NHS
East Midlands
Ambulance Service
NHS Trust

Capacity to Consent and Regional Mental Health Conveyance Policy

EMAS regional policy, aimed at support multi-agency partnership working.

Links

The following documents are closely associated with this policy
Internal EMAS policies and procedures:

- Chaperone Policy
- Health and Safety Policy
- Infection Prevention and Control Operational Procedures
- Infection Prevention and Control Policy
- On Scene Conveyance and Referral Procedure
- Safe Holding Policy
- Research Management and Governance Policy and Procedure
- Safeguarding Children and Young People Policy
- Safeguarding Adults Policy
- Untoward Incident Reporting Policy
- Clinical Record Keeping Policy
- Diagnosis of Death Procedure
- End of Life Care Policy

External References:

- Family Reform Act 1969
- Children Act 1989
- Mental Capacity Act 2005
- Mental Health Act 1983 – Revised 2007
- Care Act 2014
- Mental Capacity Act Bill 2019
- Health and Social Care Act and associated regulations
- JRCALC Guidance

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1.0	13 July 2010	August 2010	Clinical Governance Group	New Policy for EMAS Trust
2.0	19 January 2011	February 2011	Clinical Governance Group	NHSLA recommendation suggested amalgamating the Non-conveyance of Patients to a treatment Centre Procedure with the Consent Policy. Section 7 has been added to the Policy to cover this. Section 8 - Includes advice regarding people with Learning Disabilities Section 7 – Makes reference to patient safety-netting
3.0	17 August 2011	October 2011	Clinical Governance Group	The following amendments have been made: Section 10.1 – Sentence added to end of paragraph Section 10.2 – Sentence added to end to paragraph. Section 11.3.2 – New point added. Appendix 4 – Flowchart amended Appendix 5 – Flowchart amended.
3.1	30 July 2012	August 2012	Quality and Governance Committee	Ratified by Quality & Governance Committee
3.2	16 June 2014	June 2014	Clinical Governance Group	Review date extended to 30 September 2014
4.0	21 July 2014	July 2014	Clinical Governance Group	Update and added section on Gillick competence in older children
4.1	16 September 2015	September 2015	Clinical Governance Group	Name changed from Consent Policy to Capacity to Consent Policy. Updated with further clarity around capacity assessment process and inclusion of new appendices

5.0	21 December 2017	12 January 2017	Clinical Governance Group	Full document review. Minor amendments required
6.0	22 January 2019	25 January 2019	Clinical Governance Group	Full document review.
7.0	23 January 2020	10 February 2020	Clinical Governance Group	Full review of the document included fluctuating capacity and documentation of communication also changes to titles
7.1	16 March 2020	23 March 2020	Clinical Governance Group	Addition of DOLs/LPS, LPA and MCA statement for staff
7.2	11 January 2021	28 January 2021	Clinical Governance Group	3-month extension to review deadline until 30 April 2021
8.0	10 May 2021	20 May 2021	Clinical Governance Group	Combine previous Capacity to Consent Policy V7.2 and Regional Mental Health Conveyance Policy V3.0, which has now been withdrawn, in line with changes to legislation, best practice and local multi-agency processes
9.0	10 May 2022	17 May 2022	Clinical Governance Group	Full document review Bookmarks added

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1. Introduction

1.1 East Midlands Ambulance Service NHS Trust is committed to providing the best healthcare to the public it serves with all partnership agencies. Patients presenting with mental health conditions along with complex health and social care needs are required to be managed in a consistent and professional manner at all times.

In this policy all references to the Mental Health Act refer to the Mental Health Act 1983 as amended by the Mental Health Act 2007. The Mental Capacity Act refers to the Mental Capacity Act 2005.

This Policy sets out the standards and guidance for all staff employed by East Midlands Ambulance Service (EMAS) NHS Trust who provide care to patients. This policy is in accordance with the requirements laid down by the Department of Health (DoH) with respect to seeking consent for examination and treatment of a patient.

1.2 The Mental Health Act Code of Practice requires Local Social Services Authorities (defined in S.145 (1) Mental Health Act), the NHS and the local Police Services to establish a clear policy for the use of the powers to convey a person to hospital under S.6 (1) Mental Health Act. This policy also covers the conveying arrangements for detained patient and voluntary admissions.

1.3 This policy and guidance outline the roles and responsibilities of each of the organisations. Although this is an EMAS policy it will align to local concordat divisional processes related to mental health. This policy provides guidance for ambulance service personnel, non-emergency patient transport personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHPs – as defined in S114 Mental Health Act) and police officers.

1.4 This policy and guidance reflect the requirements of:

- East Midlands Ambulance Service NHS Trust (EMAS)
- Locality mental health NHS Trust providers.
- All East Midlands Local Authorities.
- Accident & Emergency (A&E) departments and general hospitals.
- Locality Transport Solutions
- Police forces within the East Midlands region.

1.5 The overall aim of this policy and guidance is:

1.5.1 To ensure that patients detained under the Mental Health Act: “should always be conveyed in a manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people.” (Mental Health Act Code of Practice 11.2).

1.5.2 To ensure that patients not detained under the Mental Health Act are conveyed in the least restrictive most appropriate conveying vehicle with staff suitably trained and supported by Mental Health practitioners and or police if deemed clinically necessary.

1.6 For information and guidance on the management and transport of patients who lack mental capacity they will be assessed in accordance with the Mental Capacity Act. The dynamic risk assessment principles around conveyance under the Mental Capacity Act (MCA) equally apply where assistance is necessary. This always starts with the least restrictive intervention balanced against the necessity of an intervention under best interest principles.

1.7 Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination and is needed regardless of the procedure.

1.8 Consent is an essential part of medical ethics and sits within international human rights law.

2. Objectives

2.1 The objectives of this policy are to:

- Provide a robust and formal process for the transportation of patients with an associated mental health condition, in line with the Mental Health Act 1983
- Define capacity, how capacity is assessed, when capacity is used and to correctly document a patient's capacity.

3. Scope

3.1. This document applies to all staff who are employed both directly and indirectly by EMAS, including students, volunteers and those on temporary contracts, secondments, other flexible working arrangements or commissioned services.

3.2. This document will provide staff with the knowledge, understanding and guidance around a patient's capacity to consent and the transportation of patients with a mental health condition.

