

Supplementary guidance on consent

For consultation

June 2016



Contents page

Contents page.....	2
Section 1: About the General Optical Council	3
Section 2: Consultation summary.....	4
Section 3: How to respond	6
Consultation questions	7
Annex 1 – Draft guidance on consent	12

Section 1: About the General Optical Council

1. We are one of 12 organisations in the UK known as health and social care regulators. These organisations oversee the health and social care professions by regulating individual professionals.
2. We are the regulator for the optical professions in the UK. We currently register around 29,000 optometrists, dispensing opticians, student opticians and optical businesses.
3. Our primary legislation is the Opticians Act 1989 (as amended) ('the Act'), and we also have a series of related rules that describe how we carry out our statutory functions. Our legislation can be found on our website at http://www.optical.org/en/about_us/legislation/index.cfm
4. The GOC has four main functions:
 - setting standards for optical education and training, performance and conduct;
 - approving qualifications leading to registration;
 - maintaining a register of those who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians; and
 - investigating and acting where registrants' fitness to practise, train or carry on business is impaired.
5. More information about the GOC can be found on our website: <https://www.optical.org/>

Section 2: Consultation summary

7. This consultation seeks the views of stakeholders on the new supplementary guidance (annex 1) we have developed on obtaining valid consent.
8. The aim of the guidance is to give registrants further support and clarity on the principles set out in the GOC's *Standards of Practice for Optometrists and Dispensing Opticians* and *Standards for Optical Students*.
9. The guidance on consent gives further information on:
 - what consent is;
 - the process of obtaining valid consent;
 - consent to share patient information;
 - refusal or withdrawal of consent;
 - capacity to consent;
 - advance decisions on healthcare arrangements; and
 - what to do in emergencies.
10. The consultation will run from **14 June 2016 to 6 September 2016** and applies to the whole of the UK.

Background

11. The GOC's new *Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students* came into effect on 1 April 2016 replacing the previous Code of Conduct for individual registrants.
12. The Standards are designed to make clear what we expect of our registrants, while allowing room for them to use their professional judgement in deciding how to meet the Standards in any given situation.
13. To view the Standards please use the following link:
<https://www.optical.org/en/Standards/index.cfm>

Obtaining valid consent

14. Patients have a basic right to be involved in decisions about their healthcare and agree or 'consent' to any examination or treatment that is proposed by their healthcare professional. The process of obtaining consent is a fundamental part of respect for patients' rights.
15. The new Standards Framework provides more detailed information for registrants on how to obtain valid consent from patients. The new Standards also make explicit reference to the legal obligations registrants have in relation to consent, for example, towards children, young people and vulnerable adults.

Supplementary guidance

16. When we first consulted stakeholders in 2015 in relation to our new Standards Framework, a number of stakeholders expressed a view that the GOC should

provide additional support and guidance to registrants on how to meet some of the Standards, including the standard on consent.

17. We considered this feedback and decided that additional guidance was required.
18. The aim of the supplementary guidance is to give registrants more detailed information on how to meet a specific standard.

Consultation

19. The aim of the consultation is for stakeholders to review the draft guidance and provide their feedback in the consultation questions.

Next steps

20. After the consultation period, we will analyse the consultation responses and present a revised version of the supplementary guidance on consent, along with our response to the consultation, to Council at their meeting on 16 November 2016.
21. We will aim to publish the guidance shortly after approval by Council.

Section 3: How to respond

The simplest way to provide a response is through our online consultation response form, which can be accessed here: <https://www.optical.org/en/get-involved/consultations/index.cfm>

If you are unable to submit your feedback online, then please use the form below to submit your written feedback. If you are unable to provide your response in writing or you require the consultation form in a different format, please contact us on +44 (0)2007 580 3898 to discuss reasonable adjustments that would help you to respond.

This form should be emailed or posted to:

Angharad Jones
General Optical Council
10 Old Bailey
London
EC4M 7NG

Email: ajones@optical.org

The data presented in our analysis will be summarised and supported by direct quotes from some of the responses received. These quotes will either be attributed to a named respondent or anonymised, depending on your preference as indicated in the consultation response form.

