may be used by staff when it is considered to be in the best interests of a person who lacks capacity but **ONLY** then when the restraint is appropriate and reasonable and they are likely to harm themselves and is the only less restrictive method option available. It should only be applied as long as necessary and all staff should be the advocate of the patient at all times.

The following guidance relates to the use of restraint for a person who has been assessed as lacking capacity and staff actions are in keeping with the person's best interests.

There is no specific national guidance to define what is appropriate, proportionate and reasonable restraint, under the Mental Capacity Act restraint is defined as:

- Use of force – or threats to use force – to make someone do something that they are resisting, or
- Restricting a person's freedom of movement, whether they are resisting or not. The law identifies both physical and verbal actions as types of restraint

In the circumstances where restraint is considered

- The person taking the action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, **and**
- The amount or type of restraint used and the amount of time it takes must be a proportionate response to the likelihood and seriousness of harm

The use of force and restraint **MUST** be seen as a last resort when all other interventions such as de-escalation have failed. The type and nature of the restraint that crew may be required to use will be based upon factors at the time and clinical judgement. However, in cases where a person needs to be physically restrained in their best interests due to aggressive behaviour urgent assistance should be sought from the Police.

In cases where a person is being restrained by Police officers and ambulance staff are in attendance the sole responsibility for the person's medical care and advocacy rests with the ambulance staff.

During all cases of physical restraint or when a person's freedom of movement is restricted, staff must be aware of the potential for positional asphyxia, 'excited delirium' or any other condition exacerbated by the use of restraint which might compromise the medical safety of the person. When a person is being restrained staff must be attentive to these possible risks and monitor accordingly.

When transporting persons existing straps fitted to either the ambulance stretcher or chair should be used to keep the person safe. These straps should be placed around the person's chest and legs as appropriate and in keeping with instruction received in Patient Safety training and safer holding. Further restraint of the person's arms may be required if the person is presenting with significantly difficult behaviours such as attempting to hit staff or pull out necessary

No other form of restraint other than that taught as part of Patient Safety/safer holding Training should be used.

If the person presents with aggressive behaviour and there are concerns for the safety of the crew or the person, Police should be summoned immediately for assistance if all other less restrictive methods have been exhausted or the situation doesn't allow for de-escalation.

Ambulance crew transporting a person who lacks capacity must remain extra vigilant for further actions which might put the person at risk e.g. a person trying to exit the vehicle whilst it is moving.

In all cases where restraint is used it **MUST** be for the least amount of time and proportionate to the risk to the person.

In all cases where restraint has been used, staff must document fully in the patient report form and on the Trust Capacity to Consent Assessment Form and report through DATIX:

- Who made the decision to use restraint.
- What were the reasons for using restraint.
- What restraint was used and specifically whether the person's movement was restricted.
- How long the restraint was used for.
- Did the person suffer any adverse effects due to the restraint. Staff are advised to record all apparent injuries noticed prior to restraint being used as well as following the use of restraint.

Appendix D Checklists for staff to protections from liability under the Mental Capacity Act 2005

12 key points on consent: The Law in England (taken from DH Good practice Consent Implementation Guide 2001)

When do health professionals need consent from persons?

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

Can children give consent for themselves?

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** override 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?

It is always best for the health care professional actually treating the person to seek the person’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?

A person needs 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 person 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.

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 person gives consent?

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 person's decision, and also increasingly the discussions that have taken place.

Refusal of treatment

Any competent adult is entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the person 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

No-one can give consent on behalf of an incompetent adult, but an LPA can with Personal Welfare aspects but it must be registered and the person must have been deemed as lacking the capacity to make that particular decision. However, you may still treat such a person if the treatment would be in their best interests (Doctrine of Emergency).

'Best interests' can be explored wider than best medical interests, to include factors such as the wishes and beliefs of the person when competent, their current wishes, their general wellbeing and their spiritual and religious welfare. People close to the person may be able to give you information on some of these factors. Where the person has never been competent, relatives, carers and friends may be best placed to advise on the person's needs and preferences.

If an incompetent person 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.

All completed forms received by the Clinical Governance Department will be audited to ensure the Trust can identify trends and patterns.

24. Assessing Capacity

The following checklist is a summary of points to consider when assessing a person's capacity to make a specific decision.

