Leicestershire Partnership NHS Trust

Consent to Examination or Treatment Policy

This Policy sets out the standards and procedures to ensure that health professionals comply with consent guidance

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
3	March 2012	
4	12.9.2012	Additional content added to ensure the Trust complies with NHSLA criteria 5.3.
5	28.2.2013	Amendments incorporated to NHSLA Monitoring Section
6	15.10.14	Clarified an individual's duty to obtain consent (section 1.1) Consent for anaesthesia removed (section 4.3) Clarified simultaneous T2 and T3 (section 9.2) Tissue section (section 10) removed Latest policy format utilised
6.4	February 2015	Inclusion of further sections
6.7	April 2015	Inclusion of legal information and minor amendments
7 7.1	February 2020	General review Removal of Clozapine statement Update to titles 3 month ext agreed at CEG

For Further Information Contact:

Lead Nurse for Professional Standards

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- **Strategies, policies and services are free from discrimination;**
- **LPT complies with current equality legislation;**
- **Due regard is given to equality in decision making and subsequent processes;**
- **Opportunities for promoting equality are identified.**

Definitions that apply to this Policy

Advance Directive	A way of making views known before a crisis which would cause an inability to make informed choices.
Consent	a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must: ▪ be competent to take the particular decision; ▪ have received sufficient information to take it and not be acting under duress.
ECT	Electro Convulsive Therapy, a procedure for which formal written consent is required. ECT is governed by the Electro Convulsive Therapy Clinical Guidelines within LPT.
Gillick or Fraser competent	Following the case of Gillick-v-West Norfolk and Wisbech AHA [1986] AC 112, the Courts have held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being 'Gillick or Fraser competent.'
Due Regard	Having **due regard** for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Mental Capacity	Mental capacity ('capacity') can be affected by many conditions, e.g. learning disability, mental health problems, stroke, head injury, alcohol/drug use, medication, extreme pain or shock. Capacity can fluctuate, and change over time. A person may have the capacity to make a simple decision but may lack the capacity to make a more complex one. The Mental Capacity Act builds on the existing best practice of placing the individual at the centre of decision making, i.e. staff will: ▪ Identify and record patients views and wishes ▪ Support them to make their own decisions ▪ Involve them as much as possible in all decisions that are made on their behalf. http://www.legislation.gov.uk/ukpga/2005/9/contents

1.0 Summary

This policy provides guidance on consent and obtaining consent for patient interactions at LPT. It is good practice to obtain consent from a patient and to involve patients in their care and treatment. Individual practitioners must take responsibility for obtaining the appropriate consent from a patient but are encouraged to seek advice and use national guidance in conjunction with the LPT consent policy. Consent is a fluid concept that is decision and time-specific, much like capacity. All practical efforts must be made to ensure that a patient is providing valid consent for an intervention and this consent must be sought by the clinician carrying out the intervention.

2.0 Introduction

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

While there is no English statute setting out the general principles of consent, case law ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, 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. Poor handling of the consent process may also result in complaints from patients through the NHS complaints procedure or to professional bodies.

It is the responsibility of the person undertaking the procedure to obtain valid consent for that procedure – whether this is assisting a patient with activities of daily living or administering electroconvulsive therapy (ECT). The person undertaking the procedure must decide what sort of consent is required - unless there is a legal responsibility, such as with medication after three months for detained patients. Although this policy acts as a guide the expectation is that staff at LPT will contact appropriate staff for advice if they are unsure about consent. This is likely to be their line manager in the first instance.

Consent can vary from taking someone's blood pressure (where the presentation of an arm by the patient indicates implied consent) to a more formal assessment – such as when a patient is admitted informally to a mental health hospital. The admitting clinician needs to consider whether the patient has the capacity to consent to an informal admission.

Link to the mental capacity act(MCA) - http://www.legislation.gov.uk/ukpga/2005/9/contents

3.0 Purpose

This purpose of this policy and related documents is to ensure that all permanent employees including medical staff who work for LPT including those on bank, agency or honorary contracts are clear of their responsibilities around gaining consent to treatment and provide a clear assurance framework for the LPT board.

4.0 Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively, including this, the Consent Policy.

4.2. The Quality Assurance Committee, (QAC) as a Trust Board Sub-committee, has the responsibility for ratifying policies and protocols. Its sub-group, the Patient and Carer Experience Group, has responsibility for considering and agreeing this policy.

4.3 Divisional Directors and Heads of Service are responsible for ensuring that comprehensive arrangements are in place regarding adherence to this policy and how Consent procedures are managed within their own Department or Service in line with the guidelines in this policy. They will ensure that team managers and other management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction. These arrangements will include ensuring that all staff have access to this policy, and maintaining a system for recording that policies and procedures have been distributed to and received by staff within the Department / Service and for having these records available for inspection upon request for audit purposes.