Alongside the analysis, we intend to publish the individual responses that we have received, unless you have indicated that your response is to remain private.

All data submitted will be stored securely and in accordance with data protection principles.

Publication of consultation responses

Unless you state otherwise we will assume you are happy for us to publish your response, including your name, and to share it with other appropriate bodies and stakeholders. We would however encourage named responses where possible and particularly from representative organisations so that we can reflect that the response is on behalf of members / stakeholders rather than an individual response.

Please tick here if you are only happy for us to share your responses anonymously:

Your name or the name of your organisation:

Which category of respondent best describes you?

- Member of the public
- Optical patient
- Optometrist
- Dispensing optician
- Student – optometry
- Student – dispensing
- Optical business
- Education or training provider
- Optical professional body
- Other optical employer
- Healthcare regulator
- Other (please specify below)

Consultation questions

Section 1: Our guidance

1. Do you support the GOC's approach in providing supplementary guidance on consent to support registrants in meeting their obligations in the *Standards of Practice for Optometrists and Dispensing Opticians* and *Standards for Optical Students*?

- Yes No

Please give your reasons below:

2. Does the new supplementary guidance on consent make it clear what the GOC expects of its registrants?

- Yes No

Please give your reasons below:

3. Is the guidance on consent presented in a way that is clear, accessible and easy to use?

- Yes No

Please give your reasons below:

4. Is there anything missing, incorrect or unclear in the guidance on consent?

Yes No

Please give your reasons below:

5. Are there any specific issues or barriers that could prevent stakeholders from implementing or complying with the guidance on consent?

Yes No

Please give your reasons below:

6. What action could the GOC (or other organisations) take to help registrants to implement the guidance on consent?

Please give your comments below:

Section 2: Impact

7. Overall, do you expect that the guidance on consent will be beneficial to, or have a positive impact on, the protection of the public?

Yes No

Please give your reasons below:

8. Are there any aspects of the guidance that could have an adverse or negative impact on certain groups of patients, optometrists, dispensing opticians, optical students, optical businesses, optical training institutions or any other groups?

Yes No

Please give your reasons below:

9. Are there any areas of the guidance that could discriminate against stakeholders with specific characteristics? Please consider sex, age, race, religion or belief, disability, sexual orientation, gender reassignment, pregnancy or maternity, caring responsibilities or any other characteristics.

- Yes No

Please give your reasons below:

Section 3: Additional comments

10. Do you have any additional comments you wish to make on the guidance for consent?

- Yes No

Please set out your additional comments below:

More about you

The GOC strives to be as diverse as the public it protects and welcomes consultation responses from everyone, regardless of age, disability, gender reassignment, race, religion or belief, ethnicity, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity. We monitor the diversity of all the individuals who respond to our consultations to ensure that we have heard from a diverse range of people and that we can identify where further engagement or consultation may be required. To help us to monitor this, please complete the following questions if you feel comfortable to do so. Providing this information is optional, but we would be grateful for your co-operation. Information provided will be treated in the strictest confidence under the Data Protection Act 1998 and will be only used for monitoring purposes.

No information in this section will be published or used in any way which allows any individuals to be identified.

Gender

- Female Male Prefer not to say

Age

- 16-24 25-34 35-44 45-54 55-64 65+
 Prefer not to say

Sexual orientation

- Bisexual Heterosexual/Straight Gay/Lesbian/Homosexual
 Other Prefer not to say

Disability

The Equality Act 2010 defines disability as a physical or mental impairment which has a substantial long-term effect on a person's ability to carry out normal day to day activities.

Do you consider yourself to have a disability?

- Yes No Prefer not to say

Gender Identity

My gender identity is different from the gender I was assigned at birth:

- Yes No Prefer not to say

Pregnancy/Maternity

Are you pregnant, on maternity leave, or returning from maternity leave?

