University Hospitals of Derby and Burton NHS Foundation Trust

THE MENTAL CAPACITY ACT POLICY (LAWFUL AUTHORITY FOR PROVIDING EXAMINATION, CARE OR TREATMENT WHEN THE PATIENT LACKS CAPACITY)

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1. Introduction

The Mental Capacity Act Policy has been developed to link closely with the Trust Consent Policy to standardise the consent process for patients who may not have capacity and to improve patient safety and patient experience across the five sites which make up the University Hospitals of Derby and Burton (UHDB): Royal Derby Hospital (RDH), Queen's Hospital, Burton (QHB), Florence Nightingale Community Hospital (FNCH), Sir Robert Peel Community Hospital (SRP) and Samuel Johnson Community Hospital (SJH) referred to in this document as "The Trust".

The aim of the Policy is to ensure that the Trust is operating effective controls that protect the human rights and safety of patients, and to support good practice.

Healthcare Professionals taking consent must ensure that patients are aware of any "material risks" involved in a proposed treatment, and of reasonable alternatives, following the judgment in the case of *Montgomery v Laharkshire Health Board*.

A person has a fundamental legal and ethical right to determine what happens to their own body. Valid consent is therefore central in all forms of healthcare, from undertaking a physical examination or providing personal care, through to performing major surgery. Seeking consent is also a matter of common courtesy between healthcare professionals and a person and staff must work in partnership with them.

The right to be given clear and transparent information about a recommended examination, treatment or investigation, including the risks and benefits associated with that treatment and available alternatives, and the right to accept or refuse examination, treatment or investigation is enshrined in the NHS Constitution and is a CQC Fundamental Standard of care.

This Policy provides comprehensive advice on the process of ensuring treatment with lawful authority within the framework of the Mental Capacity Act 2005 and Codes of Practice (the MCA generally applies to those that are 16+) where the patient requiring care and treatment lacks capacity to give consent. Health professionals must also be aware of the relevant legislation and Codes of Practice and any guidance on consent and mental capacity issued by their own regulatory body. This will ensure patient autonomy and personhood are protected, protect individual professionals from unfounded complaints or claims as well as protect the Trust, given the vicarious liability they have for the individuals they employ.

Valid lawful authority for providing or administering examination, care or treatment is always required. Ensuring appropriate lawful authority is in place to undertake examination, care or treatment is central in all forms of healthcare, from providing personal care to undertaking major surgery. Where a person lacks the requisite capacity, lawful authority can only be gained by application of the processes of the Mental Capacity Act 2005 (See appendix 1) or where they are detained under the Mental Health Act 1983 (MHA), by following the procedures laid out in Part 4 (or Part 4A for Community Treatment Order patients) of the MHA (for treatment for mental disorder only).

The situation in relation to 16 and 17year-old patients is generally now the same as for adults. Although the common law still suggests that a competent 16 or 17year-old patients' refusal of examination, care or treatment can be overridden by the consent of a person with parental responsibility (PR) in certain circumstances , all guidance and advice is that further legal authority is sought before proceeding (e.g. court order) should this situation arise. (See Appendix 2 for guidance regarding identification of who has PR).

In relation to children of 15 and under: Where a child of 15 or under lacks the capacity to make the decision, the lawful authority to proceed can be found in the consent of an individual with parental responsibility (see Appendix 2). There remains the remit of specific legal advice however for serious medical treatment decisions that are not immediately life threatening.

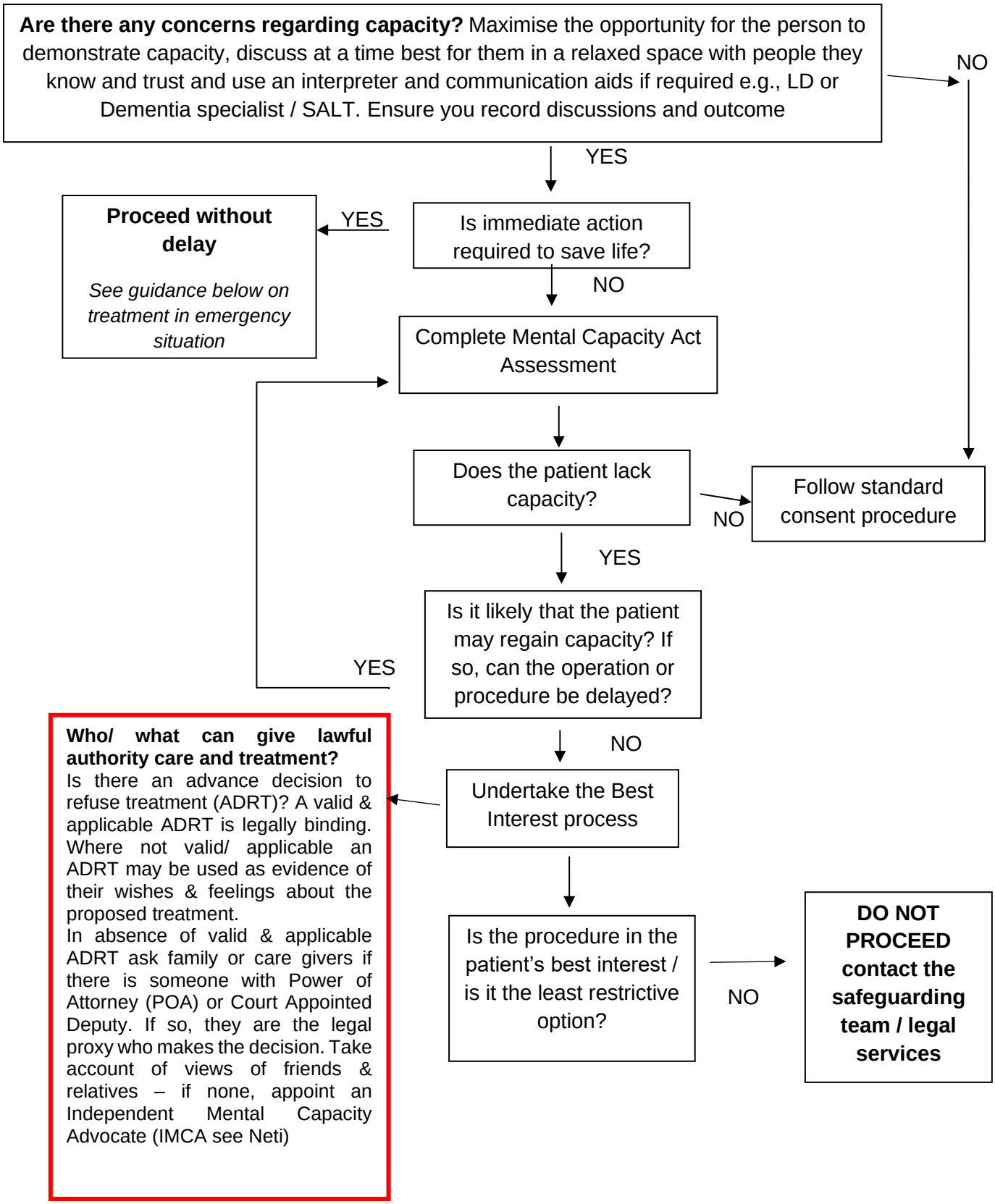
In interpreting this Policy and the procedures contained within it staff are expected to consider the following overarching principles:

