Sheffield Health and Social Care NHS
NHS Foundation Trust

Policy:

Capacity and Consent to Care, Support and Treatment

Executive or Associate Director lead	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
Policy author/ lead	Zara Clarke, Clinical Psychologist, (supported by Anita Winter, Service Director (on behalf of the MCA/DoLS Steering Group)
Feedback on implementation to	Zara Clarke, Clinical Psychologist

Document type	Policy
Document status	Final
Date of initial draft	March 2016
Date of consultation	May to October 2016
Date of verification	18 October 2016
Date of ratification	27 October 2016
Ratified by	Executive Directors Group
Date of issue	11 November 2016
Date for review	30 September 2019

Target audience	All staff

Keywords	Mental capacity, capacity, consent, acre, support, treatment

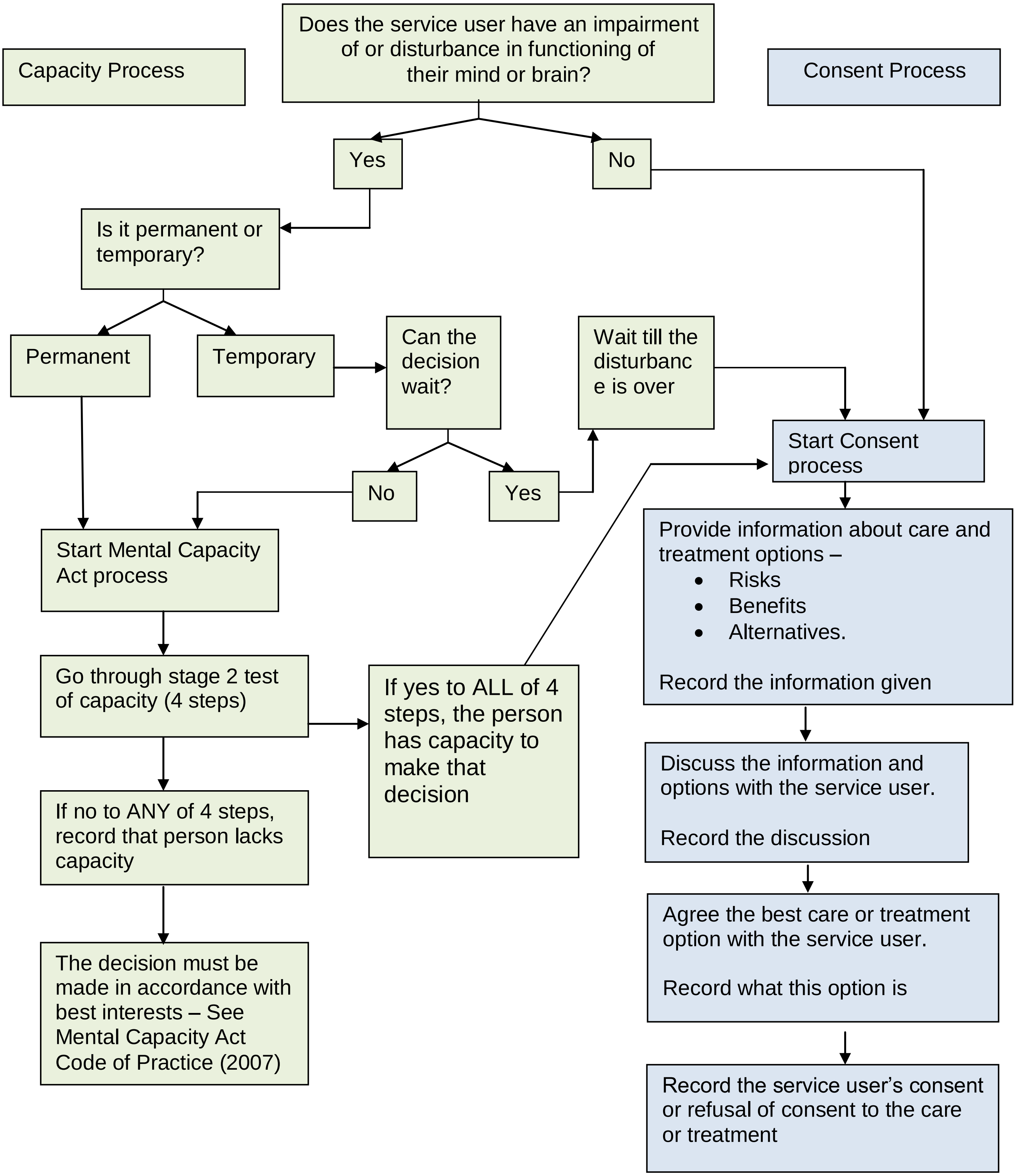
Policy Version and advice on document history, availability and storage
This is version 5.0 of this policy and replaces version 4 (November 2008). This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V4) should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

Flowchart – Summary of the Capacity and Consent to Care and Treatment Processes under the Mental Capacity Act



1. Introduction

It is a legal and ethical principle that valid consent must be obtained before starting treatment, physical examination or investigation, or providing personal care. This principle reflects the right of service users to determine what happens to their own bodies and is a fundamental part of good practice. A worker who does not respect this principle may be liable both to legal action by the person and action by their professional body. Valid consent to treatment is, therefore, absolutely central in all forms of health and social care, from providing personal care to undertaking major surgery.

The NHS Constitution (2013) states that service users have rights relating to consent including:

- 'You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests [note: there are some exceptions where treatment is given under the Mental Health Act 1983]
- You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

NHS Constitution for England, Department of Health (2013)

The Department of Health has published guidance on consent *Reference Guide to Consent for Examination or Treatment* (Second edition 2009).

The Care Quality Commission (CQC) makes it clear that this right should also apply to people receiving social care. Sheffield Health and Social Care NHS Foundation Trust is registered for health and social care by the CQC. The CQC describes what service users should expect from the Trust as:

What should people who use services experience?

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has previously been agreed.
- Can be confident that their human rights are respected and taken into account.

This is because providers who comply with the regulations will:
- Have systems in place to gain and review consent from people who use services and act on them.

Outcome 2: Consent to Care and Treatment
Essential Standards of Quality and Safety, Care Quality Commission (2010)

The NHS Litigation Authority (NHSLA) Risk Management Standards (2013-14 p121) state that "organisations providing acute and community services and non-NHS providers must have an approved documented process for obtaining consent".

Professional health and social care staff are bound by the codes of ethics and practice of their professional regulatory bodies e.g. General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), General Pharmaceutical Council (GPhC), or their successor bodies. They must follow these organisations' guidance on consent in order to maintain registration and their employment with the Trust.

Employees of the Trust provide a diverse range of services in a wide variety of different contexts. In some situations, the process for obtaining valid consent is relatively straightforward. In other situations this presents more challenges.

2. Scope

This policy applies to all health and social care staff working for the Trust, including those seconded in, those on fixed term or temporary contracts or on the flexible workforce. It also applies to those Trust staff who are working in other Trusts and organisations. It covers all Trust services. This policy should be read in conjunction with relevant updates in case law.

The majority of this policy should be read as applying to adults (aged 18+). The situation around people aged under 18 is discussed in detail in section 6.5 below.

It should be noted that this guidance is specific to consent for care, support and treatment on living people, and the following areas are, therefore, not included:

- Consent to take part in research
- Consent to take part in audit/service evaluation
- Consent around information/data sharing
- The use of organs or tissues after death

In these situations, appropriate advice and guidance should be taken from other local and national documentation, as well as line managers/professional bodies.

With the exception of where someone is detained under the Mental Health Act and receiving treatment for the mental disorder, valid consent must be obtained and recorded in the care record for all aspects of care, support and treatment including:

- Medication and changes to medication;
- All physical interventions including surgery, anaesthesia and Electroconvulsive Therapy (ECT)
- All psychological interventions and therapies;
- Physical examinations;
- Physical investigations;
- Psychological testing;
- Personal care;
- Care plans of all types including Care Programme Approach, Common Assessment Framework.

If the person is felt to lack mental capacity to make the decision in question, then the assessment of this and the best interests decision (as appropriate) should be clearly documented.

3. Definitions

‘**Treatment**’ - should be read to include physical or surgical treatments including ECT, medication, dietary (for example, Percutaneous Endoscopic Gastrostomy (PEG)), urinary care and also psychological therapies and interventions.

Medical treatment as defined in the Mental Health Act 1983 includes nursing, psychological intervention & specialist mental health habilitation, rehabilitation and care

‘**Care**’ **–** means personal care such as assistance with bathing, using the toilet or eating.

‘**Care Plan**’ – a written document detailing how the person’s care will be provided.

‘**Worker**’ **–** all health and social care staff working for the Trust, including those seconded in, those on fixed term or temporary contracts or on the flexible workforce.

‘**Valid consent’** - For consent to be valid it must be given voluntarily by an appropriately informed person who has the capacity to consent to the assessment/intervention in question. The informed person may either be the person, someone with parental responsibility for a child, or a person who has authority under a Power of Attorney. Consent will not be legally valid if the person has not been given adequate information or where they are under the undue influence of another. Acquiescence where the person does not know what the intervention entails is not consent. Where a person does not have capacity to give consent, then assessment/treatment may be given providing it is given in accordance with the Mental Capacity Act 2005.

‘Case law/common law’ – law developed by Judges through decisions in the Courts.

‘**Court of Protection’**- The specialist Court for all issues relating to people who lack capacity to make specific decisions.

‘**Lasting Power of Attorney’** - A Power of Attorney created under the Mental Capacity Act appointing an attorney (or attorneys) to make decisions about the donor’s personal welfare (including healthcare) and/or deal with the donor’s property and affairs.

‘Court Appointed Deputy’ – An individual appointed by the Court of Protection to make decisions about Property and Affairs and/or Health and Welfare for an individual.

‘Advance Decision to Refuse Treatment’ - A decision to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. Specific rules apply to advance decisions to refuse life-sustaining treatment.

‘**Capacity**’ **–** The ability to make ones own decision about a specific issue, as defined by the Mental Capacity Act (2005).

4. Purpose of This Policy

This policy is based on national guidance which applies to all parts of health and social care. The policy sets out the legal requirements for obtaining valid consent and gives guidance on the circumstances in which treatment may be given to a person who cannot give their valid consent.

This policy sets out the standards and procedures in **Sheffield Health and Social Care NHS Foundation Trust**. The aim is to ensure that all health and social care professionals are able to comply with the guidance and with legal requirements.

5. Duties

5.1 Trust Board

The Trust Board has ultimate responsibility and ‘ownership’ for the quality of care, support and treatment provided by the Trust. This includes the implementation of the Policy throughout the Trust and ensuring its effectiveness in the delivery of good practice with regard to consent. This is provided by:

- Demonstrating strong and active leadership from the top; ensuring there is visible, active commitment from the Board and appropriate board-level review of good practice with regard to consent;
- Ensuring there is a nominated Executive Director leading on the Board’s responsibilities with regard to consent;
- Ensuring there are effective ‘downward’ and ‘upward’ communication channels embedded within the management structures; to ensure the communication of the need for all staff to assess capacity and obtain valid consent to care, support and treatment;
- Ensuring adequate finances, personnel, training, care records and other resources are made available so that the requirements of this policy can be fulfilled;
- Expecting all health and social care staff to play a part in the responsibility for meeting the requirements of this Policy;
- Maintaining ongoing accountability for good practice in consent through management roles and responsibilities.

