

CONSENT AND CAPACITY TO CONSENT TO EXAMINATION AND/OR TREATMENT

To be read in conjunction with the Photographic Identification Policy

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DOCUMENT CONTROL

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Amendments	<p>The Trust had 2 separate policies- one for mental health services and one for community health services. The Trust no longer differentiates its services this way, and so this policy combines the two.</p> <p>The policy has also provided much more accurate information about consent and children/young people.</p> <p>Amendments ensure compliance with the New MHA Code of Practice and new CQC section.</p>		
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1. INTRODUCTION

Why consent is crucial

1.1 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 intimate care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

1.1.1 Staff should ensure the patient is able to understand the information given to them and are able to give their valid consent. This may necessitate the use of a professional interpreter and the translation of written information. A capacity assessment should be considered for those patients who are unable to consent to the procedure and reference should be made to the relevant Trust policy.

1.1.2 Legislation relating to consent and capacity to consent to treatment is complex and made more difficult by having two Acts, the Mental Capacity Act 2005 and the Mental Health Act 1983, which are incompatible in the sense that the former is capacity based and the latter risk based. The two Acts are independent but interact, making it frequently difficult for practitioners to determine which Act to use and which authorises or forbids treatment in particular circumstances.

1.1.3 This policy and guidance covers:

- Valid consent
- The provisions of the Mental Capacity Act 2005 (MCA) and its Code of Practice.
- When it could be more appropriate to use the Mental Health Act 1983 (MHA '83), rather than the MCA, to treat a mental disorder.
- The definition of 'deprivation of liberty'.
- Treating patients on Community Treatment Orders
- How capacity affects treatment under the MHA '83. Guidance is provided on the duties of the approved clinician responsible for treatment, and nurse administering medication, under Part IV of the MHA '83.
- Consent and capacity in relation to children and young people under the age of 18

Guidance on Consent

1.2 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.

The Reference Guide to Consent for Examination or Treatment (second edition) 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. Copies may be accessed on the internet at

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

2. PURPOSE AND SCOPE

- 2.1 The purpose of the policy and guidance is to provide information and ensure that all practitioners act in ways which are compliant with the legislation relating to capacity and consent with regard to Codes of Practice relating to the legislation. References to the statutory frameworks, and where additional guidance can be obtained, are provided at the end of this policy and guidance document.
- 2.2 The policy and guidance has been written to take account of developments in common law, new legislation and guidance relevant to capacity and consent, and clarification in the interpretation of Part IV of the MHA '83. It provides a means whereby practitioners can ensure they are adhering to notions of best practice in relation to capacity and consent.
- 2.3 Employees and those attached to Somerset Partnership NHS Foundation Trust have a duty to follow the provisions of the MCA, the MHA '83 and any other legislation relevant to the law on capacity and consent. The MCA makes it a criminal offence to ill-treat or wilfully neglect a person who lacks capacity. The MCA applies to anyone aged 16 or over, although children younger than 16 can benefit from the Court of Protection making a decision about their property and affairs. The offences of ill treatment and wilful neglect apply to anyone lacking capacity regardless of age.
- 2.4 The Code of Practice relevant to legislation on capacity and consent to treatment does not have statutory force but can provide a defence against ill treatment or wilful neglect if followed. A failure to comply can be used in evidence before a court or tribunal in any civil or criminal proceedings. All staff should adhere to the Codes of Practice unless, in so doing, there is a significant risk to the welfare of the individual or others.
- 2.5 Where there is uncertainty or dispute about the interpretation or implementation of the MCA, its Code of Practice, or the MHA '83, practitioners should always try to resolve the matter through discussion with their line manager, the Mental Health Act administrators or senior managers in the Trust before getting authority from the Chief Operating Officer or the Director of Governance and Corporate Development to seek external legal advice.
- 2.6 The policy and guidance applies to all who work with patients of the Trust, regardless of whether the patient is detained under the MHA '83, an informal or voluntary hospital patient, or in the community. It also applies to those involved with patients being deprived of their liberty but not subject to the