4.4 Managers and Team leaders are responsible for providing advice and support to staff on consent issues/concerns raised within their service areas, and are responsible for ensuring all clinical staff have been trained to the required standards. They are responsible for ensuring that the Consent Policy is followed and understood as appropriate to each staff member's role and function

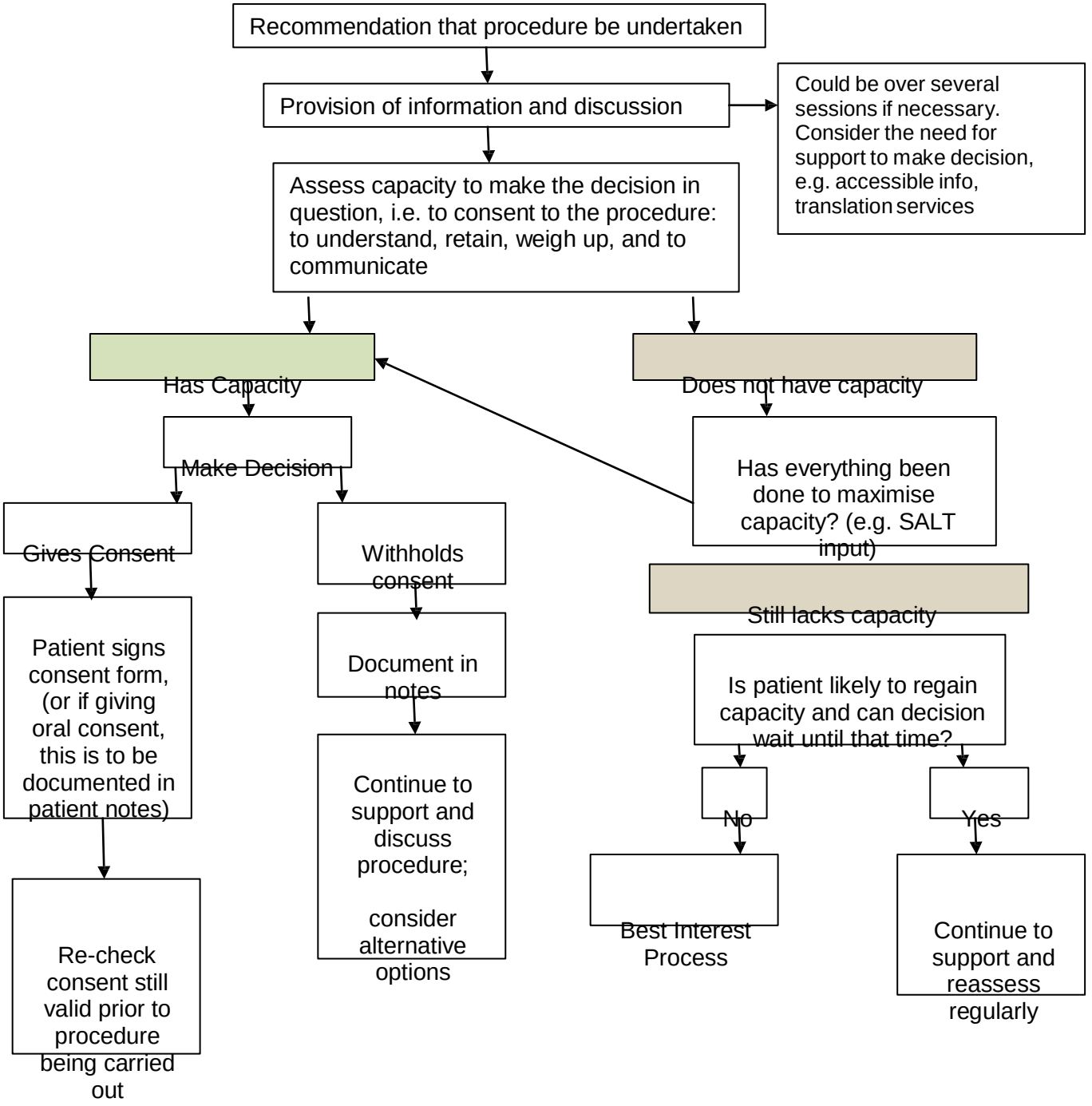
- This information must be given to all new staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes policies and procedures
- Ensuring that the staff understand how and where to access current policies and procedures; via Intranet/ e-source.
- Ensuring that a system is in place for their area of responsibility that keeps staff up to date with the Consent Policy and any recommended training related to it

4.5 All staff (including seconded staff) should be aware that despite the above responsibilities of senior staff, every staff member has a professional responsibility to have an understanding of consent in their day-to-day clinical practice and to follow the guidance of their professional body, the Department of Health as well as local trust policies.