- Yes No Prefer not to say

Ethnicity**White**

- English / Welsh / Scottish / Northern Irish / British
 Irish
 Gypsy or Irish Traveller
 Any other white background – please specify:

Mixed / multiple ethnic groups

- White and Asian / British
 White and Black Caribbean / British
 White and Black African / British
 Any other mixed / multiple ethnic background – please specify:

Asian / Asian British

- Indian / Indian British
 Pakistani / Pakistani British
 Bangladeshi / Bangladeshi British
 Chinese / Chinese British
 Any other Asian background – please specify:

Black / Black British

- African / African British
 Caribbean / Caribbean British
 Any other Black background – please specify:

Other ethnic group

- Arab / Arab British
 Any other ethnic group – please specify:
 Prefer not to say

Marital status

- Civil partnership Divorced/legally dissolved
 Married Partner Separated
 Single Not stated Prefer not to say

Carer Responsibilities

Do you perform the role of a carer?

- Yes No Prefer not to say

Religion/Belief

- No religion Buddhist Christian
 Hindu Jewish Muslim
 Sikh
 Any other religion / faith – please specify _____
 Prefer not to say

Many thanks for completing this confidential monitoring form.

Annex 1 – Draft guidance on consent

About this guidance

1. This guidance should be read alongside the *Standards of Practice for Optometrists and Dispensing Opticians* ('Standards of Practice') which all optometrists and dispensing opticians must apply to their practice.
2. This document gives guidance on standard 3 of the Standards of Practice which states:

'Standard 3. Obtain valid consent

3.1 Obtain valid consent before examining a patient, providing treatment or involving patients in teaching and research activities.

For consent to be valid it must be given:

3.1.1. Voluntarily

3.1.2. By the patient or someone authorised to act on the patient's behalf

3.1.3. By an appropriately informed person. "Informed" means explaining what you are going to do and ensuring that patients are aware of any risks and options in terms of examination, treatment, sale and supply of optical appliances or research they are participating in. This includes the right of the patient to refuse treatment or have a chaperone or interpreter present.

3.2 Be aware of your legal obligations in relation to consent, including the differences in the provision of consent for children, young people and vulnerable adults. When working in a nation of the UK, other than where you normally practise, be aware of any differences in consent law and apply these to your practice.

3.3 Ensure that the patient's consent remains valid at each stage of the examination or treatment and during any research in which they are participating.'

The status of this guidance

3. This document gives guidance on how to meet the standard of consent. The guidance is not intended to cover every situation and it does not give detailed legal advice.
4. You must use your professional judgement to apply this guidance to your own practice and the variety of settings in which you might work. You must make sure that you keep up to date with the law, and with any NHS or employment policies for consent that apply to your practice.

5. You must also make sure that any staff members you are responsible for are aware of this guidance and are appropriately trained in all areas that are relevant to their duties.
6. If you are not sure about how the law applies in a specific situation, you should always ask for advice from appropriate professional colleagues, your employer, your professional indemnity insurance provider, your professional body, or obtain independent legal advice.

This guidance describes:

- the process of obtaining consent;
 - the importance of establishing whether the person has capacity to give consent;
 - what constitutes valid consent;
 - the form that consent might take; and
 - the duration of that consent.
7. It highlights the need to ensure that the consent is given voluntarily and that sufficient information has been imparted to allow valid consent to be given.
 8. It is a general legal and ethical principle that valid consent must be obtained before starting treatment, conducting a physical investigation, or providing care. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. Failure to respect this principle may result in legal action or fitness to practise proceedings.
 9. If healthcare professionals (or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved, or even be the basis of criminal proceedings. Poor handling of the consent process may also result in complaints from patients resulting in regulatory action.

What is consent?

10. Patients have a basic right to be involved in decisions about their healthcare and agree or 'consent' to any examination or treatment that is proposed by their healthcare professional. The process of obtaining consent is a fundamental part of respect for patients' rights.
11. Obtaining consent is also essential in forming and maintaining effective communication between you and your patients (standard 2 of the Standards of Practice).

12. You have a professional and legal duty to obtain a patient's consent for the services, treatment or care you provide, or to use or share patient information.
13. You must know and comply with the law, Standards of Practice and the good practice requirements relating to consent, which apply to you in your day-to-day practice.