MHA '83. Parts of the policy and guidance will only relate to specific professional groups. Where this is the case, it will be made clear which group(s) it relates to.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has a duty to care for patients receiving care and treatment from the Trust.
- 3.2 The **Chief Operating Officer** is the Executive Lead responsible for this policy covering Consent and Capacity to Consent to Examination and/or Treatment, but will delegate authority for the operational implementation and ongoing management of this policy to the Senior Nurse for Clinical Practice.
- 3.3 The Mental Health Act Coordination Lead is the author of this policy, who will review this policy at least every three years.
- 3.4 Each **registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.
- 3.5 **All staff** working with patients where consent or capacity to consent to examination and treatment is an issue should be familiar with the procedures detailed in this document and other related policies.
- 3.6 **Line managers** are responsible for ensuring all staff are conversant with this policy and related policies.

4 EXPLANATIONS OF TERMS

AC	- Approved Clinician
AMHP	- Approved Mental Health Professional
CTO	- Community Treatment Order
Child	- Person aged 15 years or below
CQC	- Care Quality Commission
DoLS	- Deprivation of Liberty Safeguards
ECT	- Electroconvulsive therapy
EPA	- Enduring Powers of Attorney
IMCA	- Independent Mental Capacity Advocate
LPA	- Lasting Powers of Attorney
MCA	- Mental Capacity Act 2005
MHA '83	- Mental Health Act 1983 (as amended by the MHA 2007)
OPG	- Office of the Public Guardian
RC	- Responsible Clinician
RCPA	- Recovery Care Programme Approach

- CTO - Community Treatment Order
SOAD - Second Opinion Appointed Doctor
Young Person - Person aged 16 or 17.

5. STATEMENT OF POLICY

5.1 This policy explains what consent is, and the different issues it raises in different settings and for different groups of people. Separate procedures, and an understanding of different legal frameworks, are required for the following groups:

- Adults
- Children aged 15 years or below
- Young people aged between 16 and 17 years
- Adults and children who are subject to the Mental Health Act

6. CONSENT- GENERAL POINTS

6.1 Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

6.2 By definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it.

6.3 It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.

6.4 The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients.

6.5 A patient's notes should summarise the information provided to the patient (incorporating a record of both discussions and written information provided to the patient, including any decisions, and reasons underpinning those decisions, not to investigate or treat). If the patient expresses a wish to receive very little information related to their proposed treatment, but still consents, then this fact should also be recorded.

6.6 Patients should be invited to ask questions and professionals should answer fully, frankly and truthfully. If a patient asks about a risk, they should always be given an honest answer. There may sometimes be a compelling reason, in the patient's interests, for not disclosing certain information. A professional

who chooses not to disclose information should be prepared to justify the decision. A professional who chooses not to answer a patient's question should make this clear to the patient so that the patient knows where they stand. A record should be kept of any decision not to disclose information, and the reasons for that decision.

- 6.7 Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (if they are subject to the Mental Health Act) the circumstances in which the treatment may be given without their consent under the Mental Health Act. A record should be kept of the information provided to patients
- 6.8 If new information, relevant to the treatment to which the patient had already consented, becomes available, a professional with sufficient knowledge of the treatment being provided and the new information should inform the patient and re-establish their consent to the treatment. A brief record of the conversation should be recorded.
- 6.9 Where a person's capacity to consent is in doubt, for example where there is uncertainty about the person's ability to sufficiently understand the treatment or care being proposed, then the lack of an objection to the treatment or care being proposed should not be seen as consent (see 4.2 above). A formal assessment of the person's capacity should be undertaken in line with the principles of the MCA.