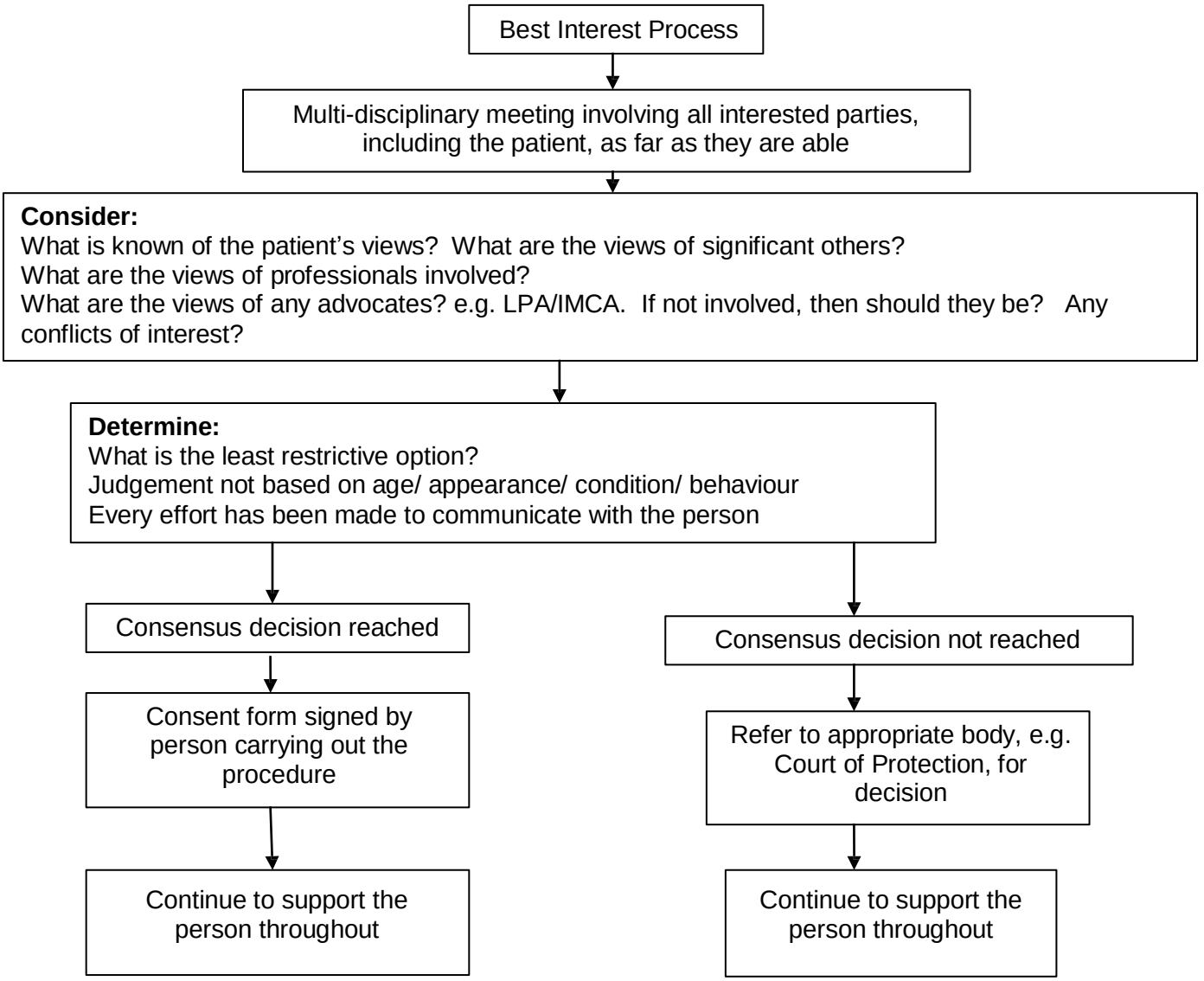
5.0 Flowchart

Flowchart of Capacity and Consent Process

(Assessment of capacity is only necessary when capacity is thought to be in doubt)