Obtaining consent

14. When obtaining consent you must ensure you provide your patient with clear and accurate information presented in a way that they can understand. For example, you must consider any disabilities, literacy or language barriers that may affect a patient's understanding and amend your communication approach to take account of this.
15. You should not make assumptions about the patient's level of knowledge and you should give them the opportunity to ask questions. You should discuss risks that occur commonly, those that are serious, and those that the patient is particularly concerned about, so the patient is aware of the potential for adverse outcomes when giving consent to treatment or investigation.
16. You are personally responsible for making sure that a patient has given valid consent. This includes ensuring that the patient understands what they are consenting to, is aware of relevant risks and is consenting voluntarily.
17. Getting consent is an on-going process between you and the patient. Consent cannot be presumed just because it was given on a previous occasion. You must get a patient's consent on each occasion that it is needed, for example, when there is a change in treatment or service options.
18. There are two types of consent:
 - a. explicit (or 'express') consent: when a patient gives you specific permission to do something, either spoken or written; and
 - b. implied consent: when a patient indicates their consent indirectly. This is not a lesser form of consent but might be appropriate only for more minor or routine procedures, where you are confident that the patient understands your intended treatment and the reasons for it.
19. You must use your professional judgement to decide what type of consent to get, taking into account legal requirements.

Example of explicit consent:

20. When conducting an eye examination consent must be obtained for all aspects of the examination. This should be explicit and can be verbal or written.
21. Consent cannot be implied simply on the basis of a patient having attended an eye examination. In order for consent to be valid you must satisfy yourself that

the patient understands what the eye examination will involve. This understanding cannot be automatically assumed just because the patient has attended the appointment.

22. The patient must also be given the opportunity to consent to all elements of the examination, for example, refraction, tonometry, visual fields etc. This may mean seeking a positive affirmation that the patient continues to consent at different stages of the examination. This is particularly important if any aspect of the examination is delegated to a colleague or where the patient may not be familiar with the test or apparatus.
23. Information explaining what an eye examination involves may be given to the patient either verbally during the course of the examination, for example, before conducting a refraction by stating “I am now going to ask you to read the letters on this chart. This will allow me to determine your prescription. Are you happy for me to continue?”, or in written form such as a leaflet prior to the examination explaining what the examination will involve. In either case the patient must be given the opportunity to ask questions.
24. The patient must positively acknowledge that they have understood what they are consenting to and that they are happy to proceed.
25. When consent is given verbally it should be noted in the patient’s record what they have consented to. This does not have to be detailed, but should clearly outline the consent given.
26. It is good practice to obtain written consent in circumstances where you have outlined the material risks involved to the patient; the patient should be asked to sign to confirm they have understood the risks and agree to the procedure. You should also obtain written consent where the procedure, treatment or examination being proposed is not routine or has greater risks involved.
27. Regardless of whether consent has been given verbally or in written form, a patient can still subsequently change their mind and withdraw consent at any time. Please refer to paragraphs 43 to 46 of this guidance on withdrawal of consent.

Example of implied consent

28. There may be some aspects of the eye examination where consent can be implied as a result of the information already given to the patient or by the patient’s behaviour.
29. For example, when conducting tonometry, you may explain to the patient you are going to test their eye pressure; this will involve small puffs of air into their eye and they will need to place their chin on the rest and look into the device. If the patient proceeds to place their chin on the rest and look into the device,

consent can be assumed based on the patient's behaviour. This is implied consent.

30. If you are not sure whether you have obtained implied consent, you should obtain explicit consent, i.e. by asking the patient to confirm that they understand and consent to the procedure.
31. Implied consent should not be used in circumstances involving an invasive procedure or physical contact such as instilling drops or inserting a contact lens. Before any physical contact the patient should be asked to provide explicit verbal consent.