- For lawful authority to be valid there must be no coercion or force.
- Acquiescence or compliance where the person does not know what the intervention entails does not confer lawful authority.
- All patients aged 16 or over should be assumed to have the capacity to give or with-hold their consent to all examination, care or treatment proposed or suggested unless it can be demonstrated that they lack this capacity in respect of that decision at that time. As above, there are also some cases where a court can also overrule a minor.
- Whether it is thought that the patient has capacity or not, all patients (and their carers) must be provided with time and easily understandable information about their care and treatment that helps them to make informed decisions and choices
- All efforts should be made to involve and communicate with the patient. The MCA requires that all practicable steps should be taken to facilitate a person's capacity
- ous decision (subject to urgency constraints). Consideration should always be given to whether a translator, signer, speech and language therapist or specialist team is required as well as the use of terminology and general language
- Just because a patient refuses the examination, care or treatment proposed or chooses an option considered ‘unwise’ by healthcare professionals does not mean they lack capacity. Unless it can be shown that the patient lacks capacity to make the decision, evidenced by the Mental Capacity Act 2 stage test, (i.e., they cannot understand information given to them, retain or weigh it up or communicate their decision), the patient must be allowed to make autonomous decisions
- Where an adult patient lacks the mental capacity to give or with-hold consent for themselves in relation to examination, care or treatment at a particular time, any decision must be made following the person’s “best interests” processes outlined by the MCA and Codes of Practice
- Care and treatment to achieve what is in a patient’s best interests should be delivered in the least restrictive way possible, enabling patients to maintain the maximum possible level of independence, choice, and control.
- A patient’s ability to make a decision may be different for different decisions at different times and therefore any determination that a patient lacks capacity is only in relation to the specific decision in question and at the time the determination was made.

This Policy applies to all employees of the Trust, including Non-Executive Directors, Governors, volunteers, individuals on secondment and trainees or those on placement. Contracted third parties and staff of partner organisations who provide services on behalf of the Trust to patients are also expected to adhere to this Policy.

1.1 MCA: overview of process

Lawful authority - Process for Patients who lack mental capacity when procedures, interventions or operations are proposed.



2. Key Responsibilities and Duties

Safeguarding Adult Boards (Staffordshire, Derbyshire and Derby City Local Authorities)	Safeguarding Adult Boards / Partnerships are required to lead adult safeguarding arrangements across their locality, monitor and coordinate the effectiveness of the safeguarding and MCA performance of partner agencies. The Trust is required to undertake Safeguarding Adult (including MCA) assurance processes led by the CCG and Safeguarding Adult Boards on a yearly basis.
Integrated Care Board (ICB)	Derby and Derbyshire ICB and Staffordshire and Stoke on Trent ICB monitor Trust performance in safeguarding in regular meetings with the Trust. The Head of Adult Safeguarding for the ICB coordinates assurance processes across health providers including the Trust
Trust Board	To ensure that the Trust has in place the necessary policies and procedures to enable staff to meet the standards aimed at by the Trust. To receive reports and approve action plans.
Chief Executive	As Accounting Officer of the Trust, the Chief Executive has ultimate responsibility for staff adherence to legislation, guidance, and Policy. Ensure appropriate management chains are in place to enable adherence to this Policy.
Executive Medical Director and Executive Chief Nurse	To ensure the Trust Board is fully briefed on areas of responsibility and Executive Committee decisions. To ensure implementation of this Policy is monitored and staff adhere to legislation, regulation, and guidance in respect of mental capacity.
Chief Operating Officer	To ensure the Trust Board is fully briefed on areas of responsibility and Executive Committee decision; supports the Executive Medical Director and the Executive Chief Nurse in ensuring implementation of this Policy is monitored and staff adheres to legislation, regulation, and guidance in respect of consent and mental capacity.
Quality Assurance Committee	Sub-Committee of the Board with overall delegated responsibility for ensuring lawful authority is in place for all Examination, Care and Treatment carried out by the Trust.
Quality Governance Steering Group	See Section 7: Implementation, Monitoring Compliance and Effectiveness
Trust Vulnerable People Group (TVPG)	See Section 7: Implementation, Monitoring Compliance and Effectiveness
MCA Improvement Group (MCAIG)	The MCAIG has responsibility for identifying and improving barriers at the frontline to effective implementation of the Trusts duties and obligations, and to provide consultation feedback and perspective on Policy and practice development at the frontline.

Divisional Business Units	• To ensure all staff within their divisions are familiar with this Policy • To ensure all staff have the tools, resources, and skills to deliver the standards detailed in this Policy and to follow the procedures • To ensure advice and guidance, relevant legislation, Codes of Practice, and guidance are available to all staff. • To provide reports to the Chief Operating Officer / Executive Medical Director / Executive Chief Nurse, when requested.
Head of Safeguarding and Vulnerable People and the Trust MCA Lead	The Head of Safeguarding and Vulnerable People is responsible for the MCA Lead who provides training for frontline staff in MCA and undertakes audit of performance and for ensuring that MCA action plans are implemented, monitored, and followed up where necessary. To provide advice and guidance to General Managers / team leaders and frontline staff regarding the lawful authority for proposed examination, care or treatment and the Deprivation of Liberty Safeguards. To notify the CQC of any Deprivation of Liberty Safeguards applications.
All Staff	To practice within the legislative framework and comply with professional Codes of Practice relevant to their discipline. To follow the procedures described in this Policy and aim to achieve the target standards.

3. Definitions

Advance Decision to Refuse Treatment (ADRT)	At a time when a patient has the capacity to make the decision, they may decide that if they lack capacity at some point in the future, they do not want to receive certain forms or methods of treatment. Advance Decisions can only be made by people 18 or over. (See Appendix 4). If an advance decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party - but not by a member of Trust staff unless there are special circumstances. Advance Decisions cannot be made to refuse 'basic care', defined by the British Medical Association (BMA) as procedures essential to keep the individual comfortable e.g., warmth, shelter, personal hygiene, pain relief and the management of distressing symptoms. If an advance decision is deemed to be 'valid and applicable' then it is legally binding on healthcare professionals once a patient has lost the mental capacity to make the decision contemporaneously.
Best Interests	The MCA (s.4) defines those to be consulted with widely as 'anyone engaged in caring for the person or interested in welfare'. This process should be carried out in consultation with relevant friends / family or carers. Best interest is not necessarily the same as clinical best interest and the least restrictive option should always be considered; Ultimately clinical teams should be aiming for the least restrictive, best interest outcome.

