

INCLUDE Impaired Capacity to Consent Framework

Key questions to ensure your trial is designed for all who could benefit

Trial teams need to do everything possible to make their trial relevant to the people that the results are intended to apply to (often patients) and those who are expected to apply them (often healthcare professionals). The **four generic questions** below are intended to prompt trial teams to think about who should be involved in their trial as participants, and how to facilitate their involvement as much as possible. These questions should be considered by trial teams in partnership with patient and public partners, including individuals from, or representing, groups identified in Question 1. Note that:

* *‘Intervention*’ means the treatment, initiative or service being evaluated.
* ‘*Comparator*’ means what the intervention is being compared to.
* Diagram, timeline

  Description automatically generated‘*Effective*’ means the intervention provides important benefits for people with the disease or condition that is the focus of the trial.

We have developed a **series of worksheets** to help answer these with respect to adults with impaired capacity. We recommend that trial teams use these questions and worksheets (preferably at the design stage) to help them think through their answers to the four key questions identified below and then identify any considerations needed. See **Figure 1** for a diagram of the framework.

**1. Who should my trial results apply to?**

**Figure 1. Diagram of INCLUDE Impaired Capacity Consent Framework**

The underlying principle is that all groups should be offered the chance to participate in research. Consider whether there are reasons why any groups should be excluded from this study, and which groups in the population could benefit from the intervention if found to be effective (or benefit from not having it if found to be ineffective and/or harmful)? Consider whether the disease or condition you are studying is more prevalent in certain groups of the population (e. g people with particular conditions or disabilities) or if it would affect groups differently (e.g have a greater severity or impact on people with a particular condition or disability). As this framework relates to adult populations with impaired capacity to consent, think particularly about conditions or disabilities that can affect a person’s ability to provide consent but there may be other conditions or intersecting factors to consider.

**2. Are the groups identified in Question 1 likely to respond to the intervention and/or comparator in different ways?**

How might some groups in the population respond to, or engage with, the intervention(s) being tested in different ways?

**3. Will my trial intervention and/or comparator make it harder for any of the groups identified in Question 1 to engage with the intervention and/or comparator?**

How might the intervention and/or comparator, including how they are provided, make it harder for some groups in the population to take part in the trial?

**4. Will the way I have planned and designed my trial make it harder for any of the groups identified in Question 1 to consider taking part and remain in the trial?**

How might elements of trial design, such as eligibility criteria, recruitment and consent process, or data collection methods, make it harder for some groups in the population to take part and remain in the trial?

Worksheets for thinking through factors that might limit the involvement of adults with a condition or disability that may impair their capacity to consent

The **worksheets A-F** are intended to be used by trial teams in partnership with patient and public partners (and other stakeholders) to ensure that the involvement of adults with a condition or disability that may impair their capacity to consent is considered at the trial design stage.This impaired capacity may be **due to the condition** or disability that is the focus of the trial or may be **co-existing** with the condition or disability that the trial is focused on. The impairment may be **long-term,** a **temporary or** **acute** impairment where the intervention being tested cannot wait for the person to recover capacity, or the person’s capacity may **fluctuate**. While the framework may cover issues that some trial teams already think about, the worksheets will help to highlight issues consistently across trials for all trial teams, as well as raising some questions that may not be considered at present.

The final **worksheet G** provides a space to summarise the actions you may need to take in order to address the issues you have identified, and any resources/costs needed to enable the participation of adults with impaired capacity to consent. You may wish to populate this summary with the actions/considerations you have identified as you go along.

While the worksheets ask trial teams to think about possible differences between groups who may experience impaired capacity, it is important to remember that there are also differences *within* groups. No group is homogenous, and there will be intersectionality between these and other factors or personal characteristics. Tailored support can help meet individuals’ information and decision support needs to maximize their ability to understand information and provide their own consent or contribute to decisions about participation.

See [**Appendix 1**](#Appendix1) for more on the legal definition of capacity and the legal arrangements for including adults with impaired capacity to consent. As the legal frameworks require researchers to justify the inclusion of adults who lack capacity to consent, the benefit and risks, and that appropriate consent arrangements are in place, working through the framework may enable researchers to explore and clarify these aspects. This might include **why** the intervention could not solely be evaluated with people who are able to provide their own consent, **how** consent arrangements will be tailored according to the needs of participants and aligned with the specific trial context, and **whether** processes for data collection and use of data may need to be flexible to account for changes in capacity over time. This could then inform the initial trial design, help justify any additional resources being requested in a funding application, and provide the information needed to support an application to include adults lacking capacity when seeking ethical approval.

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| **Who should my trial results apply to?** |
| The underlying principle is that all groups should have an opportunity to participate in research. Think about **who could benefit from the intervention** if effective, or not having it if found to be ineffective (e.g people with particular types/severity of conditions or disabilities that may affect their capacity to consent).  **Q1** |
| *[NB: The information in the framework may not be a proper reflection of the trial, and is intended to be illustrative, rather than definitive. It was completed by Victoria Shepherd, Cardiff University who was not involved in the trial nor discussed the framework with the trial team. The worksheets were completed retrospectively rather than at trial design. The documents used were obtained from NIHR website* [*https://fundingawards.nihr.ac.uk/award/16/167/09*](https://fundingawards.nihr.ac.uk/award/16/167/09)*, including protocol v5.0.]*  This is a trial of a community-based multi-disciplinary rehabilitation package for older adults (aged ≥60) recovering from surgical treatment following hip fracture, with an embedded process evaluation and cost effectiveness analysis. Follows from a [NIHR HTA commissioned call](https://fundingawards.nihr.ac.uk/award/11/33/03).  Hip fractures are most common amongst older people. Having dementia doubles the risk of falling at home (Petersen et al 2018) and the incidence of hip fracture among people living with Alzheimer’s disease is almost three times higher than those without (Baker et al 2011). Evidence from systematic reviews shows that 30-47% of patients who sustain a hip fracture also have cognitive impairment or dementia (Mundi et al 2013, Schnell et al 2010).  There is evidence to suggest that patients with dementia typically experience poorer functional outcomes and increased morbidity and mortality following a hip fracture, with some studies reporting that patients with dementia were 45% more likely to die postinjury than those without dementia (Mundi et al 2013, Schnell et al 2010). There are also differences in intervention specific outcomes such as dislocation and requiring revision surgery (Mundi et al 2013).  Although far from conclusive, there is evidence to suggest that intensive rehabilitation and exercise activities are beneficial for people with cognitive impairment with improved mobility, functional, and cognitive outcomes (Sheehan et al 2019). With some systematic reviews suggesting that people with mild or moderate dementia may show improved function and ambulation and decreased fall risk after rehabilitation post hip fracture, similar to gains achieved by those without dementia (Allen et al 2012).  Systematic reviews have shown it is feasible to implement rehabilitation programs focused on individuals with cognitive impairment (Allen et al 2012, Resnick et al 2016), although innovative approaches may be needed to engage people with cognitive impairment (Resnick et al 2016). NICE guidance on hip fracture management recognises that people with cognitive impairment are a subgroup who may experience health inequalities. Systematic reviews have found that >80% hip fracture trials excluded or ignored this population, which challenges the external validity of these trials (Sheehan et al 2019, Mundi et al 2013). The review authors and NICE guidance recommend that future trials should include participants with cognitive impairment and those admitted from nursing homes.  **In summary:**  Up to a half of older people with a hip fracture will also have a cognitive impairment. There is evidence that they may benefit from a rehabilitation intervention, with similar interventions being found to be feasible for this population. |