7. CONSENT- PATIENTS SUBJECT TO THE MENTAL HEALTH ACT

- 7.1 All of the points in section 6 above apply, however, Part IV of The Mental Health Act provides the express power to treat certain patients for their mental disorder whether or not they are consenting to it. References to 'The Act' in this section relate to The Mental Health Act.
- 7.2 Once it has been decided to assess and use the provisions of The Act, the person lacking capacity can be treated for their mental disorder without consideration needing to be given to the provisions of the MCA. However, where treatment is necessary for a physical condition unrelated to their mental disorder, then the provisions of the MCA will still apply.
- 7.3 Patients detained under any of the long-term detention sections of The Act (this excludes Sections 5(4), 5(2), 4, 35, 37(4), 135 and 136), whether or not they have capacity in relation to any specific decision, and receiving medical treatment for their mental disorder, will be subject to the provisions of Part IV of the Act, 'Consent to Treatment'. The approved clinician (AC) in charge of treatment should ensure we comply with all the provisions of Part IV of the Act and Code of Practice.
- 7.4 When taking decisions about patients under the Act, it should be remembered that:
- mental disorder does not necessarily mean that a patient lacks

capacity to give or refuse consent, or to take any other decision

- any assessment of an individual's capacity has to be made in relation to the particular decision being made – a person may, for example, have the capacity to consent to or refuse one form of treatment but not to another
- capacity in an individual with a mental disorder can vary over time and should be assessed at the time the decision in question needs to be taken
- where a patient's capacity fluctuates in this way, consideration should be given, if a decision is not urgently required, to delaying the decision until the patient has capacity again to make it for themselves
- not everyone is equally capable of understanding the same explanation –
- explanations should be appropriate to the level of the patient's assessed ability, and
- all assessments of an individual's capacity should be fully recorded in the patient's notes.

7.5 To give time to develop a treatment programme suitable for the patient's needs, the Act allows treatment to be given in the initial three month period starting the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act.

7.6 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 by the approved clinician in charge of treatment. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.

7.7 Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and must therefore comply with the Human Rights Act (HRA) 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

7.8 In particular, the following should be noted:

- compulsory administration of treatment which would otherwise require consent is invariably an infringement of article 8 of the ECHR (respect for family and private life). However, it may be justified where it is in accordance with law (in this case the procedures in the Act) and where it

is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health)

- compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture) contrary to article 3 of the ECHR, if its effect on the person concerned reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

- 7.9 Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no breach of The Human Rights Act. If clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.
- 7.10 Detained patients are entitled to a second and independent medical opinion after 3 months have elapsed in any continuous period of detention, and since they first received medication for the treatment of their mental disorder, if they either refuse to continue to take the medication or lack the capacity to consent. The second opinion is provided through the Care Quality Commission (CQC), who provides a Second Opinion Appointed Doctor (SOAD) on request. The AC in charge of treatment should ensure a SOAD is secured when either consent is refused or capacity to consent is lacking.
- 7.11 The AC in charge of treatment should complete a form T2 if the patient has capacity to consent to the treatment and obtain a form T3 from the SOAD if the patient lacks the capacity to consent or refuses treatment. Only the medication authorised by either a form T2 or form T3 can be given to the detained patient, except in an emergency when urgent treatment necessary to save life, prevent a serious deterioration in the patient's condition, alleviate serious suffering or prevent the patient from behaving violently or being a danger to self or others can be given under the provisions of the MHA '83, Section 62. When urgent treatment is given a note of that treatment should be made in the patient's progress notes (RiO) and a form T2 completed, or SOAD requested, at the earliest opportunity if the treatment is to continue.
- 7.12 The AC must also ensure the forms T2 or T3 are reviewed if the treatment authorised by the forms changes or there is a permanent change of AC in charge of treatment, in which case the new AC should review the forms. The new AC in charge of treatment, at the earliest opportunity, should produce a fresh form T2, or request a SOAD if there is any addition needed to the existing form T3.
- 7.13 The AC in charge of treatment must also ensure that the patient's capacity to consent to ECT is assessed and recorded if this treatment is proposed at any time during the patient's detention. A SOAD should be requested if the patient lacks capacity to consent (even if this is during the first three months of treatment). Patients with the capacity to do so may refuse to consent to ECT, unless it is immediately necessary to save the patient's life or to prevent a serious deterioration of the patient's condition, and the treatment does not

have unfavourable physical or psychological consequences which cannot be reversed (see the Trust's ECT Policy for more details).