Consent to share patient information

32. Information in a patient's record is subject to professional, ethical and legal duties of confidentiality. But most patients understand and expect that some confidential information will be shared between health and social care professionals in order to provide their care.
33. The usual basis for sharing information in order to provide care is the patient's consent, whether it is explicit (when a patient actively agrees, either verbally or in writing, to a particular use or disclosure of information), or implied (circumstances in which it would be reasonable to assume that the patient agrees to the use of their information, even though this has not been directly expressed).
34. As a regulated optical professional you may rely on implied consent to share confidential information with those who are providing (or supporting the provision of) direct care to the patient if you are satisfied that all of the following apply:
 - a. the person accessing or receiving the information is providing or supporting the patient's care;
 - b. information is readily available to patients explaining how their information will be used, and they have the right to object;
 - c. the patient has not objected; and
 - d. that anyone to whom confidential information is disclosed understands that it is given to them in confidence, which they must respect.
35. Information for patients can be provided in leaflets, posters, on websites or face to face. It should be tailored to individual needs as far as possible.
36. Patients should not be surprised to learn about how their personal information is being used, accessed or disclosed. If information is being used in ways that patients would not reasonably expect you should seek explicit consent for this from the patient.

37. The patient has the right for their wishes to be respected if they object to particular personal information being shared within your own healthcare team or with others involved in their care – unless disclosure would be justified in the public interest, is required by law, or it is in the best interests of a patient who lacks capacity to make the decision.
38. If a patient cannot be informed about the disclosure of their information, for example, in an emergency, you should pass relevant information promptly to those providing care. If and when the patient is capable of understanding, you should tell them how their personal information was disclosed if it was in a way they would not reasonably expect.

Example of explicit consent to share patient information:

39. *Verbal* – You have explained to your patient that you need to refer them to the hospital for further tests, and that this may require you to share their information with other healthcare colleagues. You ask the patient to confirm they understand and agree for their information to be disclosed to other professionals involved in their care.
40. *Written* – The patient has signed the NHS sight test form which asks them to confirm their consent for all relevant information to be disclosed to Her Majesty's Revenue and Customs (HMRC) and local authorities.

Example of implied consent to share patient information:

41. The patient has chosen to have their prescription dispensed by your practice, and in placing an order for spectacles or lenses the patient's consent for their prescription to be shared with colleagues involved in the dispensing process can be implied.

Example of implied consent to access patient information:

42. You are asked to cover a colleague's appointments. The patients have been telephoned and advised of this fact and have confirmed they are happy for the appointment to go ahead. In these circumstances the patient's consent for you to have access to their record can be implied.

Refusal or withdrawal of consent

43. A person with capacity has the right to refuse treatment or care or to withdraw consent at any time. You must respect their decision even if you believe the treatment to be in their best interests.
44. In these circumstances you should clearly explain the consequences of their decision but you must make sure that you do not pressure the patient to accept your advice; if the patient agrees only as a result of pressure they perceive was put on them, then this may not be considered valid consent.

45. You should make a detailed record if a patient refuses to give consent. This should include the discussions that have taken place and the advice you gave. If the patient has stated why they are withdrawing consent you should include this in your notes. However, the patient is not required to give a reason for withdrawing consent.
46. If you believe that the patient is at risk of serious harm due to their decision to refuse a service or treatment, you must raise this issue with appropriate healthcare colleagues or people involved in their care, and your employer (if applicable). Consider getting legal advice if necessary.

Capacity to consent:

47. In order for consent to be valid it must be given by someone with the capacity to consent.
48. 'Capacity' refers to your patient's ability to:
 - a. understand and retain information relevant to the decision required relating to their treatment or care;
 - b. weigh up the information provided and the options available (including the consequences of not consenting); and
 - c. communicate their decision (verbally, by signing or by any other means of communication).
49. You must make an assessment of your patient's capacity based on their ability to make a specific decision at the time it needs to be made. There may be some circumstances where a patient may be capable of making some decisions but not others.
50. In some situations, a patient may be able to understand the relevant information if they are given an appropriate explanation, such as by using simpler language or visual aids. In these situations, the patient must be considered as having capacity and you must take reasonable steps to communicate the relevant information in a way the patient understands and can choose to consent (or not to consent to).
51. You must not assume that because a patient lacks capacity on one occasion, or in relation to one type of service, that they lack capacity to make all decisions or the capacity to make decisions at all times.
52. A patient's capacity to consent may be temporarily affected by other factors, for example, illness, shock, panic, fatigue, confusion, pain or the effects of drugs or alcohol.
53. The existence of these factors should not lead to an automatic assumption that the patient does not have the capacity to consent. Instead you should use your

professional judgement to make a decision based on the individual circumstances.