Presuming someone has capacity.

The starting assumption must always be the person has the capacity to make a decision unless it can be established that they lack capacity

Understanding what is meant by capacity and lack of capacity.

A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made

Treating everyone as an individual and providing support and care appropriate to their needs

A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour.

Supporting the person to make the decision for themselves.

It is important to take all possible steps to try to help people make a decision for themselves.

Assessing capacity.

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

Assessing ability to make decisions.

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have an understanding of the likely consequences of making or not making the decision?
- Is the person able to understand, retain, use and weigh up the information relevant to the decision?
- Can the person communicate their decision by any means?

Assessing capacity to make more complex or serious decisions.

- Is there a need for a more thorough assessment perhaps by involving a Doctor or other professional expert?

The following steps list the things that people providing care or treatment should bear in mind to ensure they are protected under the Mental Capacity Act.

Acting in connection with the care or treatment of someone who lacks capacity

- Is the action to be carried out in connection with the care and treatment of someone who lacks capacity to give consent to the act?
- Who is carrying out the action and is it appropriate for that person to do so at the relevant time?

Checking whether the person has capacity to consent

- Have all possible steps been taken to try to help the person make a decision for themselves about the action?
- Have all possible steps been taken to try to help the person understand the situation and the implication of the decision they are making?
- Has the Trust Capacity to Consent Assessment form been completed?
- Are there reasonable grounds for believing the person lacks capacity to give permission?

Acting in the person's best interest

- Has the best interest checklist been applied and all relevant circumstances considered?
- Is a less restrictive option available?
- Is it reasonable to believe that the proposed act is in the person's best interest?

Understanding possible limitations on protection from liability

- If restraint is being considered, is it necessary to prevent harm to the person who lacks capacity, and is it a proportionate response to the likelihood of the person suffering harm- and to the seriousness of that harm?
- Does the action conflict with a decision that has been made by a person appointed by the courts using powers appointed to them?

Appendix E Information Sharing

The following steps should be considered when making decisions about sharing information for people who lack capacity

The person who is asked or intends to disclose information should ask:

- Is the disclosure lawful?
- Is the disclosure justified, having balanced the best interests of the person lacking capacity and/or the public interest against the rights to privacy of the person lacking capacity?

The following questions should help to answer the last two points

- Do I (or does my organisation) have the information requested?
- Am I satisfied that the person concerned lacks capacity to consent to the information being disclosed?
- Does the person requesting the information have any formal authority to act on behalf of the person lacking capacity, e.g. an LPA?
- Am I satisfied that the person making the request is acting in the best interests of the person who lacks the capacity?
- Am I satisfied that they need the information in order to act properly?
- Am I satisfied that they will respect any confidentiality?
- Am I satisfied that they will keep the information for no longer than necessary?
- Should I seek a formal undertaking as to these matters?

Appendix F Capacity to Consent Form (Currently Under Review due to new Data Protection Legislation & Law Commission Update on MCA Revision)



East of England Ambulance Service **NHS**
NHS Trust

Capacity to Consent Form

Date / / Time : CAD number

Patient Name

Age NHS Number / /

Address

All Trust staff must undertake a capacity assessment if the patient refuses reasonable treatment and/or transport to an acute unit.

The MCA dictates that all people over the age of 16 must be assumed to have capacity unless their decision making/behaviour is felt to be questionable. The following 2 stage assessment must be undertaken, both aspects must be covered by law to complete a full capacity assessment.

Stage 1

Does the person have an impairment of brain or brain function?

Is the person orientated to time, place and person?

Stage 2

The impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made meaning they cannot:

- understand information about the decision to be made
- retain that information
- weigh that information as part of a decision making process; or
- communicate that decision

Ensure the person is clear of all the details relevant to the decision you want them to make.

Outline your conversation below:

If the patient demonstrates a capacity to understand, retain, weigh up and communicate their decision making then by law they have capacity.
Even if the decision is not one you agree with

If the patient cannot understand, retain, weigh up, and communicate their decision making, (this can be done in writing), then they have no capacity

You MUST remove them to the hospital for treatment, record the means of the removal below and also log who helped you to undertake the removal of the patient

Clinician Signature _____ Print Name _____

Top copy return to Medical Records - 2nd copy as required



When should you complete a form?