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| **Are the groups identified in Q 1 likely to respond to the**  **Q2**  **intervention and/or comparator in different ways?**  [**(VIEW WORKSHEET A)**](#WorksheetONE) |
| How might some groups in the population **respond to, or engage with, the intervention(s)** being tested in different ways (e.g if they have particular types/severity of capacity-affecting conditions or disabilities)? |
| **Summarised from Worksheet A:**   * It is likely that the presence/severity of cognitive impairment will affect a person’s ability to respond to or engage with the rehabilitation intervention. * The trial should include people who lack capacity to consent, with reasonable adjustments to support their inclusion. * Eligibility criteria, consent and data collection processes need to take account of pre-existing cognitive impairment, acute development of delirium, and delirium superimposed on dementia. * Consent and consultee process will need to take account of this, with corresponding PIS/ICF documents. Consider option of seeking consent pre-operatively. If loss of capacity should remain in the trial with appropriate consent arrangements. * Consider alternative methods of engagement and data collection such as options to involve family carer as supporter or alternative contact, proxy-reported outcomes and/or process measures, use of routine data. * The trial needs to be designed to be culturally sensitive and accessible to people with additional language and/or communication needs. This will include translation and interpretation provision and ensuring there is diverse public involvement throughout the trial. * Pre-trial public involvement activities will need to include the perspectives of people living with cognitive impairment and their carers. This should include how dementia and delirium are described in relation to falls and hip fractures, with a focus on understanding and acceptability of rehabilitation interventions. * The trial could explore options for including people living in a care home prior to their hip fracture. |

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| **Worksheet A** | | | | |
| Consider how any **FACTORS RELATED TO THE PERSON’S CONDITION OR DISABILITY** might influence their response to (or engagement with) the intervention/comparator. Please add details of any actions/considerations required to the summary [**Worksheet G**](#WorksheetG). | | | | |
| **Condition or disability related factors** | How might the **prevalence or severity** of the capacity-affecting condition or disability vary between groups who are able to consent and those who may not be able to consent? | Response:  30-47% of patients who sustain a hip fracture also have cognitive impairment or dementia. Patients with dementia may also develop delirium. Therefore, their cognitive function may be more impaired than prior to hip fracture. Patients with cognitive impairment are more likely to experience poorer functional outcomes and increased morbidity and mortality. Recruiting only those able to consent will exclude those at highest risk of poorer outcomes. |
| Action/consideration required?  Trial should include people who lack capacity to consent, including reasonable adjustments to support their inclusion. |
| How might the **presence of co-morbid conditions** vary between groups who are able to consent and those who may not be able to consent? | Response:  Older people with a hip fracture are at risk of developing delirium (approx. 35% will develop delirium post fracture), especially people living with dementia (approx. 58%). Patients who experience an episode of delirium are at increased risk of adverse outcomes such as higher incidence of complications, longer length of hospital stay, higher functional dependency, and a higher rate of mortality within 6 months. |
| Action/consideration required?  Eligibility criteria, consent and data collection processes need to take account of pre-existing cognitive impairment, acute development of delirium, and delirium superimposed on dementia |
| How might the **nature** of impaired capacity affect their response (e.g due to an acute condition, long-standing/chronic condition, or acute superimposed on long-standing/chronic)? Might capacity to consent **change** over time? What impact might that have? What are the relevant **legal arrangements** (see [**Appendix 1**](#Appendix1))? | Response:  May be due to delirium and/or dementia participants may lack capacity at outset, may lose or regain capacity during the trial, or have fluctuating capacity. |
| Action/consideration required?  Consent and consultee process will need to take account of this, with corresponding PIS/ICF documents. Consider option of seeking consent pre-operatively. If loss of capacity should remain in the trial with appropriate consent arrangements. |
| How might the condition or disability **present** in people from each group (this may include symptoms, type or pattern or rate of disease progression) and how might that impact on capacity to consent? | Response:  Patients may have a formal diagnosis of dementia or may not (see notes and consulting family members). May affect recall (e.g clinical history), reporting of symptoms (e.g pain), outcomes or adverse events (e.g falls) as well as ability to understand and retain information about trial and engage with intervention. Progression of dementia may affect longer term engagement and follow-up (e.g data collection at later time periods). | |
| Action/consideration required?  Consider alternative methods of engagement and data collection such as options to involve family carer as supporter or alternative contact, proxy-reported outcomes and/or process measures, use of routine data. | |
| Any other condition or disability related factors to consider:  No | | |
| **Other factors** | How might **perceptions** of the condition or disability and social stigma around it be different for people who may not be able to consent? Might any **cultural or language** factors influence the acceptability of, and adherence to, the treatment(s)? | Response:  Cognitive impairment may be unrecognized, or not reported due to misconceptions or stigma. This may be the case for communities where misconceptions can be higher such as Black, Asian and minority ethnic populations. Additionally, language and cultural factors may also influence peoples’ ability to engage with relevant services and interventions. Social/familial support arrangements may differ between communities. | |
| Action/consideration required?  The trial needs to be designed to be culturally sensitive and accessible to people with additional language and/or communication needs. This will include translation and interpretation provision and ensuring there is diverse public involvement throughout the trial. | |
| How might **ways of describing** the condition or disability be different for people who may not be able to consent? | Response:  Dementia/delirium and falls may be considered as a normal part of ageing by some or referred to by different terms (e.g some South Asian languages don’t have a word for dementia). | |
| Action/consideration required?  Pre-trial public involvement activities will need to include the perspectives of people living with cognitive impairment and their carers. This should include how dementia and delirium are described in relation to falls and hip fractures, with a focus on understanding and acceptability of rehabilitation interventions. | |
| How or when might people who may not be able to consent **access healthcare** (or other care) for this condition or disability differently? | Response:  People living with dementia may or may not access services such as memory clinics and may or may not have access to falls prevention services and rehabilitation programmes. There may be misconceptions from healthcare professionals and commissioners about the value/need for people living with dementia to have access such services. This may be particularly relevant for people living in care homes who have less access to rehabilitation interventions following hip fracture – in part due to the lack of evidence-base for the effectiveness and cost effectiveness of providing such services (e.g Best Practice Tariff) due to exclusion from trials. | |
| Action/consideration required?  Explore options for including care home residents (with appropriate outcome measures) beyond those moving into a care home post-op as currently included. | |
| Any other factors to consider:  In addition to cognitive impairment and cultural and language factors, socio-economic and geographical factors may affect a person’s ability to engage with the intervention. This will need to be explored further (consider Ethnicity Framework and Socio-economically Disadvantaged Framework). | | |