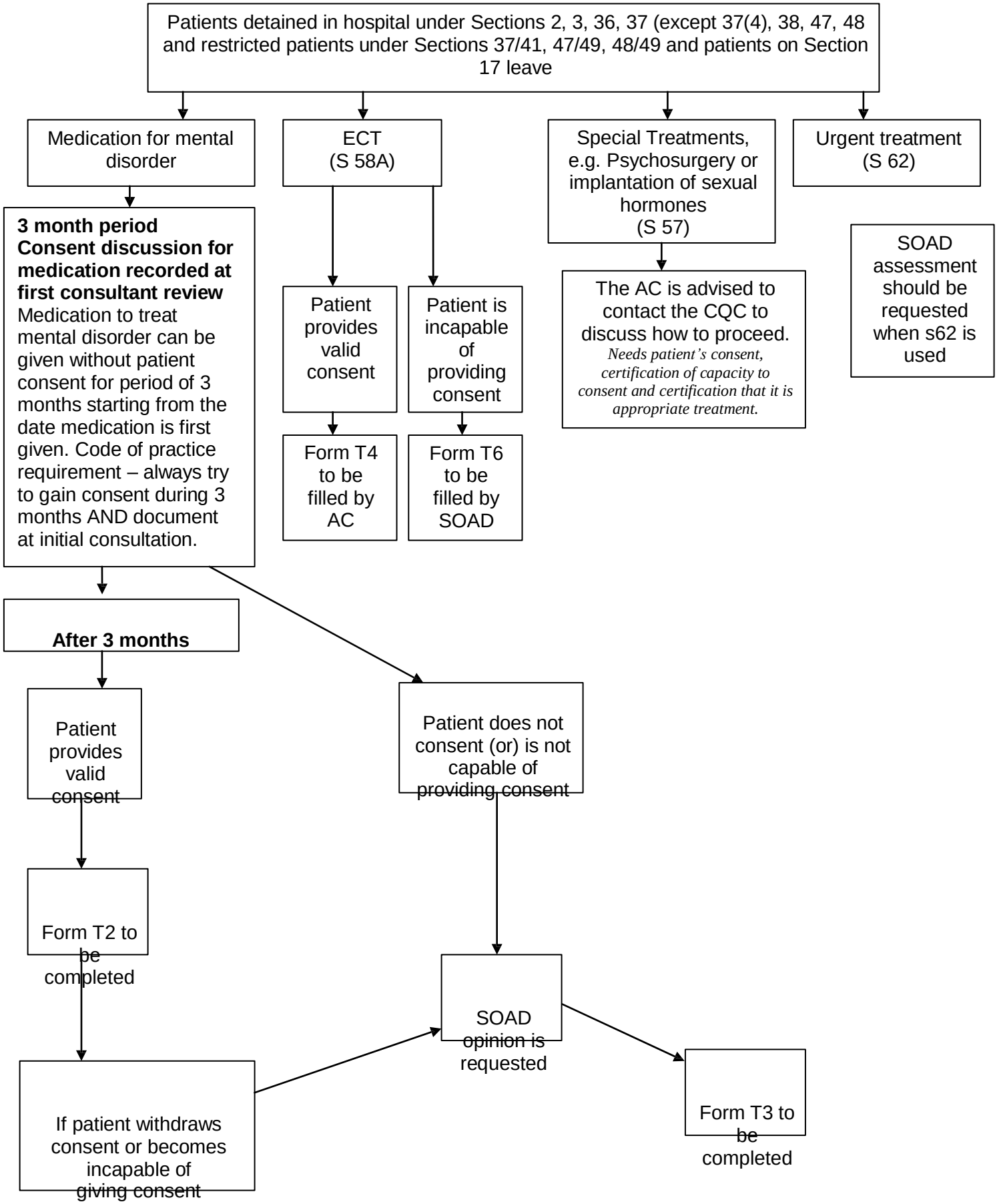


Best Interest Process



Ensure the Mental Capacity Assessment form is completed for Best Interest Decisions – see MCA policy

Flowchart of Consent Procedure related to the Mental Health Act



6.1 Consent

6.2 This policy gives guidance on **what is and is not consent**.

'Consent' is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it and not be acting under duress.

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision- making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable Advance Directive. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19).
(Refer also to the MCA Policy)

6.3 Guidance on Consent

The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

'Reference guide to consent for examination or treatment' provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. This is available at www.doh.gov.uk/consent.

'12 key points on consent: the law in England' has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis and is available from www.doh.gov.uk/consent.

Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available at www.doh.gov.uk/consent.

'The Mental Capacity Act 2005' provides a 2 stage test for identifying persons who lack capacity to make decisions about healthcare and treatment. The Act sets out a statutory framework for making treatment decisions on behalf of a patient who lacks capacity. Copies of the Code of Practice are available in all localities, on all wards and on the internet. Mental Capacity Act 2005 Code of Practice -www.publicguardian.gov.uk/mca/code-of-practice.htm

6.4 When Should Consent Be Sought?

When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

6.4.1 Single Stage Process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

6.4.2 Two or More Stage Process

In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team must check with the patient

at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

6.5 Emergencies

Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

6.6 Documentation

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

It is important that each group of health care professionals charged with obtaining consent are: -

- Consistent in the form of words used in the documentation that indicates that the patient has given oral consent (if a consent form is not being used)
- in general agreement as to what procedures require oral as opposed to written consent and that there is consistency in this approach.

For medication for a mental disorder, despite the law allowing treatment without consent for three months, there must be a consideration at the first consultant review of a patient about the patient's capacity to consent to their treatment. This must be documented in the patient's notes.

6.7 Provision of Information

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments / investigations and their risks and benefits (including the risks / benefits of doing nothing). It should be recorded in the health care records what information has been provided (e.g. leaflets) in the patient's health care records.

They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example, a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

The following sources of patient information are available in the Trust:

- Braille
- Large Print Information Sheets.
- Easy Read
- Tape recording of consultation.
- Taped and Audio facilities.

LPT is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

Translation and interpreting services are available from:
Ujala Resource Centre, St Peter's Health Centre
0116 295 4747

6.8 Access to Health Professionals Between Formal Appointments

After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they make their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). The patient should also be encouraged to contact their own GP if they require further information. Most GP surgeries prefer patients with telephone queries to ring between 11:00am and 3:00pm. Alternatively they may encourage the patient to make an appointment to see their General Practitioner to discuss the issues of concern.

6.9 Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the patient's employment, social or personal life
- the treatment is part of a project or programme of research approved by the Trust.

Formal written consent is required for Electro Convulsive Therapy (ECT) and this is governed by the Electro Convulsive Therapy Clinical Guidelines within LPT.

Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional. It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example, if they have declined, or become very distressed about, similar care in the past) it would be helpful to do so.

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005. More information about the Act is given in the Code of Practice. Treatment can be given to a patient who is unable to consent, only if:

- the patient lacks the capacity to give or withhold consent to this procedure

AND

- the procedure is in the patient's best interests.

6.10 Capacity

A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision.
- Retain that information long enough to be able to make the decision.
- Use or weigh up the information as part of the decision-making process.
- Communicate their decision - this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient

(spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity. (Refer also to the MCA Policy)

6.11 Best Interests

The Mental Capacity Act (see MCA Policy Section 4, and MCA Codes of Practice) requires that a health professional must consider all the relevant circumstances relating to the decision in question, including, as far as possible considering:

- the person's past and present wishes and feelings (in particular if they have been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors
- other factors that the person would be likely to consider if they were able to do so.

When determining what is in a person's best interests, a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death. The Act also requires that, as far as possible, health professionals must consult other people, if it is appropriate to do so, and take into account their views as to what would be in the best interests of the person lacking capacity, especially anyone previously named by the person lacking capacity as someone to be consulted and anyone engaging in caring for patient and their family and friends.

Unless the person has an attorney or deputy, the final responsibility for determining what is in a person's best interest will rest with the relevant health professional. However, the health professional must consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) as far as is practicable and as appropriate.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be necessary for a formal assessment to be carried out by a suitably qualified professional.

6.12 Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are not decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the *Act*.