Carer	Spends a significant proportion of their life providing (unpaid)* support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disables or has mental health or substance misuse problems. *Carers in receipt of Carer's Allowance are seen as unpaid carers.
Mental Capacity	A person's ability to make their own choices and decisions. Capacity is judged according to the specific decision to be made at that time. In England the Mental Capacity Act says that a person lacks capacity to make a decision if they have an "impairment or disturbance in the function of the brain" either temporary or permanent and as a result they cannot **understand** the information relating to the decision (including its benefits and risks); **Retain** the information for long enough to make this decision; **Weigh up / use** the information involved in making the decision and **communicate** their decision. There must be a causative nexus between the impairment and the inability to understand, retain, weigh/use and communicate.
Court Appointed Deputy	In certain situations where an individual does not have an LPA, but a series of decisions needs to be made, the Court of Protection may appoint a deputy who then takes on the same functions as an attorney either for a specified period or indefinitely.
Court of Protection	The court with jurisdiction over cases involving patients who lack mental capacity. If a capacity or best interest decision is challenged, and the matter cannot be resolved amicably an application can be made to the Court of Protection for a ruling. There are also categories of serious medical treatment that require an application to court. The Court of Protection can appoint deputies and monitor Lasting Powers of Attorney.
Decision Maker	The individual(s) who, in the absence of ADRT, LPA or court of protection deputy, makes a best interest's decision on behalf of an individual who lacks the capacity to make the decision for themselves. This person / professional is required to be the one responsible for carrying out the care and treatment. It is the decision maker's responsibility to undertake the Best Interest process.
Deprivation of Liberty (DoL)	There is no comprehensive definition of what constitutes a deprivation of liberty but case law is broadly defined as where a person is under continuous supervision and control and is not free to leave. In case law regarding DoL it has been established that "the difference between restrictions on liberty and deprivation is one of degree or intensity not nature or substance". See para 5.14 for further detail. However Article 5 is clear that no person shall be deprived of their liberty except by lawful process.

Independent Mental Capacity Advocate (IMCA)	A specialist advocate who can represent the patient and their best interests if they have no family/friends to speak to on their behalf. The Mental Capacity Act 2005 introduced a duty on NHS bodies to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions or residence / placement decision when a person who lacks the capacity to decide has no-one who can speak for them other than paid staff. The IMCA makes representations about the person's wishes, feelings, beliefs, and values. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. To contact IMCA Services go to the Safeguarding and Vulnerable People team pages here
Lasting Power of Attorney (LPA)	A Lasting Power of Attorney (LPA) is a formal legal document which confers on the attorney (or donee as it is sometimes called) the authority to make decisions on the patient's behalf. There are 2 types of LPA: Personal Welfare and Property and Affairs. Since 2007 you cannot create an Enduring Power of Attorney and so these are now rare to see. The decisions that can be made by the attorney will depend on the type of attorney they are and what is written in the LPA. To be valid an LPA must be formally written down, signed, and registered with a body known as the Office of the Public Guardian. An LPA can also be verified through this body – and should be verified if a paper copy cannot be presented to staff. Click here for contact details
Life Sustaining Treatment	Treatment that in the view of the person providing healthcare is necessary to keep a person alive.
Office of the Public Guardian	The Public Guardian and his/her staff are the registering authority for Lasting Powers of Attorney. They can be contacted directly to check that an LPA has been registered for details click here.
Parental Responsibility (PR)	Those individuals with the legal rights and responsibilities of parents. All biological mothers have parental responsibility automatically (and is only removed by court authority). Having parental responsibility gives the parent (or other individual) rights in terms of consent for examination, care, or treatment where the child is unable to consent for themselves due to their age. For details of who else in the family circumstances may have PR see Appendix 3.
Serious Medical Treatment	Treatment which involves providing, withdrawing, or with-holding treatment in circumstances where: • There is a fine balance between the benefits of a single proposed treatment and the burdens and risks it is likely to entail for the patient. • There is a choice of treatments and the decision as to which one to use is finely balanced; or • What is proposed would be likely to have serious consequences for the patient. Specific advice should be taken as there may be a requirement to take these to the Court of Protection. The list is not exhaustive but there are also categories of cases (such as bone marrow donation or non-therapeutic sterilization) that must have court approval.

4. Purpose and Outcomes

The purpose of this Policy is to outline the principles and process regarding ensuring lawful authority for care and treatment of patients who do not have capacity to consent.

The expected outcomes of compliance with this Policy are compliance with the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC Essential Standards, Outcome 2: Consent to care and treatment)

5. Information sharing

When undertaking consent processes it is vital to understand and communicate what the decision is that needs to be made and provide relevant information to the patient, person with power of attorney, or family / carers. In the conversations identified above it may well become apparent that the patient is unable to understand, retain, weigh up or communicate the information or decision.

There may be other considerations around the provision and communication of information:

- Communicating in an appropriate way. For example, could the information be explained or presented in a way that is easier for the person to understand?
- Simple language should be used, avoiding jargon. Use of pictures or objects could be helpful.
- Making the person feel at ease. For example, are there particular times of the day when a person's understanding is better, or will a particular environment make them feel more at ease?
- Supporting the person. For example, can anyone else help or support the person to understand information and to make a choice? For example, specialist teams, such as SALT or the learning disability team.
- Family, carers and others who know the person well can advise on the most effective methods of communication.
- People whose First Language is not English need extra consideration. The Trust is committed to ensuring that a person whose first language is not English receives the information they need and are able to communicate appropriately with healthcare professionals. It is not routinely appropriate to use family members or friends to interpret for those who do not speak English unless it is imperative. For information relating to interpreting services and booking please click here for access to the Trust Processes and Procedures for Interpreting and Translation Services Policy (POL-CL/2233/18)

Information will normally be provided verbally through discussion, but a patient (and carers) may also be offered written information in the form of information leaflets or printed sheets to aid in the decision-making process. It may also be appropriate to direct patients/ carers to websites/ external organisations where further information is available.

The first principle of the Mental Capacity Act is that all individuals aged 16 or over should be presumed to have the ability (mental capacity) to make any decision asked of them. You should ensure that all reasonable efforts have been taken to ensure that the person has been given the best opportunity to demonstrate capacity and to ensure lawful authority is in place healthcare professionals should also be able to detect when it is possible that the patient does not have capacity to consent and ensure that they then follow the Mental Capacity processes to ensure lawful consent is evidenced. Doubts about a patient's ability (mental capacity) to make a specific decision at a particular time may arise for several reasons, including:

- Patient making decisions in a manner out of keeping with their normal methods of reasoning
- Assessments have shown that the patient lacks capacity for other decisions
- The patient is behaving, or has a history of behaving, in such a way as to suggest they lack capacity

- Someone who knows the patient suggests that they may lack capacity or “aren’t themselves”.

If, during discussions with the patient about the examination, care or treatment or the risks or benefits of different options available, there is reason to doubt the patient’s capacity the 2-stage test as required in the MCA 2005 should be adopted. The professional should use the Trust template to record the assessment. See Appendix 1.

5.1 Responsibility for ensuring lawful authority for examination, care or treatment is in place.

The health professional carrying out the examination, care or treatment is ultimately responsible for ensuring that there is adequate lawful authority in place i.e. that the patient is either genuinely consenting to what is being done or that the patient lacks capacity to give consent and the best interests of the patient have been determined according to the processes described in the Mental Capacity Act 2005: This is a legal requirement as well as a condition of registration with their professional body. Any healthcare professional should be able to obtain consent / undertake a capacity assessment in respect of the examination, care, or treatment they themselves undertake on a patient. For example, a healthcare assistant should be able to obtain consent / undertake a capacity assessment from a patient to assist them with washing and dressing and a cardiovascular surgeon should be able to obtain consent / undertake a capacity assessment from a patient to undertake heart surgery.