A form must be completed for the following patient groups: Patients who have **refused** recommended treatment/conveyance and you doubt a person's ability to make that decision at the time, Patients who have had to be restrained by ambulance staff for their own safety (in their best interests) and other patients who lack capacity at the time of recommended assessment/treatment.

After completing a form the top copy should be submitted to Medical Records as part of the patient care record. The second copy can be used for onward referral, left with the patient or returned to Medical records as appropriate.

Step 1: Clinical Presentation

Is the patient suffering from an impairment or disturbance in the functioning of the mind or brain? This may include: Conditions associated with some forms of mental illness; Dementia, significant learning disabilities, the long-term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, Delirium, confusion following a head injury, symptoms of alcohol or drug abuse

Then check:

- Q1. Is the person orientated for time, place and person?
- Q2. Is the patient able to identify or locate familiar objects? Example – location of medicines in the home, identification of a personal item such as wallet, purse, keys
- Q3. Is the patient able to follow simple commands? Example – lifting arm to allow BP to be taken, standing or sitting when asked (if appropriate)

Step 2: Cognitive functioning

- Q4. Does the patient have a general understanding of what decision they need to make and why they need to make it? **Example** - does the patient recognise their current health situation and what actions are required to provide further assessment or treatment?
- Q5. Does the patient understand the consequences of making, or not making, the decision, or of deciding one way or another? **Example** – can the patient state what will happen if they elect not to follow recommended course of action?
- Q6. Is the patient able to understand and weigh up the importance of the information relevant to the decision? **Example** – can the patient state what factors they are taking into account when making the decision?
- Q7. Is the patient able to retain the information as part of the decision making process? **Example** – can the patient demonstrate recall of what has been discussed?
- Q8. Can the patient communicate their decision, using any means available to them?

Use of restraint (EEAST Capacity to Consent Policy)

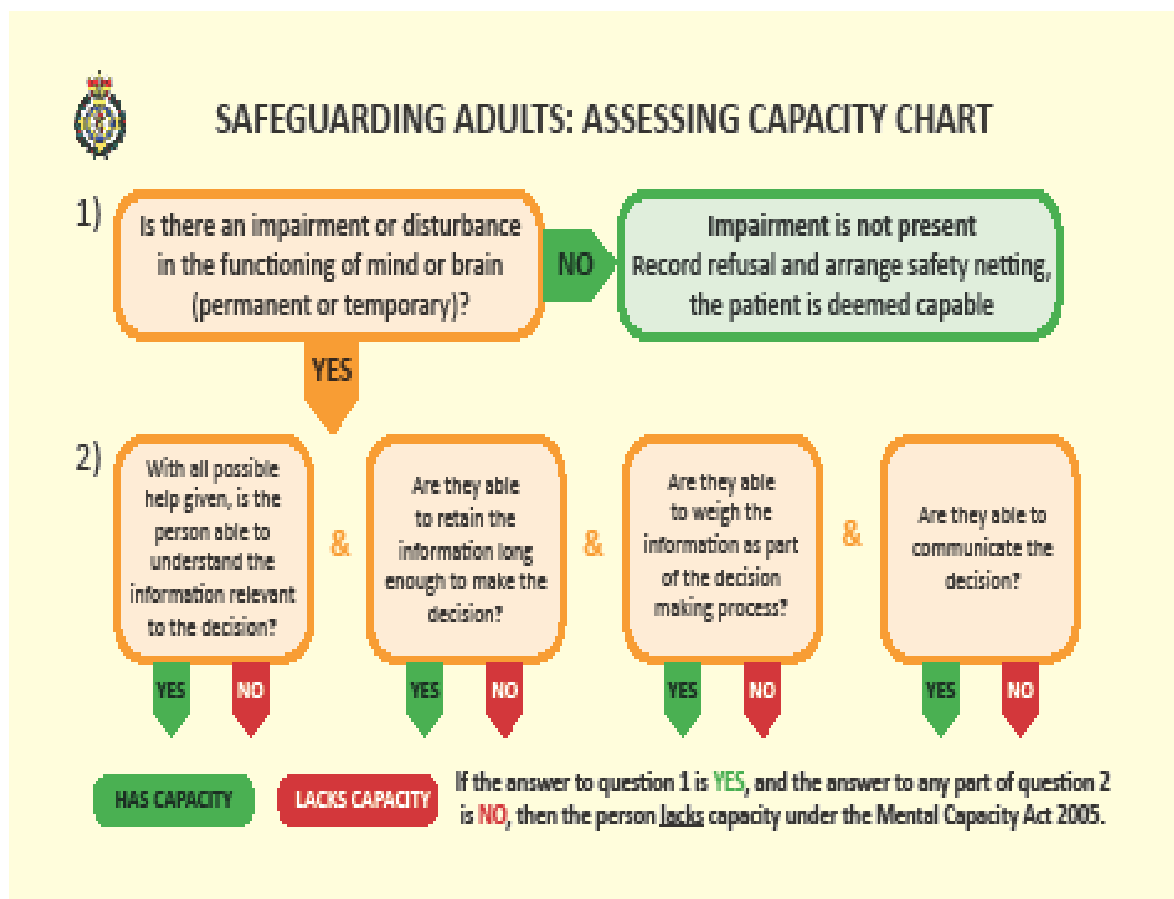
EEAST has a policy of **no restraint** being used when attending to patients except in exceptional circumstances under Common Law. However, under the Mental Capacity Act restraint may be used by staff when it is considered to be in the best interests of a patient who lacks capacity but then **ONLY** that which is proportionate and reasonable may be used.