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| **Will my trial intervention and/or comparator make it**  **Q3**  **harder for any of the groups identified in Q 1 to respond to or** **engage with?** [**(VIEW WORKSHEET B)**](#WorksheetTWO) |
| How might **the intervention and/or comparator**, including how they are provided, make it harder for some groups in the population to take part in the trial (e.g if they have particular types/severity of capacity-affecting conditions or disabilities)? |
| **Summarised from Worksheet B:**  The main aim of the intervention is to enhance usual rehabilitation by enhancing patients’ self-efficacy and increasing the amount and quality of patients’ practice of physical exercise and activities of daily living in order to improve their functional outcomes at 17 and 52-week follow up.   * The intervention needs to be developed using person-centred principles e.g clear and accessible information, personalized activities, be flexible and suitably paced, and with reminders/follow-up in a format that is preferred and accessible to the person * Public involvement throughout the trial should include a diverse range of people, including those with experience of cognitive impairment and hip fracture and/or caring for someone who does * Therapists delivering the intervention should receive training around delivering the intervention to people with cognitive impairment and their carers * The workbook should be developed to ensure it is accessible to people with cognitive impairment and piloted with this population * If delivered remotely, additional support may be needed to enable people with cognitive impairment and other factors that may limit the ability to participate * Flexibility around the timing and intensity of intervention delivery is needed to support participation of people with cognitive impairments and other factors that may limit the ability to participate |

**Worksheet B**

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| Consider any factors related to the **INTERVENTION AND/OR COMPARATOR** that might affect how some groups respond or engage^. Please add details of any actions/considerations required to the summary in [**Worksheet G**](#WorksheetG). | | |
| **What** | How might the intervention(s) and comparator **limit participation** of people with the condition or disability who may not be able to consent? | Response:  The intervention aims to enhance patients’ self-efficacy and increase the amount and quality of patients’ practice of physical exercise and activities of daily living in order to improve their functional outcomes. Following a rehabilitation programme may be difficult for people with problems with their memory and/or understanding. They may find it difficult to engage with self-directed activities which involves the use of following an information workbook. | |
| Action/consideration required?  The intervention will need to be developed using person-centred principles in a way that supports self-efficacy e.g with clear and accessible information, involves activities that the person is able to engage with and enjoys, be flexible and suitably paced, and with reminders/follow-up in a format that is preferred and accessible to the person. | |
| How, and in what way, were people with the condition or disability (and/or carers) and other stakeholders **involved** in selecting or designing the trial intervention/comparator? | Response:  The intervention was developed in a previous HTA funded study which also included a randomised feasibility trial. The previous study excluded people who lacked capacity to consent. A patient and public involvement representative was involved in the previous development study and feasibility trial (no details given about their characteristics). Focus groups included hip fracture patients and carers who, according to the inclusion criteria, may have been carers for people with cognitive impairment. It is not clear from the trial protocol what the public involvement arrangements are for the trial nor input into trial design e.g as co-applicant. | |
| Action/consideration required?  Those who contributed to the development of the intervention (focus groups participants and public involvement contributors) should include a diverse range of people, including those with experience of cognitive impairment (dementia, delirum) and hip fracture and/or caring for someone who does. These perspectives should be included in public involvement throughout the trial. | |
| Other factors to consider:  None | | |
| **Who** | How might the **person(s)** delivering the intervention/comparator limit participation of people who may not be able to consent (e.g the person’s role, skills, experiences, or characteristics)? | Response:  In addition to the usual community-based rehabilitation, the intervention includes to up to six additional therapist (physiotherapist or occupational therapist) or technical instructor sessions. The extra sessions will be tailored by the therapists delivering them, and so the total number of sessions used, the timescale for their delivery, and the sessions’ content will vary between patients according to clinical need. Therapists will be trained in each site to deliver the enhanced rehabilitation programme with fidelity. Following COVID-19 amendments, the enhanced rehabilitation therapy sessions may be face-to-face or remotely (via teleconference or videoconference). The workbook will also include information about what to expect from their recovery and information about NHS, council, and voluntary sector services they may be able to use. This will include a variety of community services such as falls prevention programmes.  It is not clear from the protocol whether the person delivering the intervention will have any skills/experience of providing rehabilitation to people with cognitive impairment, or whether the workbook has been designed to be accessible to these groups. | |
| Action/consideration required?  Therapists delivering the intervention should receive specific training on delivering the intervention to people with cognitive impairment and effective strategies to engage people with cognitive impairment and their carers in the programme. The workbook should be developed to take account of the accessibility needs of people with cognitive impairment, in conjunction with public involvement contributors with relevant experience, and piloted with this population. | |
| Other factors to consider: | | |
| **How** | How might the **mode of delivery** of the intervention/comparator (e.g telephone, video-call, face-to-face, in groups, drug administration route) limit the participation of people who may not be able to consent? | Response:  It is assumed that the intervention will be delivered individually in the participant’s place of residence (own home or care home if they have been admitted permanently to a care home). Due to COVID-19 changes, COVID-19 amendments, the intervention may be delivered be face-to-face or remotely (via teleconference or videoconference). Carers who provide the person with face-to-face support most days may also be involved (and be asked to complete questionnaires). | |
| Action/consideration required?  Delivering the intervention in the person’s home reduces the need to travel. However, delivering the intervention remotely may limit the participation of people who are unable to access teleconference/videoconference facilities due to a number of reasons. | |
| Other factors to consider: | | |
| **Where** | How might **where** the intervention/comparator is being delivered (e.g hospital, general practice, local library, emergency setting) limit the participation of people who may not be able to consent? | Response:  See response to previous question. | |
| Action/consideration required?  If the intervention is delivered remotely, additional support may be needed to enable people with cognitive impairment, lower levels of digital literacy, or with reduced access to IT/internet to participate. | |
| Other factors to consider: | | |
| **When** | How might **when** the intervention/comparator is delivered (e.g during working hours, requirement to deliver the intervention urgently and cannot wait until capacity is regained) or **the intensity** (e.g number of times it is delivered, over what period, time commitment for each session and overall) limit participation of people who may not be able to consent? | Response:  It is not clear when the intervention will be delivered, but if it can be timed to coincide with a carer being present that may support participation (this may or may not be during working hours). The intensity needed may be different for people with cognitive impairment (and between people). | |
| Action/consideration required?  Flexibility around the timing and intensity of intervention delivery will support participation of people with cognitive impairments and other factors that may limit the ability to participate. | |
| Other factors to consider: | | |

^These factors are taken from TIDieR ([http://www.equator-network.org/reporting-guidelines/tidier/](about:blank)).