5.2 Senior Managers and Directors

Senior Managers and Directors have responsibility for developing, implementing and improving the Trust’s policies and procedures as an integral part of day-to-day operations. They have a duty to take all practicable measures to ensure that health and social care staff-assess capacity and always obtain and record valid consent to care and treatment. These include the following:

- Providing leadership and direction in regard to obtaining and recording valid consent;
- Ensuring staff receive training and supervision in consent;
- Ensuring the implementation of this policy is monitored through clinical audit, service user or staff surveys or other appropriate methods;
- Ensuring improvements are made to the staff performance on consent if needed;
- Ensuring suitable access, arrangements, IT provision and support and

documentation are provided to enable staff to record consent in the care record.

5.3 Team, Ward and Departmental Managers

Team, Ward and Departmental Managers have responsibility for:

- Ensuring the dissemination, implementation and monitoring of this Policy through existing staff forums;
- Ensuring all staff they manage always obtain and record valid consent to care and treatment;
- Ensuring all staff follow Trust policy and their professional regulatory body guidance on consent;
- Ensure that staff are conversant with the Policy and associated procedures and documentation and that they understand the importance of complying with its requirements;
- Ensuring consent is monitored through audits, staff surveys, service user surveys etc and taking active steps to remedy any deficiencies found;
- Allocating the necessary resources to achieve the goals of this policy.

5.4 Individual Employees

All health and social care staff working for the Trust have a responsibility to:

- Always be mindful of the need to assess capacity in order to obtain and record valid consent to care and treatment, having regard to the Mental Capacity Act (2005) where appropriate;
- Become familiar with and abide by this Capacity and Consent to Care and Treatment Policy and all associated procedures, guidelines and documentation;
- Abide by the code of ethics and practice and associated guidelines on consent defined by their professional regulatory body e.g. GMC, NMC, HCPC, GPhC;
- Undertake the relevant training around the Mental Capacity Act and consent, as required by the Trust;
- Undertake regular clinical supervision and seek advice on any areas of difficulty or complexity with regard to consent;
- Seek advice and report any concerns with regard to colleagues' ethical practice on consent to the appropriate manager or clinical supervisor.

6. Process: Specific details of processes to be followed

6.1 Seeking Valid Consent

6.1.1 In seeking valid consent to care and treatment, the member of staff must consider 3 questions:

- Does the person have the capacity to give consent?
- Has the person been informed about the risks, benefits and alternatives to the proposed care or treatment?
- Are they giving consent voluntarily and not under undue pressure?

6.2 Does the person have capacity to give consent?

6.2.1 The Mental Capacity Act 2005 applies when determining whether an individual has capacity to give their consent. It is a principle of the Act that a person is assumed to have capacity to make decisions for themselves unless it is established that they do not. Being diagnosed with a mental disorder does not necessarily mean that an individual lacks capacity to give or refuse consent or take any specific decision

6.2.2 A person lacks capacity if they are unable to make a decision for themselves in relation to a particular matter, because they have an impairment or disturbance in functioning of the mind or brain. This impairment or disturbance can either be temporary or permanent. Where there is any doubt about a person's capacity to consent to care or treatment, an assessment must be undertaken. If a formal assessment is inconclusive an application for determination of person's capacity may be made to the Court of Protection.

6.2.3 The worker must not make assumptions based on age, appearance, condition or any aspect of behaviour. They must instead follow the 2 stage test set out in the MCA Code of Practice for establishing whether a person lacks capacity.

6.2.3.1 Stage 1 concerns whether there is an impairment of or disturbance in the functioning of the person's mind or brain? The presence of an impairment or disturbance of the mind must not in itself be taken to imply that a person lacks capacity to make a particular decision and stage 2 of the test must also be applied, as follows.

6.2.3.2 Does this impairment or disturbance of the mind make the person unable to make that particular decision at that particular time? In order to answer this question, the following functional test must be applied.

6.2.3.3 After providing all reasonable support to enable a person to make their own decision, can the person:

- Understand information given to them relevant to the decision;
- Retain that information long enough to be able to make the decision;
- Use or weigh up the information available to make the decision;
- Communicate their decision (whether by talking, using sign language or any other means).

If, even after all reasonable steps have been taken to empower the person the answer to any of these questions is no, it should be recorded that the person lacks capacity and the reasons why. This will be proof of the assessor's reasonable belief of incapacity at that time for that specific decision.

6.2.4 If a person is assessed as not having capacity to make a particular decision it should not be assumed that they do not have capacity to make any decisions.

Temporary Lack of Capacity

6.2.5 A person's capacity to understand may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication. However in such circumstances it should not be assumed that they do not have capacity to consent.

6.2.6 If the treatment decision can wait until capacity returns, then it should be delayed until that time.

6.2.7 If urgent treatment is required and the decision cannot wait then the person should be treated as is reasonably required in their best interests, pending the recovery of capacity.

Fluctuating Capacity

6.2.8 It is possible for capacity to fluctuate e.g. in the course of mental illness. In such cases it is good practice to establish, while the person has capacity, what their views are about any care or treatment that may become necessary and record their views. The person may wish to make an advance decision to refuse certain types of treatment. Further guidance on advance decisions and advance statements is available in the Trust's Advance Decisions to Refuse Treatment/Advance Statements Policy (October 2016).

Decisions that may seem Unreasonable or Irrational

6.2.9 Capacity should not be confused with a worker's assessment of the reasonableness of the person's decision. The person is entitled to make a decision which is based on their own religious belief or value system. Even if it is perceived by others that the decision is unwise or irrational, the person may still make that decision if they have capacity to do so.

6.2.10 Making a decision that others view as unwise does not necessarily mean that a person lacks capacity to make that decision. However, if the person repeatedly makes decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character, there might be a need for further investigation.

6.2.11 Some cases may not be that clear, and the person who would normally have capacity may refuse treatment because of a phobia. For example, the courts have held that a woman who required a caesarean to save her and her baby's life and refused anaesthetic because of a phobia of needles was suffering from a temporary lack of capacity brought about by panic and fear [Re MB (Adult, Medical Treatment) [1997] 38 BMLP 175 CA.

6.2.12 The person might refuse consent because they do not believe the advice that they are being given. In these cases the worker must make further enquiries as to why the person does not believe that advice. The person may be refusing treatment because they have a poor relationship with the worker and simply do not trust them, or the person may consider that the worker is not sufficiently senior to give the advice.

6.2.13 Care should be taken not to underestimate the capacity of a person with a learning disability or other cognitive impairment. Many people have the capacity to consent if time is spent explaining to the individual the issues in simple language, using visual aids and signing if necessary.

6.2.14 Further information about assessing the capacity of people generally can be found in the Mental Capacity Act 2005 Code of Practice 2007.

Has the Person Received Appropriate Information?

6.2.15 To give valid consent the person needs to understand in broad terms the nature and purpose of the decision to be made. They need to be informed about risks, benefits and alternatives. Where consent for ECT is being discussed, workers should refer to the Trust's ECT Operational Policy and Procedures.

6.2.16 The use of information leaflets is considered to be an effective tool that can be used by workers to provide people with the information they need to help them to arrive at an informed decision. People can review the information after the consultation, which may prompt the person to ask further questions of the worker to more fully understand the treatment being proposed. In this context, the use of information leaflets is considered by the Trust to be an example of best practice. The use of Easyread information in the leaflets which are specially written to assist people with learning disabilities and other cognitive impairments is also encouraged. If a person is given an information leaflet, a record of the name of the leaflet and version number should be kept in their notes. Copies of leaflets (including version numbers) used by services should be centrally archived within those services.

6.2.17 However, workers must not regard the use of information leaflets as providing the person with all of the necessary information for the purpose of obtaining consent for admission, examination or treatment. The obtaining of consent is a process, which involves effective communication and dialogue between the worker and the person, and merely providing a person with an information leaflet will not meet the workers' obligations. Any person carrying out a procedure on a person must ensure that, immediately before the procedure, the person has understood the information and that they still give their consent. If the person has queries or concerns they must be given time to consider any additional information.

6.2.18 Although informing people of the nature and purpose of procedures may be sufficient for the purposes of giving valid consent as far as any legal claim of battery is concerned, this is not sufficient to fulfil the legal duty of care to the person. Failure to provide other relevant information may render the professional liable to an action for negligence if a person subsequently suffers harm as a result of the treatment received.

6.2.19 In Montgomery v Lanarkshire Health Board (Scotland) [2015], the Supreme Court ruled that doctors are under a duty to inform service users of any "material" risks involved in proposed treatment or of reasonable alternatives. A risk is "material" if a reasonable person in the service user's position would be likely to attach significance to it or of the doctor was or should reasonably be aware that their service user would be likely to attach significance to it. Exceptions can be made when telling the person would cause them harm, but these exceptions are limited and should not be abused.

Communication

6.2.20 A person will not be deemed to lack capacity merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a person to communicate, whatever their condition. In some cases it may be because English is not the person's first language. Workers should take all steps which are reasonable in the circumstances to facilitate communication with the person, using interpreters or communication aids as appropriate and ensuring that the person feels at ease. In particular careful consideration should be given to the way in which information is explained or presented to the person. Where a family member or friend is used to communicate via a language other than English with the individual, it could place a burden on them to understand and interpret often complicated procedures. Using an interpreter helps to ensure that a person's wishes are properly communicated and removes the risk of undue influence by family and friends. Workers should contact Sheffield Community Access and Interpreting Service (SCAIS) to book an interpreter.

6.2.21 Where appropriate, those who know the person well, including their family, carers and staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the person.

Reluctance to Make a Decision

6.2.22 Some people may wish to know very little about the treatment which is being proposed and may ask that the health professional or other person should make decisions on their behalf. In such circumstances, the health professional should explain the importance of knowing about the treatment and try to encourage the person to make the decisions for themselves. However if the person still declines any information offered, it is essential to record this fact in the notes, and to ask the person to sign the record to confirm their decision. It is possible that people’s wishes may change over time, and it is important to provide opportunities for them to express this.

Attendance by Students and Trainees

6.2.23 Where a student or trainee health professional is undertaking examination or treatment of the person where the procedure will further the person’s care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the person that the health professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

6.2.24 In contrast, where a student proposes to conduct a physical examination which is not part of the person’s care, then it is essential to explain that the purpose of the examination is to further the student’s training and to seek consent for that to take place. Again, consent should be recorded in the person's notes.

6.2.25 A person's explicit consent should be obtained prior to any occasion when a student or trainee is going to be present during an examination or when treatment is to be given. People have the right to refuse consent for the student or trainee to be present in these circumstances without any detrimental effect on their treatment. Where it is proposed that a student or trainee will be present during or involved in examination using sedation or anaesthetic, consent should be obtained before the procedure.

Innovative Treatment

6.2.26 If the treatment being offered is of an experimental nature, but not actually part of a research trial, this fact must be clearly explained to people before their consent is sought, along with information about standard alternatives. It is good practice (where applicable) to give people information about the evidence to date of the effectiveness of the new treatment, both at national/international level and in the practitioner’s own experience, including information about known possible side-effects.

Is the Consent Given Voluntarily?

6.2.27 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 treatment. Such pressure can come from partners or family members as well as health or care workers. Workers 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.

6.2.28 When people are seen and treated in environments where involuntary detention may be an issue, such as prisons and hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the person makes a decision freely. Coercion should be distinguished from providing the person with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for the person's health. However, threats such as withdrawal of any privileges or leave from the ward or using such matters to induce the person to give consent are not acceptable. Consent that has been obtained in this way will be classed as fraud and will not be valid.

Who should Seek Consent?

6.2.29 The worker giving the treatment or carrying out the intervention is responsible for ensuring that the person has given valid consent before treatment begins. The GMC guidance states that the task of seeking consent may be delegated to another worker, as long as that professional is suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved in order to be able to provide information about the treatment or procedure to the person and discuss the risks. Inappropriate delegation (for example where the worker seeking consent has inadequate knowledge of the procedure) may mean that the "consent" obtained is not valid. Workers are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

When Should Consent Be Sought?