Anaesthesia	Where an anaesthetist is involved in a patient’s care, it is their responsibility (not that of a surgeon) to seek consent / follow the MCA for anaesthesia.
Delegating responsibility for seeking consent/assessing ability to consent	There are situations in which it may be appropriate for an individual other than the one who will be undertaking the examination, care, or treatment to seek to obtain the consent of the patient. The development of more specialised roles within nursing, midwifery and therapies has resulted in patients receiving much of the information about complex surgical or medical procedures from non-medical staff. Where the responsibility for seeking and documenting consent is delegated, the responsibility is also delegated for assessing, where necessary and appropriate, whether the patient lacks the capacity to give or withhold consent. However, it is the healthcare professional undertaking the examination, care or treatment who remains ultimately responsible for ensuring appropriate lawful authority is in place. They must therefore ensure that when they ask colleagues to seek and document consent on their behalf, they are confident that the colleague is competent to do so.

5.2 Stages in assessment

a. Stage 1:-

1. Can the patient understand the decision they need to make, why they need to make it and the information about the different options available?
2. Can the patient retain the information long enough to decide or choice?
3. Can the patient weigh up the consequences, benefits, risks, and impact of choosing different options (or of not deciding at all)?
4. Can the patient communicate the outcome of their decision by any means (i.e., speech, sign language)?

If the answer to any one of these 4 questions is 'no,' the patient is determined to have failed this element of the test.

b. Stage 2:-

Is whether there is a known or suspected Impairment of, or a disturbance in the functioning of, the mind or brain.

Lastly, if there is a known or suspected impairment, there must be a causal nexus between that and the inability to understand, retain, weigh up and communicate. If there is, the Best Interest process must be completed.

5.3 The Best Interest Process

The Trust template should be used to evidence compliance with the law where treatment is more than minimally invasive or transient.
(Click here to open: https://neti.uhdb.nhs.uk/download.cfm?doc=docm93jijm4n21147.docx&ver=57463
see appendix 1)
In relation to examination, care or treatment the first steps are to try and find out if any of the following exist:

Advance Decision to Refuse Treatment	Where a valid and applicable Advance Decision to Refuse Treatment exists this may limit the options available when considering which option is in the patient's best interests. (See Appendix 1).
Lasting Power of Attorney for Health and Welfare	Under English law, no-one can "give consent" to the examination, care or treatment of an adult who lacks the capacity to consent for themselves. There can however be a nominated person for that decision making under a Lasting Power of Attorney or they may have the authority to make treatment decisions as a Court Appointed Deputy. In order to determine if the decision falls within the scope of authority of a Lasting Power of Attorney or a Court Appointed Deputy the full court approved document will need to be seen and checked to ensure it has been registered; please click here for details of how to contact the Office of the Public Guardian (OPG). Where a Lasting Power of Attorney exists with the decision falling within their scope of authority, they will be the decision maker. Where they appear to be acting maliciously or willfully against the interests of the patient the safeguarding team must be contacted, and possible approach made to the court of protection/OPG. It has not been possible to create Enduring Powers of Attorney since 2007 and so are seen very rarely. Please contact safeguarding/legal in these circumstances.
Court Appointed Deputy or court order	Where a Court Appointed Deputy exists with the decision falling within their scope of authority, they will be the decision maker.
The Decision Maker	In the circumstances where there is no Power of Attorney (POA) / court appointed deputy or valid ADRT, it is the person responsible for carrying out the care and treatment that is the Decision Maker and can act in connection with the care or treatment of a patient (without valid informed consent), as long as: • Reasonable steps have been taken to establish that the patient lacks capacity • The person taking the action believes that the patient lacks capacity • The person taking the action believes that the action is in the patient's best interests, and it is the least restrictive option. The Mental Capacity Act therefore provides healthcare professionals with protection from criminal and civil legal liability for acts or decisions made as long as the requirements of the Act are followed. Please however consider the role of the Court of Protection where the patient resists, there are different views on best interests or there is a serious medical treatment decision required. This process should consider the effects of different options on the patient's overall medical, psychological, emotional and social well- being. Steps that need to be followed in determining what is in a patient's best interests are as follows:

	• When determining what is in a person's best interests, assumptions must not be made about what is in someone's best interests on the basis of the person's age, appearance, condition, or any aspect of their behaviour. • All of the relevant circumstances should be considered and all of the different ways the possible examination, care or treatment options may affect the patient. • Consider how urgently the decision needs to be made and whether the patient may regain the capacity to make the decision for them if the decision can be delayed safely and without lasting detriment to the patient. • Even though the patient has been assessed as lacking the capacity to make the decision about the examination, care, or treatment, encourage their participation in the decision-making process as this will help in determining any wishes, feelings, or beliefs they may have. • The decision-maker must not be motivated by a desire to bring about death. This still allows for decisions not to provide life-saving treatment e.g., CPR as these are motivated by a desire not to prolong suffering. • The past and present wishes, beliefs and values of the patient and any factors they would be likely to consider should be ascertained and considered • Any relevant individuals e.g., carers, family and people named by the patient should be consulted about their understanding of what the patient would want and what they believe would be in the patient's best interests and why. Whilst a valid and applicable Advance Decision to Refuse Treatment will be legally binding on the healthcare professional, other advance statements of wishes or preferences are not legally binding. However, these statements should be taken into consideration by the healthcare professional as an expression of the wishes and feelings of the patient. Where a patient acts inconsistently with an ADRT or there are doubts on its continuing applicability, seek advice from safeguarding/legal services. Based on all the information gathered the decision maker will need to decide what they believe to be in the patient's best interests. Once the Best Interests of the patient have been determined, this provides sufficient lawful authority to undertake the examination, care or treatment deemed to be in their best interests in the least restrictive way possible (thought please take account of those cases that may require court approval).

5.4 <u>Care in an Emergency.</u>

Clearly in emergency situations, the extent to which other individuals can be consulted with and the past wishes, feelings and beliefs of the patient ascertained will be limited and the best interests will primarily be focused on what is in the medical best interests of the individual to save life or prevent serious deterioration at that time. The more time available to make a Best Interests decision the greater the expectation will be that thorough consultation and engagement occurs and all options and consequences are considered and discussed with relevant individuals. Nevertheless, the record of decision making should reflect the MCA principles.

5.5 Independent Mental Capacity Professionals.

An IMCA must be instructed by the decision maker where there are safeguarding concerns or serious medical treatment, long-term care is proposed, and where there are no appropriate families or friends who are willing and able to be consulted with and involved in determining Best Interests.

Details of appropriate IMCA services can be seen here.

5.6 Withdrawing and withholding life-sustaining treatment.

When treating a patient who has reached the end of life, clear communication and collective decision making are important. A healthcare professional's legal duty is to care for a patient and to take reasonable steps to prolong their life. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment stops providing a benefit to a patient and is not clinically indicated. There is no legal distinction between withdrawing and withholding life-sustaining treatment.

A person with capacity may decide either contemporaneously or by a valid and applicable advance decision that they have reached a stage where they no longer wish treatment to continue. If a person lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes (if these are known). A second opinion should be sought from an independent clinician who should reach their own conclusion in this matter and on whether life-sustaining treatment should be withdrawn / withheld. When families and doctors agree and believe it is in the patient's best interests, medical staff can remove feeding apparatus without applying to the Court of Protection. However, where there is disagreement legal advice should be accessed.