7.14 Where the patient has capacity, and a SOAD has visited, the AC in charge of treatment should ensure the patient receives a copy of the SOAD's reasons for authorising treatment.

7.15 Nurses engaged in administering medication or ECT to detained patients, for the treatment of the patient's mental disorder, must always ensure, at the point of its administration, that the medication or ECT is authorised by an extant T form.

7.16 The 'T' forms are forms produced by the DoH, please contact the Trust's Mental Health Act Administrators if wards are low on these forms and need further supplies, or print out copies from the following link:
[http://www.mentalhealthlaw.co.uk/Mental Health Act 1983 Statutory Forms](http://www.mentalhealthlaw.co.uk/Mental_Health_Act_1983_Statutory_Forms)

7.17 Who is responsible for seeking consent?

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

7.17.2 Where verbal or non-verbal consent is being sought at the point the procedure or intervention 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.

7.18 Completing consent forms

7.18.1 The standard consent form includes 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.

7.18.2 If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), 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 (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

7.18.3 Health professionals may sometimes provide information to patients about procedures that colleagues are going to carry out. In these cases staff

providing information should make it clear to the patients that consent will be gained by the colleague who is actually going to carry out the procedure and that the information is being provided to help the patient make a decision.

- 7.18.4 To ensure that the provision of information is delegated appropriately the following points must be reviewed:
- 7.18.5 The person giving the information is conversant with the procedure, understands the risks involved, has received training on obtaining consent, and is aware of his or her own knowledge limitations.
- 7.18.6 The patient is made aware of the implications of the treatment including pre-, peri- and post-operative effects and consequences.
- 7.18.7 The person explaining the procedure will, via internal audit, be able to explain the information given to the patient.
- 7.18.8 Adequate literature describing the procedure, its benefits and risks and any alternatives, is always given to the patient.
- 7.18.9 The patient has proper access to the delegating clinician so that any problems or queries which cannot be answered by the person explaining the treatment can be easily and speedily addressed.
- 7.18.10 In cases where an appropriate colleague is not available to answer questions the member of staff must not provide the second signature and must inform their line manager.

7.19 **Responsibility of health professionals**

- 7.19.1 It is a health professional's own responsibility:
- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so and
 - to work within their own competence and not to agree to perform tasks which exceed that competence
- 7.19.2 Staff must not feel pressurised to seek consent when they do not feel competent to do so. They should contact their Line Manager or the relevant Clinical Lead for advice and support.

7.20 **Documentation**

- 7.20.1 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 verbal consent.

7.21 **Written consent**

7.21.1 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. The consent may not be valid if it was not given voluntarily and not enough information had been provided, 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.

7.21.2 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 Somerset Partnership NHS Foundation Trust

7.21.3 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.

7.21.4 It will not usually be necessary to document a patient's implied consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if there are 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.

7.21.5 The standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix A.

7.22 **Availability of forms**

7.22.1 Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix A and are available from Somerset Partnership NHS Foundation Trust Headquarters. There are four versions of the standard consent form:

- **Form 1** for adults or competent children
- **Form 2** for parental consent for a child or young person
- **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 make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary

- **Form 4** for adults who are unable to consent to investigation or treatment

Please ensure you read and understand the 'Guidance to health professionals' section of the consent forms.

7.23 **When Should Consent Be Sought?**

7.23.1 When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to understand 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.

7.24 **Single stage process**

7.24.1 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 manual therapy 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 verbally.

7.24.2 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. Information should, where possible, be provided both verbally and in a written form and should include the identified risks. As long as it is clear that the patient understands and consents, the health professional may then proceed.