3.3. EMAS is committed to promoting equality of opportunity, celebrating, and valuing diversity and eliminating unlawful discrimination. We are committed to achieving equality for our patients and staff members by reducing discrimination in employment and service delivery on the grounds of age, disability, gender, gender reassignment, marriage and

civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

4. Definitions

4.1. **Valid Consent –** The voluntary and continuing permission of the patient. For consent to be valid, it must be voluntary and informed, and the patient must have the capacity to make the decision. The patient must not be acting under duress.

4.2. **Informed Consent –** A patient's consent to a procedure after being advised by the Health Care Professional of all the relevant facts, the reasoning and the risks involved. Consideration must be given to what the patient would wish to know about the risks involved with any decision and be based upon an agreement with the patient. It should include whether there are alternative treatments and what would happen if they do not have the treatment.

4.3. **Capacity to Consent –** the ability to understand and retain information, material to the decision that is being made – especially as to the consequences of having or not having the treatment, and the ability to believe it and use it to weigh up the information to make an informed decision.

4.4. **Fluctuating Capacity -** A patient who has the intermittent inability to make a decision for themselves, based on their clinical presentation at the time.

4.5. **Duration of Consent -** the length of approval gained through valid consent being given by the patient. Consent usually remains valid unless it is withdrawn by a patient. New information must be given to the patient as and when it arises, and consent regained.

4.6. **Gillick Competence -** defined as: "...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent." (Mr Justice Woolf, 1982)

4.7. **Duty of Care –** The absolute responsibility of the Health Care Professional, to treat and care for the patient with a reasonable degree of skill and care.

4.8. **Best Interests –** An act completed, or decision made for a patient who lacks capacity, and is carried out under the Mental Capacity Act (2005).

4.9. **Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards (LPS) –** provides the legal authority to deprive the patient of their liberty in their best interests criteria whilst in a care home or hospital.

4.10. **Lasting Power of Attorney (Health and Welfare)–** A legal document which allows a patient to appoint one or more people to help make decisions on their behalf, when they are no longer able to make these decisions for themselves.

4.11. **NHSLA -** National Health Service Litigation Authority

4.12. **JRCALC -** Joint Royal Colleges Ambulance Liaison Committee

4.13. **ADRT -** Advance Decision to Refuse Treatment

4.14. **MCA –** Mental Capacity Act (2005)

4.15. **MHA –** Mental Health Act (1983)

4.16. **AMHP –** Approved Mental Health Professional

4.17. **HCP -** Health Care Professional

5. Responsibilities

5.1 Chief Executive

5.1.1 The Chief Executive is the executive member of the Trust board, with overall accountability in relation to consent, patient transport, patient safety and experience.

5.2 The Director of Quality Improvement and Patient Safety

5.2.1 The Director of Quality Improvement and Patient Safety has overall responsibility for the implementation of this policy, in accordance with National guidance and for ensuring that all clinicians deliver care in accordance with this policy.

5.3 The Deputy Director of Clinical Quality

5.3.1 Has the responsibility for assuring that there are arrangements in place to maintain the safety and wellbeing of all patients.

5.4 Mental Health Lead

5.4.1 Is responsible for ensuring that the policy is up to date with and in line with the national guidance, legislation and benchmarking.

5.5 **Safeguarding Lead**

5.5.1 Is responsible for ensuring this policy links with the Trust's safeguarding responsibilities for vulnerable adults and children.

5.6 **Organisational Learning**

5.6.1 Organisational Learning should work in partnership with internal and/or external identified leads in subject specific areas so that the most current guidelines and recommendations are incorporated into the education programme.

5.7 **EMAS Clinical Staff**

5.7.1 Should ensure that they maintain their knowledge of the topics contained within this policy – in line with their scope of practice.

5.7.2 Treat patients with respect and understand their own responsibilities and duty of care when patients have fluctuating capacity or when transporting patients with a mental health condition.

5.7.3 Be aware of the law surrounding mental capacity, consent and act in accordance of this.

5.7.4 Document their decision-making process clearly and all actions carried out whilst on scene with the patient and during transportation.

5.7.5 Be familiar with and adhere to the contents of this policy.

5.8 **Emergency Operations Centre (EOC)**
Is responsible for dispatching a resource in accordance to the operational guidance

5.9 **Dispatch Officer**

5.9.1 Is responsible for sending, if appropriate, resource for managing and transporting patients who are presenting with a mental health condition.

6. Capacity to Consent

6.1. **What is Consent?**

6.1.1. The consent to treatment means that a patient must give the Healthcare Professional their permission before they receive any type of medical treatment or examination.

6.1.2. Consent must be provided on the basis that the Healthcare Professional has provided the patient with an explanation as to why the treatment, test or examination is required.

6.1.3. Principles of the Mental Capacity Act (2005) are;

- A patient must be assumed to have capacity, unless it is established that they lack capacity
- A patient is not treated as unable to make a decision, unless all practicable steps to help them to do so have been taken without success
- A patient is not treated as unable to make a decision merely because they make an unwise decision

6.2. **Defining Consent**

6.2.1. Consent is only valid when it is given by the patient voluntarily and is informed, the patient providing consent must also have capacity to do so.

6.2.2. Voluntary – the decision made by the patient on whether or not to consent to the medical treatment must not be influenced by others, for example; a Health Care Professional, friends of family.

6.2.3. Informed – the Health Care Professional must provide the patient with what the treatment may involve, the reasons for the requirement, the risks involved and any alternatives that may be available to the patient.

6.2.4. Capacity – the patient must be able to provide consent, which means that the patient is able to understand all of the information which has been provided to them and can use this information to make the best decision for themselves.

6.2.5. If a patient has the capacity to consent and their decision is informed and voluntary, they have the right to withdraw their permission and consent to medical treatment, and this decision must be respected.

6.3. **How Consent is given**

6.3.1. A patient can provide their consent verbally, by communicating that they are happy for the medical treatment and written consent can be provided, such as via a signed consent form.

6.3.2. Non-verbal consent can be provided by a patient, as long as they fully understand the treatment or examination that will be carried out. This can be done for example by a patient holding their arm out for their blood pressure to be taken.

6.4. **Consent for Patients whose First Language is not English**

6.4.1. The Trust is committed to ensuring that patients whose first language is not English receive the information they need to consent to treatment and are able to communicate appropriately with healthcare staff. It is not best practice to use family members to interpret for the patient who does not speak English, however it is recognised that this may be the only option available.