54. In some circumstances it may be appropriate to defer the decision until the temporary effects subside and capacity is restored.
55. You must not assume that a patient lacks capacity based just upon their age, disability, beliefs, condition, or behaviour, or because they make a decision you disagree with.
56. Your assessment should be objective and you should bear in mind the principle that, where possible, patients should be assisted to make informed decisions about their treatment and care.
57. In England and Wales, patients over the age of 16 are presumed to have the capacity to consent unless it is established that they lack capacity, although the position for young people aged 16 and 17 is discussed in more detail below. In Scotland and Northern Ireland, persons over 16 are presumed to have full legal capacity.
58. In England and Wales, the Mental Capacity Act 2005 states that a person is deemed to lack capacity if:
 - a. he or she has an impairment or disturbance (whether temporary or permanent) that affects the way their mind or brain works; and
 - b. that impairment or disturbance means they are unable to make a decision at the time it needs to be made. In order to make a decision, they must be able to understand, retain and weigh up the information relevant to the decision as well as communicate their decision.
59. In Scotland the Adults with Incapacity (Scotland) Act 2000 sets out the criteria and procedures to be followed in making decisions when people aged 16 and over lack the capacity to take some or all decisions for themselves, because of a mental disorder or inability to communicate. It also allows other people to make decisions on their behalf. The Act provides various methods of intervening (that is, taking decisions or action) on behalf of an adult who lacks capacity, including in relation to healthcare. The Act sets out the principles that must be followed when deciding whether to intervene. Any intervention must be necessary and must benefit the person, and must be the minimum necessary to achieve the purpose. Those making decisions must (a) take account of the person's present and past wishes and feelings, and must try every possible means of communicating with the person to find out what these are, (b) take into account the views of the person's nearest relative and primary carer, and of any other person with powers to intervene in the person's affairs or personal welfare, or with an interest in the person, so far as it is reasonable and practical to do so, (c) encourage the person to use any skills they have to make

decisions and (d) consider whether it would be possible to intervene without using the Act. In this Act, incapacity means being incapable of acting on, making, communicating, understanding, or remembering decisions by reason of mental disorder or inability to communicate due to physical disorder. The Act is supported by codes of practice setting out guidance for those acting under the legislation, including doctors and other healthcare professionals who are treating adults with incapacity. The *Code of Practice for Practitioners Authorised to Carry out Medical Treatment or Research Under Part 5 of the Act*¹ covers decisions about medical treatment and research.

60. The Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision as to when a person can be taken into hospital against their will, when they can be given treatment against their will, the rights of patients with an order of the Act applied to them and provides for safeguards to make sure their rights are protected.
61. In Northern Ireland, the Mental Capacity Act 2016 (not yet in force) will set out the criteria and procedures to be followed in making decisions when people aged 16 and over lack the capacity to take some or all decisions for themselves, because of a mental disorder or inability to communicate. The process of establishing capacity has two components requiring the person making the determination to consider (a) whether all practical help and support has been given to help the person make the decision and then (b) whether the person lacks the capacity to make a particular decision at a material time. The Act requires any substitute decision maker to consider what is in the individual's best interests in all the relevant circumstances before intervening and lists relevant people who might be consulted on this (where practicable and appropriate). The Department of Health, Social Services and Public Safety (DHSSPS) is required to produce one or more codes of practice in relation to the Bill which will contain guidance for those acting in connection with the care, treatment and personal welfare of those over 16 who lack capacity.
62. If you are unsure about a patient's capacity you must get advice from other colleagues, healthcare professionals or people involved in their care. If you are still unsure you may need to consult your professional association or obtain legal advice. Any advice you get or assessments carried out should be properly recorded, along with the outcome.

Adults who lack capacity

63. If your patient is not able to make decisions for themselves, you must work with people close to members and other healthcare colleagues.