7.25 **Two or more stage process**

7.25.1 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.

- 7.25.2 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?"
- 7.25.3 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.

7.26 **Seeking consent for anaesthesia**

- 7.26.1 If an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. It is not acceptable for the patient to receive no information about general anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient's notes or on the consent form.

Where the clinician providing the care is personally responsible for anaesthesia (for example, where local or regional anaesthesia is being used in services such as MIU, podiatric surgery, MSk physiotherapy or Orthopaedic Assessment Service in Somerset West – OASIS West), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

- 7.26.2 In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

7.27 **Emergencies**

7.27.1 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.

8 COMPETENCE TO CONSENT TO TREATMENT/HOSPITAL ADMISSION-CHILDREN UNDER 16.

8.1 The MCA does not apply to medical treatment for children under 16. Children who have sufficient understanding and intelligence to enable them fully to understand what is involved in a proposed treatment are considered to be competent (or 'Gillick competent') to consent to it. Practitioners with expertise in working with children and young people should be consulted in relation to these assessments.

8.2 Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. This is because in the case of Gillick, the court 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 competence to consent to that intervention. In such cases, the child is sometimes described as being 'Gillick competent'. A child may be Gillick competent to consent to admission to hospital, medical treatment, research, or any other activity that requires their consent.

8.3 The concept of Gillick competence reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.

8.4 When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions.

- Does the child understand the information that is relevant to the decision that needs to be made?
- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

8.5 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as

because a mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.

8.6 The valid consent of a child or young person will be sufficient authority for their admission to hospital and/or treatment; additional consent by a person with parental responsibility will not be required. It is good practice to involve the child or young person's parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

8.7 A child must have competence to make the particular decision in question. They must have sufficient information to make that decision and not be subject to any undue influence when doing so. Unlike adults, the refusal by a competent child or young person with capacity under the age of 18 may in certain circumstances, be overridden by a court. Staff should seek urgent legal advice in such a case.

9. **CAPACITY TO CONSENT TO TREATMENT/HOSPITAL ADMISSION- 16 AND 17 YEAR OLDS**

9.1 The Mental Health Act contains specific rules about the admission to hospital for treatment of mental disorder for 16 and 17 year olds. The principles behind these rules are directly applicable to decisions outside The Mental Health Act about admission to any hospital for any treatment (see 11.6 below).

9.2 The effect of section 131 of the Mental Health Act is that where a young person aged 16 or 17 has capacity (as defined in the MCA) to consent to being admitted to hospital for treatment for mental disorder; they may either consent, or refuse to consent, to the proposed informal admission. If a young person has the capacity to consent to informal admission and gives such consent, they can be admitted, irrespective of the views of a person with parental responsibility (who cannot prevent the admission). If the young person with capacity does not consent to the admission, then a person with parental responsibility cannot consent on their behalf.

9.3 In some cases, the young person may be unable to decide whether or not to agree to their admission to hospital, but not because they lack capacity within the meaning of the MCA. For example, this might be because, despite every effort in helping the young person to make this decision, the young person finds the decision too difficult to make. In such cases, it will not be possible for a person with parental responsibility to consent on their behalf. This is because section 131 of the Act only allows informal admission on the basis of parental consent if the young person lacks capacity within the meaning of the MCA.