6.4.2. If language is a barrier to effective communication, then staff should contact 'Language Line'. Language line information is available in the back of the EMAS communication booklet or on the GETAC.

6.4.3. Should a staff member wish to use a translation application on a mobile device this is also acceptable.

6.5. **Consent for Patient with Speech and Language difficulties**

6.5.1. The Trust is committed to ensuring that any patient for whom communication is difficult receive the information they require and are able to communicate effectively with EMAS staff with this in mind all EMAS frontline staff are issued with a communication booklet and it is also available on the GETAC.

6.5.2. The booklet has been primarily developed in easy read to enable communication for individual with learning disabilities however it also provides support for individuals with aphasia and/or hearing impairment.

6.6. **Clinical Photography and Conventional or Digital Photography**

6.6.1. Photography intended to benefit the patient's treatment is seen as 'treatment' in itself and requires valid consent. All photographs should be taken using the GETAC, these photos will then be retained digitally within the EPRF. It must be noted that the use of photography should be rare.

6.6.2. Staff should not use personal devices to take photographs or videos.

6.6.3. All other photography and video for purposes such as media promotion require patient and staff consent, which needs to be sought in writing.

6.7. **When Consent is not required**

6.7.1. There may be occasions when consent is not required by a patient, even when they can provide it.

6.7.2. Examples of this are:

- The patient needs emergency life-saving treatment and are incapacitated (such as being unconscious). Detailed reasoning on why the treatment was necessary should be provided to the patient on their recovery.

- A patient has a severe mental health condition and lacks the capacity to consent to treatment for their mental health (under the Mental Health Act 1983). In these circumstances, treatment that is unrelated to the patient's mental health, still requires the patients consent – which the patient may still be able to provide, despite their mental health condition. NB: Suicide/Self harm attempts may be seemed by an approved mental health clinician to form part of a mental health condition.

- An unborn foetus has no rights under consent law. A pregnant mother has every right to refuse treatment for herself or her foetus, irrespective of the potential harm that may arise to the foetus. In situations where a mother makes risky lifestyle choices during pregnancy (Drug and alcohol abuse) that will continue when the child is born staff should make a safeguarding referral.

- The Public Health (Control of Disease) Act 1984 provides that, on an order made by the magistrate or sheriff, persons suffering from certain notifiable infectious diseases can be medically examined, removed to, and detained in hospital without their consent.

- If a patient refuses decontamination treatment, for example following a chemical, biological, radiological or nuclear (CBRN) incident, ambulance clinicians should liaise with the Police, Public Health England and Public Health laboratories to decide on an appropriate course of action. Powers lie within these groups to take action for the public good.

6.8. **What is Capacity**

6.8.1. Capacity is the ability to understand and use information provided, to make a decision and communicate any decisions made.

6.8.2. A patient lacks capacity if their mind is impaired or disturbed in some way, which results in the patient being unable to make a decision at any time. Examples of these are;

- Mental Health Conditions

- Dementia
- Severe Learning Difficulties
- Brain Damage – for example Stroke
- Physical or mental conditions which cause confusion, drowsiness or a loss of consciousness
- Intoxication caused by drugs or alcohol misuse

6.8.3. A patient with such an impairment is thought to be unable to make a decision if they cannot;

- Understand information about the decision they are required to make
- Remember the information that is provided to them
- Use the information provided to them to make a decision
- Communicate their decision by talking, using sign language or another method

6.9. **Assessing Capacity**

6.9.1. Capacity can sometimes alter over time and it should be assessed by a Health Care Professional at the time in which it is required.

6.9.2. Capacity is usually assessed by the decision maker who is either;

- Recommending the treatment or investigation
- Involved in carrying out the treatment or investigation

6.9.3. If it is felt that the patient lacked the capacity to consent and there are no advance decisions made or a formally appointed individual to make decisions on the patient's behalf, the decision maker will have to consider the best interests of the patient.

6.10. **Determining a Patient's Best Interest**

6.10.1. Where a patient is identified has lacking the capacity to consent, the Health Care Professional must consider whether to go ahead with the treatment. To make a decision, the Health Care Professional, must consider the patient's best interest.

6.10.2. Elements to consider when making a best interest decision are;

- Whether it is safe to wait until the patient can provide their consent, if it is likely that they could regain their capacity at a later date or time.
- Involvement of the patient, as much as it is possible.
- Trying to identify if there are any issues in which the patient would take into account themselves if they were making the decision for themselves. This could include any religious or moral belief, any views the patient

may have previously expressed and any insight that the patient's friends and family can provide.

6.11. **Changes in Capacity**

6.11.1. A patient's capacity may alter over time, such as they may have the capacity to make some decisions, but not others. Patient's capacity may also come and go. In some cases, a patient may be considered to make decisions on some aspects of their care and not others.

6.11.2. An example of this is a patient with a learning disability who may be capable of making decisions on their day to day treatment but may not be capable of understand complex medical issues, which are long standing.

A patient's capacity may also be affected temporarily by;

- Shock
- Panic
- Extreme tiredness (Fatigue)
- Medications

6.12. **Advance Decisions and Power of Attorney**

6.12.1. If a patient is aware that their capacity to consent may be affected at some point in the near future, they may choose to put a living will (also known as a legally binding advance decision). This sets out the procedures and treatments that a person refuses to undergo.

6.12.2. A patient can also choose to formally arrange for an individual – which is often a close family member – to have Lasting Power of Attorney (LPA).

6.12.3. An individual who has an LPA, can make decisions about the health and treatment of a patient, a patient can also choose in advance which treatments they wish to refuse. These documents must be checked to confirm that they are in place.

6.13. **Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards (LPS)**

6.13.1. DoLS apply to people over the age of 18 only residing in care homes or hospitals. DoLS aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. Anyone over 16 may

be deprived of their liberty outside these setting and any such deprivation can only be authorised via an Application to the Court of Protection.

6.13.2. Sometimes restrictions have to be placed on people for their own safety. There are different levels of restriction ranging from a locked door to physical restraint. These restrictions become what is legally known as a deprivation of liberty.

6.13.3. A Deprivation of Liberty is defined by applying the 'Acid Test' created by Lady Hale in the Cheshire West (2014) case, the test is as follows;

- The patient/resident lacks the mental capacity to consent to their care plans and accommodation AND
- They are under continuous supervision and control AND
- They are not free to leave and live elsewhere.