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| **Will the way I have planned and designed my trial make it harder for any of the groups identified in Q 1 to consider taking part and remain in the trial?\***  **Q4**  **(VIEW WORKSHEETS** [**C**](#WorksheetC)**,** [**D**](#WorksheetD)**,** [**E**](#WorksheetE) **and** [**F**](#WorksheetF)**)** |
| How might **elements of the trial design**, such as eligibility criteria, recruitment and consent process, or data collection methods, make it harder for some groups to take part and remain in the trial (e.g if they have particular types/severity of capacity-affecting conditions or disabilities)? |
| **Summarised from Worksheets C-F:**   * Revising the exclusion criteria, particularly capacity to consent, would increase the pool of potential participants and ensure that the trial population better reflects the clinical population. Amending the need to withdraw participants who lose capacity would enable participants to remain in the study and better reflect changes in cognitive function that are a secondary outcome. Although this will require additional considerations around appropriate outcomes/measures, and sub-group analyses etc * If participants lacking capacity are able to participate in and remain in the trial, consultee arrangements will be needed together with additional documents for consultees and regaining capacity (information sheets, consent/declaration forms) * Accessible and culturally sensitive participant information should be developed, in conjunction with diverse public involvement contributors with relevant experience, to support people with impaired capacity to make/participate in a decision about taking part in the trial and to disseminate the findings * Consultee arrangements will need to take account of the availability of personal consultees e.g nominated consultee if no family/friend able or willing * The use of translation/interpreter services should be considered. Recruiting staff and those involved in data collection should be trained in assessing and supporting communication needs and assessing capacity as required * Use of alternative outcome measures and proxy versions should be considered, with data collection methods tailored to take account of any additional communication and/or capacity needs * Sub-group analyses should be planned for those with and without cognitive impairment * Additional/altered processes for reporting adverse events may be needed |

\*See <https://www.capacityconsentresearch.com/> for a range of resources and practical suggestions about how you can address factors that affect the involvement of adults with conditions or disabilities that may impair their capacity to consent.

**Worksheet C**

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| Consider which factors around **TRIAL ELIGIBILITY AND PARTICIPATION** might affect the inclusion of some groups. Please add details of any actions/considerations required to the summary in [**Worksheet G**](#WorksheetG). | | | | |
| **Eligibility criteria** | How might the **eligibility criteria** exclude people with the condition or disability for reasons other than their clinical eligibility for the trial (e.g ability to provide consent, availability of family member as consultee/legal representative, requirement to speak English, location, age, internet/mobile telephone access)? | | Response:  Exclusion criteria are: living in care home prior to hip fracture, not able to understand English or Welsh, lacks capacity to consent. The exclusion criteria aren’t justified in the protocol, so it is unclear whether these are based on (i) potential for benefit, (ii) feasibility of participation, (iii) feasibility of outcome measurement or (iv) target population.  Around 30-47% of people with hip fracture also have cognitive impairment. In the previous feasibility trial, which used the same criteria, the main reason for ineligibility was a lack of mental capacity, which accounted for 49% of ineligible patients.  Residents of care and nursing homes account for about 30% of all patients with hip fracture admitted to hospital. These patients are frailer, more functionally dependent and have a higher prevalence of cognitive impairment than patients admitted from their own homes. Ineligibility due to lack of ‘independence’ accounted for 19% in the feasibility trial. [NICE](https://www.nice.org.uk/researchrecommendation/early-supported-discharge-in-care-home-patients-what-is-the-clinical-and-cost-effectiveness-of-early-supported-discharge-on-mortality-quality-of-life-and-functional-status-in-patients-with-hip-fracture-who-are-admitted-from-a-care-home) have previously highlighted that there are no clinical trials to define the optimal rehabilitation pathway following hip fracture for care home residents and therefore represent a discrete cohort where the existing meta-analyses do not apply. As a consequence, many patients are denied structured rehabilitation and are discharged back to their care home or nursing home with very little or no rehabilitation input.  Disparities in morbidity, mortality, and function between people with different ethnic backgrounds are unclear.  While it is not an eligibility criteria, the move to delivering the intervention remotely means that participants will be limited to those with internet access (potentially can use telephone for ‘teleconference’?) |
| Action/consideration required?  Removing some/all of the exclusion criteria, particularly the requirement to have capacity to consent, would increase the pool of potential participants and ensure that the trial population better reflects the clinical population. It will require additional considerations around outcome measurement and sub-group analyses (see sections). |
| Other factors to consider:  Consultee arrangements will need to take account of the availability of personal and nominated consultees. | | |
| **Opportunity to participate** | How might the way(s) potential participants are **made aware** of the trial (e.g posters in a clinic, written letter from a doctor, asked by a nurse) and by whom, limit the participation of people who may not be able to consent for themselves? | | Response:  Potential participants will be identified during their hospital stay and provided with information about the trial, (both verbal and written). when the clinical team believe that it is appropriate according to individual circumstances |
| Action/consideration required?  No |
| How might the **information** that tells potential participants about the trial (e.g format and content of participant information leaflet) limit the participation of people who may not be able to consent for themselves? What accessible information or format may be needed? | | Response:  Participant information sheets are available in English and Welsh, with a carer version. There does not appear to be a shorter/more accessible version (e.g pictorial) to support patients with cognitive impairment to be able to understand the information and make their own decision about participating. |
| Action/consideration required?  Accessible participant information should be developed, in conjunction with public involvement contributors with relevant experience. |
| How, and in what way, were people with the condition or disability (and/or carers) and other stakeholders **involved** in developing the information for potential participants? | | Response:  It is not clear from the trial protocol what the public involvement arrangements are for the trial nor input into developing the trial information. |
| Action/consideration required?  See previous actions |
| How might **cultural or language factors** change the way people with the condition or disability (and/or carers) perceive the information they are given (e.g beliefs about consent, language proficiency)? What language(s) should information be provided in? | | Response:  See previous responses about additional language and cultural factors which may also influence peoples’ ability to engage with the trial |
| Action/consideration required?  As previously, the information needs to be culturally sensitive and accessible to people with additional language and/or communication needs. |
| Other factors to consider: | | |
| **Consent procedures** | How might the **way consent is sought** (i.e. when, where, by whom, written vs verbal vs electronic, availability of language/translation and access to interpreters) limit the participation of people who may not be able to consent? What alternative **consent documents** **and processes** (e.g recruitment without prior consent in an emergency) are needed? | | Response:  Currently participants who lack capacity are excluded from participating or withdrawn if capacity is lost following enrolment. The protocol does not refer to any translation/interpreter arrangements. | |
| Action/consideration required?  If the exclusion of participants who lack capacity is removed, consultee information sheets and declaration forms are needed, together with documents if capacity is regained. The use of translation/interpreter should be considered. | |
| How might the **consent arrangements** differ for people who are able to consent and those who may not be able to consent (e.g need for assessment of capacity, availability of personal consultees/legal representatives, involvement of professionals as consultees/legal representatives, deferred)? This may differ between acute and chronic conditions, and in emergency situations. | | Response:  If there are concerns about a person’s capacity to consent then an assessment if required. If the exclusion of participants who lack capacity is removed, would they be excluded if there is no family/friend to act as a personal consultee? | |
| Action/consideration required?  Recruiting staff should be trained in assessing capacity as required. Consider enabling a nominated consultee to be involved e.g member of care home staff. | |
| How might the ways in which the research team can check how well consent **information is understood** differ for people who may not be able to consent (e.g presence of communication disorders, use of communication aids)? | | Response:  Recruiting staff will need to be aware of assessing and supporting additional communication needs | |
| Action/consideration required?  Consider the use of tools such as [Consent Support Tool](https://www.jr-press.co.uk/consent-support-tool.html) | |
| How might consent arrangements need to **change over time**? When might consent need to be revisited (e.g data collection points)? How might the ongoing consent arrangements limit the participation of people who may not be able to consent (e.g where capacity fluctuates, capacity is lost or regained during the trial)? What **consent** **documents and processes** are needed? | | Response:  Currently participants are withdrawn if lose capacity during the trial. No explanation given in protocol. | |
| Action/consideration required?  Amend to enable participants to remain in the study if lose capacity, with appropriate consultee involvement | |
| Other factors to consider: | | | |
| **Trial design** | How might the **design** of the trial (e.g cluster vs individual randomisation) limit the participation of people who may not be able to consent? | Response:  N/A | | |
| Action/consideration required? | | |
| Other factors to consider: | | | |