9.4 Where the young person does not consent to their admission to hospital, but the admission is thought to be necessary, consideration should be given to whether the criteria for admission under the Mental Health Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

- 9.5 Where a young person aged 16 or 17 lacks capacity it may be possible for them to be admitted informally, in accordance with the MCA, unless the admission and treatment amounts to a deprivation of liberty. In cases where the MCA cannot authorise informal admission, but the admission is thought to be necessary, consideration should be given to as whether the criteria for admission under the Mental Health Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken. The Deprivation of Liberty Safeguards may not be applied to anyone below the age of 18.
- 9.6 Section 8 of the Family Law Reform Act 1969 means that young people aged 16 or 17 can consent to their medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. Accordingly, treatment can be given if the young person, who has capacity, gives valid consent.
- 9.7 Different considerations apply to a decision to treat a young person aged 16 or 17 informally where the young person lacks capacity or is otherwise not able to decide whether or not to consent to the proposed treatment.
- 9.8 Where the young person lacks capacity, the MCA will apply in the same way as it does to those aged 18 and over, and treatment may be given in accordance with the MCA, unless it amounts to a deprivation of liberty.
- 9.9 A person with parental responsibility may also be able to consent on behalf of the young person who lacks capacity to make decisions about their treatment. It may even be possible, in some situations, to rely on parental consent to authorise restrictions that would otherwise amount to a deprivation of liberty. Staff should seek urgent legal advice before doing this.
- 9.10 If it is not possible to provide treatment relying on the MCA or parental consent, consideration should be given to whether admission under the Mental Health Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.
- 9.11 The role of those with parental responsibility and decisions within the scope of parental responsibility**
- 9.11.1 Those who have parental responsibility for the child or young person, who may be able to provide parental consent to a proposed admission to hospital and/or treatment, should be identified. This is because, subject to the child or young person's right to confidentiality, they should be consulted about the proposed decision concerning their child. In relation to 16 and 17 year olds, if decisions are to be made in accordance with the MCA (on the basis that the young person lacks capacity within the meaning of the MCA) those with parental responsibility should be consulted about the best interests of the young person (see Section 4 of the MCA).

- 9.11.2 Parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision. Under The Mental Health Act the effect of section 131(4) in relation to the informal admission to hospital of a 16 or 17 year old, who has capacity, is that parental consent cannot be relied upon to override that young person's decision about their admission. In relation to decisions about any young person's (aged 16-17) treatment, it is inadvisable to rely on the consent of a person with parental responsibility to treat a young person who has capacity to make the decision and has refused the treatment. Similarly, in relation to children, it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it. Although in the past the courts have found that a person with parental responsibility can overrule their child's refusal, most such decisions were made before the introduction of the HRA and since then court decisions concerning children and young people have given greater weight to their views. Each case must be taken on its own merits, and staff should seek advice urgently when in any doubt about how to proceed.
- 9.11.3 In some circumstances, it will be possible for children lacking competence and young people lacking capacity to be admitted to hospital and/or treated on the basis of parental consent. However, staff must be satisfied that it is appropriate to rely on parental consent. This is important because court decisions relating to parental consent have emphasised that there are limits to both the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made. For example, when making decisions on behalf of their child, parents must act in their child's best interests. The limits to what a parent can consent to on behalf of their child is relevant to whether a deprivation of liberty has arisen. This policy uses the term from the MHA Code of Practice 'scope of parental responsibility' to highlight the need to establish whether the particular decision can be authorised by parental consent or not. Those cases in which parental consent is sufficient are described as falling within the scope of parental responsibility.
- 9.11.4 Whether the particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case. Staff will need to consider a range of factors. These are set out below, under the two key questions that must be addressed (the term 'parent' is used to cover all people with parental responsibility):
- 9.11.5 **First, is this a decision that a parent should reasonably be expected to make?** If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required. When considering this question, any relevant human rights decisions made by the courts should be taken into account. Significant factors in determining this question are likely to include:
- the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. Relying on parental consent to authorise an intrusive form of treatment might be justified because it is necessary to prevent a serious

deterioration of the child or young person's health, but this would need to be balanced against other factors such as whether the child or young person is resisting the treatment; whether the specific form of treatment is particularly invasive and/or controversial (eg careful consideration should be given to the appropriateness of relying on parental consent to authorise electro-convulsive therapy (ECT)).