6.13.4. Transporting a person who lacks capacity from their home in an emergency, via ambulance to hospital will not usually amount to a deprivation of liberty.

7. Key Provisions of the Mental Capacity Act (2005)

- There must always be the presumption that people you provide care of treatment for have the capacity to make decisions for themselves. If there is reason to believe a patient may lack capacity, a capacity assessment should be completed.

- A single clear test for assessing whether a person lacks capacity to make a decision.

- A check list of key factors which provides a starting point to help you determine what is in the 'best interests' of a person lacking capacity.

- Several ways that people can influence what happens to them if they are unable to make particular decisions in the future, including advance decision to refuse medical treatment, statements of wishes and feelings, and creating a Lasting Power of Attorney (LPA).

- Clarification about the actions you can take if someone does lack capacity, and the legal safeguards that will govern this.

- An obligation for you to consult, where practical and appropriate, people who are involved in caring for the person who lacks capacity, and anyone interested in their welfare (for example family members, friends, partners and carers) about decisions affecting that person.

- A new advocacy service called the Independent Mental Capacity Advocate (IMCA) service.

- A new criminal offence of ill-treatment or wilful neglect of people who lack capacity.

7.1. The Five Principles of the MCA (2005)

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

7.1.2. The five principles are:

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

2. An individual must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means every effort should be made to support and encourage the person to make their own decisions (this includes all the steps to ensure the patient understands (i.e. consideration of language line or pre-hospital communication booklet).

3. An individual has the right to make what others might regard as unwise or eccentric decisions. This means individuals have their own values, beliefs and preferences which may differ from other people, and they should not be seen as lacking capacity because of this.

4. Anything done for on behalf of a person who lacks capacity must be done in their best interest and in the less restrictive method. An explanation of the term “best interest” is not specifically defined in the MCA, although the principle is set out in the Act as “An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interest”. The person who has to make the decision on behalf of the person who lacks capacity is known as the decision-maker.

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

   These include:

- Assumptions about best interest cannot be made merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.
- The decision maker must consider all the relevant circumstances relating to the decision in question.
- The decision maker must consider whether the person is likely to regain capacity e.g. after receiving medical treatment. If so, can the decision or act wait until then.
- The decision maker must involve the person as fully as possible in the decision that is being made on their behalf
- If the decision concerns the provision or withdrawal of life sustaining treatment the decision maker must not be motivated by a desire to bring about the person's death.
- The decision maker should consider the persons past and present wishes and feelings – if they have been written down.
- Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors should be considered by the decision maker.

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

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

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

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

7.2. **Children and Young People Under 16:**

7.2.1. Consent may be given either by the person with parental responsibility for the child or where the child has capacity to give consent, by the child. Where the child has sufficient maturity and understanding of the proposed procedure ('Gillick Competent') then the child is legally able to consent to treatment (but may not be able to refuse treatment). We must

ensure they are protected and their best interests are taken into account. To prevent a child from risk of significant harm parental consent may be overridden. Staff should also contact Police via EOC in an emergency situation to enable police use their powers of protection.

7.3. Appendix 2 is a guide that helps support assessing capacity in an emergency situation and where concerns about a patient's capacity has been identified.

8. Safe-Holding

8.1. EMAS use the terminology safe holding rather than restraint.

8.2. Safe holding covers a wide range of actions, including the use, or threat, of force to do something that the person concerned resists, for example by using ambulance stretcher sides for confining people's movements or a restriction of his/her liberty of movement (falling short of a restriction that would deprive them of their liberty).

8.3. The Mental Capacity Act 2005, identified two additional conditions which must be satisfied for protection from liability for safe holding to be available:

- You must be reasonably believing that it is necessary to safe hold the person who lacks capacity in order to prevent them from coming to harm
- Any safe holding must be reasonable and in proportion to the potential harm.

8.4. If any safe holding is used, the type of safe holding, staff positioning, application of force, and location of patient force was applied and the duration it was applied for must be recorded on the Electronic Patient Report Form (ePRF) or Patient Record Form (PRF) and an incident report form (IR1) must also be completed.

8.5. If the patient is not acutely unwell, further support and advice can be sought from the community-based services such as the patients GP, Out of Hours Providers and Mental Health Services.

8.6. Within EMAS further advice can be sought from the Clinical Assessment Team (CAT) or relevant Metal Health Pathways.

8.7. In instances where the level of restraint required goes above that of EMAS safe holding training and where a patient requires conveyance, police assistance can be sought as the last resort, when all other proportionate avenues have been ruled out.

8.8. In cases where police colleagues are requested, crews should contact EOC to request support.

9. Record Keeping

9.1. The assessment and the conclusions drawn from any assessment regarding loss of capacity or consent should be recorded on the ePRF.

9.2. This record is made in order to evidence that the crew attending the patient had a reasonable belief that the patient lacked capacity to make the decision at the time it needed to be made, that they were acting in that person's best interest and to record what, if any safe holding was used.

10. Mental Health Act Conveyance

EMAS is contracted to convey patients under specific sections of the Mental Health Act – which are sections 2, 3, 4, 135(1) and 135(2), following the detention by an AMHP, to an inpatient facility operated by the Local Mental Health Partnership Trust/private provider, or, in case of section 136, within the area covered by the requesting police force to the least restrictive place of safety available. This also applies to patients who are informal, therefore being admitted to hospital voluntarily.

In the case of a medical emergency, patients who are assessed to lack capacity will be conveyed to an appropriate Emergency Department. The police may be requested to assist in conveying patients who pose a risk of violence and aggression to staff and public.

Incidents where patients are detained or lack capacity and the risk to staff is low requiring coercion or guided assistance should be managed by EMAS staff and not normally require police assistance. There may also be a clinical reason for the ambulance to be in attendance and provide the transport platform. Any necessary clinical triage or screening will be done by the responding EMAS staff and where necessary with the advice of EOC CAT for more complex cases.

A patient will be conveyed to hospital or appropriate mental health facility in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient, staff or to others.

Under the authority of an AMHP, EMAS will convey under the 1983 Mental Health Act, using the most clinically appropriate vehicle and the most appropriate response including time span. A dynamic risk assessment will take place between the AMHP, EMAS and any other partnership agency, with the most appropriate mode of transport.