6.2.30 The seeking and giving of consent is usually a process, rather than a one-off event. Individuals with capacity must be given the opportunity to consent to admission to hospital (although this is not an absolute rule, especially if the reasons for admission is that the person presents a clear risk to themselves or to others because of their mental disorder).

It is good practice where possible for both major and minor interventions to seek the person's consent to the proposed procedure well in advance, when there is time to respond to the person's questions and provide adequate information. Workers should then check, before the procedure starts that the person still consents. If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity. In no circumstances should people be given routine pre-operative medication before being asked for their consent to proceed with the treatment.

Recording of Consent

6.2.31 The validity of consent does not depend on the form in which it is given and it can either be given in writing on a form or given verbally. Written consent merely serves as evidence of consent: the fact that a person has signed a consent form will not be valid consent if the person does not have capacity, has not been given adequate information or is under undue pressure or influence.

6.2.32 In all circumstances the worker should record the consent process that has been undertaken in the person's care plan/electronic record. Where the facility exists, they should 'tag' this information relating to consent/capacity in order to make it more easily identifiable via the professions.

6.2.33 Where there is a specific section within the electronic/paper record system, for recording consent/capacity then this should always be used.

6.2.34 Although completion of a consent form is in most cases not a legal requirement the use of such forms is good practice where an intervention such as surgery and the prescribing of neuroleptic medication is to be undertaken. Where there is any doubt about the person's capacity, it is important, before the person is asked to sign the form, to establish both that they have the capacity to consent to the intervention and that they have received enough information to enable valid consent to be given. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

6.2.35 Whilst obtaining the person's written consent is considered to be good practice in particular situations, for many procedures, particularly in a primary care setting or within a person's home, verbal consent will be adequate. However it is good practice for it to be given expressly by the person rather than implied through their actions.

6.2.36 If the person has capacity, but is unable to sign their name, the person may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes. If consent has been validly given, the lack of a completed form is no bar to treatment. If the person gives their consent in other forms than written form, this must be documented by the worker involved.

Duration of Consent

6.2.37 When a person gives valid consent to an intervention, in general that consent remains valid for an indefinite duration unless it is withdrawn by the person. However, if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken, the GMC guidance states that a doctor or member of the healthcare team should inform the person and reconfirm their consent. The worker should consider whether the new information should be drawn to the attention of the person and the process of seeking consent repeated on the basis of this information. Similarly, if the person's condition has changed significantly in the intervening time, it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention may also have changed.

6.2.38 If consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent (assuming they retain capacity) still wishes the intervention to proceed even if no new information needs to be provided or further questions answered. If it is thought that the person may have lost capacity in the intervening period then the provisions of the Mental Capacity Act (2005) should be followed.

6.2.39 If treatment is of an ongoing nature (for example, Psychological therapy), then consideration should be given to the frequency with which the issue of consent is revisited. This will vary from person to person and situation to situation. For example, for some people with learning disabilities, it may be necessary to revisit the issue at every appointment.

6.3 People Refusing Treatment

6.3.1 If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment this decision must be respected, (except where a statutory exception applies such as the Mental Health Act 1983 (amended 2007) (see below)) and any attempt to treat that person against their wishes could amount to criminal offence. It is the right of an adult person with capacity to refuse treatment even if that refusal might result in the death of the person. However in cases of doubt or where refusal leads to serious consequences for the person, workers should always refer the matter to their legal advisers who may advise that a declaration from the court should be sought.

6.3.2 Whilst a person has the right to refuse treatment this does not mean that they have the right to insist on a particular course of treatment (see Mr Leslie Burke v GMC [2005] EWCA Civ 1003).

Treatment given under the Mental Health Act 1983 (amended 2007)

6.3.3 Where a person is capable of giving consent and refuses, that person may only be given medical treatment if it is for a mental disorder and the health professional has legal authority in accordance with the Mental Health Act to give that treatment. Treatment for a mental disorder means any treatment the purpose of which is to cure or alleviate the effects of the disorder itself. However the courts have extended the scope to include “a range of acts ancillary to the core treatment”. Part IV of the Mental Health Act 1983 provides express power to treat certain service user’s for their mental disorder whether or not they are consenting to it.

Treatment without consent under the Mental Health Act

To give time to develop a treatment programme suitable for the service user’s needs, the MHA allows treatment to be given without consent in the initial three months period starting the day on which any form of medication for mental disorder was first administered to the service user during the current period in which the service user is liable to be detained under the MHA. During this time the service user’s consent should still be sought before any medication is administered wherever practicable. The service user’s consent, refusal to consent, or lack of capacity to consent should be recorded in the notes. If a person has capacity to consent but refuses or withdraws consent during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment. For more detailed information please refer to:
Appendix G - Flowchart of Consent Procedure relating to the Mental Health Act and
Appendix H – Flowchart of Capacity Assessment under the Mental Health Act

Clinicians authorising or administering treatment without consent under the MHA are performing a function of a public nature and must therefore comply with the Human Rights Act 1998.

Once the Mental Health Act is in use to authorise the person's treatment, consideration does not need to be given to the provisions of the Mental Capacity Act. The person lacking capacity can be treated for their mental disorder without consideration needing to be given to the provisions of the Mental Capacity Act. However, where treatment is necessary for a physical condition unrelated to their mental disorder, then the provisions of the Mental Capacity Act will still apply.

6.3.4 Treatment of an adult person who is detained under the Mental Health Act for an unconnected ailment or condition will require consent if that person is deemed to have capacity. In the case of Re: C (Adult: Refusal of Treatment) a person diagnosed as a chronic paranoid schizophrenic refused consent to the amputation of his gangrenous leg. The Court held that the person had capacity to understand the nature, purpose and effects of the treatment advised, and consequently his right of self-determination had not been displaced even though he was a person detained under the Mental Health Act. In this case the Court found that the treatment for the person's leg was unrelated to this mental disorder. However, in this case, if the cause of gangrene had been as a result of the person inflicting injury to his leg because of his mental disorder, then it is likely that any treatment would be considered as treatment for a symptom of the disorder. Therefore, workers should exercise extreme caution in such cases and seek legal advice.

6.3.5 Further information about consent and the Mental Health Act 1983 is in the Mental Health Act Code of Practice (2015).

Other Exceptions

6.3.6 The Public Health (Control of Disease) Act 1984 (as amended by the Health and Social Care Act 2008) provides that, subject to an order made by a magistrate, people suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in a hospital without their consent.

Medical Treatment and an Unborn Child

If an adult person with capacity is pregnant and refuses treatment, the courts have made it clear that even if refusal of treatment amounts to adverse consequences for the foetus, workers cannot intervene. Medical intervention can only be taken if it is believed that the person lacks capacity to consent (see the Mental Capacity Act, 2005). However where a refusal leads to serious consequences for the person or her unborn child and/or there is any doubt as to her capacity, then legal advice should be obtained.

Withdrawal of Consent

6.3.7 A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the health 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 professional to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at immediate risk, and the health professional believes that the person is unable to understand the implications of their objection, this may be because the person temporarily lacks capacity as a result of the pain. In this case the health professional may continue until the risk no longer applies but only while the person lacks capacity and providing they are acting in the best interests of the person.

6.3.8 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 professional should try to establish whether at that time the person has capacity to withdraw consent previously given. If capacity is lacking, it may sometimes be justified to continue in the person's best interests (see the Mental Capacity Act Code of Practice 2007), although this should not be used as an excuse to ignore distress.

Advance Statements

6.3.9 A person with capacity may make a statement setting out their wishes concerning their future health care in the event that they no longer have capacity and are unable to express their wishes for themselves (they may do this, for example, through a Solicitor or as a stipulation when a Lasting Power of Attorney is being set up). There are various different types of statements sometimes referred to as "living wills" or "advance directives". A person may make an advance decision in accordance with the Mental Capacity Act to refuse a particular type of treatment, or may make a general statement about their treatment or course of action to be taken.

Advance Decisions to Refuse Treatment

6.3.10 A person who is 18 or over and has capacity may make an advance decision to refuse treatment to take effect at a time when they no longer have capacity. Any advance decision that complies with the Mental Capacity Act 2005 and is valid and applicable to the treatment that is proposed, has the same effect as if that person has capacity and is contemporaneously refusing consent to treatment. In other words, if a person has made a valid and applicable advance decision and has the right to refuse the treatment when they make that advance decision, they will have the same right when they no longer have capacity unless a statutory exception applies. A worker who knowingly treats a person where there is an advance decision could be acting unlawfully and liable to a claim of battery. This type of advance decision is only valid if it is to refuse treatment.

6.3.11 A valid and applicable advance decision:

- must clearly specify the type of treatment that is being refused although this can be expressed in layman's terms;
- may be withdrawn or altered at any time whilst the person has capacity;
- may be overridden by the decision of a lasting power of attorney who is appointed after the advance decision has been made. This only applies where authority has been conferred on that done to give or refuse consent to the type of treatment that is specified in the decision;
- will not be valid if the person has done anything that might be perceived as acting inconsistently with that decision, or there are reasonable grounds for believing that there are circumstances that had the person known about they would not have made the decision. For example there may be a medical

advancement of which a person was unaware of at the time they made the advance decision, which could significantly improve that person's condition;

- if it relates to life-sustaining treatment, will not be applicable unless the person has made a written statement which has been signed (someone else may write and sign if the person cannot write) and witnessed that the decision is to apply even if the person's life is at risk. For example, in some situations antibiotics may be life-sustaining, but in others they can be used to treat conditions that do not threaten life.

6.3.12 A health professional will not be acting unlawfully if they treat a person and are genuinely unaware of the existence of an advance decision. Conversely they will not act unlawfully if they act in accordance with an advance decision that they believe is valid and applicable at the time but is later proved to be invalid. If there is any doubt about the validity or applicability of an advance decision and it is necessary to refer the matter to the Court, then workers may provide life-sustaining treatment or treatment that prevents serious deterioration in the person's condition whilst the decision of the Court is awaited.

6.3.13 If a person has made a valid and applicable advance decision to refuse treatment but that treatment is for a mental disorder, a health professional may still give that treatment to the person if they have authority to do so under the Mental Health Act 1983 (as amended 2007) and consent is not required. However clinicians should, where practicable, try to comply with the person's wishes as expressed in the advance decision. Except where the Mental Health Act means that they need not, clinicians must follow all other advance decisions made by their service users which they are satisfied are valid and applicable. By definition this includes all valid and applicable advance decisions to refuse treatment which is not for mental disorder.

6.3.14 Further information about advance decisions is available in the Mental Capacity Act Code of Practice.

Other Types of Advance Statements

6.3.15 If an advance statement has been made that is not valid and applicable under the Mental Capacity Act 2005, this does not mean that the statement can be ignored. It should at least be noted as an expression of the person's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

6.3.16 As well as an advance statement to refuse treatment, some statements will express the person's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. A health professional is not under a legal obligation to provide treatment because the person demands it. The decision to treat is ultimately a matter for his or her professional judgement acting in the interests of the person. In making that decision the health professional will, however, be required to take into account the person's wishes as expressed in determining what is in his or her best interests.

Self Harm and Attempted Suicide

6.3.17 Cases of self harm present a particular difficulty for workers but the same law and guidance, as set out above, applies to treatment of these cases. Where the person is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

6.3.18 If the person is judged not to have capacity, they may be treated in accordance with the Mental Capacity Act 2005. If a person has attempted suicide and is unconscious, they should be given emergency treatment unless the health professional is aware of any valid and applicable advance decision to refuse life-sustaining treatment in these circumstances.