6.13 Lasting Power of Attorney and Court Appointed Deputy

A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment, are potentially serious, a court declaration may be sought (Appendix 7). (If a court declaration is required practitioners should contact the Chief Nurse, or a member of the Clinical Governance team, who will refer the matter to the Trust's solicitors).

6.14 Availability of Forms

Standard consent forms and forms for adults who are unable to consent for themselves are available to download on the Department of Health website. There are three versions of the standard consent form: form 1 for adults or competent children, form 2 for parental consent for a child or young person, and form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

There are specific forms for medication following three months of treatment (currently T2 forms for patients with capacity who consent or T3 forms for patients who lack capacity or have capacity but refuse treatment). T2 forms are available from the Mental Health Act office and SOAD requests are made online through the CQC (https://webdataforms.cqc.org.uk/Checkbox/SOAD.aspx).

6.15 Open Access Clinics

Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment.

Patients attending open access clinics should contact them direct for further information relating to any proposed treatment.

6.16 Informed Consent and the Duty to Warn

Following the Supreme Court decision in *Montgomery* (Appellant) v *Lanarkshire Health Board* (Respondent) [2015] clinicians need to make patients aware of any "material risks" i.e risks involved in proposed treatment which:

1. a reasonable person in the patient's position would be likely to attach significance to; or
2. the doctor is or should be aware that the particular patient would be likely to attach significance to, taking into account factors such as the nature of the risk, the effect of its occurrence on the patient's life and the importance to the patient of the beneficial aim of the treatment.

Clinicians have a duty to inform patients of any reasonable alternatives to the treatment proposed.
While the goal is not to overwhelm patients with information clinicians need to demonstrate that they have had a dialogue with patients where the risks of a treatment and reasonable alternatives have been discussed. Instead of an individual clinician deciding what risks a patient may find important it is better to make the patient aware of all the risks, however unlikely, so that the patient can make a truly informed decision.

7.1 Children and Consent

It is important to note that the position concerning consent and refusal of treatment for those patients under the age of 18 is different from the position for adults and in particular where treatment is being refused.

7.2 Treatment of Young Children

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

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their

children, for example, unmarried fathers do not automatically have such responsibility although they can acquire it if:

- they are registered as the child's father
- there is an agreement made with the child's mother providing for him to have parental responsibility for the child
- there is a successful application to the court by the father for parental responsibility

A mother automatically has parental responsibility upon the birth of the child. The child's father will have parental responsibility if he was married to the mother at the time of the child's birth, if he later marries the mother, (for children born after 1 December 2003), he is named on the birth certificate, he enters a parental responsibility agreement with the mother; or is awarded parental responsibility by the Court via parental residency or residence order. It should also be noted that anyone can obtain parental responsibility if they are granted a residence, special guardianship or adoption order by the Court. If in doubt about whether an individual has parental responsibility, legal advice should be sought.

If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

7.3 Young People Aged 16-17

Section 8 of the Family Law Reform Act 1969 enables young people aged 16 or 17 to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as anaesthetic. As is the case for adults, the consent will only be valid if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention. However, it is important to note that, the refusal of a competent person aged 16 to 17 may in certain circumstances be overridden by either a person with parental responsibility or a Court.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults and referred to above should be used. If the requirements for valid consent have been met, it is not legally necessary to obtain consent from a person with parental responsibility but good practice directs that in the case of a patient aged 16 to 17 the family should be involved in the decision-making process, unless the young person specifically wishes to exclude them.

7.4 Children Under the Age of 16 – the Concept of 'Gillick or Fraser Competence'

Unlike 16 or 17 year olds, children under 16 are not automatically presumed to be legally competent to make decisions about their healthcare. However, the courts have stated that under 16's will be competent to give valid consent to a particular intervention if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (known as the Fraser Law competence, previously known as "Gillick competence" The test to apply when considering Fraser or Gillick competency can be found at Appendix 8). In other words, there is no specific age when a child becomes competent to consent to treatment: it depends both on the child and on the seriousness and complexity of the treatment being proposed.

‘Competence’ is not a simple attribute that a child either possesses or does not possess: much will depend on the relationship and trust between you and your colleagues, and the child and their family. You can help children to develop competence by involving them from an early age in decisions and encouraging them to take an increasing part in the decisions about their care. This will particularly apply where you are caring for a particular child over a period of time, for example where the child needs a series of operations.

If a child under 16 is competent to consent for himself or herself to a particular intervention, it is still good practice to involve their family in decision-making unless the child specifically asks you not to do so and you cannot persuade them otherwise. As with older children, you must respect any request from a competent under-16 year old to keep their treatment confidential, unless you can justify disclosure on the grounds that you have reasonable cause to suspect that the child is suffering, or is likely to suffer, significant harm.

Following the case of Gillick-v-West Norfolk and Wisbech AHA [1986] AC 112, the Courts have held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being ‘Gillick or Fraser competent.’

In cases such as where contraceptive advice is given, if a child is deemed Gillick or Fraser competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. However, as stated above, where the decision will have ongoing implications, such as long term use of contraception, it is good practice to encourage the child to inform his or her parents unless it would clearly not be in the child’s best interests to do so.