10.1. All calls received by EOC are prioritised for response using the Ambulance Priority Dispatch System (AMPDS) and calls which identify mental health associated presenting conditions will refer to Protocol 25 – Mental Health Protocol. For transport only calls, and depending on the acuity of the call, the most suitable available resource will be dispatched to the patient, based on their needs.

Mental Health Act section 2, 3, 135(1) and 135(2), requests for non-emergency transport use telephone 0115 967 5099 which is the urgent booking line.

Please note a section 135(1) refers to a warrant issued by a magistrate requiring AMHP, police and EMAS attendance to remove a patient from a residential address and transport to a place of safety, for the purpose of a Mental Health Act assessment. As such, the AMHP will request a specific Estimated Time of Arrival (ETA) from EMAS, where possible, to coordinate all resources.

These calls should refer to requests for transport following a community or Emergency Department Mental Health Act assessment. In these circumstances the urgent booking line should be used in the first instance unless there is concern, regarding an associated potential life-threatening emergency. In those cases, the 999 option should be used.

10.2. Calls for mental health transport and response times for EMAS are as follows:

Category 2 – police should request a Cat 2 via 999 response for patients already detained under section 136. This is in line with nationally agreed ambulance and police protocols to achieve and average response time of 30 minutes.

Please note that if a patient is being actively restrained in a way which indicates they are medically compromised, the police should highlight this and it should be coded appropriately under AMPDs, which may require a Category 1 response (e.g. positional respiratory compromise, positional asphyxia or acute behavioural disturbance).

The patient remains detained by the police, who transport in convoy to the identified place of safety.

AMHP booking processes for patients detained under sections 2, 3, 4, 135(1) or 135(2) of the MHA and voluntary admissions in the community. Social care and Patient Transport Services (PTS) transports are excluded and are by local arrangement only. These types of calls are processed via the urgent booking line as highlighted above. These calls will receive a 1, 2 or 4 hour booking option based on AMHP clinical need request.

Section 135(1) involves an AMHP co-ordinating a response incorporating the police, AMHP and EMAS to be on scene together for the police to execute a magistrate warrant at a private dwelling to take a patient to a place of safety. As such the AMHP may request an ETA, on the ambulance or regularly for updates on an ETA. Section 135(2) warrant is to provide police officers with powers to enter a private dwelling to remove and take a patient or return them to hospital or another place of safety as

coordinated by a responsible person (AMHP, Care coordinator, member of a multi-disciplinary team etc.)

If the patient is also experiencing a serious medical problem (such as a toxic intentional overdose), then the AMHP should phone 999 as a medical emergency and ED attendance for treatment becomes the priority. However, dialling 999 purely for a transport booking process leads to unnecessary screening of the AMPDS protocol. This will delay the booking process and apply pressure to the Emergency Medical Dispatchers (EMD) call system.

10.3. EMAS are currently commissioned to convey patients detained under section in the community to the nearest available mental health locality trust bed, bed identified by the responsible CCG, or police place of safety. Where there is not a local bed within the division, the mental health provider trust bed management team and AMHP are required to arrange a private ambulance transport under their locally agreed processes for conveyance out of area. During this time the safety of the patient is managed through negotiation between the AMHP and mental health provider trust. It is recognised that there is a gap in out of area provision, which impacts on patient experience and lead commissioners are aware.

10.4. When considering the most appropriate and least restrictive conveyance platform, the AMHP must consider a dynamic risk assessment related to the potential risk of absconding from a moving vehicle and potential risk of patient harm. Although rare, potential risk to Trust property, risk of aggression to the public or escorting staff should also be considered. This risk assessment should be done in consultation with all agencies and where there is a difference of opinion, this should be escalated within the line management structures.

10.5. In exceptional circumstances and where police escorts and/or mental health nurse escorts are required for conveying patients longer distances, close co-operation between agencies will be needed to agree the most practical timeframe and suitable way to manage the conveyance.

10.6. Court Sections under the Mental Health Act include section 35, 36, 37, 38, 45a, 47 and 48. The courts will usually take responsibility for deciding who will undertake transportation to hospital. However, in a medical emergency, normal 999 processes will apply. Patients subject to conditional discharge under section 41 in the community may also be recalled to hospital by a warrant issued by the Ministry of Justice. This transfer will require an ambulance but a plan of the best way of transportation will be agreed between the ambulance service and the police.

11. Risk Assessment

11.1. Where a risk assessment conducted by an AMHP concludes that there is justifiable evidence that staff are likely to face physical active resistance, aggression or violence, the AMHP will discuss with EMAS the merits of requesting police to assist with the escort and any subsequent conveyance of the patient to hospital. Each organisation will use their own approved risk assessment process to complete the risk assessment.

11.2. If the situation during the assessment deteriorates and risks increase, prior to the arrival of the police, the AMHP will liaise with the police via 999. The AMHP will then telephone EMAS, via 999, providing the incident number and ask for the request for assistance to be upgraded. The evidence for the upgrade request will be based on previous knowledge from all agencies of the patient and their presenting behaviour.

11.3. If the patient has been sedated, EMAS will advise on the most appropriate vehicle to be used. In such circumstances, the patient may need to be accompanied by a nurse, doctor or ambulance clinician experienced in this area, related to risks associated with sedation and being clinically assessed. Only suitably qualified medical practitioners can prescribe medication and/or authorised and arrange any nurse escort.

11.4. Should the patient require a police presence, this should be arranged by the AMHP, or if there is not an AMHP present, the EMAS EOC Dispatcher. They should contact the police control room, to request police assistance as soon as a resource is available to be allocated. The police will complete their own risk assessment to determine the most appropriate response, which will be based on the National Decision Making-Model, therefore, the information provided at the point of the request should be clear and relevant.

The dispatcher will ensure police control and the AMHP are kept informed should there be any delays in the ambulance response. Where appropriate, a rendezvous point may be required. Either EMAS or the AMHP making the request must be in a position to outline what steps have been taken, and why the police assistance is required.

11.5. For any inter-facility transfers, the duty of care for the patient remains with the referring Trust and as such a clinical escort must be provided. EMAS provision is for a transport platform only.

12. Escorting Patients

12.1. Were patents are detained under the Mental Health Act the AMHP has the power to delegate the task of conveying the patient to another person, such as personnel from the transport provider or police – in cases involving requests for police conveyance, the police will first consider the risks in collaboration prior to accepting the delegated task.