6.3.19 As noted above, unless one of the statutory exceptions apply, adults with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the health professional believes that the person's decision is unwise or irrational. If a person with capacity has harmed themselves and refuses treatment, a psychiatric assessment should be obtained. Unless the adult person with capacity is detained under the Mental Health Act 1983 (amended 2007) and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although clearly attempts should be made to encourage them to accept help and workers should consult legal advisers.

6.4. Adults without Capacity

General Principles

6.4.1 Where an adult person lacks capacity to give his or her consent to treatment, no one can give consent for that person unless they have authority under a Lasting Power of Attorney or have been authorised to make treatment decisions as a deputy appointed by the Court. However, decisions still need to be made about the person's care and treatment. The Mental Capacity Act 2005 ("the Act") has provided a statutory basis on which treatment may be given to people who are 16 years or above and lack capacity, and sets out general principles which must be applied. These principles are as follows:

- a person must be assumed to have capacity unless it is established that they lack capacity;
- a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success;
- a person is not to be treated as unable to make a decision merely because they make an unwise decision;
- 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 or her best interests;
- before the act is done, or the decision is made, regard must be had to whether the purpose of which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.4.2 The Act sets out the circumstances in which decisions may be made on behalf of a person and makes it an offence to ill-treat or neglect them. Detailed guidance is provided in the Mental Capacity Act Code of Practice (2007) and any person engaged in the care and treatment of an adult who lacks capacity must have regard to this Code.

6.4.3 The Act provides that any treatment of an adult who lacks capacity will be lawful, provided that the worker reasonably believes that the person lacks capacity to make a decision in relation to the matter, and the treatment proposed is in the person's best interests.

Best Interests

6.4.4 In determining what is in the person's best interests, the worker must look at the person's circumstances as a whole and not just at what is in the person's best medical interests. They must try to ascertain what the person would have wanted if they had capacity, rather than what that worker believes to be in his or her best interests. The worker must consider the person's past and present wishes and feelings, the beliefs and values that would be likely to influence the person's decision if they had capacity, and must take account of any other factors that the person might think relevant.

6.4.5 They must also, so far as is practicable and appropriate, take account of the views of any of the following people:

- Person who is named by the person as a person who should be consulted on such matters;
- The person's carers or any other person interested in his or her welfare;
- The person who has been granted a Lasting Power of Attorney by the person; and
- Any deputy appointed for the person by the Court.

6.4.6 Where a person has made a Lasting Power of Attorney or a deputy of the Court has been appointed then, if it is within their authority, it may be for the attorney or deputy to make the decision on the person's behalf. However, they too must act in the person's best interests and, where practicable and appropriate, all of the above named people must still be consulted.

6.4.7 Lack of capacity will not automatically mean that the person is unable to participate in the decision making process, and every assistance should be given to enable them to do so.

6.4.8 If a person has no one who may be consulted then workers must consider whether the circumstances are such that an advocate or Independent Mental Capacity Advocate (IMCA) should be instructed.

6.4.9 Where a person has made an advance statement then this will be relevant in deciding what is in the person's interests. If it is a valid and applicable advance decision made under the Mental Capacity Act (2005), then the question of what is in the person's best interests is irrelevant and the person's refusal of treatment is binding on the health professional unless treatment may be provided under a statutory exception. If the person has made an advance statement that is not valid and applicable in accordance with the Act, then the health professional should still take that statement into account in deciding what is in the person's interests. However, if it is the health professional's clinical judgement that to act in accordance with the advance statement would not be appropriate and not in the person's best interests, they are not bound where the advance statement is not a valid and applicable advance decision.

Temporary Incapacity

6.4.10 Where a service user lacks capacity it is important to establish whether or not they may regain capacity, for example where they are under sedation, suffering from an infection and with time or treatment they may well regain the capacity to consent to a procedure or make a decision. If the treatment or decision can be delayed then it should be in order for the service user to give valid consent or make the decision for themselves.

Where the treatment is an emergency which is defined as "to save a life or prevent a serious deterioration of a service user's condition" staff will be protected under common law and the doctrine of necessity if treatment is undertaken unless there is a valid and applicable advance decision in respect of the proposed treatment. The Department of Health does not consider a state of unconsciousness alone as a mental disorder, therefore it may not fit Stage one of the capacity test as it may be difficult to establish the service users capacity."

Fluctuating Capacity

6.4.11 It is possible for capacity to fluctuate. In such cases, it is good practice to establish whilst the person has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The person may wish to make an advance decision to refuse certain types of treatment. If the person does not make any relevant advance decision, the person's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated.

Lasting Power of Attorney

6.4.12 The Mental Capacity Act introduced a new form of power of attorney called a lasting power of attorney (LPA). An LPA may be executed by any person of 18 or over whilst they have capacity and takes effect when they no longer have capacity. An LPA may appoint a person as an attorney to make personal decisions about a person's welfare and medical treatment. An LPA that meets the various legal requirements and is registered with the Office of the Public Guardian may give the attorney power to refuse or consent to any treatment being proposed.

An LPA does not, however, authorise an attorney to refuse or give consent to life-sustaining treatment unless this is specifically expressed in the instrument that creates the LPA. An Attorney cannot consent on the service user's behalf to treatment which is regulated by part IV Mental Health Act. If two or more people have been appointed as attorneys, then they may either be appointed to act jointly or jointly and severally. If they are acting jointly then any decision must be by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other. If it is not clear how the attorneys have been appointed, then it is assumed that they are appointed to act jointly.

6.4.13 If the person has made a valid and applicable advance decision to refuse treatment, then this can be overridden by an attorney providing that his or her authority extends to making decisions about treatment that is the subject of the advance decision and providing that the advance decision was made before they were granted Power of Attorney. An attorney, like any person who is making a decision on behalf of a person who lacks capacity, must act in accordance with the Act and must have regard to the Code of Practice.

6.4.14 When acting on the basis of a decision by an attorney, a worker should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a worker and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the person, should be referred to the Court of Protection.

Court Appointed Deputies

6.4.15 Whilst the decision made by the Court is always preferred the Mental Capacity Act now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the person. Deputies will normally be family, partners, friends or people who are well known to the person.

6.4.16 As with attorneys appointed under a Lasting Power of Attorney, deputies may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the Act. Deputies are also subject to a number of restrictions in the exercising of their powers. For example, a deputy cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the person, nor can they direct a person responsible for the person's healthcare to allow a different person to take over that responsibility. As with LPA appointed attorneys, court appointed Deputies cannot consent to treatment which is regulated by part IV of the Mental Health Act. A deputy cannot restrict a named person from having access to the person.

6.4.17 Workers should co-operate with deputies with the aim of doing what is best for the person. Where a deputy acting within their authority makes a decision that the person should not receive a treatment that is not life-sustaining or requires that a treatment that is not life-sustaining should be discontinued, that professional must act in accordance those instructions. However a deputy cannot require a health professional to give a particular type of treatment, as this is a matter for his or her clinical judgement. In such cases where a health professional has declined to give treatment, then it is good practice to seek a second opinion, although the deputy cannot insist that the health professional steps aside to allow another professional to take over the case. Deputies are supervised by the Office of the Public Guardian, and where a health professional suspects that a deputy is not acting in the interests of the person, they should refer the matter to the Public Guardian.

Independent Mental Capacity Advocates

6.4.18 If a person who lacks capacity is to receive serious medical treatment, or arrangements are to be made about their accommodation but that person has no family or friends to represent and support them. Then (unless a decision has to be made urgently) an Independent Mental Capacity Advocate ("IMCA") must be instructed. The duty to instruct rests with the organisation proposing to make the decision.

6.4.19 The role of the IMCA is to represent and support the person. They will not make decisions on the person's behalf and such decisions will still be decided by the professional or hospital managers on the basis of what is in the person's best interests. However the IMCA will speak to the person and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the person's best interests and the health professional must take into account the views of the IMCA in deciding what actions to take. They are entitled to information about the person and to see his or her relevant health records. Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

6.4.20 Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- Where there is a fine balance between the benefits and burdens the treatment would have on the person and taking into account the likely risks;
- Where there is a choice of treatments, a decision as to which one to use is finely balanced; or
- What is proposed would be likely to involve serious consequences for the person.

Referral to the Court of Protection

6.4.21 Where there are difficult or complex decisions to make on behalf of a person who lacks capacity, the matter can be referred to the Court of Protection.

6.4.22 Workers are most likely to involve the Court of Protection where there is a dispute about a person's capacity to make a decision about a particular type of medical treatment, or whether a person had capacity when an advance decisions or Lasting Power of Attorney was made. The Court can also make declarations about the lawfulness of a particular course of action such as withdrawing or withholding medical treatment. It can make orders about a person's welfare or property and affairs. As with any other person who makes a decision on behalf of the person, the Court will act in the person's best interests.

6.4.23 Where a person lacks capacity then a referral to the Court should always be made in the following circumstances:

- Where it is proposed that the person should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes);
- To withdraw nutrition and hydration from a person in a persistent vegetative state (PVS);
- There are doubts or is a dispute about whether a particular treatment would be in the best interests of the person.

6.4.24 This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. In other circumstances it may be necessary to refer a matter to the Court where:

- There is a dispute between workers, members of the family, partners, carers or any other interested people such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the person's best interests;
- There is doubt about whether the person lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term;
- Treatment of an experimental nature is proposed.

6.4.25 The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral, although such procedures can give rise to special concern about the best interests and rights of a person who lacks capacity. In the case of a woman with learning disabilities, it is good practice to involve a Consultant in Psychiatry of Learning Disability, the multidisciplinary team and the person's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

6.4.26 A health professional who is faced with a situation that may require intervention of the Court of Protection should immediately contact legal advisers (please see the Trust's Legal Advice Policy and any relevant professional guidance for further information).

Restraint of an Incapacitated Person

6.4.27 In some cases, a person who lacks capacity may resist treatment and the health professional may need to restrain that person to carry out the assessment or administer the treatment. The Mental Capacity Act 2005 provides that a person may lawfully restrain a person who lacks capacity, providing that person believes it is reasonably necessary to prevent harm to the person, and it is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm. In this context, restraint means:

- Using, or threatening to use, force to secure the doing of an act which the person resists; or
- Restricting the person's liberty of movement, whether or not the person resists.

6.4.28 Workers should only use restraint where absolutely necessary and should consider the least restrictive means of administering care or treatment.

Deprivation of Liberty

6.4.29 If the restrictions placed upon a person lacking capacity to consent to be in the setting in which they are accommodated amount to depriving them of their liberty, then appropriate legal authorisation must be sought. This will be via the Deprivation of Liberty Safeguards for hospitals and registered care homes and via the Court of Protection for people in other settings.

6.4.30 The 'acid test' to determine whether a person is deprived of their liberty is –

- They are under continuous supervision and control AND
- They are not free to leave

If the person is required to be deprived of their liberty for the purposes of assessment or treatment of their mental disorder, then the Mental Health Act should be used.

Clinical Trials

6.4.31 A clinical trial is not research for the purposes of the Mental Capacity Act and in such cases the trial should be carried out in accordance with the Medicines for Human Use (Clinical Trials) Regulations 2004 and other regulations relating to clinical trial that may from time to time be in effect.

Withdrawing and Withholding Life-prolonging Treatment

6.4.32 The Mental Capacity Act applies equally to withdrawing and withholding life-prolonging treatment as it applies to any other medical intervention in respect of an adult person who lacks capacity. However, the gravity and sensitivity of these decisions are such that the assessment of capacity and of best interests is particularly important. A decision to give or withdraw treatment is ultimately a decision for the health professional and they must decide what is in the person's best interests. However, in reaching that decision, if it is practical to do so, they must consult the person's relatives, partner, friends, carers or other professionals involved in the person's care or treatment. It may not always be possible to consult all of these people, particularly if an urgent decision needs to be made – for example a decision about whether it is appropriate to attempt resuscitation after severe trauma. In situations where Do Not Attempt Resuscitation notices are being considered, workers should consult the Trust's Resuscitation Policy.