5.7 Covert administration of medicines (disguising medication).

As a general principle, a patient who lacks capacity to make a decision in relation to a specific treatment element of care cannot "refuse" treatment found to be in their best interest. Where a level of restraint or sedation goes beyond that that would be given to a patient with capacity to ensure treatment is provided, discussion should be had with the Safeguarding Team and, potentially, Legal Services who will advise on whether specialist legal advice needs to be obtained and approach made to the Court of Protection. A Deprivation of Liberty Authorisation should also be considered, and discussion had with the Safeguarding Team.

In administering covert medication, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication, when in fact they are. Where the patient lacks capacity, the registered professional must ensure that the capacity assessment is competed, that the patient does lack capacity and complete the best interest process in relation to the prescription plan. Administering medicines covertly to patients should be carefully considered and there should be adherence to this Policy. The decision to use covert medication must be made by the multidisciplinary team (ideally including the presence of the pharmacist) including the views of relatives and carers and any advanced statement or directive made by the patient. This decision must be kept under review.

If, following completion of the capacity assessment, it is clear that the patient has capacity, and they refuse medication it cannot then be given covertly.

5.8 Ensuring lawful authority remains valid.

Regarding patients who lack capacity, the two-stage test should be repeated in relation to care and treatment when it appears that there has been a noted change in the patient's condition or behaviours.

5.9 Lawful authority for undertaking examination, care or treatment for 16 - 17 year olds.

The situation in relation to 16- and 17-year-olds is generally now the same as for adults, though the courts do have the ability to overrule a minor.

- The Mental Capacity Act applies to all individuals aged 16 and over. 16 and 17 year olds are therefore assumed to have the capacity to make all decisions regarding their examination, care, or treatment; unless for particular decisions it is shown that they lack capacity.
- Where 16 or 17 year olds have capacity to give or withhold consent (which will be assumed until demonstrated otherwise) their refusal should be respected. Parental wishes for the examination, care, or treatment to go ahead should not be relied upon as sufficient lawful authority. If in any doubt seek legal advice regarding whether an application to the Court of Protection is required.
- Where 16 or 17 year olds are found to lack capacity because of an impairment of or disturbance in the functioning of the mind or brain that prevents them from understanding, retaining, weighing up or communicating information relating to the decision, the Mental Capacity Act and Trust templates for recording this must be followed as for adults.
- To lack capacity to make a decision as per the two-stage test of the Mental Capacity Act, an individual must have an impairment of or a disturbance in the functioning of the mind or brain. It is, however, possible that a 16 or 17 year old may be unable to make a decision simply because of the immaturity of their understanding. For decisions where a 16 or 17 year old falls into this category the Mental Capacity Act would not be applied and the situation is as for under 16s.

5.10 Lawful authority for undertaking examination, care or treatment for children under 16 (see Appendix 3).

- Children under 16 do not have the same assumptions as under the MCA on presumed capacity. However, dependent on the complexity of the decision and the stage of development and maturity of the child, the child may have the competence to make the decision for themselves. This is called Gillick competence, (related to Fraser guidelines concerning contraception and sexual health) and relates to a specific decision (i.e., we would say that a child is Gillick competent to make ***X*** decision at the time of assessment). There is no defined set of questions to determine competence, but requires assessment of the child's age and maturity, their understanding of the issue and what it involves, including advantages, disadvantages, risks and implications. This would extend to other available options as per normal consenting processes. Gillick competence is where a patient under the age of 16 is deemed to have the maturity and understanding capable to make the decision about their healthcare.).

- Where children do have competence to give consent their valid, informed consent provides sufficient lawful authority to provide examination, care, or treatment.

- Where a child has the competence to refuse treatment, but their actions appear contrary to their welfare, seek advise from safeguarding / legal services. There may be scenarios where parental responsibility confers sufficient authority or, as above, there may be a requirement to seek court approval to overrule the minor.

- Where children do not have the ability to give or withhold consent someone with PR is able to give consent on their behalf (See Appendix 2 for detail on who can provide PR as not all parents do).

5.11 Deprivation of Liberty (DOL).

Any deprivation of liberty in hospital must be lawful. In other words

- it should be consented to by the capacitous patient,
- or it should be under the Mental Health Act where that applies,
- or it should be authorised under the Deprivation of Liberty Safeguards if the patient lacks capacity.

When a patient lacks capacity and they are required to be in the acute trust, a series of restrictions/restraints could cumulatively add up to a deprivation of liberty (eg regular use of sedation / increasing sedation / use of bridles / bed rails / 1:1 / physical restraint). The restrictions placed on any individual should be considered regarding the following:

- the duration of the restrictions,
- the frequency with which the restrictions are applied,
- the force used to implement the restrictions and
- the frequency & intensity of distress in relation to the restrictions that is experienced by the patient (or opposition from the individual or from family / friends / carers).

If restrictions of a sufficient degree or intensity are placed on a patient that it amounts to a deprivation of liberty this must be in accordance with the Deprivation of Liberty Safeguards. Examples include:-

- Where the patient can be considered to be "in their ordinary circumstances of living" (ie they are not receiving lifesaving or life sustaining treatment or treatment to prevent a serious deterioration) they should always be assessed for Deprivation of Liberty.
- If they are being considered for discharge into a care home or residential provision when they have been admitted from their own home a DOL must be sought.
- If they require 1:1 enhanced care a DOL must be sought.
- If there is a disagreement with the family carers regarding the plan of care

Staff are advised to undertake the DoLS checklist (contained within the Nursing Care and Assessment Record) and when indicated by the checklist, discuss with the safeguarding team to ensure effective authorisation. Authorisation forms are available on Extramed at RDH & FNCH and downloaded from Neti MCA / DOLS pages and emailed to uhdb.safeguarding@nhs.net

5.11.1 DoLS - Children and Young People

Children and young people under the age of 16 may be restricted to care in the hospital with the authority of the person or Local Authority with parental responsibility. However, the level of restraint or restriction required to maintain safety of themselves or others, or where the restraints and restrictions are significant and causing distress, this may nevertheless require authorisation from the Courts. Parental responsibility is not sufficient to restrict the child or young person over the age of 16.

In both situations above, contact must be made with the Trust Legal Team.

6.0 Training Requirements

All healthcare professionals must understand the core principles of consent. Healthcare professionals who are required to obtain consent must receive appropriate generic and specific training which must be readily available. Training content will include updates to the consent policy, relevant legal framework and guidance. Specific training must cover the relevant scope of practice and appropriate delegation with defined accountability and responsibility.