¹ <http://www.gov.scot/Publications/2010/10/20153801/0>

64. The law sets out the criteria and processes to be followed in making decisions and providing care services when a patient lacks capacity to make some or all decisions for themselves. It also grants legal authority to certain people to make decisions on behalf of patients who lack capacity.
65. If you believe that a patient lacks capacity to make decisions for themselves, you should consult the codes of practice that accompany the Mental Capacity Act 2005 for England and Wales, or the Adults with Incapacity (Scotland) Act 2000 for Scotland (the code of practice for Northern Ireland is not yet in force). These set out who can make decisions on the patient's behalf, in which decisions, and how they should go about this.
66. When examining or treating adults who lack capacity, it is important that you comply with the relevant law.
67. A person may be authorised to provide consent for your patient to be treated if they have previously been named by the patient as someone to be consulted, if they are caring for or are interested in the patient's welfare, under a lasting power of attorney or when appointed by the Court (i.e. as a deputy appointed by the Court of Protection), if that person is authorised in respect of personal welfare matters.
68. These principles also apply to decisions about the use of information about patients who lack capacity. For example, the codes of practice must be consulted when deciding to share confidential information about a patient who lacks capacity with their loved ones, as well as making decisions about treatment.

Young people and children

69. The capacity to consent depends more on the patient's ability to understand and consider their decision than on their age.
70. In this guidance, a young person means anyone aged 16 or 17 and a child means anyone aged under 16.
71. People gain full legal capacity in relation to healthcare treatment at a different age in Scotland than in England, Northern Ireland and Wales. In Northern Ireland, a child is defined as a person under the age of 18, although the presumed age of capacity is 16.
72. As with any patient, a young person or child may have the capacity to consent to some services or treatments but not to others. Therefore it is important that you assess maturity and understanding individually, and bearing in mind the complexity and importance of the decision to be made.
73. If a young person or child does not have the capacity to consent, consent must be provided by a person with parental responsibility. If a person with parental

responsibility is required to provide consent, you may need to get legal advice if:

- a. you are in any doubt about who has parental responsibility for the individual; or
- b. the views of those that have parental responsibility differ.

74. Young people and children should be involved as much as possible in decisions about their care, even when they are not able to make decisions on their own.

Young people with capacity

75. Young people are presumed to have the capacity to make their own decisions and give consent for a service or treatment, unless there is enough evidence to suggest otherwise.

76. To decide whether a young person has the capacity to consent to a service or treatment, use the same criteria as for adults (see paragraphs 47 to 62, 'Capacity to consent').

77. While not a legal requirement, you should encourage young people to involve their parents in making important decisions. However, you should respect a competent young person's request for confidentiality.

Children with competence

78. Children are not presumed to have the capacity to consent; instead, the issue is whether children can demonstrate their competence.

79. A child is competent and can give consent if you are satisfied that they have the maturity, intelligence and ability to fully understand the information given and what they are consenting to, including any implications of the treatment they are consenting to. In this case you do not also need consent from a person with parental responsibility.

80. Where a competent child has been provided with appropriate information and voluntarily gives his or her consent to treatment, that consent cannot be overridden by a person with parental responsibility. If you consider that the decision of a competent child to give consent is not in their best interests, you should consult colleagues and get legal advice before proceeding.

When competent young people and children refuse to give consent

England, Northern Ireland and Wales

81. In some circumstances, the courts can override the refusal of consent of a competent young person or child if health and care professionals involved in their care believe that the refused treatment would be in their best interests. You should get legal advice if needed on this issue.

82. The law is complex when a competent young person or child refuses to give consent for a treatment or service and someone with parental responsibility wants to override their decision. You should get legal advice if you are faced with this situation.

Scotland

83. When a child has capacity to make a decision and the child declines the recommended treatment, it is likely that the law would expect you to respect and comply with an informed decision. If such a situation arises, you should obtain legal advice. Of course if circumstances change, for example, the child's condition is at risk of deterioration, a further dialogue will probably be necessary. Depending on the circumstances, it might be necessary to involve another member of the healthcare team or other family members or carers in that dialogue, depending on any issues of confidentiality. As with all these discussions and decisions, full and proper records should be kept.