6.4.33 Legally, the use of artificial nutrition and hydration (ANH) constitutes medical treatment. Thus the legal principles which apply to the use of ANH are the same as those which apply to all other medical treatments such as medication or ventilation. The British Medical Association has suggested: that extra safeguards should be followed before a decision to withhold or withdraw ANH is made; that a senior clinician not otherwise involved in the person's care should formally review the case; that details of cases where ANH has been withdrawn should later be made available for clinical audit; and, where the person is in PVS or a state closely resembling PVS, that legal advice should be sought. Further, Mental Capacity Act Code of Practice (2007) states that it is good practice for court approval to be sought before ANH is withdrawn from people in PVS.

6.4.34 It is for the clinician to decide what treatment options are clinically indicated, and they will discuss with the person the benefits and risks of each treatment. It is for the person to decide whether they wish to accept any of those treatments and a competent person has an absolute right to refuse any treatment. However, if a person refuses all treatment options offered to them and decides they want an alternative form of treatment but the clinician considers that the treatment is not clinically indicated, then the clinician has no duty to provide that treatment. The clinician must however offer the person a second opinion.

6.4.35 There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the person or is not in the person's best interests, and taking a deliberate action to end the person's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a person's best interests.

6.4.36 "Best interests" is a concept which only applies to the living. The courts of England and Wales have recognised what were originally referred to as the "brain death criteria" as part of the law for the purposes of diagnosing death. The criteria are more accurately described as "brain stem death criteria". Updated guidance on the diagnosis of brain stem death is available – Academy of the Medical Royal Colleges – A Code of practice for the diagnosis and confirmation of death. (2008).

6.4.37 When the diagnosis of brain stem death has been confirmed, all clinical interventions can be withdrawn. If, subject to the requirements of the Human Tissue Act 2004, the deceased person will become an organ donor, medical interventions to facilitate donation, such as maintaining electrolyte balance, may be continued.

6.4.38 If a person is expected to die shortly but brain stem death has not been established, the Department of Health has issued national guidance based on legal advice that artificial ventilation with the sole aim of preserving organ function is unlawful. The purpose of artificial ventilation in these circumstances would not be to benefit the person and may run the risk of causing serious harm. It is therefore not in the best interests of the person.

6.5 Children and Young People

This section sets out the legal position concerning consent and refusal of treatment by those under the age of 18. As in the case for adults, valid consent will normally be required before any treatment can lawfully be given to a child. Consent may be given by a competent child, by any person who has parental responsibility for the child or by the court. A ‘child’ is defined in the Children Act 1989 as any person who is under the age of 18 although children who are 16 or 17 are often referred to as ‘young people’, The legal position for young people of 16 or 17 is different to that of other children. Refer to Chapter 19 of the Mental Health Act Code of Practice 2015 which describes in detail the concept of scope of parental responsibility.

Young People aged 16 or 17

6.5.1 Section 8 of the Family Law Reform Act 1969 provides that people aged 16 or 17 may give consent to any surgical, medical or dental treatment. ‘Treatment’ for the purposes of section 8 will include any procedure undertaken for the purposes of diagnosis or which is ancillary to the treatment such as an anaesthetic. Section 8 does not apply to interventions that do not confer a direct health benefit on the young person such as the donation of organs, blood or other bodily substances (other than for diagnostic purposes).

6.5.2 As in the case for adults, consent will be valid only if it is given voluntarily by an appropriately informed person who has capacity to consent to the particular treatment. The mental capacity of the person should be assessed in accordance with the Mental Capacity Act and if that person has capacity their informed consent should be obtained, additional consent by a person with parental responsibility is not required. However unlike adults, the refusal by a competent child or your person with capacity under the age of 18 may in certain circumstances be overridden by a court. If that person lacks capacity then the health professional must act in the best interests of the person. Whilst the treatment should not be carried out on the basis of parental consent alone, the views of the person with parental responsibility will be important in determining whether the treatment would be in the person’s best interests.

6.5.3 If a young person with capacity has given valid consent, it is good practice to encourage that person to involve his or her family in the decision-making process, unless it is not appropriate to do so.

6.5.4 Where a young person who has capacity is to be admitted to hospital for treatment for a mental disorder, provisions in the Mental Health Act 1983 provide that where that person consents or refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that consent or refusal.

When assessing a young person’s capacity to make the decision in question practitioners should be aware that in some cases a young person may be unable to make a decision for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain (even if that is only temporary). For example when the decision is “overwhelming” e.g. starting antipsychotic medication for early onset psychosis. The young person might understand, retain...etc but find the decision too complex. In such cases the person will not lack capacity within the meaning of the MCA.

It is important that practitioners are aware of the distinction between those cases that fall within the MCA and those that do not. If it is not clear whether the young persons inability to decide is due to an ‘impairment of, or a disturbance in the functioning of, the mind or brain, or whether due to some other reason, a specialist opinion should be sought from a professional with expertise in working with children and young people.

Competent Children under 16

6.5.5 The case of Gillick determined that children, who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention, will have the capacity to give their consent to that intervention. Determining whether a child is competent is a question of fact for the court. The courts will consider whether the child is able to reach a mature and balanced judgement, and has sufficient discretion to enable them to exercise a wise choice in their own interests. The courts will take into account the child’s chronological, mental and emotional age and intellectual development and maturity. A child must not just be able to understand the nature of the advice which is being given, but must also have a sufficient maturity to understand what is involved in the proposed treatment.

6.5.6 The concept of Gillick competence is said to reflect the child’s increasing development to maturity. In some cases, for example because of a mental disorder, a child’s mental state may fluctuate significantly so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given to whether the child is truly Gillick competent at any time to take this decision.

6.5.7 If the child is Gillick 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, such as long-term use of contraception, 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. If a child cannot be persuaded to inform his or her parents, or it is not in the child’s interest to inform them, then every effort must be made to help the child find another adult (such as another family member or a specialist youth worker) to provide support.

The Requirement of Voluntariness

6.5.8 Although a child or young person may be competent to give consent, valid consent must be given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parents, other carers, or a potential sexual partner, and it is important to establish that the decision is that of the individual themselves.

Child or Young Person with Capacity Refusing Treatment

6.5.9 Where either a young person of 16 or 17 with capacity or a Gillick competent child under 16 refuses treatment and by doing so this may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection. Parents of a young person may consent but it is usually thought of as good practice to take it through the Court of Protection.

6.5.10 A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible or the people with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that 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.

Children Without Capacity

6.5.11 Where a young person of 16 or 17 lacks capacity then they are treated the same as an adult who lacks capacity and any decision must be taken in accordance with the Mental Capacity Act (2005). The Act requires that in making decisions any person who has an interest in the welfare of that person must be consulted and their views taken into account. In the case of a young person this is likely to be the parents or any other person with parental responsibility.

6.5.12 Where a child who is under the age of 16 is not competent to give consent, consent can be given on their behalf by any one person with parental responsibility or by the Court. As is the case where people are giving consent for themselves, those giving consent on behalf of a child must have the capacity to consent to the intervention in question, be acting voluntarily, and be appropriately informed. In the case of a child who is under the age of 16, the power to consent must be exercised according to the “welfare principle“: that the child’s “welfare” or “best interests” must be paramount.

6.5.13 Even where a child does not have competency to consent on their own behalf, if possible it is good practice to involve the child as much as possible in the decision-making process. If a child has been competent but then loses competence, then any views they may have had while they had competence should be taken into account in making any decision about treatment.

6.5.14 Where necessary the courts can, as with competent children, over-rule a refusal by a person with parental responsibility. In some circumstances it may be appropriate to refer important decisions to the Court, even if those with parental responsibility consent to a particular intervention.

Parental Consent

6.5.15 The Children Act 1989 defines “parental responsibility” as “all the rights, duties, powers, responsibilities and authority which by law a parent has in relation to the child and his property.” This includes the right to consent or refuse to medical treatment on behalf of the child but this is not an absolute right and any power must be exercised for the benefit of and protection of the child. A person with parental responsibility must always act in the best interests and welfare of the child. In some cases even where parental consent has been given the decision may still need to be sanctioned by the Court.

6.5.16 The Children Act 1989 sets out people who may have parental responsibility. These include:

- The child’s mother;
- The child’s father if he was married to the mother at the time of the birth.

6.5.17 Where the father is not married to the mother at the time of the birth he can acquire parental responsibility:

- In the case of a child born before 1 December 2003 if he marries the mother of their child or has a parental responsibility order;
- In the case of a child born after 1 December 2003 he is registered on the birth certificate as the child's father, he marries the mother or has a parental responsibility order from the court.

6.5.18 People other than the mother and father who may have parental responsibility are:

- The child's legally appointed guardian;
- A person in whose favour the court has made a residence order concerning the child;
- A Local Authority designated in a care order in respect of the child;
- A Local Authority or other authorised person who holds an emergency protection order in respect of the child.

6.5.19 In some cases a person may not have parental responsibility for the child but may, for the time being, be responsible for their care. For example a person might be a childminder or the member of staff of a boarding school having regular care of the child. That person may consent to medical treatment on behalf of the child if it is reasonable to act without first obtaining the consent of the person with parental responsibility, for example, where the treatment is urgently required or is trivial.

6.5.20 Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent. However, the courts have stated that a "small group of important decisions" should not be taken by one person with parental responsibility against the wishes of another, citing in particular non-therapeutic male circumcision. This category has now been extended to cover cases that have been described as "hotly contested issues of immunisation". Where people with parental responsibility disagree as to whether non-therapeutic procedures are in the child's best interests, it is advisable to refer the decision to the courts. It is possible that major experimental treatment, where opinion is divided as to the benefits it may bring the child, might also fall into this category of important decisions. A health professional should not rely on the consent of a parent if they have any doubts about whether the parent is acting in the interests of child.

6.5.21 In order to consent on behalf of a child, the person with parental responsibility must have capacity. Where the parent of a child is under 16, they will only be able to give valid consent for the child's treatment if they would have been Gillick competent to consent if they themselves were being given the treatment.

6.5.22 Where a child is a ward of court, no important step may be taken in the life of the ward without the prior consent of the court. This is likely to include more significant medical interventions but not treatment for minor injuries or common diseases of childhood.

6.5.23 In an emergency, it is justifiable to treat a child who lacks capacity without the consent of a person with parental responsibility, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child. Where abuse or neglect is suspected then workers should act in accordance with guidance in Working Together to Safeguard Children (2013).

Person with Parental Responsibility Refusing Consent

6.5.24 As in the case for adults the decision to give medical treatment to a child without capacity is ultimately a decision for the health professional based upon their clinical judgement. However in such circumstances the Court has held that the views of the parents should be “accorded profound respect and given weight although their views cannot be decisive”.

6.5.25 In the event of a disagreement about treatment between people with parental responsibility and the workers and this cannot be resolved; the Court should be involved unless it is an emergency situation. The decision by the European Court of Human Rights in the case of Glass v. United Kingdom made clear that the failure to refer such cases to the Court is potentially a breach of the Human Rights Act. All NHS Trusts should have procedures for dealing with such circumstances.

6.5.26 Although there is no directly relevant case law on the issue of children participating in research that involves experimental or innovative treatment, the court has considered this in the relation to incompetent adults. In Simms v Simms the court was prepared to sanction the treatment providing certain criteria were satisfied, and it is helpful for workers to consider these criteria when contemplating such treatment on a child. These are that:

- The person did not have the mental capacity to make the decision about the treatment his or herself;
- The treatment proposed came within the Bolam test in that a reasonable body of medical opinion would support the treatment within the United Kingdom;
- It was in the best interests of the person that the treatment should be given; and
- The treatment proposed was capable of being carried out within the NHS.