**Worksheet D**

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| Consider which factors around **DATA COLLECTION** might affect how some groups engage with the trial. Please summarise any actions/considerations required in [**Worksheet G**](#WorksheetG). | | |
| **What** | How, and in what way, were people with the condition or disability (and/or carers) in the target population **involved** in selecting the trial outcomes? Is there a relevant core outcome set? | Response:  Primary effectiveness outcome measure is the NEADL scale and secondary outcome measure is HADS. Process measures (potential mediators of outcomes): Visual Analogue Scale (VAS) for hip pain intensity, Falls Efficacy Scale International, VAS for Fear of Falling, Abbreviated Mental Test Score. Objective measurement of physical function is the grip strength test and the short physical performance battery of tests. Carers will complete the Caregiver Strain Index and HADS. Interviews will be conducted for the process evaluation.  It is not clear from the trial protocol what the public involvement arrangements are for the trial nor input into selecting the trial outcomes (e.g acceptability, feasibility, appropriateness to different population groups). A [COS](https://online.boneandjoint.org.uk/doi/full/10.1302/0301-620X.96B8.33766) has been developed for hip fracture trials which includes single-item measures of mortality and mobility (indoor/outdoor walking status) and EQ-5D (including proxy reported). |
| Action/consideration required?  Current outcome measures have limitations for people with cognitive impairment, and proxy reported versions are only available/validated for some. However, the COS suggests that single-item measures and proxy versions may be used. |
| How might the trial outcomes themselves, or other **data being collected** (e.g. where data is self-reported) limit the participation of people who may not be able to consent (and may not be able to self-report)? | Response:  Use of self-reported outcome measures (with carers completing carer-related rather than proxy versions) will limit the ability for people with cognitive impairment to participate. |
| Action/consideration required?  See previous response |
| **Who** | How might the **people** who collect data limit the participation of people who may not be able to consent (e.g the person’s role, skills, experiences, or characteristics)? | Response:  Data collection at baseline and follow-up will be done by the Research Project Support Officer either in person or, particularly during COVID-19, the paperwork can be sent to the participant by post or email prior to the assessment, so that they have it to hand during the teleconference or videoconference call. |
| Action/consideration required?  The Research Project Support Officer should be trained in supporting people with cognitive impairment during data collection, both in person and remotely, and the processes for raising concerns about capacity. |
| **How** | How might data collection **methods** limit the participation of people who may not be able to consent (e.g method of data collection such as online)? Are arrangements to access confidential patient information **without consent** (e.g CAG approval) appropriate or required? | Response:  It is presumed that data collection will primarily use paper-based methods, although this may be reported verbally when remote data collection is required. |
| Action/consideration required?  Accessible (e.g large print) versions of paper-based data collection tools may be needed. Communication methods will need to be tailored to take account of any additional communication and/or capacity needs. |
| **Where** | How might **where** data are collected (e.g hospital, general practice, local library, emergency setting) limit the participation of people who may not be able to consent? | Response:  See previous response |
| Action/consideration required? |
| Other factors to consider: | |

**Worksheet E**

|  |  |  |  |
| --- | --- | --- | --- |
| Consider which factors might affect the planned **ANALYSIS** of trial results. Please summarise any actions/considerations required in [**Worksheet G**](#WorksheetG). | | | |
| **Retention** | How might **follow up** differ between groups who are able to consent and those who may not be able to consent (e.g ability to remain in the trial if capacity is lost, use of data if unable to obtain retrospective/deferred consent or in event of death or withdrawal, whether consent survives any loss of capacity depending on different legal frameworks)? Might re-assessment of capacity be required? | Response:  Participants who lose capacity during the trial will not be able to remain in the trial, although the Abbreviated Mental Test Score is used during the follow-up as a secondary outcome measure for cognitive functioning. | |
| Action/consideration required?  Consider enabling participants to remain in the trial if they lose capacity in order to reduce bias and loss to follow up. | |
| Other factors to consider: | | |
| **Benefits** | How might the **benefits** of the trial intervention(s) differ between groups who are able to consent and those who may not be able to consent (or between other diagnostic groups)? | Response:  There is evidence to show that people with cognitive impairment may benefit from the intervention, although not known. | |
| Action/consideration required? | |
| Other factors to consider: | | |
| **Harms** | How might the possible **harms or burdens** of the trial intervention(s) differ between groups who are able to consent and those who may not be able to consent (or between other diagnostic groups)? | Response:  The harms or burdens for those with and without cognitive impairment are unclear. Reporting of adverse events e.g falls will need to take account of any memory, understanding, and/or communication issues. | |
| Action/consideration required?  Consider whether additional/altered process for reporting adverse events are needed (e.g carer reported) | |
| Other factors to consider: | | |
| **Subgroup analyses** | How should **variation** between groups who are able to consent and those who may not be able to consent in the target population be explored– should there be planned subgroup analyses? | Response:  The benefits and harms from the intervention are likely to differ between those with and without cognitive impairment | |
| Action/consideration required?  An *a priori* planned sub-group analysis should be considered, alongside those already planned. | |
| Other factors to consider: | | |
| **Interim analyses** | How should any **interim analysis** handle variation between groups who are able to consent and those who may not be able to consent in the target population? How might any variations or differences in experiences be explored or known (e.g through embedded qualitative research)? | | Response:  Any planned interim analysis should look for signals suggesting that benefits or harms were importantly different between these groups. |
| Action/consideration required? |
| Other factors to consider: | | |
| **Stopping triggers** | How should any **rules to stop** the trial early on safety or benefit grounds handle variation between groups who are able to consent and those who may not be able to consent? | | Response:  Any planned stopping triggers should look for signals suggesting that benefits or harms were importantly different between these groups. |
| Action/consideration required? |
| Other factors to consider: | | |