7.5 Child or Young Person with Capacity Refusing Treatment

A competent child may accept treatment. In instances where a patient aged 16 or 17 who could consent to treatment in accordance with Section 8 of the Family Law Reformat 1969, but refuses treatment, that refusal can be overruled either by a person with parental responsibility for the child or by the Court. However, the power to overrule must be exercised on the basis of the welfare of the child/young person is paramount. As with the concept of best interests ‘welfare’ does not just mean physical health. The psychological effects of having the decision overruled must also be considered. Whilst there is no definitive guidance as to when it is appropriate to overrule a competent young person’s refusal, it has been suggested that it should be restricted to occasions where the child is at risk of suffering ‘grave and irreversible mental or physical harm’.

For parents or those with parental responsibility to be in a position to overrule a competent child’s refusal, they must inevitably be provided with sufficient information about their child’s condition, which the child may not be willing for them to receive. While this will constitute a breach of confidence on the part of the clinician treating the child, this may be justifiable where it is in the child’s best interests. Such a justification may only apply where the child is at serious risk as a result of their refusal or treatment.

Refusal by a competent child and all persons with parental responsibility for the child can be overruled by the Court if the welfare of the child so requires.

If a life threatening emergency arises where consultation with either a person with parental

responsibility or the Court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of the child, in such cases the Courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life and prevent serious damage to health.

8.1 Who is Responsible for Seeking Consent?

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

Staff who are not capable of undertaking the procedure are not authorised to gain consent for that procedure.

8.2 Completing Consent Forms

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

If the patient signs the form in advance of the procedure, a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

If a health professional obtains consent where it has not been authorised this should be reported as an incident. The incident should be managed through the Disciplinary Policy and Procedure and a referral made to the General Medical Council (GMC) using the required form where appropriate.

9.1 Refusal of Treatment

It must not be assumed that the person who refuses treatment lacks capacity even if the professionals demonstrate that the treatment is in the person's best interests. It must be demonstrated that the person:

A. lacks capacity and
B. the treatment is in the person's best interests

for the treatment to take place in compliance with the law. A person is allowed by *The*

Mental Capacity Act 2005 to make an 'unwise decision' to refuse treatment.

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983*. (This might apply to patients detained under the Mental Health Act in in-patient CAMHS – seek advice in these types of cases). The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal (for example, a Jehovah's witness who may agree to a procedure but refuses a blood transfusion which may be required as a consequence of that procedure). If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

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

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

- Detained in hospital Sections 2, 3, 36, 37 (except 37(4), 38, 47, 48 and restricted patients on Sections 37/42, 47/49, 48/49.
- Detained under the sections specified above and on Section 17 leave.
- Patients specially **excluded** from part 5 provisions are:
    - Patients detained under Section 4, 5(2), 5(4), 35, 37(4), 135 and 136.
    - Patients on Section 7 (Guardianship) or Supervision Community Treatment (SCT) who are 'liable to be detained in hospital'.
    - Patients conditionally discharged from a Hospital Order but subject to restrictions in the community under Sections 41 or Sections 49.

For patients subject to SCT see separate Trust Policy, but note that patients with capacity cannot be given treatment without consent in the community (though if recalled they may be given treatment under Part 4A).

10.2 Part 4 of the Act uses the terms 'treatment' to refer to medication or Electro Convulsive Therapy (ECT). Section 57 and 58 of the Act applies specifically to medical treatment for mental disorder. Treatment for physical disorders is outside the remit of this Act and can only be given in the absence of consent if it can be justified under the Mental Capacity Act 2005.

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

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

10.5 Clinicians must clearly record the rationale used to provide treatment in such cases including the assessment of capacity.

10.6 **Medication Treatment for Mental Disorder**

10.6.1 The Three Month Period

For patients who are subject to Part 4 of the Act, medication to treat mental disorder can be given without the consent of the patient for three months starting from the date of commencement of the medication During this time, the patient's consent should still be sought before any medication
is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes(24.41)

1. The three month period does not apply to ECT and some other special treatments (e.g. Psychosurgery or implantation of sexual hormones)
2. The three month period is not affected by renewal of detention, leave or change or discontinuation of treatment. A fresh three month period will only start if the section ends and a new one commences.
3. For patients on Section 2 prior to Section 3, the date of medication was started under Section 2 will be the date of the three month period starts.
4. It is the responsibility of the **Approved Clinician (AC)**, which in Leicestershire Partnership Trust will be the **Responsible Clinician (RC),** in charge of the treatment to be aware of the start and end of the three month period.

10.6.2 After the three month period

For patients subject to Part 4 of the Act and who are given either a) medication for mental disorder after 3 months or b) ECT or some other forms of treatment at any time, the provisions of Section 58 apply and there are two possible courses. The RC must record the capacity assessment using the Trust form designed for this purpose. The form is available from the MHA Office, on the MHA Office webpage on e-source or where a s58 reminder letter has been sent the form will be on the reverse of the T2 sent with the letter:

1. <u>The patient has capacity to consent and gives informed consent</u>

A form T2 must be completed by the AC in charge of the patient's treatment to signify the patient's consent to treatment.

When completing the Form T2 the AC in charge of the patient's treatment should indicate in the case notes that the patient's ability to give valid consent has been assessed (capacity to consent for medication is assessed and recorded in the notes using recommended forms), that the treatment has been discussed with the patient and that the patient gives their consent to treatment.

Note: Treatment by consent under Part 4 of the MHA cannot lawfully be given after the three month period unless it is authorised by a Form T2.

2. If the patient does not give consent, or does not have capacity to consent In the case of a patient refusing or withdrawing consent or lacking capacity to give consent, treatment can only proceed on the authority of a **Second Opinion Approved Doctor (SOAD).** A visit and assessment for a SOAD can be requested from the **Care Quality Commission (CQC)** using the standard CQC SOAD request form. The CQC will arrange for a SOAD to visit – this can take up to a week and the RC should remember that a SOAD can be requested up to one month before the end of the three month period.