Vaccination and Immunisation

6.5.27 Advice on gaining consent for the immunisation and vaccination of children is given in the 'Green Book' published by the Department of Health.

6.5.28 Immunisation practitioners and workers are advised not to accept the action of attendance at the clinic as reconfirmation of consent for the immunisation to be given. Reconfirmation of consent should be sought verbally.

Using children lacking capacity as bone marrow donors.

6.5.29 Donation of bone marrow can be painful and carries some significant risks. Normally it will not be appropriate for a child lacking capacity to be a bone marrow donor. However in some cases their bone marrow may be a match and will assist in the treatment of a sibling. Any decision of this nature should still be justified in the best interests and welfare of the child. However the Court has held that by prolonging the life of a sibling a person would receive emotional, psychological and social benefit. However, the Court also considered the particular circumstances under which the intervention would take place and came to the view that it would be of minimal detriment to the person compared with the benefits she would receive.

6.5.30 Under the Human Tissue Act 2004, the donation of bone marrow by any child who lacks competence requires prior approval from the Human Tissue Authority having first been assessed by an Accredited Assessor.

Children and Confidentiality

6.5.31 If a child is competent to consent to treatment then the clinician will owe the same duty of confidence to the child as they would to an adult and that child's confidence must be respected. However, where a parent wishes to overrule a competent child's refusal, then in order to make such a decision, they must inevitably be provided with sufficient information about their child's condition, which the child may not be willing for them to receive. If a clinician gives information to the parent in these circumstances, then this may constitute a breach of confidence by the clinician. However, such a breach of confidence may be justified if it is in the child's best interests particularly if the treatment proposed is for a life threatening condition. Article 16 of the United Nations Convention on the Rights of the Child 1989, which states that no child shall be subjected to arbitrary or unlawful interference with his or her privacy.

6.5.32 If a child does not have capacity to give consent to treatment, then the clinician may share the information with a person who has parental responsibility if it is in the interests of the child to do so. However the privacy of the child must still be respected.

7. Dissemination, Storage and Archiving

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Managers are responsible for ensuring the hard copies of the previous versions are removed from any policy/procedure manual or files stored locally.

A copy of the policy will also be issued to the employment agencies with which the Trust recruits agency workers.

8. Training and Other Resource Implications for this Policy

As a Trust policy, the Trust will ensure that there is an annual programme of learning events in which Consent is incorporated e.g. Trust Induction, Mental Capacity Act Level 2 Mandatory Training.

9. Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Timescale/ Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Directorates to be assured that policy is being followed in their service	Audit: application of policy and training compliance	Service/Clinical Directors	Annual	MCA/DoLS Steering Group	MCA/DoLS Steering Group	Executive Directors Group

10. Implementation Plan

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
Managers are responsible for ensuring the hard copies of the previous versions are removed from any policy/procedure manual or files stored locally.	*Trust Managers*	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to Other Policies, Standards and Legislation

This policy should be read in conjunction with the following Trust policies and guidance:

- Advance Decisions to Refuse Treatment/Advance Statements Policy
- CPA (Care Programme Approach) policies and procedures Aug 2008
- Prevention and Management of the use of Restraint Framework for Good Practise July 2015
- ECT (Electro Convulsive Therapy) January 2014
- Mental Health Act 1983:Code of Practise 2015
- The Royal Marsden Manuel of Clinical Procedures May 2015
- Caldecott Review: Information Governance in the Health and Care system
- Transition of Young People from CAMHS to Adult Health Services Protocol

The guidance reflects the Trust's commitment to promoting equality of opportunity for all, whatever their race, language, religion or other belief system, disability, age gender and sexual orientation, to ensure that every citizen has the opportunity to make informed choices regarding their health care.

12. Contact Details

Title	***Name***	***Phone***	***Email***
Clinical Psychologist	Zara Clarke	0114 2261562	Zara.Clarke@shsc.nhs.uk
Service Director (on behalf of the MCA/DoLS Steering Group)	Anita Winter	0114 2716741	Anita.Winter@shsc.nhs.uk

13. References

- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Mental Capacity Act 2005: Deprivation of liberty safeguards- Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice (2008). Ministry of Justice
- Mental Health Act 1983 [as amended by the Mental Health Act 2007]
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- Advance Decisions to Refuse Treatment/Advance Statements October 2016
- Human Rights Act
- Human Tissue Act 2004
- British Institute of Learning Disabilities (2010) Code of Practice for the Use and Reduction of Restrictive Physical Interventions (3rd edition)
- Positive and Proactive Care: Reducing the need for restrictive interventions, DoH, (2014)
- Royal College of Nursing (2008) Let's Talk About Restraint – Rights, Risks and Responsibilities
- CPA (Care Programme Approach) policies and procedures August 2008
- ECT (Electro Convulsive Therapy) Policy-note revised version 2014

- The Royal Marsden Manuel of Clinical Procedures May 2015)
- Caldecott Report April 2013 Caldecott Review: Information Governance in the Health and Care system
- Transition of Young People from CAMHS to Adult Health Services Protocol (October 2008)
- Prevention and Management of the use of Restraint: Framework for Good Practice (2011) – Sheffield City Council and NHS Sheffield.
- R (on the application of Burke) v General Medical Council (2005) EWCA Civ 1003
- Glass v United Kingdom (2004) 1 F.L.R. 1019
- Consent Toolkit-fifth edition British Medical Association (2009)
- Sidaway v Board of Governors of the Bethlem Royal Hospital (1985) AC 871
- GMC, Seeking service users consent: the ethical considerations November 1998
- Human Fertilisation and Embryology Act 1990
- Information Commissioners "Use and Disclosure of Health Data: Guidance on the Application of the Data Protection Act 1998" May 2002
- Re T (an adult) (Consent to Medical Treatment): CA 1993, Fam 95 Lord Donaldson M.R.)
- Re: C (Adult: Refusal of Treatment (1994) 1 WLR 290.
- Public Health (Control of Disease) Act 1984
- HL v United Kingdom (2004) 40 E.H.R.R.761
- JE v DE and Surrey Country Council (2006) EWHC 3459 (fam)
- Medicines for Human Use (Clinical Trials) Regulations 2004
- Childrens Act 1989 (Found 2004)
- Family Law Reform Act 1995
- Gillick v West Norfolk and Wisbech AHA (1986) AC 112
- NHS Trust v D (2000) 2 FLR 677
- Glass v United Kingdom (2004) 1 F.L.R. 1019
- Simms v Simms (2003) Fam 83
- Bolam v Friern Hospital Management Committee (1957) 1 WLR 582
- www.dh. Bolam v Friern Hospital Management Committee (1957) 1 WLR 582

Appendix A – Version Control and Amendment Log

.

Version No.	Type of Change	Date	Description of change(s)
V5D0.1	November 2008 Policy out of date and requires review and update	March 2016	Review of current policy commissioned by EDG.
V5D0.2–0.5	Updated during consultation	June – September 2016	Amendments made during consultation, prior to ratification.
V5D0.6	Reformatted for new policy document template	October 2016	Re-formatted for new policy document template. Appendices updated.
V5	Ratification / finalisation /issue	November 2016	Ratification / finalisation / issue

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
V5	Nov 2016	Nov 2016 – via Communications Digest	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – Relevance - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, service users or the public? If **NO –** No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, service users or the public (insert name and date)

Stage 3 – Policy Screening - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice this can be found at http://www.shsc.nhs.uk/about-us/equality--human-rights

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
DISABILITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
GENDER REASSIGNMENT	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
PREGNANCY AND MATERNITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
	No specific impact identified.	No further action identified.	Due consideration given in developing

RACE			policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
RELIGION OR BELIEF	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
SEX	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015
SEXUAL ORIENTATION	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2015

Stage 4 – Policy Revision - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date

Anita Winter, Service Director (on behalf of the MCA/DoLS Steering Group (25 October 2016)

Supplementary Section C - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a persons Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.sct.nhs.uk/humanrights-273.asp (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including caselaw) or policy?**

   ☒ **Yes. No further action needed.**
   ☐ **No. Work through the flow diagram over the page and then answer question 2 and 3 below.**

2. **On completion of flow diagram – is further action needed?**

   ☐ **No, no further action needed.**
   ☐ **Yes, go to question 3**

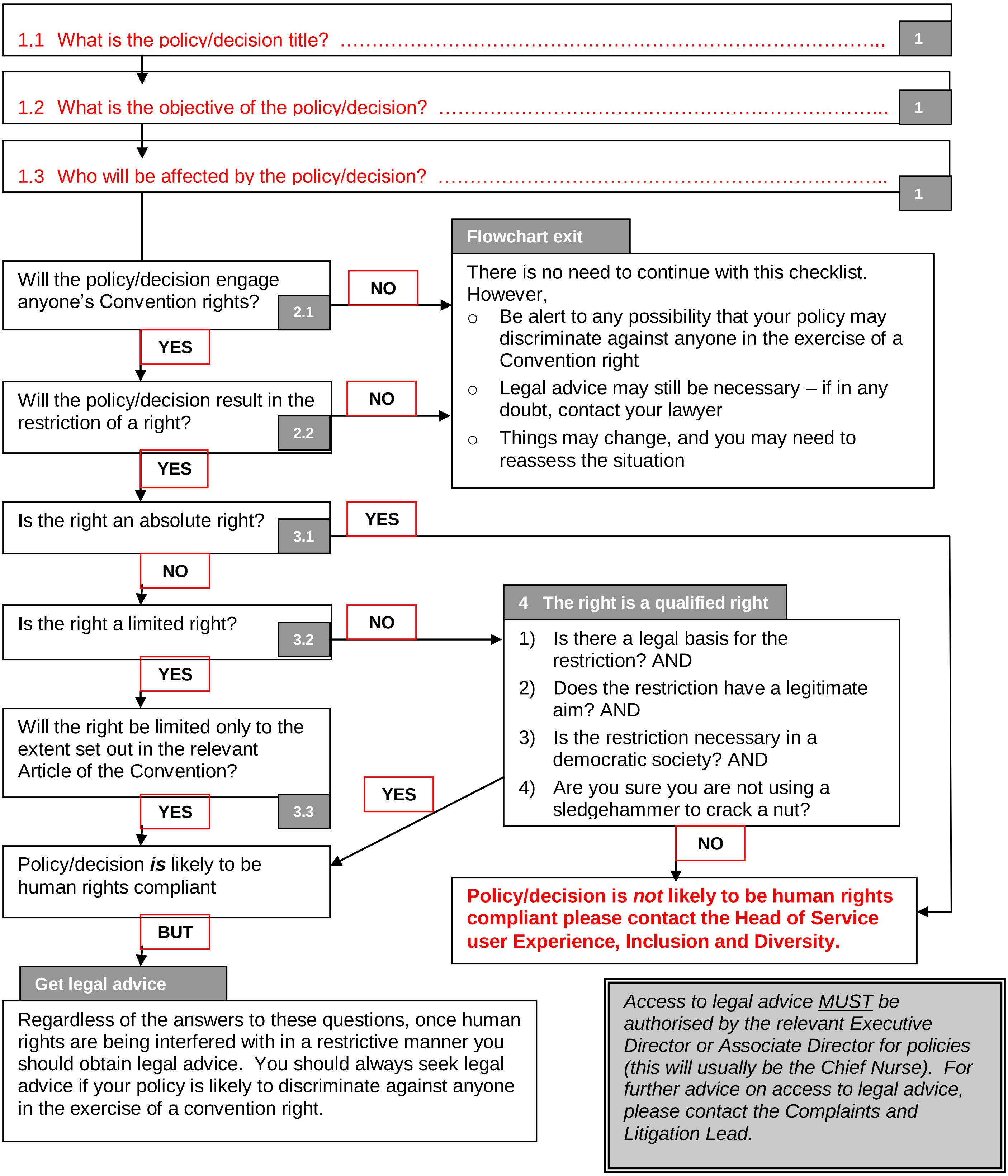
3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose ‘Format Text Box’ and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



1.1 What is the policy/decision title? ………………………………………………………………………….. 1

1.2 What is the objective of the policy/decision? ……………………………………………………………….. 1

1.3 Who will be affected by the policy/decision? ……………………………………………………………….. 1

Will the policy/decision engage anyone’s Convention rights? 2.1

Will the policy/decision result in the restriction of a right? 2.2

Is the right an absolute right? 3.1

Is the right a limited right? 3.2

Will the right be limited only to the extent set out in the relevant Article of the Convention? 3.3

Policy/decision *is* likely to be human rights compliant

Flowchart exit

There is no need to continue with this checklist. However,

- Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
- Legal advice may still be necessary – if in any doubt, contact your lawyer
- Things may change, and you may need to reassess the situation

4 The right is a qualified right

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

Policy/decision is *not* likely to be human rights compliant please contact the Head of Service user Experience, Inclusion and Diversity.