Under the Mental Capacity Act, a person is defined as using restraint if they:
Use force – or threaten to use force – to make someone do something that they are resisting, or
Restrict a person's freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two recommendations are met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person, who lacks capacity,
- and the amount or type of restraint used and the amount of time it takes must be a proportionate response to the likelihood and seriousness of harm

In addition, Common Law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviours, or is in the acute stages of an illness causing them to act in a way that may cause harm to others, staff may under Common Law, take appropriate and necessary action to restrain or remove the person in order to prevent harm both to the person concerned and anyone else. Acts under Common Law would not provide sufficient grounds to deprive someone of their liberty. It should always be the less restrictive method and last only as long as necessary.



Appendix G Equality Impact Assessment

Executive Summary Page for Equality Impact Assessment:	
Document Reference:	Document Title: Capacity to Consent Policy
Assessment Date: November 2015-2017	Document Type: Policy and Procedures
Responsible Director: Sandy Brown	Lead Manager: Simon Chase
Conclusion of Equality Impact Assessment: This policy sets out the standards and guidance for the Trust, which aim to ensure that health professionals are able to comply with the law and Department of Health Guidance with regards to the principles of consent and also mental capacity assessment. The policy has been extended for six months due to the impending Law Commission decision to change current law.	
Recommendations for Action Plan: None identified at time of submission.	
Risks Identified: In breach of DH guidance and legislation if not applying correct best interest tests to support assessment and treatment and increase risk of injury if restraint not applied appropriately and under correct circumstances.	
Approved by a member of the executive team:	
YES	
Name: Sandy Brown	Position: Director of Nursing and Clinical Quality
Signature:	Date: 30 th November 2017
This whole document should be stored with the master document and a final approved electronic copy must be sent to the Equality & Diversity Lead at Bedford Office	

Equality analysis

Title: Capacity to Consent Policy

What are the intended outcomes of this work?

This policy sets out the standards and guidance for the Trust, which aim to ensure that health professionals are able to comply with the law and Department of Health Guidance with regards to the principles of consent and also mental capacity assessment.

Who will be affected?

Staff inclusive of volunteers, third party contractors, patients and the general population.

Evidence

What evidence have you considered: the Policy meets all requirements /guidance released by the Department of Health in relation to Mental Capacity Act 2005 along with legislative requirements / standards under the Children's Act 2004, Family Reform Act 1969, Mental Health Act Revised 2007 to include Deprivation of Liberty Safeguards, Code of Practice Mental Capacity Act 2005 (2013), Care Act 2014 and Criminal Justice and Courts Act 2015.

Disability

The policy can be made available in different formats if required.

Gender

No evidence found to highlight any differences/ allowances required.

Race

The policy can be made available in different formats if required.

Age

The policy can be made available in different formats if required.

Gender reassignment (including transgender)

No evidence found to highlight any differences/ allowances required.