If the SOAD feels that the treatment as prescribed by the AC in charge of treatment is reasonable, taking into account all circumstances of the case, the SOAD will complete a Form T3, which provides the legal authority for treatment. It is now a legal requirement for the SOAD to provide a written explanation of the reasons for the decision either to authorise or refuse to authorise treatment. The SOAD will complete a form documenting the nature and reasons for their decision and a copy will be sent to the AC who should then explain the reasons to the patient and if appropriate give them a copy, and document this in the clinical notes.

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

It is possible to have both a T2 and T3 simultaneously where a patient has the capacity to consent to some but not all treatment.

10.6.3 Change of treatment under plan after three month period

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

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

Old consent forms should be crossed through to signify that they are no longer valid and then filed in the case notes. Although crossed through, the forms should remain legible.

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

Refer also to ECT policy, and see Notes in Appendix 10

Although ECT is a treatment for mental disorder, it is subject to a different legal position. ECT cannot be given to a capable person who is refusing it, when that person is detained (except when this treatment is given under a Section 62 as an urgent treatment). This is as a result of the specific amendments made to the Mental Health Act 1983 by the 2007 Act. ECT is **not** subject to the three month period which applies for medication.

Before any course of ECT, a detained patient must:

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

Or

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

Or

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

10.6.5 Special treatments under Section 57

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

Section 57 treatments can only be given if:

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

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

10.6.6 Urgent treatment under Section 62

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

Under Section 62, medication must be immediately necessary to:

- Save a patient's life, or (note being irreversible) prevent a serious deterioration in their condition, or
- Alleviate serious suffering, or
- Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or other.

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

Treatment under Section 62 must be documented on the relevant form, which is filed in the patient's case notes and copied to the MHA office.

11.0 Clinical Photography and Conventional or Digital Video Recordings

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication.

If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give

consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent. Where children may be involved, seek advice from Children's Services on photography and video recording confidentiality and consent, copyright and storage for specific policies.

12.0 Training

LPT recognises the importance of consent education and training. Following training needs analysis, all clinical staff require formal training on consent. The level of training required is as follows:

New Starters - receive basic training in consent issues as part of their induction via Clinical Mandatory Training (in the Record Keeping session)

Existing Staff - receive bi-annual updates via Clinical Mandatory Training (in the Record Keeping session).

Medical Staff not directly employed by LPT must provide evidence of yearly consent training from their direct employer.

Training needs are identified and addressed in appendix 2 'training template'.

In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role essential training.

The course directory e- source link will identify: who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

A record of the event will be recorded on u-Learn.

The governance group responsible for monitoring the training is the Patient and Carer Experience Group.

13.0 Monitoring Compliance and Effectiveness

The primary responsibility for ensuring all clinical staff have been trained to the required standard lies with the Managers. All consent training is logged on to the LPT trustwide mandatory training database. LPT formally monitors compliance via the Performance Review process which takes place across all localities and their services.

The risks associated with the consent process are monitored via a number of routes: All patient safety incidents and complaints relating to the consent process are monitored via LPT clinical governance processes. Yearly audits will be undertaken to monitor compliance with this policy to ensure that the appropriate process is followed for obtaining consent and that this is recorded.

This policy is compliant with standard 5.2 (Patient Information & Consent). To understand how this standard is monitored, refer to the table in Appendix 3. The audit will use an approved methodology and will be performance managed by the Patient and Carer Experience Group.

14.0 Links to Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
100%	Compliance with Clinical Mandatory consent training
100%	Written consent present for ECT

References and Associated Documentation

This policy was drafted with reference to the following:

Mental Health Act 1983 (Amended 2007)
Mental Capacity Act 2005
Mental Capacity Act 2005 Code of Practice -www.publicguardian.gov.uk/mca/code-of-practice.htm

Appendix 1

Policy Training Requirements

The purpose of this template is to provide assurance that any training implications have been considered

Training topic:	Consent
Type of training:	☐ Mandatory (must be on mandatory training register) ✓ Role specific ☐ Personal development
Division(s) to which the training is applicable:	✓Adult Learning Disability Services ✓Adult Mental Health Services ✓Community Health Services ✓Enabling Services ✓Families Young People Children ✓Hosted Services
Staff groups who require the training:	New Starters - receive basic training in consent issues as part of their induction via Clinical Mandatory Training (in the Record Keeping session) Existing Staff - receive bi-annual updates via Clinical Mandatory Training (in the Record Keeping session).
Update requirement:	Bi-annual updates via Clinical Mandatory Training (in the Record Keeping session).
Who is responsible for delivery of this training?	Learning and Development
Have resources been identified?	**To be addressed**
Has a training plan been agreed?	**To be addressed**
Where will completion of this training be recorded?	✓ Trust learning management system ☐ Other (please specify)
How is this training going to be monitored?	Medical Staff not directly employed by LPT must provide evidence of yearly consent training from their direct employer.