There is no requirement for the AMHP to travel in the same vehicle as the patient to hospital. If the task is delegated, a form of authorisation may be used and given to the delegated person. The AMHP should travel behind the ambulance to handover the patient to the inpatient mental health ward. The patient's detention papers can be provided to the crew prior to travel, however, if these are completed online, the AMHP should complete the EMAS mental health transporting paperwork, which provides specific information related to the patient – see appendix 5 Authority to Transport Form.

12.2. In exceptional circumstances, where the AMHP delegates the conveyance of the patient, they must be confident that the person accepting the responsibility is competent and fully aware of their responsibilities in relation to this task. This decision must be made following a full risk assessment of the patient's current mental health condition, their potential for deterioration and the ability of the staff transporting the patient to safely care for the patient and safely manage their condition, if they do deteriorate on route. It is the responsibility of the person accepting the delegation to act on their own initiative where safe holding may be required to prevent a patient from absconding (MHA Code 17.18).

12.3. The AMHP will take the lead in coordinating conveyance to hospital of patients who are liable to be detained under the Mental Health Act.

12.4. The AMHP retains responsibility to ensure that the patient is conveyed in a lawful, safe and humane manner, and must be ready to give the necessary guidance to those asked to assist and will consult appropriately with staff from other agencies and take account of the views of the patient and relative/carer.

12.5. The AMHP, ambulance transport provider staff and police (or whoever is present) will review a dynamic risk assessment and agree the most appropriate method of transfer to ensure the safety of all concerned – which may or may not require action by the police. Police assistance should only be necessary in the most exceptional of circumstances for example, where there is justifiable evidence that staff are likely to face physical active resistance, aggression – more than merely verbal, violence or a realistic prospect of the patient absconding. (see appendix 3).

12.6. The police ensure that any action they take is proportionate to the situation presenting. They will also, where this is consistent with their duty to protect persons or property or the need to protect themselves, consider any directions or guidance given by the AMHP or ambulance transport provider staff, while the patient is being conveyed to hospital.

12.7. The AMHP may contact the EOC at any stage providing the EMAS incident number, to update or discuss the progress of the incident. Where

available, the AMHP should also provide the EOC with the police incident number.

12.8. If the admission is stopped at any stage, it is the responsibility of the AMHP to contact the EOC and cancel the request. The cancellation request should be made through the urgent booking line and not the emergency 999 line.

12.9. If, following a dynamic risk assessment (Appendix 3), the transport crew believe that by conveying the patient in their vehicle, they would put themselves at risk, they should review the risk assessment in conjunction with the AMHP and agree a plan to manage the patient using other assistance as required. It should be noted that the AMHP has the authority as the decision maker in law, in line with services commissioned by the relevant CCG.

12.10. It is always preferable to transport someone by ambulance vehicle. However, when there are identified risks, then measures may need to be taken to ensure the safety of the patient, ambulance staff, healthcare professionals and police officers. The safety of staff always needs to be a consideration in these circumstances.

12.11. If the patient would prefer to be accompanied by another professional or by any other adult, that person may be asked to escort the patient, provided the AMHP is satisfied that this will not increase the risk of harm to the patient or to others.

12.12. The AMHP should attempt to arrive at the same time as the patient at the hospital and remain there until they have ensured that the admission documents have been delivered, checked for accuracy and received on behalf of the hospital managers, any other information is given to the appropriate hospital personnel.

12.13. Police support may be required to follow the transporting vehicle, dependent on the level of risk as outlined in the risk assessment. Police support to travel in the transporting vehicle, with the medically trained staff, if indicated as clinically necessary, based on the risk of aggression.

12.14. The admission documents must be delivered by the AMHP or nominee. They will be checked for accuracy and received on behalf of the hospital managers on the admitting ward.

13. Inter-Facility Transfer

13.1. Where it is necessary to use transport services to convey the patient to hospital, responsibility to arrange this lies with the Trust in whose area the journey arises. This is the situation for both NHS and independent hospital patients. Both emergency and non-emergency transfers should follow the outcome of the fitness to travel assessment. IFT Level 3 (IFT3) is

30 minutes to 2 hours from request. There may be requests to upgrade an urgent response to an emergency response in certain circumstances where clinically indicated (i.e. where the patient's condition requires a quicker response for example when the patient is extremely agitated / anxious but compliant) or where the environmental situation is compromised to the detriment of the patient, to be undertaken in accordance with locally agreed procedures.

For emergency transfers, the card 25 protocol will be followed, and the call assessed for clinical priority using AMPDS. For non-emergency transfers the local agreed PTS authorisation process should be followed.

Conveyance for patients assessed and detained under the MHA from a medical hospital, following assessment, should follow the same process as indicated previously, for a community assessment.

Patients who have been sedated before being conveyed should always be accompanied by a healthcare professional that is knowledgeable in care of such patients, is able to identify and respond to any physical distress or complications which may occur and has access to the necessary emergency equipment to do so.

13.2. Where the AMHP is the applicant in these circumstances, they have a duty to ensure that all the necessary arrangements are made for the patient to be conveyed to the hospital and will consult closely with NHS staff identifying an available bed.

Both emergency and non-emergency transfers should follow the outcome of the fitness to travel assessment. For emergency transfers the EMAS EOC manager will assess operational demand/current pressures and authorise or deny the booking request. For non-emergency transfers, the agreed authorisation process should be followed.

13.3. The arrangement responsibility for patients who originate from out of area – beyond the geographical boundary covered by EMAS and require transport to return the patient to their local hospital, will be negotiated with the locality provider.

13.4. A joint discussion with EMAS, should initially take place and focus on the patient's presenting concerns and needs. However, if there is an agreement that such cases will be transported by EMAS as an extra-contractual referral and any costs will be fully met by the appropriate receiving organisation. The needs of the patient are paramount and cost questions should not unnecessarily delay conveyance as these can be discussed retrospectively.

14. Further Advice / Escalation of Concerns

14.1. A conflict of views between police, AMHPs and EMAS staff, with regards to how a patient should be transported and/or restrained will be resolved. This should be by formal escalation pathway, involving negotiation between the relevant attending police officer's supervisor. If unavailable, the police duty inspector, duty AMHP manager and the EMAS management structure should be contacted.

14.2. Police officer's and ambulance clinicians should seek further guidance from their supervisors or the mental health triage car, if available locally and as indicated.

14.3. Where there is a failure to reach an agreement, each organisation should escalate through their command, management or on call structure.