MCA specific training for clinical patient facing staff is identified below:

Staff group	Training	Frequency	Mode of delivery
All clinical patient facing staff	MCA (Treatment with lawful consent)	3 yrly	e-learning or face to face sessions. Access / booking via MLP

7.0 Monitoring Compliance and Effectiveness

Monitoring Requirement:	Compliance with MCA 2005
Monitoring Method:	Quarterly case file audit of in-patient health records
Reports Prepared by:	MCA Lead.
Report presented to:	MCAIG - TVPG - QGSG - QAC; PMM
Frequency of Report:	Quarterly reports

University Hospitals of Derby and Burton NHS Foundation Trust

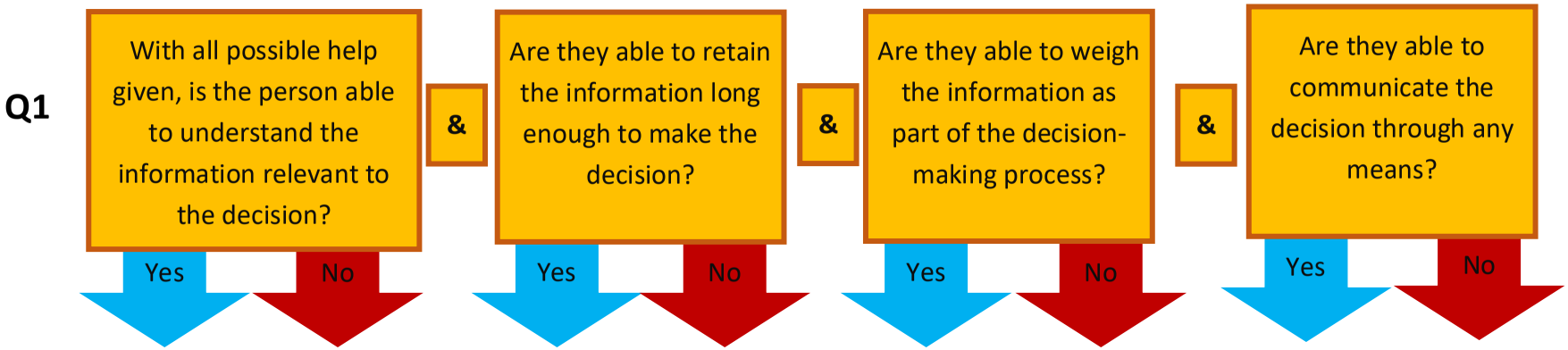
[Place patient label here]

Mental Capacity Act 2005 Capacity Assessment and Best Interest Documentation

(for procedures requiring written consent)

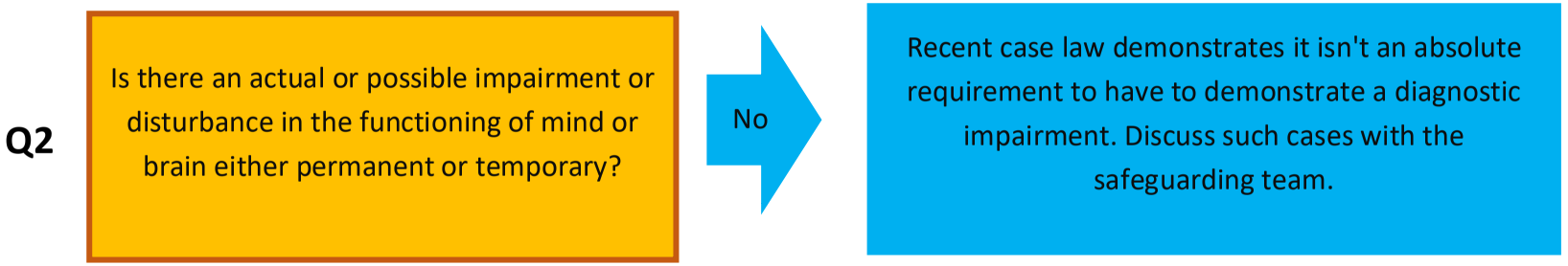
To be retained in the patient's notes

The Two Stage Mental Capacity Assessment



Patient has Capacity

Patient Lacks Capacity



If the answer to any of the four questions in section 1 is NO and the answer to question 2 is YES, then the person lacks capacity under the Mental Capacity Act 2005. A best interests assessment then needs to be undertaken.

See Trust Policy on Treatment with Lawful Consent.

Consent Process for Patients without Capacity –

when procedures, interventions or operations are proposed.

This Clinical Guideline relates to adult patients for whom UHDB has a duty of care. It should be used in conjunction with the Policy on Treatment with Lawful Consent available on the Trust Intranet in the KOHA section. Please follow the 9 steps below in order.

1. Where there is a proposal to perform a procedure or intervention or operation, where written confirmation of consent is required *and there are concerns from any member of the clinical team, the patient, or an advocate of the patient that the patient may lack mental capacity to give informed consent*, you must assess the patient's capacity using the Mental Capacity Act 2005 Capacity Assessment and Best Interest Documentation

2. If the patient is assessed to have capacity for this decision at this time, obtain informed consent (or refusal) and do not follow this guidance further.

3. If the patient is assessed as lacking capacity to consent for this decision at this time, consider if capacity may improve in the near future and if the proposed procedure, intervention or operation can safely be delayed.

4. If the procedure, intervention or operation cannot safely be delayed and the patient lacks capacity then the Best Interest process within the Mental Capacity Act 2005 Capacity Assessment and Best Interest Documentation is required to be completed.

5. Anyone in the clinical team (eg ACP/Junior doctor) can undertake the MCA assessment and Best Interest process with the oversight and agreement of The Consultant or most senior clinician proposing the procedure or operation. The Consultant / most senior clinician retain overall responsibility for the assessment process.

6. The Best Interest Decision must take account of any valid Advance Decision to Refuse Treatment (ADRT), the views of any person holding Lasting Power of Attorney (LPA)for Health and Wellbeing and those close to the patient e.g., friends, relatives or carers.

7. Once the above is completed, the consultant or most senior clinician proposing the procedure, intervention or operation must complete The Form for Adults who are Unable to Consent to Investigation or Treatment (contained in the Mental Capacity Act 2005 Capacity Assessment and Best Interest Documentation) and ensure it is counter signed by a second health care professional. The second health care professional must be the person undertaking the procedure when they are not the first signatory (e.g., endoscopy or interventional radiology procedure). This may be done in the relevant department prior to the procedure being undertaken.

8. The completed Mental Capacity Assessment and Best Interest Documentation must then be filed in the case notes.

9. In an emergency situation where an intervention is indicated and to delay would pose a risk to the patient the procedure or operation must not be delayed. Please see the further guidance (page 5) in respect of emergency situations.

IS THIS AN EMERGENCY SITUATION?

Please note that emergency out of hours legal advice can be sought where required. Please speak to the silver / gold on call.

YES

- Communicate with the patient as much as possible as to what is happening and why.
- Is there an Advance Decision to Refuse Treatment (ADRT)? Does it relate to the specific treatment and is it valid? **If** obvious, it must be followed (an ADRT refusing specific treatment will overrule a Lasting Power of Attorney (LPA), Court Appointed Deputy (CAD) & medical staff decisions). The Best Interests principles will not apply where there is a valid ADRT.
- If there is no valid ADRT as above, is there someone with a valid LPA? If so, they can make the decision. If there is a disagreement between the clinicians involved and the LPA , seek immediate legal advice. If the LPA is manifestly acting in bad faith they can be set aside-refer to safeguarding. If the procedure or operation is clearly indicated **and** in the patient's best interests, proceed with emergency treatment without delay.
    - Is there a Court Appointed Deputy (CAD) or relevant Court Order?
- **If there is no ADRT/ LPA /CAD or CO - you are the Decision Maker**.
- **Discuss with those close to the patient e.g., relatives or carers if available, either "face to face" or by telephone,** and clearly record this discussion in the sections of the MCA recording tool / document and file in medical notes. *However,* do not delay emergency treatment whilst undertaking this process.
- **Healthcare professional proposing treatment must complete consent form.**
- **Consent form must be countersigned by a second healthcare professional.** This must be the healthcare professional undertaking the procedure if not the first signatory e.g., surgeon, endoscopist or interventional radiologist.