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.

Access to legal advice <u>MUST</u> be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.

Appendix E - Development and consultation process

It is Version 5 of the Policy and is a major revision.
It replaces all previous versions which must be destroyed.
Archive copies of previous versions are stored and available for reference from the Director of Corporate Governance:

- Version 4 (November 2008)
- Version 3 (January 2008)
- Version 2 (December 2006)
- Version 1 (January 2004)

- Zara Clarke (Clinical Psychologist) reviewed the existing policy dated [Version 4, 2008] with support from Anita Winter, Service Director.
- A range of senior clinicians and medics from across the Trust have contributed to the formulation of the policy.
- **SHSC Nurse Leaders** Eva Rix advised on safeguarding.
- **SHSC MHA Manager** Cath Dixon and Sobhi Girgis, Medic, advised on the Mental Health Act.
- The policy was sent to the **Mental Capacity Act/Deprivation of Liberty Safeguards Steering Group** for consultation.
- The draft policy was verified by this group following a total review and re-write on 18 October 2016, prior to being sent for ratification by the Executive Directors Group.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart ✓

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. **Implementation plan** ✓

14. **Links to other policies (associated documents)** ✓

15. **Contact details** ✓

16. **References** ✓

17. **Version control and amendment log (Appendix A)** ✓

18. **Dissemination Record (Appendix B)** ✓

19. **Equality Impact Assessment Form (Appendix C)** ✓

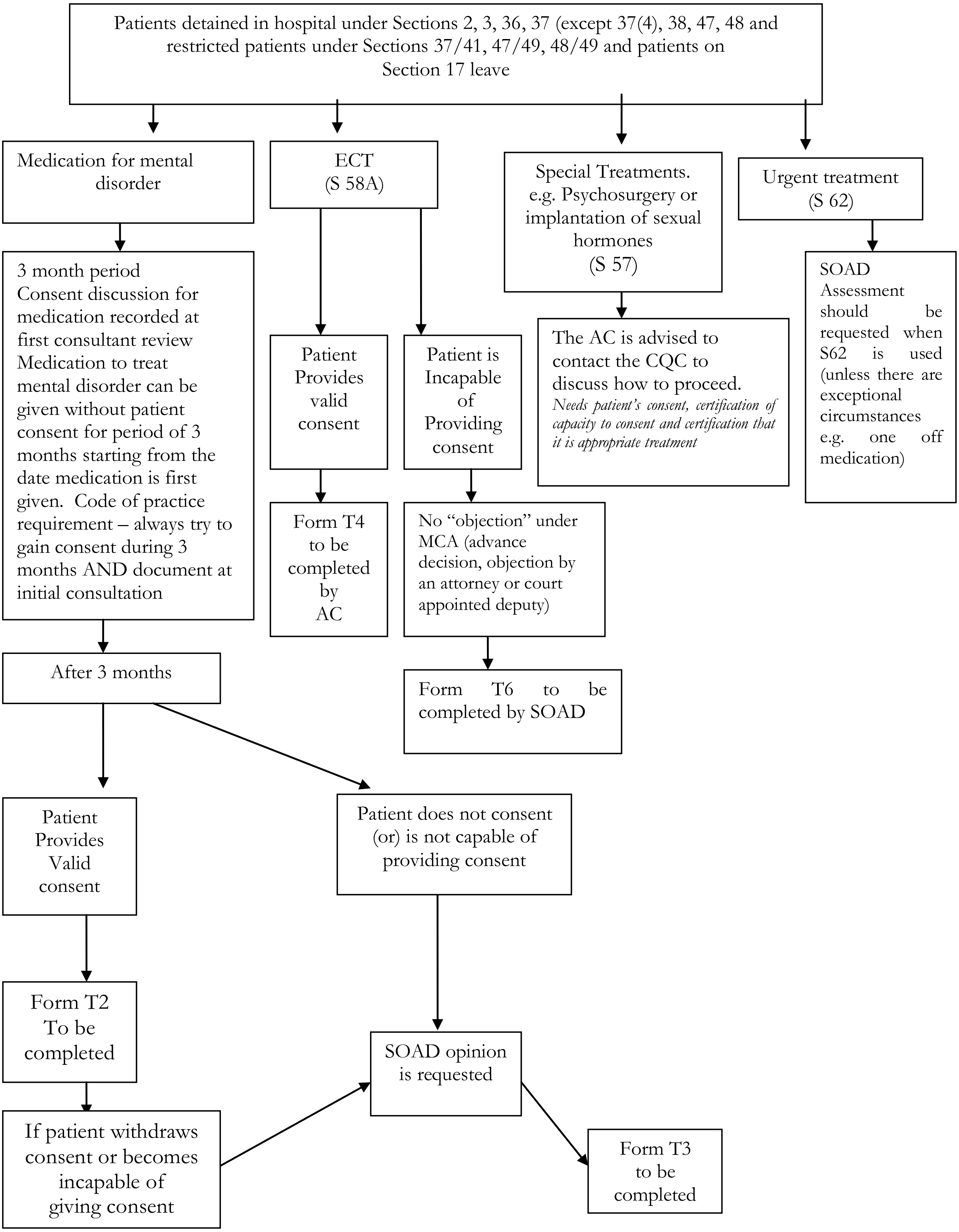
20. **Human Rights Act Assessment Checklist (Appendix D)** ✓

21. **Policy development and consultation process (Appendix E)** ✓

22. **Policy Checklist (Appendix F)** ✓

Appendix G: Consent Procedure Relating to the Mental Health Act

Flow chart does not cover s 45A or ECT for under-18s who are not detained



1. Procedures for Capacity and Consent for Informal admission and treatment

1.1 On admission all informal patients should be informed of their rights as an informal patient. They should also be advised of the relevant Trust Policies (e.g. locked door, smoking), in addition to an induction to the ward to which they are being admitted (as per local admission procedure).

1.2 Patients who become ‘informal’ following removal of a section should also be provided with the information at 1.1 above.

1.3 A record of the date and time this information is provided must be made on the patient record.

1.2 This information can then be used by the patient to inform their decision making regarding their willingness to remain and accept treatment.

1.3 All informal patients will then be formally assessed for their capacity to consent to the admission.

1.4 This will be done using Form CAT 1

1.5 By testing capacity and emphasising their rights to refuse treatment and leave hospital, any concerns that the patient’s consent is implied and not informed, will be addressed.

1.6 All informal patients will also be assessed for capacity to consent to treatment at the point of first administration of medication using Form CAT 2

1.7 The issue of the patient’s capacity must be regularly reviewed at the Multi- Disciplinary Team (MDT) meeting and in particular if there was change in presentation. The outcome should be recorded on the individual’s MDT record.

2. Consent to Treatment Procedures for Patient Detained Under Mental Health Act 1983 (Amended 2007)

2.1 The Mental Health Act 1983 (Amended 2007), provides the legal framework for the treatment of mental disorders without the patient’s consent. This is governed by Part 4 of the Act which applies to patients who are:

- Detained in hospital Sections 2, 3, 36, 37 (except 37(4)), 38, 45A, 47, 48 and restricted patients on Sections 37/41, 47/49, 48/49.
- Detained under the sections specified while they are on Section 17 leave.
- Patients specially excluded from part 4 provisions are: A) Patients detained under Section 4, 5(2), 5(4), 35, 37(4), 135 and 136. B) Patients on Section 7 (Guardianship) or Community Treatment Order who are ‘liable to be detained in hospital’. C) Patients conditionally discharged from a Hospital Order but subject to restrictions in the community under Sections 41.

2.2 Section 57 of the Act applies currently to surgical operations to destroy brain tissue or its functioning, and to the surgical implantation of hormones to reduce male sex drive. Section 57 requires consent and a second opinion.
Section 58 of the Act applies specifically to medicine, in effect oral and injectable preparations, for mental disorder.
Section 58A applies currently to ECT only. If the patient is under the age of 18, S58A applies whether s/he is detained or not.

Treatment for physical disorders is outside the remit of this Act and can only be given in the absence of consent if it can be justified under the Mental Capacity Act 2005 or if the physical disorder is the cause of the mental disorder or one of its manifestations.

2.3 The Mental Capacity Act applies to patients subject to provisions of the Mental Health Act in the same way as to anyone else, with the exception of medical treatment given to them for a mental disorder pursuant to Part 4 MHA (see Mental Health Act Code of Practice 24.54).

2.4 A detained patient with capacity can refuse treatment for a physical disorder not related to their mental disorder and cannot be treated under section 5 of the Mental Capacity Act under the 'best interests' principle.

2.5 Physical treatment might be given in best interests if patient lacks capacity to consent. Clinicians must clearly record the rationale used to provide treatment in such cases including the assessment of capacity and best interest decision making process.

2.6 Medication Treatment for Mental Disorder

2.6.1 The Three Month Period

For patients who are subject to Part 4 of the Act, medication to treat mental disorder can be given without the consent of the patient for three months starting from the date of commencement of the medication. During this time, the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in Form CAT 2

1. The three month period does not apply to ECT and some other special treatments (e.g. Psychosurgery or implantation of sexual hormones), i.e. not to sections 57 and 58A
2. The three month period is not affected by renewal of detention, leave or change or discontinuation of treatment. It also does not apply when CTO is revoked.
3. For patients on Section 2 prior to Section 3, the date of medication was started under Section 2 will be the date of the three month period starts.
4. It is the responsibility of the Approved Clinician (AC) in charge of the treatment to be aware of the start and end of the three month period. The MHA Office will send a reminder before the expiry of 3 months of detention.

2.6.2 Towards the end of the three month period

For patients subject to Part 4 of the Act and who are given either a) medication for mental disorder after 3 months or b) ECT or some other forms of treatment at any time, the provisions of Section 58 and S58A apply and there are two possible courses. The RC must record the capacity assessment using the relevant capacity assessment form.

Course 1: The patient has capacity to consent and gives informed consent
A form T2 must be completed by the AC in charge of the patient's treatment to signify the patient's consent to treatment.
When completing the Form T2 the AC in charge of the patient's treatment should indicate on the relevant form that the patient's ability to give valid consent has been assessed (capacity to consent for medication is assessed and recorded using Form CAT 3), that the treatment has been discussed with the patient and that the patient gives their consent to treatment.