**Worksheet F**

|  |  |  |
| --- | --- | --- |
| Consider which factors might affect the planned**REPORTING AND DISSEMINATION** of trial results. Please summarise any actions/considerations required in [**Worksheet G**](#WorksheetG). | | |
| **What** | How, and in what way, were people with the condition or disability (and/or carers) and other stakeholders **involved** in planning the reporting and dissemination of the trial results? | Response:  The results will be disseminated to key stakeholders and presented at scientific meetings and journals. It is not clear from the trial protocol what the public involvement arrangements are for the trial including input into reporting or disseminating the results, nor whether participants and carers be provided with a summary. |
| Action/consideration required?  Diverse public involvement contributors with relevant experience, will be needed to ensure that the dissemination routes, mode, and information shared are accessible to people with impaired capacity and carers. |
| Other factors to consider: | |
| **How** | How might planned **reporting and dissemination** methods limit engagement with people who may be unable to consent (e.g accessible versions available)? | Response:  See previous response |
| Action/consideration required? |
| Other factors to consider: | |
| **Where** | How might **where** trial results will be reported and disseminated limit engagement of people who may be unable to consent (e.g online only)? | Response:  Posting results on a study website will be accessible to people with cognitive impairment and their carers, nor to groups who do not have access to IT/internet. |
| Action/consideration required? |
| Other factors to consider: | |

**Worksheet G**

|  |  |  |
| --- | --- | --- |
| **Summary of actions and resources needed\*** | | |
| **Lightbulb and gear with solid fill**Use this worksheet to summarise the **KEY FACTORS** you have identified that might affect the involvement of people with capacity-affecting conditions or disabilities in your trial, along with **ACTIONS OR CONSIDERATIONS** that are needed to support their inclusion, and the **COSTS OR RESOURCES** that might be required. Add extra rows as needed.  Please remember that there are also differences *within* groups who may experience impaired capacity. No group is homogenous, and there will be intersection between these and other factors such as ethnicity or language. | | |
| **Factors that may prevent the involvement of adults who have impaired capacity to consent** | **Proposed actions or considerations (several options may be needed)\*** | **Costs or resources required (if any)** |
| Accessibility of participant information sheets | Develop accessible or ‘easy read’ versions of participant information sheets | Obtain quote for accessible documents from [Thinklusive](https://thinklusive.org/) |
| Additional communication needs and assessment of capacity to consent | Resources to support assessment of communication needs and capacity to consent | Ensure training on assessing capacity and [Consent Support Tool](https://www.jr-press.co.uk/consent-support-tool.html) available for recruiting staff |
| Public involvement may not be designed to include perspective of people with cognitive impairment | Design public involvement activities to be accessible for people with cognitive impairment and their carers | Arrange smaller and more accessible meetings; include costs for creating accessible information prior to meetings; provide payment for more time to review information; and cover carer/supporter costs |
| More time needed to recruit participants (tailored information and support, assess capacity, contact consultees/legal representatives) | Ensure sufficient research nurse time available to support participants and consultees/legal representatives, to revisit capacity and consent as needed, and to support data collection | Include costs for additional research nurse time (e.g in Schedule of Events Cost Attribution Template) |
| Etc. |  |  |
|  |  |  |

\*See <https://www.capacityconsentresearch.com/> for a range of resources and practical suggestions about how you can address factors that affect the involvement of adults with conditions or disabilities that may impair their capacity to consent

Acknowledgements

This INCLUDE Impaired Capacity to Consent Framework builds on work by [NIHR INCLUDE](https://sites.google.com/nihr.ac.uk/include/home) and their [Ethnicity Framework](https://www.trialforge.org/trial-forge-centre/include/). It was developed by members of the [Trial Conduct Working Group](https://www.methodologyhubs.mrc.ac.uk/files/8815/8091/5879/NEW_TCWG_remit_300120_002.pdf) Inclusivity subgroup of the [MRC-NIHR Trials Methodology Research Partnership](https://www.methodologyhubs.mrc.ac.uk/about/tmrp/).

The development of the INCLUDE Impaired Capacity to Consent Framework was led by Victoria Shepherd (Centre for Trials Research, Cardiff University) and Katie Joyce (Bristol Trials Centre, University of Bristol) with Samantha Flynn (CEDAR, University of Warwick), Amanda Lewis (Bristol Trials Centre, University of Bristol) and Madeleine Clout (Bristol Trials Centre, University of Bristol). It was developed in collaboration with [Trial Forge](https://www.trialforge.org/).

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**Appendix 1. Research involving adults who lack capacity to consent – legal summary**

***Background***

Research is an important way for us to understand illness and disabilities, and to improve the treatment, care and support people receive. Sometimes this research can only be carried out if it involves people who lack the mental capacity to provide informed consent to take part. Capacity can only be assessed in relation to a particular decision and a particular time – a person may have the capacity to make some decisions but not others, or their capacity to make a decision may vary over time. Adults are presumed to have capacity to make decisions about themselves unless proven otherwise through a formal assessment.

For those who are unable to provide informed consent for themselves, there are alternative legal provisions for their participation in research. The law allows such research to take place but sets out strict rules to protect people who lack capacity to consent to take part in research, and to make sure their wishes and preferences are taken into account.

***The legal frameworks***

There are separate laws governing research involving adults who lack capacity to consent in England and Wales. The Mental Capacity Act 2005 (MCA) governs how adults lacking capacity can be involved in research, although it excludes clinical trials of investigational medicinal products (CTIMPs) which are regulated separately by the Medicines for Human Use (Clinical Trials) Regulations 2004 (CTR). The CTR also apply to CTIMPs in Scotland, with non-CTIMPs governed by the Adults with Incapacity (Scotland) Act 2001 (AWI).

Although there are many similarities between the regulations, there are important differences in who is involved in decisions about participation and the legal basis for their decision (e.g whether it constitutes consent or not). A summary of the main differences are shown in **Table 1** below. Other legal frameworks apply to non-CTIMPs in N Ireland and the Republic of Ireland.