15. Consultation

15.1. Circulated through Trade Union Leads for comment.

15.2. Circulated through Regional Police Mental Health Leads for comment.

15.3. Circulated through Regional mental health providers for comment.

15.4. Circulated through Regional AMHP leads and Local Authorities for comment.

15.5. Circulated through relevant CCG's for comment.

15.6. Circulated through members of the Mental Health Programme Board for comment.

15.7. Advice and guidance sought from Trust's Equality and Diversity Leads

16. References

- Mental Health Act (1983)
- Mental Health Act (1983), Code of Practice (2015)
- Mental Capacity Act (2005)
- Mental Capacity Act (2005), Code of Practice (2007)
- Department of Health Reference Guide to Consent for Examination of Treatment: The Stationary Office: London
- JRCALC Clinical Practice Guidelines
- The Public Health Act (1968)

17. Monitoring Compliance and Effectiveness of the Policy

17.1. All organisations included in this agreement will ensure it is implemented in accordance with local procedures and will include provision for auditing the maintenance of compliance within the terms of the document.

17.2. The EMAS Mental Health Programme Board will review compliance and monitor any difficulties encountered and will report or escalate any matters via the appropriate committee or the Director of Quality Improvement and Patient Safety.

APPENDIX 1

Plan for Dissemination of Procedural Document

<table>
<tr><td>Title of document:</td><td colspan="4">Capacity to Consent and Regional Mental Health Conveyance Policy</td></tr>
<tr><td>Version Number:</td><td>V9.0</td><td rowspan="2" colspan="2">Dissemination lead:
Print name, title and contact details</td><td rowspan="2">Helen Auld</td></tr>
<tr><td>Previous document already being used?</td><td>Yes</td></tr>
<tr><td colspan="3" rowspan="2">Reading Categories
The Policy Reading Matrix helps staff identify which documents they must read dependent upon their role. Does the document need to be included on the Policy Reading Matrix as essential reading for certain staffing groups?</td><td>Yes</td><td>X</td></tr>
<tr><td>No</td><td></td></tr>
<tr><td>Essential Reading</td><td colspan="4">All operational staff</td></tr>
<tr><td>Awareness for Reference Purposes</td><td colspan="4"></td></tr>
<tr><td>As part of the dissemination process, who does the document need to be disseminated to?</td><td colspan="4">All operational staff

External multi-agency partners</td></tr>
<tr><td>Proposed methods of dissemination:

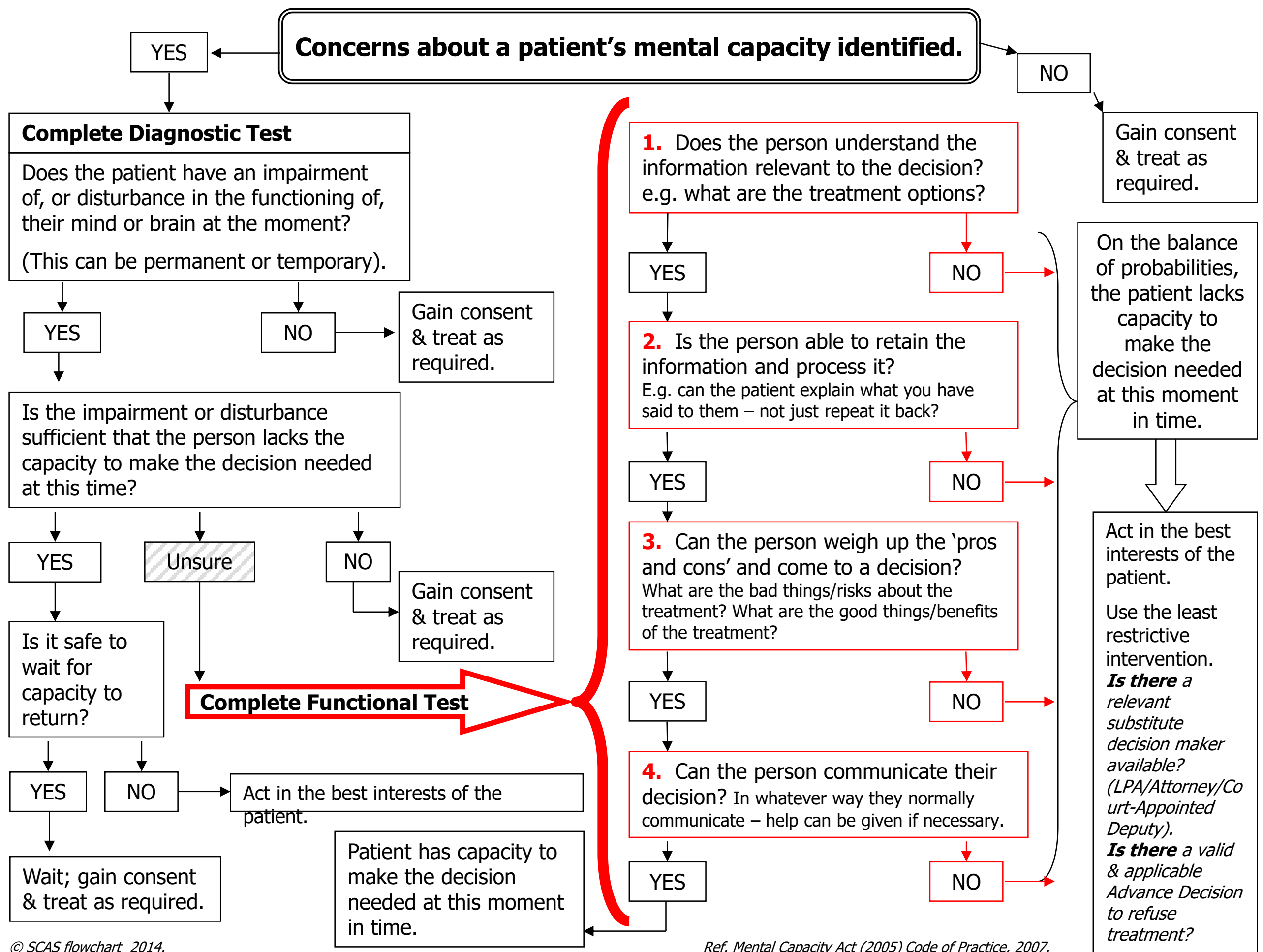
Including who will disseminate and when

Some examples of methods of disseminating information on procedural documents include:
• Information cascade by managers
• Communication via Management/ Departmental/Team meetings
• Notice board administration
• Articles in bulletins
• Briefing roadshows
• Posting on the Intranet</td><td colspan="4">Information cascade by managers
CPD Sessions
Clinical Governance
Publication in current policies section on Trust intranet
Electronic mail to multi agency partners</td></tr>
<tr><td>Summary for inclusion on the iEMAS section of the JRCALC Plus application</td><td colspan="4"></td></tr>
<tr><td>Key Words associated with the document (to aid searches on Insite)</td><td colspan="4"></td></tr>
</table>

Note: Following approval of procedural documents it is imperative that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.