Young people without capacity

England, Northern Ireland and Wales

84. A person with parental responsibility for a young person who is not considered to have capacity can give consent on behalf of that young person to investigations and treatment that are in the young person's best interests. If you are concerned that the investigations or treatment may not be in the young person's best interests you should get legal advice before proceeding further.

Scotland

85. The rights of a person with parental responsibility to make decisions on behalf of a child ends when the child reaches the age of 16. (Please see paragraph 59.)

Children without competence

86. When a child lacks competence to give consent, any person with parental responsibility for that child, or the court, can give consent on their behalf, but this will vary depending on the nation and the child's age. Who will be considered to have parent responsibility may also vary. You should refer to relevant national legislation as appropriate.
87. While the consent of only one person with parental responsibility is required, where there is disagreement between those with parental responsibility you may wish to seek further advice.

Advance decisions on healthcare arrangements

88. People with capacity can say in advance how they want to be treated if they later suffer loss of mental capacity. An advance decision can only refuse later treatment, as a patient cannot demand specific treatment.
89. An unambiguous advance refusal for a treatment, procedure or intervention which is voluntarily made by an adult with capacity and does not appear to have been withdrawn or not applicable in the circumstances is likely to have legal force.
90. An advance refusal of treatment cannot override the legal authority to give compulsory treatment under the mental health laws.
91. Any advance decision can be superseded by a later decision by the person concerned at any time when they have capacity. This later decision may be made at any point between the making of the advance decision and the beginning of treatment. An advance decision will only apply in relation to treatment if the person giving it does not have capacity at the point that consent would be sought or treatment is given.

England and Wales

92. Advance decisions are covered by the Mental Capacity Act 2005. For an advance refusal of treatment to be legally valid, it must meet certain criteria set out in sections 24 to 26 of the Mental Capacity Act 2005.
93. If an advance decision does not meet these criteria, it is not legally binding but can still be used in deciding the patient's best interests.
94. You must follow an advance decision if it is valid and applicable to current circumstances.

Scotland

95. The Adults with Incapacity (Scotland) Act 2000 does not specifically cover advance decisions. However, it says that health professionals must take account of the patient's past and present wishes, however they were communicated.
96. Advance decisions are also known as advance directives, living wills, advance directions and advance statements. Provided that the advance decision was made by an adult with capacity who was properly informed, and clearly sets out the person's intentions, it is likely that a Court would consider it binding. If however the factual situation falls outside the scope of the advance decision, or if the assumptions upon which it was based are rebutted, then the advance decision is likely to cease to be effective. You should obtain legal advice on the effectiveness of any advance decision.

Northern Ireland

97. In the absence of specific statute provisions, the position in Northern Ireland is governed by common law principles. An advance decision is still binding, and must be followed by healthcare professionals, provided they know about it.
98. In all jurisdictions, an advance decision requires the same level of capacity as a contemporaneous decision.

Emergencies

99. In an emergency, if you cannot get consent, you can provide treatment that is in the patient's best interests and is needed to save their life or prevent deterioration in the patient's condition (this applies to children, young people and adults).
100. There is an exception to this if you know there is a valid and applicable advance decision to refuse a particular treatment. For more information see the relevant incapacity legislation and its code of practice (see paragraph 65), or ask your professional indemnity insurance provider or a legal adviser.

Additional information

England and Wales

Mental Capacity Act 2005

www.legislation.gov.uk/ukpga/2005/9/contents

Mental Capacity Act Code of Practice

www.publicguardian.gov.uk/mca/code-of-practice.htm

Department of Health Reference guide to consent for examination or treatment (Second edition)

<https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

Northern Ireland

Mental Capacity Act 2016 (hyperlink to be added when this legislation comes into force)

Scotland

Adults with Incapacity (Scotland) Act 2000

The Age of Legal Capacity (Scotland) Act 1991

Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Amendment Regulations 2012 SSI 2012/170

www.legislation.gov.uk/asp/2000/4/contents

www.scotland.gov.uk/Topics/Justice/Civil/awi

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