Course 2: If the patient does not give consent, or does not have capacity to consent.
In the case of a patient refusing or withdrawing consent or lacking capacity to give consent, treatment can only proceed on the certification of a Second Opinion Approved Doctor (SOAD). A visit and assessment for a SOAD can be requested from the Care Quality Commission (CQC). The CQC will arrange for a SOAD to visit – this can take some time and the RC should remember that a SOAD can be requested up to one month before the end of the three month period.
If the SOAD feels that the treatment as prescribed by the AC in charge of treatment is appropriate, taking into account all circumstances of the case, the SOAD will complete a Form T3, which provides the legal authority for treatment. It is now a legal requirement for the SOAD to provide a written explanation of the reasons for the decision either to certify or refuse to certify treatment. The SOAD will complete a form documenting the nature and reasons for their decision and a copy will be sent to the AC who should then explain the reasons to the patient and if appropriate give

them a copy, and document this in the relevant form. Occasionally the SOAD concludes that the patient has capacity to consent to the treatment plan and has consented. In that case the SOAD will complete Form T2.

Note: In circumstances of a patient who has consented to treatment and is receiving treatment under Form T2, but then decides to withdraw consent or loses capacity to consent at any stage, an application should be made to the CQC for a SOAD certification under Form T3.

It is possible to have both a T2 and T3 simultaneously where a patient has the capacity to consent to some but not all treatment, or refuses consent to part of the treatment while consenting to the remainder.

2.6.3 Change of treatment under plan after three month period

If the RC or AC in charge of the treatment (if different) wishes to change the patient's medication or switch to a different form of treatment they must discuss this with the patient and explain any possible benefits, significant or frequently occurring risks or side-effects. CAT3 Form should be completed. Based on capacity assessment, one of the following actions needs to be taken:

- If the patient is consenting to medication, a new Form T2 must be completed by the AC in charge of treatment.
- If the patient is refusing or incapable of consenting to treatment, a SOAD must be obtained to completed a new Form T3.

Old consent forms should be crossed through to signify that they are no longer valid.

2.6.4 Administration of Electro-Convulsive Therapy (ECT) (Section 58A)

Although ECT is a treatment for mental disorder, it is subject to a different legal position. ECT cannot be given to a capable person who is refusing it, when that person is detained (except when this treatment is given under a Section 62 as an urgent treatment). ECT is not subject to the three month period which applies for medication. The doctor in charge of treatment must assess capacity to consent to ECT and record it on CAT5 Form.

Before any course of ECT, a detained patient must:

- Either give a valid consent and have a consent form T4 completed by the AC in charge.

Or

- If lacking capacity to give consent have a form T6 completed by a SOAD

Or

- Meet the conditions for urgent administration of ECT under Section 62 in which case, ECT must be immediately necessary to:
- Save the patient's life
- Prevent a serious deterioration in their condition.

2. Patients under 18 years of age who are consenting to ECT can only be given ECT if a SOAD has assessed and completed a form T5.

Note that if the patient is under 18, whether detained or not, their consent to ECT must be recorded by the SOAD.

Note however, that ECT cannot be administered to people who lack capacity if there is one of the following:

- Valid and applicable advanced decision objecting to ECT or
- A lasting Power of Attorney for treatment, or a court appointed deputy who objects to ECT or
- A decision of the Court of Protection conflicting with the giving of ECT.

Authorisation Forms for ECT must always specify the upper limit for the number of times ECT is to be given.

In SHSC, capacity is reviewed by the referring team, documented and confirmed by the ECT consultant and documented before every treatment.

2.6.5 Special treatments under Section 57

Certain forms of treatment (e.g. psycho-surgery or implantation of sexual hormones) are defined in Section 57 and can only be given if the patient has consented and a second opinion has been obtained.

Section 57 treatments can only be given if:

- The patient consents to the treatment
- A SOAD (and two other people arranged by CQC) certify that the patient has the capacity to consent and does so
- The SOAD also certifies that it is appropriate for the treatment to be given to the patient.

Any Approved Clinician considering giving treatment under Section 57 is advised to contact the Care Quality Commission in advance to discuss how to proceed.

2.6.6 Urgent treatment under Section 62

Section 62 allows for urgent treatment to be given to detained patients in advance of the Section 58 safeguards. A SOAD assessment should normally have been requested before Section 62 is used.

Under Section 62, medication must be immediately necessary to:

- Save a patient's life, or (not being irreversible) prevent a serious deterioration in their condition, or
- Not being irreversible or hazardous, alleviate serious suffering, or
- Not being irreversible or hazardous, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or other.

Treatment under Section 62 is not limited by time or to a set number of interventions. If it is still not possible to treat under Section 58, e.g. because the SOAD has still not assessed), the treatment can continue under Section 62 as long as the conditions above still apply. Treatment under Section 62 must be documented on the relevant form.

3. Procedure for Capacity and Consent for patients subject to Community Treatment Order

3.1 TREATMENT ON RECALL (PART 4 OF THE ACT):

3.1.1 When a patient on a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients. If treatment does not include psychotropic medication or Electroconvulsive Therapy ('ECT') and a patient with capacity consents to it, it may be given under the direction of the RC.

3.1.2 If a Second Opinion Appointed Doctor ('SOAD') has approved any treatment (on form CTO11) in the event of the patient's recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the SOAD has indicated otherwise, the certificate will authorise treatment (other than ECT) whether the patient has or does not have capacity to refuse it.

3.1.3 On recall, treatment that was already being given as described on form CTO11 may continue to be given if the approved clinician in charge of the treatment considers that stopping it would cause the patient serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment. This can include previously authorised ECT treatment.

3.1.4 It is not good practice to use a certificate that was issued to a patient when detained and who has since been discharged onto a CTO to authorise treatment if the patient is then recalled to hospital, even if the certificate remains technically valid. A new certificate should be obtained as necessary. Otherwise, giving treatment under S62 might be warranted.

3.2. TREATMENT WHILE IN THE COMMUNITY (PART 4A OF THE MHA):

3.2.1 The treatment of CTO patients who have not been recalled to hospital, including CTO patients who are in hospital on a voluntary basis not having been recalled, is dealt with under Part 4A of the Act. The Code refers to them for convenience as 'Part 4A patients' and provides detailed guidance on their treatment in chapters 24 and 25.

3.2.2 There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria.

3.2.3 The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give a CTO patient any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient.

3.2.4 The MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is 'Gillick competent' in accordance with a landmark ruling of the House of Lords30. This is sometimes referred to as 'Fraser competency' acknowledging the Law Lord who set out the principles to be applied in determining such competency.

3.2.5 Part 4A patients over the age of sixteen who lack capacity may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where an attorney or deputy refuses on the patient's behalf. If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under MCA until the CTO patient is detained in hospital when Part 4 rules applies.

3.2.6 If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in section 64G which reflect the similar scheme in the MCA. The alternative mechanism is via recall to hospital but the recall criteria apply equally to patients lacking capacity.

3.2.7 In an emergency, treatment for Part 4A patients who have not been recalled can be given by anyone (it need not be an Approved Clinician or the RC) but only if the treatment is immediately necessary to:

A) Save the patient's life B) Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed; C) alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or D) prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

Form 64(G) (emergency treatment for patient under CTO in community) should be completed in these circumstances.

For ECT (or medication administered as part of ECT), only the first two categories apply.

3.2.8 In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting CTO patient without first recalling them to hospital.

3.2.9 In non-emergency situations a patient may lack capacity and object to treatment but where physical force is not required he or she can be treated with medication for mental disorder in the community during the first month following discharge on a CTO.

3.2.10 As soon as possible following the starting CTO the RC must assess the patient capacity to consent to treatment and complete Form CAT 4. This will ensure requesting SOAD assessment in good time if the patient lacks capacity to consent to treatment of the mental disorder. At one month of starting CTO (or 3 months from administering medication under detention in hospital) the RC must either certify that the patient has the capacity/competency to consent and does consent (form CTO12), OR a SOAD must certify that such treatment is appropriate on a Part 4A certificate (form

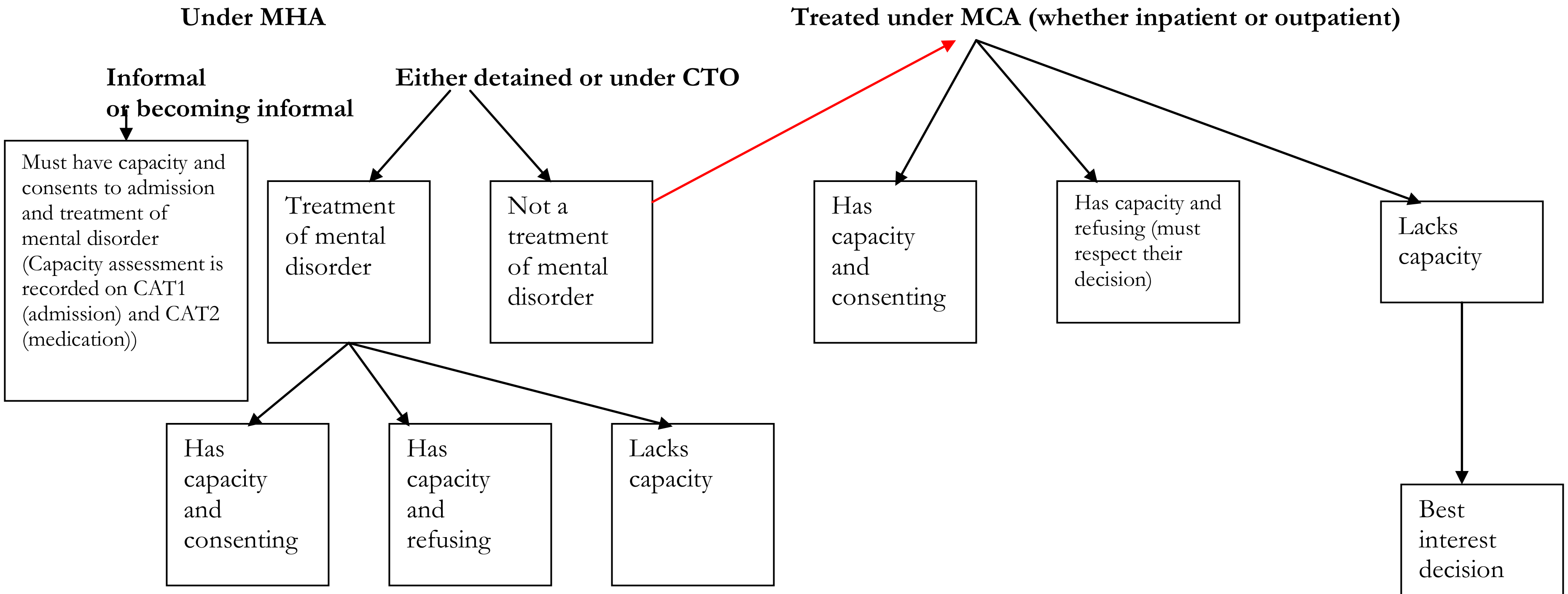
CTO11). The SOAD certifies the appropriateness of treatment and any conditions attached to it not necessarily whether a patient has or lacks capacity or is refusing.

3.2.11 The SOAD will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply.

3.2.12 The arrangements surrounding the SOAD's examination will be complicated by the fact that the patient is in the community so an appropriate person should be asked to confirm arrangements with the SOAD and coordinate the process. This will normally be their care co-coordinator.

3.2.13 Other than in exceptional circumstances, SOAD examinations will be arranged in a hospital or clinical setting. If the RC agrees that it is necessary to visit a CTO patient in a hostel or home, the SOAD will always be accompanied by an appropriate member of the care team.

Appendix H: Capacity Assessment under the Mental Health Act



Depending on length of time and whether detention or CTO, capacity assessment is recorded on CAT2 (start of treatment), CAT3 (near 3 months or subsequent change of medication), CAT4 (for CTO patients)

ECT

CAT5 in all circumstances