Appendix 2

Policy Monitoring Section

Criteria Number & Name:

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance

Ref	Minimum Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
5.2 (a)	process for obtaining consent	Sec 6.3 Page 14 - 15	Record Keeping Audit	DATA Protection group	Annually
5.2 (b)	how information is provided to patients to support their decision making, including risks, benefits and alternatives where appropriate	Sec 6.6 Page 15 - 16	Record Keeping Audit	Data protection Group	Annually
5.2 (c)	how the discussion and provision of information to patients is recorded	Sec 6.6 Page 15	Record Keeping Audit	As above	Annually
5.2 (d)	process for recording that consent has been given	Sec 6.5 Page15 Sec 6.8 Page 16 - 17	Record Keeping Audit	As above	Annually

Appendix 3

Leicestershire Partnership NHS
NHS Trust

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	X
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 4

Further information on Consent

12 key points on consent: the law in England

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example, information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8. Consent must be given voluntarily, not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place.

Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment,* available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent.

The Mental Capacity Act 2005 available on Trust Intranet, or at www.publicguardian.gov.uk/mca/code-of-practice.htm

Guidance to health professionals

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an *aide-memoire* to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and lacks the capacity to give consent, you should use form 4 (form for adults who lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- understand information about the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (by talking, using sign language or any other means).

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign a form on behalf of an adult who lacks capacity to

consent for themselves, unless they have been given the authority to so under a Lasting Power of Attorney or as a court appointed deputy."

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

Appendix 5

Current forms in use in LPT –

Form for adults who are unable to consent to investigation or treatment

Patient agreement to investigation or treatment

Parental agreement to investigation or treatment for a child or young person

Patient / parental agreement to investigation or treatment (procedures where consciousness not impaired)

Consent for the use of clinical videos/images for health professional education.

MCA assessment form

Appendix 6

How to seek a court declaration

In-hours (08.30-17.00)

Applications are to be initiated by the Medical Director
Applications process:

- The attending doctor/Consultant would need to get a formal second opinion from another doctor/Consultant first,
    - Only if both agree that a Court Declaration is required, should the Medical Director be contacted to initiate the application.

Out-of-hours (17.30 - 08.30)

Applications are to be initiated by the On-call Manager or On-Call Executive Director.
Applications are to be made:

- Only after a full assessment of the patient's capacity to give consent has been made by the clinical team, (and teams of the psychiatric on-call team where appropriate);
- Or because the patient is mentally incapacitated or is a child under the age of 16 and the parents
- Or because the guardian have refused to consent to treatment.

Where agreement has been reached that an application to the court, to obtain consent from a judge, is the only course of action open to staff, the Trust's solicitors are to be notified, (a 24 hour service is provided) so that this can be sought.

The telephone number is Bevan Brittan: 0870 1941000

Fraser or Gillick Competency

- The young person understands the health professional's advice;
- The health professional cannot persuade the young person to inform his or her parent or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- The young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health or both are likely to suffer;
- The young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent.

Notes (further to section 10.6.5 – Administration of ECT):

1. Detained patients who have capacity to consent may not be given ECT under Section 58A unless they consent; i.e. any administration of ECT under Section 62 can only be until Section 58 safeguards are compiled with. Once this is the case, i.e. the SOAD assesses, the SOAD can only authorise ECT if the patient lacks capacity.

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

3. Where patients are incapable of consenting to ECT, but are compliant (i.e. are not physically resisting its administration) they may be given ECT as an informal patient if it is in their best interests and in compliance with the Mental Capacity Act 2005. It is also recommended that a second opinion from another doctor from within the Trust is obtained beforehand. It is also recommended that a referral is made to a local advocacy service. Note however, that ECT cannot be administered if there is one of the following:
   - Valid and applicable advanced decision objecting to ECT or
   - A lasting Power of Attorney for treatment who objects to ECT or
   - A decision of the Court of Protection conflicting with the giving of ECT.

4. Where the patient is incapable but not compliant (i.e. they are physically or verbally resistant to being in hospital and receiving treatment) or where their nearest relatives are objecting on their behalf, it is not possible to rely on the Mental Capacity Act 2005. As with any incapable patient needing treatment for mental disorder, but who is resistant to that treatment consideration should be given to use the Mental Health Act 2005. Therefore a resisting incapable patient should be given ECT under section and within Section 58 safeguards. Before ECT can be given a refusing patient, authorisation must be obtained from the SOAD by completion of a From T6. Note that the SOAD will not be able to make such authorisations if there is:
   - A valid and applicable advanced decision objecting to ECT or
   - A Lasting Power of Attorney for Treatment who objects to ECT or
   - A decision of the Court of Protection conflicting with the giving of ECT.

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

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Consent to Examination or Treatment Policy**	
Completed by:	**Andrew Moonesinghe**	
Job title	**Pharmacy Services Manager**	**Date 14th February 2020**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Sam Kirkland**
Date of approval	**14th February 2020**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Due Regard Screening Template

Section 1	
Name of activity/proposal	Consent to Examination or Treatment Policy
Date Screening commenced	Dec 2019
Directorate / Service carrying out the assessment	Clinical Effectiveness Group
Name and role of person undertaking this Due Regard (Equality Analysis)	Saquib Muhammad , Consultant Psychiatrist,
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: policy provides guidance on consent and obtaining consent for patient interactions at LPT.	
OBJECTIVES: This purpose of this policy and related documents is to ensure that all permanent employees including medical staff who work for LPT including those on bank, agency or honorary contracts are clear of their responsibilities around gaining consent to treatment and provide a clear assurance framework for the LPT board.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	It has neutral impact on all the protected characteristics
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Decision at the Clinical Effectiveness Group			
Signed by reviewer/assessor		**Date**	17/2/2020

Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	17/2/2020