Sexual orientation

No evidence found to highlight any differences/ allowances required.

Religion or belief

No evidence found to highlight any differences/ allowances required.

Pregnancy and maternity

No evidence found to highlight any differences/ allowances required.

Carers

No evidence found to highlight any differences/ allowances required.

Other identified groups

No evidence found to highlight any differences/ allowances required.

Engagement and involvement

The Policy has been approved by CQSG and now looks for ELB approval in order to release to staff. An extension of six months has been awarded by ELB to allow time for Law Commission to decide on necessary

changes to the law.

Summary of Analysis

No evidence to suggest that there is any potential differential impact for any of the protected characteristics.

Eliminate discrimination, harassment and victimisation

No evidence to suggest that there is any potential differential impact for any of the protected characteristics.

Advance equality of opportunity

No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.

Promote good relations between groups

No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.

What is the overall impact?

No evidence to suggest that there is any positive or negative impact for any of the protected characteristics.

Addressing the impact on equalities

No actions required.

Action planning for:

No gaps identified.

Please give an outline of your next steps based on the challenges and opportunities you have identified;

Not applicable.

For the record

Name of person who carried out this assessment: Simon Chase, Safeguarding Lead.

Date assessment completed: 30th November 2017

Name of responsible Director: Sandy Brown

Date assessment was signed: 30th November 2017

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Greater involvement by Trust clinicians in assessing capacity and supporting any person to make informed decisions and where necessary acting under the Best interest processes and how to report.			
Providing Trust clinician's guidance and direction on when restraint is used under Mental Capacity Act only in order to prevent harm to the patient.			
If the policy is required in another format or an alternative language.			



Appendix H Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
What key element that needs monitoring	Role or group who will lead on this aspect of monitoring?	What tool will be used to monitor/ check/ observe/ asses/ inspect/ authenticate that everything is working according to this key element	How often is monitoring needed How often should a report be completed? How should a report be shared?	What type of evidence will be presented	Who or what committee will the completed report go to and how will this be monitored. How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes	Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?	How will system or practice changes be implemented lessons learned and how will these be shared.
<i>Any changes in Legislation which may have an impact on the requirements of capacity to consent & Mental Capacity which may have an impact on patients</i>	<i>Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly Safeguarding Meeting. ACL who has Mental Capacity in their portfolio</i>	<i>Reviews on cases which have an impact on the Act.</i>	<i>The Policy will be monitored yearly.</i>	<i>Changes in Legislation or recommendation's from Learnings</i>	<i>Bi-monthly Safeguarding Meeting. This will be reflected in the minutes taken at the meeting.</i>	<i>This will be led by EEAST safeguarding Lead and monitored through the bi-monthly safeguarding meeting</i>	<i>There are a number of ways this can be implemented. This will be led through the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates</i>
<i>Deprivation of Liberty Safeguards</i>	<i>Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly Safeguarding Meeting. ACL who has Mental Capacity in their portfolio</i>	<i>Reviews on cases which have an impact on the Act.</i>	<i>The Policy will be monitored yearly.</i>	<i>Changes in Legislation or recommendation's from Learnings</i>	<i>Bi-monthly Safeguarding Meeting. This will be reflected in the minutes taken at the meeting.</i>	<i>This will be led by EEAST safeguarding Lead and monitored through the bi-monthly safeguarding meeting</i>	<i>There are a number of ways this can be implemented. This will be led through the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates</i>

Capacity to Consent Policy

<p>Safer Holding (use of restraint)</p>	<p>Safeguarding Lead and Safeguarding Adult Specialist, Bi-monthly Safeguarding Meeting. ACL who has Mental Capacity in their portfolio</p>	<p>Any adverse incidents reported on Datix, any legislation reviews or changes to the way EEAST operate within the scope of safer holding</p>	<p>The Policy will be monitored yearly.</p>	<p>Changes in Legislation or recommendation's from Learnings</p>	<p>Bi-monthly Safeguarding Meeting. This will be reflected in the minutes taken at the meeting.</p>	<p>This will be led by EEAST safeguarding Lead and monitored through the bi-monthly safeguarding meeting</p>	<p>There are a number of ways this can be implemented. This will be led through the Safeguarding Lead, this can be disseminated through policy, training, clinical app, comms bulletins, mandatory updates</p>
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