Appendix 2

Assessing Capacity in an Emergency Situation



- Ensure documentation is completed as per normal protocols.
- Ensure MCA 2 stage assessment is documented in full with the time and outcome.
- Where possible document where relatives, carers, friends are on scene.
- Ensure involvement with local mental health service/crisis team if required.
- Document outcome and advice from any further assistance requested at scene such as from Police, social care, Mental Health Team, CAMHS, GP, OOH, CAT team or clinical on call through EOC.
- If patient is not transported, then where possible arrange for them to be with a responsible adult and document who this is.
- Safety net thoroughly giving worsening advice to both patient and carer/family.
- Explain to patient and carers to call again should the patient reconsider their decision.
- Where possible ensure onward referral, with consent, to GP.
- Consider safeguarding referral for care concern or concern for any dependants

Assessing Capacity in an Emergency Situation cont.…

Where a patient is in immediate risk, the ability to undertake a full and thorough assessment of their mental capacity is not always possible. (For example, a patient with reduced consciousness or catastrophic haemorrhage) In such circumstances decisions must be made based on the evidence available at that time and based on the principle that the balance of probabilities (i.e. being more likely than not) would suggest that the patient lacked capacity.

Any actions then undertaken on this basis must be considered immediately necessary to save life and or prevent serious deterioration in the patient physical or mental wellbeing. This doctrine is a positive duty in law, which means that failure to act could be deemed negligent.

Appendix 3

Name of person to be transported……………………………………Date……………………………………

DYNAMIC RISK ASSESSMENT RATING (*please circle appropriate answer)*
To be completed in consultation with patient, family and professionals involved if indicated

Risk Factor	High Risk	Medium Risk		Low
Detention under the Mental Health Act 1983	An application has been or is being completed. Patient is presenting a moderate to high risk to themselves or others. Patient has known history of violence / unpredictable behaviour. Patient actively resisting admission and physically able to do so.	An application has been, or is being completed. Patient is considered to present a potential moderate to high risk to themselves or others. Patient passively refusing admission. This can be the case for older people who may be distressed.		NO
Informal or informal admission	NO	NO		Patient accepting of situation, no evidence of presenting a risk to themselves or others
Substance misuse?	Dependent on illicit drugs or substances	Known History		No Known History
Alcohol misuse?	Alcohol dependent	Known History		No Known History
Suspected risk of suicide or self-harm?	MODERATE OR HIGH RISK	Low Risk	NO	NO
Involved in a violent and / or racial incident immediately prior to assessment	YES – serious incident	Yes – minor incident	NO	NO
Out of character, e.g. unusual behaviour prior to assessment; disappeared with no prior indication etc.	YES	NO		NO
Family / relationship problems or recent history of family conflict or abuse	YES	Maybe		NO
Recent or ongoing victim of bullying or harassment e.g. racial, sexual etc.	YES	Maybe		NO
Transportation Category (See Appendix 4)	**Risk Rating 4 Transportation**	**Risk Rating 3 TRANSPORTATION**	**Risk Rating 2 TRANSPORTATION**	**Risk Rating 1 TRANSPORTATION**

ADDITIONAL INFORMATION
Following Multi-agency discussion, please use this space to add additional information on any other risk identified or to expand on the risk rating above

Completed by…………………………………… Signature……………………………

AMPH………………………… Signature…………

Appendix 4

Available Conveyance Options

Use risk assessment tool in Appendix 3 to inform categorisation of transport required from the Ambulance Service.

Risk Rating 1 Transfer	
Informal Admission	Ambulance Required No considered risk Agreed to travel Risk Decision Tool completed Police not Required to attend Health Care Referral within 4hrs
Risk Rating 2 Transfer	
Section 2 or 3 Admission, CTO recall, Guardiansh	Ambulance Required No considered risk Agreed to travel Risk Decision Tool completed Police not Required to attend Health Care Referral 4hrs
Risk Rating 3 Transfer	
Section 2 or 3 Admission plus section 135 with warrant, CTO Recall, Guardianship	Ambulance Required Has not agreed to travel or is unsure Minimal or potential risk Risk Decision Tool completed Police to attend Immediate ambulance upon Police arrival
Risk Rating 4 Transfer	
Section 2,3 or 4 or Section 135, CTO Recall, S37 / 41 Recall	Ambulance Required Refuses to travel High risk Risk Decision Tool completed Police to attend Immediate ambulance upon arrival of Police Plan on how to transport to be agreed by Police and Ambulance Plan for how to remove patient between Police and Ambulance staff on scene
NOTE: AMHP / Worker responsible for transportation to inform ambulance service of estimated time ambulance support required ASAP for ambulance service to assist in coordinating timely transfer. Prompt cancellation required if not needed.	

NHS
East Midlands
Ambulance Service
NHS Trust

Appendix 5

Authority to Transport (Mental Health Act 1983)

I.. Approved Mental Health Professional

/ Responsible Clinician / Nearest Relative *(delete as appropriate)* within the meaning of the Mental Health Act1983, authorise

…………………………………………………………………………………………………

to transport / compulsorily remove *(delete as appropriate)*

Name of Patient……………………………………………………………………………

Address……………………………………………………………………………………..

…………………………………………………………………………………………….…

Who is currently the subject of legislation under Mental Health Act 1983 or

Requires informal admission *(delete as appropriate)*

To …………………………………………………………………………………………..

…………………………………………………………………………………………………

This Authority Expires on……………………………….

Signed……………………………………………..Date……………………………………

Address……………………………………… Emergency Tel: …………………….

Sedation

Medication..

Administered by.. at ……………am/pm

Signed…………………………………………Date..

Police Attended – Officer number........................ ....

Ambulance Transported – Crew number...