***Who is involved in decisions about adults who lack capacity to consent?***

The researcher must consult a person who, by virtue of their relationship with the person who lacks capacity, is suitable to act as an advisor on their behalf and is available and willing to act. They are either termed a Personal Consultee under the MCA, or Personal Legal Representative under the CTR, or for non-CTIMPs under AWI in Scotland they are termed either a Guardian, Welfare Attorney or Nearest Relative. A number of people may be able to act as a Personal Consultee or Personal Legal Representative, but they should be someone whom the person who lacks capacity would trust with important decisions about their welfare (MCA (s32(2)) and CTR Part 5). Usually it will be someone with a close personal relationship with the person, for example their spouse/partner, adult child or parent, but it can be a close friend. They do not have to hold Power of Attorney. If a potential consultee does not feel able to take on the role, they may suggest that someone else takes on the role, or ask that a Nominated Consultee or Professional Legal Representative be appointed. In Scotland, the AWI outlines who can act as Guardian, Welfare Attorney or, if there is no such Guardian or Welfare Attorney, then the adult’s Nearest Relative defined in the Mental Health (Scotland) Act 1984.

A Nominated Consultee (MCA) or Professional Legal Representative (CTR) is required when no-one who knows the person in a personal capacity is either available or willing to act. This is usually a healthcare professional or another nominated individual involved in their care, but they cannot be connected with the research study.

In all cases, the person lacking capacity should be informed about the research and involved in the decision as much as possible, even if they are unable to provide informed consent. If they have fluctuating capacity or are likely to regain capacity, the decision should be delayed until they regain capacity where possible. The researcher must take into account the wishes of the person who lacks capacity about whom to consult (e.g. their partner, or a particular friend or carer) and to act in accordance with any relevant previous statement or wishes.

***How should the decision be made?***

Careful thought is needed before including in research projects any adults who lack the capacity to make their own decisions. In England and Wales, unlike other decisions covered by the MCA such as those about medical treatment and care, ‘best interests’ procedures do not apply to decisions about taking part in research (MCA Code of Practice). Instead, each individual decision is based on what the person would have decided if they had capacity to do so.

The Consultee must be given information about the project and gives advice as to whether the person should take part in the project, and what the person’s wishes and feelings about taking part in the project would be if they had capacity to decide (MCA s32(4)). The Consultee gives advice on what they think the participant would want to do, rather than give consent themselves. If the Consultee so advises, the participant must not take part and, if already taking part, must be withdrawn. The responsibility whether to include the participant lies with the researcher. If the person who lacks capacity indicates (in any way) that they wish to be withdrawn from the project, they must be withdrawn without delay.

Under the AWI in Scotland governing decisions made by Guardians, Welfare Attorneys, and Nearest Relatives, Principle 3 states that account must be taken of the present and past wishes and feelings of the person, as far as this may be ascertained.

For clinical trials of medicines, the Legal Representative is provided with information about the trial that includes the objectives, risks and inconveniences of the trial and the conditions under which it is to be conducted. They are then asked to provide informed consent that represents the person’s presumed will. The person who lacks capacity should also have received information (according to their capacity of understanding) about the trial, its risks and its benefits. If the person is capable of assessing the information and forming an opinion, any refusal to participate should be considered by the researcher.

The basis for a decision by a Nominated or Professional Legal Representative is the same as for someone acting in a personal capacity (i.e. advice under MCA, informed consent under CTR) based on what the person themselves would have decided.

***What if it is in an emergency situation?***

Research carried out in emergency situations pose unique challenges in terms of obtaining consent. Emergency research is when treatment needs to be given urgently, and it is necessary to take urgent action for the purposes of the study. In some emergency situations people may lack capacity to give consent themselves and obtaining consent from a legal representative/consulting others is not reasonably practicable.

In England and Wales, the law allows adults who lack capacity to take part in emergency research without prior consent from a legal representative or consulting others, if certain conditions are met (Medicines for Human Use (Clinical Trials) Amendment (No 2) Regulations SI 2006 2984, and MCA s32(8)). Following enrolment in the study, a consultee should be consulted as soon as possible to seek advice on the person’s likely views and feelings, and for a CTIMP consent should be sought from a Legal Representative as soon as possible. Informed consent should also be sought from the person themselves as soon as possible following any regaining of capacity. Consent may be required for the person to continue in the study, or for the continued use of data or samples obtained.

The CTR arrangements for emergency research apply to CTIMPs in Scotland. However, the AWI governing non-CTIMP studies in Scotland does not provide any 'exemptions' from the requirement for consent from a Welfare Attorney/Guardian or Nearest Relative for adults not able to consent for themselves, even in emergency situations.