NO

- Is there an Advance Decision to Refuse Treatment (ADRT)? Does it relate to the specific treatment and is it valid? If so it must be followed.
- Is there someone with a valid Lasting Power of Attorney (LPA) for Health and Welfare? If so they can make the decision as to treatment / procedure. However, if there is a disagreement between the clinicians involved and the LPA in respect of the patient's best interests, seek a formal second opinion from another clinician. If agreement cannot be reached, seek legal advice as soon as possible.
- Is there a Court Appointed Deputy (CAD) or relevant Court Order?
- **If no to any of the above - you are the Decision Maker.**
- Complete the capacity assessment and the Best Interest process to record consultation with those close to the patient, e.g., family/carers before proceeding with any procedure or operation, to ascertain previously expressed wishes and feelings made by the patient and use all means to communicate with the patient to aid their participation.
- **If the patient has no one close to support them and the procedure constitutes 'serious medical treatment', an IMCA must be appointed.**
- **The Healthcare professional proposing treatment must complete consent form.**
- **Consent form must be countersigned by a second healthcare professional.** This must be the healthcare professional undertaking the procedure if not the first signatory e.g., surgeon, endoscopist or interventional radiologist.

Mental Capacity Act 2005 Capacity Assessment

NB! Capacity assessments must be undertaken by the person responsible for carrying out the care and treatment, but appropriate specialists can support the assessment e.g., psychiatrist when patient has a mental health issue / SALT where the patient has speech difficulties / LD specialist where patient has LD.

Always use an interpreter where English is not their first language

This capacity assessment relates to the ability to consent to medical care and treatment / invasive procedures – specifically the following (please list here);

Stage 1: Can the patient?: -		
Understand (*They only need a basic understanding in language appropriate for them*)	**YES**	**NO**
Evidence understanding / lack of understanding		
Retain (*They need to retain information only long enough to make the decision – give them the information and ask them to repeat what they have understood – this would be evidence of retention. They do not need to remember it later or tomorrow*)	**YES**	**NO**
Evidence ability / lack of ability to retain information		
Weigh up (*Is the person aware of the pros and cons of making this decision – just one or two suffices*)	**YES**	**NO**
Evidence of ability / lack of ability to weigh up pros and cons		
Communicate (*The person can communicate their views back in any way particular to them – again you may need SALT or LD Liaison Nurse to help with this*)	**YES**	**NO**

Evidence of ability / lack of ability to communicate
If the answer is 'no' **to any one** of questions in stage 1, the patient lacks capacity. You **must** identify in conversation with family/carers if there is anyone with lawful authority to provide consent and complete the best interest process in the next section If there are no family / carers, please refer to IMCA service (see safeguarding pages of intranet)

Stage 2

Is there an impairment in the functioning of mind or brain? What is this? (This can be a formal confirmed diagnosis or a working hypothesis). Please also record details on the link between the inability to make this specific decision and the impairment.	**YES**	**NO**
Could their capacity be restored by treatment? (If there is any treatment which may restore capacity – carry it forward without delay. Consider if the decision can wait until capacity is restored – max 48hrs)	**YES**	**NO**
If yes, describe the plans that have been made in light of the above.		

- **Best Interests Process**

ESSENTIAL INFORMATION- determining the lawful authority		
Advanced Decision - Has an Advanced Decision to refuse treatment been made about the decision in question (only in relation to healthcare decision) and is it still relevant?	**YES**	**NO**
Comments		
Lasting Power of Attorney for Health and Welfare - Is a Lasting Power of Attorney (LPA) for Health and Welfare in place for the decision in question? If yes, who holds this and is it valid and applicable?	**YES**	**NO**
Identify who has LPA and confirm that it is seen and is valid (contact safeguarding team if unsure of validity)		
Court of Protection Deputy - Has any deputy been appointed by the Court of Protection for the decision in question?	**YES**	**NO**
Comments		
Is there a court order?	**YES**	**NO**
If none of the above are in place, the person responsible for carrying out the medical care and treatment is the decision maker and, after determining the best interest of the patient -following the process below – can take forward the care plan		
IMCA Referral - Is there a requirement to refer to IMCA service? (An IMCA referral is required where there are no family, friends, or carers available to be consulted in the best interest process.)	**YES**	**NO**
Contact IMCA service to request support and confirm here that it has been done if it is required		
SERVICE USER INVOLVEMENT		
Written statement - Has any relevant written statement been made by the patient when they had capacity?	**YES**	**NO**
Please identify what and where the previous statement is:		

Past and present wishes - Have steps been taken to consider, as far as is practicable, the patient's past and present wishes about the matter, e.g., discussion with family, friends, or carers?	**YES**	**NO**
Please identify who spoken with and views as to patients previously expressed wishes / views:		
Involvement in decision - Have steps been taken to encourage and involve, as far as possible, the patient's involvement in the decision and actions being considered on their behalf?	**YES**	**NO**
Please evidence what has been done to involve the patient:		
Beliefs and values - Have you considered the beliefs and values likely to influence the patient's attitude to the decision, i.e., religious, cultural, lifestyle choices?	**YES**	**NO**
Please evidence:		
Other factors - Have you taken into account other factors that the patient would like to have considered in relation to the decision, i.e., emotional bonds, family obligations, where to reside and how to spend money?	**YES**	**NO**
Please evidence:		

CONSULTATION (The Act places a duty on the decision maker to consult anyone with an interest in the care of the patient who lacks capacity).		
Views of previously named people - Have the views of anyone previously named by the patient as someone to be consulted been sought? This would be a person named by the patient at a time they had capacity as someone they wished to be consulted.	**YES**	**NO**
If yes, please specify who has been consulted:		
Views of professionals - Have the views of people engaged in caring for the patient (e.g., carers, Mental Health professionals, GP, dentist, nurse, key worker, social worker) been sought? The views of all interested parties must be recorded.	**YES**	**NO**
Please specify who has been consulted		
Views of family and friends - Have the views of family and friends been sought? The views of all interested parties must be recorded.	**YES**	**NO**
If yes, please specify who has been consulted:		
Views of other interested parties - Have the views of other people with an interest in the persons welfare (e.g., advocate, voluntary worker, IMCA) been sought? The views of all interested parties must be recorded.	**YES**	**NO**
If yes, please specify who has been consulted and their views:		

OTHER INFORMATION		
Have all least restrictive options been explored?		
Any other relevant factors to be considered.		
ACTIONS		
Best Interest actions to be undertaken.		
What were the reasons for reaching this decision? Include any important factors taken into account		
Conflict – Are there any disagreements or conflicts regarding the process or outcome? (If so contact the safeguarding team / legal services)	**YES**	**NO**
If yes, what steps have been taken to work with or to overcome these conflicts?		
Completed by: Name: _____ Designation: _____ Date completed: _____		

Consent form for adults who lack the capacity to consent to investigation or treatment

Please tick	Male ☐ Female ☐
Special requirements (e.g., other language / communication method)	
Responsible health professional / decision maker	
Job title	

All sections to be completed by the Health Professional Proposing the Procedure

A) Details of the procedure or course of treatment proposed

_____

_____

_____

_____

B) I confirm that the patient lacks capacity to consent to the proposed treatment (see MCA assessment relating to this procedure)

Tick to confirm ☐

C) I confirm that the treatment/procedure is in the patient's best interest (see attached completed Best Interest checklist relating to this procedure) and that all / any relevant parties, (including any person with lasting power of attorney for health and welfare / court appointed deputy (where either exist)or an IMCA (where the patient is un-befriended)) have been involved in best interest discussions and this discussion is documented in the patient's records

Tick to confirm ☐

Signature of Health Professional proposing and undertaking treatment

The above procedure is deemed to be in the best interests of the patient who lacks the capacity to consent for him or herself. The best interest decision making process has been followed and where possible, and appropriate, I have discussed the patient's condition with those close to him or her and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

Signature _____ Date _____

Name (PRINT) _____ Job Title _____

Person providing the second opinion should sign below to confirm their agreement

Signature _____ Date _____

Name (PRINT) _____ Job Title _____

Appendix 2 - Guidance re Lawful authority for undertaking examination, care or treatment for children: Parental Responsibility (PR)

Births registered in England and Wales	• If the parents of a child are married when the child is born, or if they've jointly adopted a child, both have PR. • They both keep PR if they later divorce. • PR can be removed by the courts, in exceptional circumstances
Unmarried parents	An unmarried father can acquire PR for his child in 1 of 3 ways: 1. Jointly registering the birth of the child with the mother (from 1 December 2003) 2. Getting a PR agreement with the mother (A PR Agreement under the Children Act 1989 is an agreement to which all other people with PR consent. This is a formal document which needs to be signed by all the parties and then registered at court). 3. Getting a PR order from a court (A PR Order is an order under the Children Act 1989, which unmarried fathers can apply for when the mother refuses to allow the father to be registered or re-registered on the birth certificate or refuses to sign a PR Agreement with him). You must ask for evidence of any of the above in the event that an unmarried father attends with the child on his own.
Step-Parents	A step-parent can only acquire PR for a child in very specific circumstances including: • When the court makes a Child Arrangements Order that the child lives with the step-parent either on their own or with another person. • When the step-parent adopts a child which puts him / her in the same position as a birth parent. • Through the signing of a PR Agreement to which all other people with PR consent. This is a formal document which needs to be signed by all the parties and then registered at court. • When the court has made a PR Order following an application by the step-parent. On acquiring PR, a step-parent has the same duties and responsibilities as a natural parent. In all cases you should ask for evidence of any of the above in the event a step-father attends with a child and consent to treatment is required.
Same-sex parents - Civil partners	Same-sex partners will both have PR if they were civil partners at the time of the treatment, e.g., donor insemination or fertility treatment.
Same-sex parents - non-civil partners	For same-sex partners who aren't civil partners, the second parent can get PR in the following circumstances: • If a PR Agreement was made. (This would be with the mother's agreement and evidenced in the form of an Order from the Court.) • Becoming a civil partner of the other parent and making a PR Agreement or jointly registering the birth.

Legal Order Guidance	
Private Fostering	It is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person' (someone who has a pre-existing relationship with the child, for example, a teacher who knows the child in a professional capacity). Those caring for a child(ren) under these arrangements will not have PR for the child(ren), therefore consent from the person with PR is required.
Section 20 Children Act 1989	The Local Authority (LA) does **NOT** have PR for a child subject to section 20 care provision.
Interim Care Order (section 38 Children Act 1989)	This is an interim order prior to the final Care Order being made and gives the LA PR for a child. However, the LA MUST consult with and inform other PR holders about important decisions they make for the child.
Care Order (section 31 Children Act 1989)	A Care Order gives the LA PR for a child (the LA MUST consult with and inform other PR holders about important decisions they make for the child i.e., medical treatment).
Emergency Protection Order	Gives the LA PR for the child while at the same time does not remove it from anyone else who has PR in respect of the child.
Supervision Order (section 35 Children Act 1989)	Does not give the LA PR for a child; PR remains with the parent(s).
Child Arrangement Order (section 8 Children Act 1989)	If child arrangements order states that the child will live with a person, that person will have parental responsibility for that child until the order ceases. The parent(s) also retain PR as stated above under PR guidance.
Special Guardianship Order (Adoption and Children Act 2002)	This order discharges any existing care order and grants PR to the Special Guardian(s). Although parents do not lose their right to PR, the Special Guardians will have a higher level of PR than the birth parent(s) should conflict arise.
Placement Order (Adoption and Children Act 2002)	Prospective adopters will acquire PR for the child as soon as the child is placed with them, to be shared with the birth parents and the adoption agency making the placement (i.e., this could be the LA).
Adoption Order (Adoption and Children Act 2002)	When a child is adopted, the PR of their biological (birth) parents as well as any other person who holds PR will end. PR will be held solely by the adopter/s.
Looked After Children	When children and young people become accommodated by the LA, parents are asked to sign a Placement Plan which also has Consent to Medical Treatment section (NB: this does not give authority to anaesthetics). Social Workers should contact parent(s) when children and young people are required to undergo routine examination or treatment. They should involve the parent(s) in discussion regarding the examination or treatment prior to consent being given. Where a child is in need of surgery, a general anaesthetic or other specific medical treatment, the child's Social Worker should actively seek to involve the parent(s) with PR.

	• Consent should be given in writing by the parent and the local authority delegated person as above (but is equally valid if given verbally, provided it was informed and freely given). • Children's wishes and feelings where possible should be obtained, considered and accounted for. • If a Looked After child under 16, who is subject to a Care or Interim Care Order, the Team Manager should give consent if the parent(s) are unable or unwilling to do so. • If a Looked After child requires serious medical treatment, this should be brought to the attention of the LA senior management, who can then give consent and delegate a Social Worker or Team Manager to attend the hospital, discuss the surgery, anaesthetic and risks with the doctor(s). • In a 'life or limb' situation, a Doctor must act in the child's best interest and may proceed without consent. • Children receiving medical treatment who are Looked After by another LA should follow the same process as Looked After children locally.

What happens when those with PR disagree?

Disputes between parents can be difficult for everybody involved in the child's care. Health professionals must take care to concern themselves only with the welfare of the child and to avoid being drawn into extraneous matters such as marital disputes.

Generally, the law only requires doctors to have consent from one person with PR in order lawfully to provide treatment. However, doctors may feel reluctant to override the dissenting parent's strongly held views, particularly where the benefits and burdens of the treatment are finely balanced, and it is not clear what is best for the child. If the dispute is over a controversial and elective procedure (for example: male infant circumcision for religious purposes), doctors must not proceed without the authority of a court judgement in the case.

In other cases, discussion aimed at reaching consensus should be attempted. If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement. The onus is then on the dissenting parent to take steps to reverse the doctor's decision.

If you are in any doubt about whether the person with the child has PR for that child, you must check. Others (such as adopted parents, step-parents or the Local Authority) may acquire parental responsibility via specific legal processes.

When babies or young children are being cared for in hospital, it will not usually seem practicable to seek a parent's consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you must remember that, in law, such consent is required. Where a child is admitted, you must therefore discuss with their parent(s) what routine procedures will be necessary and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

Appendix 3 – Overview of Lawful Authority for examination, care or Treatment – Under 16s