**Table 1.** Summary of the provisions for adults lacking capacity under the Mental Capacity Act 2005 (MCA), Adults with Incapacity (Scotland) Act 2000 (AWI), and Medicines for Human Use (Clinical Trials) Regulations 2004 (CTR)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **MCA** | **AWI** | **CTR** |
| **Who is involved in decisions about participation** | ***Personal consultee*** - a person who is engaged in caring for the person or is interested in their welfare, except as a professional or for remuneration – friend, relative, unpaid carer, attorney acting under LPA, court appointed deputy (s32(2)).  ***Nominated consultee*** - a person who has no connection with the project - healthcare professional, nominated individual (s32(3)). | ***Guardian or welfare attorney*** *-* who has power to consent to the adult’s participation in research, or where there is no such guardian or welfare attorney, from the adult’s nearest relative (for both CTIMPs (AWI s51) and non-CTIMPs).  Guardianship is granted by the sheriff’s office upon application, can cover property and financial matters or personal welfare including health, or a combination of these.  Power of attorney is appointed by the individual whilst they have capacity, and grants someone they trust powers to act as their continuing (financial) and/or welfare attorney.  ***Nearest relative*** - the AWI uses the hierarchy of relationships defined in the Mental Health (Scotland) Act 1984 as the definition of nearest relative, | ***Personal legal representative*** – a person who, by virtue of their relationship, is suitable to act as their legal representative and is available and willing to act (Schedule 1 Part 5).  ***Professional legal representative*** – the doctor primarily responsible for their medical treatment or a person nominated by their health care provider. Must not be connected with the trial (Schedule 1 Part 5). |
| **Basis for the decision** | Consultee is asked for ***advice*** whether the participant should take part or would not have wished to participate (s32(4)). The responsibility whether to include the participant ***lies with the researcher.*** | Not stated - although general principle 3 is ***account must be taken*** of the present and past wishes and feelings of the person, as far as this may be ascertained. | ***Informed consent*** given by the legal representative represents their presumed will (Schedule 1 Part 5(12)). Representative to decide whether the participant would have wanted to participate had they capacity to do so. |
| **Requirement for provision of information** | MCA does not specify any provisions that the person has to be informed about the research once they have been assessed as lacking capacity. | Does not specify any provisions that the person has to be informed about the research once they have been assessed as lacking capacity. | Person lacking capacity must have received information about the trial, its risks and benefits, according to his or her capacity before they can be involved. |
| **Weight of any dissent/objection** | Weight is given to any refusal or dissent from the individual lacking capacity, even when the person has little or no ability to understand the situation. If the person indicates (in any way) that he wishes to be withdrawn from the project he ***must be* *withdrawn*** without delay (s33(4)). | The research ***must not be carried out*** if the adult indicates unwillingness. | The explicit wish of a subject who is capable of forming an opinion and assessing the information to refuse participation in, or to be withdrawn from, the clinical trial at any time ***must be* *considered*** by the investigator. |
| **Level of risk permitted** | Research must be connected with an impairing condition in the functioning of the mind or brain affecting the person, or its treatment. There must be reasonable grounds for believing that the risk to the person is ***negligible*** and that anything done in relation to the person will not interfere with their freedom of action or privacy in a significant way or be unduly invasive or restrictive (s31). | Purpose of research must be to gain knowledge of the causes, diagnosis, treatment and care of the adult’s incapacity or the effect of any treatment or care given to the adult while he or she is incapable. Research must be of ***real and direct benefit to the adult involved,*** or where it is not likely to but ***likely to improve the scientific understanding*** of the adult’s condition and in the long term contribute to the attainment of real and direct benefit to persons suffering from the same form of incapacity(s51(4)).  The research involves ***no foreseeable risk or only minimal risk*** to the adult and should impose ***no or only minimal discomfort***. These conditions should be seen in the context of the adult’s standard treatment, if that is appropriate. | The clinical trial must relate directly to a life-threatening or debilitating condition clinical condition from which the person suffers. There must be grounds for expecting that administering the product will ***produce a benefit* *to the person* *outweighing the risks or produce no risk at all*** (Schedule 1 Part 5(9)). |
| **Loss of capacity during research** | Unless the research started before the MCA came into force (1st October 2007), when a person loses capacity during a research project, the study must have approval under s30 of the MCA.  Consent given by a person with capacity is not considered to survive any loss of capacity during the study and the researcher must seek the views of a consultee (s34) (see also Mental Capacity Act 2005 (Loss of Capacity during Research Project) (England) Regulations 2007, and Wales equivalent). | There is no specific provision for adults who lose capacity while taking part in non-CTIMPs in Scotland. Researchers and RECs might expect that in most circumstances the original consent should be respected.  However, a request by a legal representative to withdraw someone from a study after they have lost capacity, should be considered carefully to ensure that it reflects the wishes of the person before they lost capacity, and that their current situation is fully considered. | If a capable adult gives informed consent to take part in a CTIMP and subsequently becomes unable to give informed consent by virtue of physical or mental capacity, the consent previously given when capable remains legally valid, provided the trial is not significantly altered. It is good practice in such cases to consult with carers and take note of any signs of objections or distress from the participant. The researcher should consider withdrawing a participant if any objections are raised.  If a capable adult refuses informed consent, and subsequently becomes unable to give informed consent the refusal is legally binding. They cannot be entered into the trial by seeking consent from a legal representative. |
| **Emergency situations** | s32(8) of the Act allows exceptionally for a person lacking capacity to be entered into research prior to a consultee being consulted in emergency situations, if it is also necessary to take action for the purposes of the research as a matter of urgency, but it is not reasonably practicable to consult under the previous provisions of this section. | No emergency research provisions relating to surgical, medical, nursing, dental or psychological research under AWI in Scotland, only CTIMPs under CTR. | Inclusion without prior consent from the participant or a legal representative is possible under defined circumstances under the Medicines for Human Use (Clinical Trials) (Amendment No.2) Regulations 2006. This includes that the treatment to be given as part of the trial needs to be given urgently. |

***Where can I find more information?***

**Health Research Authority (HRA)**

<https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/mental-capacity-act/> and <http://www.hra-decisiontools.org.uk/consent/principles-ALC.html>

**Medical Research Council (MRC)**

[Guidance issued by the Medical Research Council](https://www.mrc.ac.uk/documents/pdf/medical-research-involving-adults-who-cannot-consent/) on medical research involving adults who cannot consent

**Capacity to consent to research website**

<https://www.capacityconsentresearch.com/>

Collated resources and information created as part of the CONSULT project

**NIHR Learn Informed Consent with Adults Lacking Capacity (eLearning)**

<https://sites.google.com/a/nihr.ac.uk/crn-learn-help/accessing-nihr-learn> An introduction to informed consent with adults lacking capacity. It explores the requirements of the Mental Capacity Act and Medicines for Human Use (Clinical Trials) regulations when involving adults who lack capacity in non-CTIMP and CTIMP research.

***References***

[The Medicines for Human Use (Clinical Trials) Regulations 2004](http://www.legislation.gov.uk/uksi/2004/1031/pdfs/uksi_20041031_en.pdf)

[Mental Capacity Act 2005](http://www.legislation.gov.uk/ukpga/2005/9/contents)

[Adults with Incapacity (Scotland) Act 2000](https://www.legislation.gov.uk/asp/2000/4/contents)

[Guidance on nominating a consultee for research involving adults](http://webarchive.nationalarchives.gov.uk/20130123193236/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083131) who lack capacity to consent

[Mental Capacity Act 2005 (Loss of Capacity during Research Project) (England) Regulations 2007](http://www.legislation.gov.uk/uksi/2007/679/contents/made)

[Mental Capacity Act 2005 (Loss of Capacity during Research Project) (Wales) Regulations 2007](http://www.legislation.gov.uk/wsi/2007/837/contents/made)

[DH Mental Capacity Act 2005 guidance page](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/DH_078789)

[Mental Capacity Act 2005 Questions and Answers](http://www.hra.nhs.uk/resources/questions-and-answers-mental-capacity-act-2005/)

[Mental Capacity Act Code of Practice](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf)

[Ethics Guidebook – a resource for Social Scientists](http://www.ethicsguidebook.ac.uk/Mental-Capacity-Act-118)

[NIHR Clinical Trials Toolkit](http://www.ct-toolkit.ac.uk/)

***About this summary***

This summary forms part of a project to explore the ethical, legal and methodological aspects of conducting research involving adults who lack capacity (CONSULT). It is being carried out as part of an NIHR Advanced Fellowship at Cardiff University and is funded by the Welsh Government through Health and Care Research Wales. For more information, please contact Dr Victoria Shepherd [ShepherdVL1@cardiff.ac.uk](file:///C:\Users\vicky\AppData\Local\Packages\Microsoft.MicrosoftEdge_8wekyb3d8bbwe\TempState\Downloads\ShepherdVL1@cardiff.ac.uk)

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