- the age, maturity and understanding of the child or young person: the role of parents in decision-making should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person
 - i. the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision, and
 - ii. whether the child or young person had expressed any views about the proposed intervention when they had the competence or capacity to make such decisions; for example, if they had expressed a willingness to receive one form of treatment but not another, it might not be appropriate to rely on parental consent to give the treatment that they had previously refused.

9.11.6 **Secondly are there any factors that might undermine the validity of parental consent?**

9.11.7 Irrespective of the nature of the decision being proposed, there may be reasons why relying on the consent of a person with parental responsibility may be inappropriate; for example:

- where the parent is not able to make the relevant decision; for example, this may arise, if the parent lacks capacity as defined in the MCA, because of their own mental health problems or learning disabilities. In cases of doubt, the parent's capacity will need to be assessed in accordance with the MCA
- where the parent is not able to focus on what course of action is in the best interests of their child; for example, where the parents have gone through a particularly acrimonious divorce, they may find it difficult to separate the decision whether to consent to their child's admission to hospital from their own hostilities
- where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so that they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken, and
- where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility, it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and

is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court.

- 9.11.8 If the decision is not one that a parent would reasonably be expected to make, or there are concerns about the validity of the consent of the person with parental responsibility, it will not be appropriate to rely on parental consent. In such cases, the proposed intervention must be lawfully authorised by other means. In cases where the proposed intervention relates to the assessment and/or treatment of the child or young person's mental disorder, they could be admitted and treated under the Mental Health Act if the criteria are met. If the Mental Health Act is not applicable, legal advice should be sought on the need to seek authorisation from a court before further action is taken. If there is doubt as to whether or not parental consent can be relied upon to authorise the particular intervention, staff should take legal advice so that account may be taken of the most recent case law.
- 9.11.9 Decisions as to whether the child or young person's admission and/or treatment amounts to a deprivation of liberty must be considered on a case by case basis. Where children and young people are admitted to hospital, the question of whether the care regime amounts to a deprivation of liberty must be kept under regular review. This is because although initially the admission might be appropriate because the child or young person's care plan involves only restrictions of liberty, a change in circumstances may mean that the restrictions placed upon the child or young person amount to a deprivation of liberty for which lawful authority will be needed. Staff should seek urgent advice if they have any concerns about whether or not a child is being deprived of their liberty in any Trust ward.

9.12. Delegation of parental responsibility for healthcare decisions

- 9.12.1 Persons with parental responsibility can arrange for some or all of that responsibility to be met by others, for example for a teacher to consent to medical treatment in the parents' absence. The 1989 Children Act does not specify that such authority should be given in writing, but clearly it is helpful for healthcare workers if evidence is provided in terms of their professional accountability, (Department of Health , 2001). Trust staff are expected to request a written permission form from a school teacher, child minder etc. Detailing what responsibility has been granted to them in a parents' absence.
- 9.12.2 The 1989 Children Act also allows a person who does not have parental responsibility for a child but who 'has care' of a child to "do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare". This might apply, for example, to childminders or teachers, where explicit authority to consent on behalf of a child has not been given by the person with parental responsibility. However, it would rarely be 'reasonable' for those with care of a child to consent to treatment on the child's behalf if a parent could be contacted instead.
- 9.12.3 In an emergency, it would be reasonable for a teacher or childminder to take

a child for appropriate medical care, which could then be lawfully provided on the basis that the care was in the child's best interests and no-one with parental responsibility could be contacted, (Department of Health, 2001)

9.12.4 Ascertaining the identity of any adult presenting with a young child for any health treatment, (e.g. in a Minor Injury Unit), is a standard safeguarding process, (Royal College of Paediatrics and Child Health, 2012). Trust staff must confirm an adult's identity either by sight of an identity card or by a telephone call or fax to their employment base.

9.13 **Young children and babies**

9.13.1 Consent will need to be sought from those with parental responsibility. Not all parents have parental responsibility for their children. Either parent can consent if they were married at conception and birth. Since 1 December 2003 the father has parental responsibility if his name is on the birth certificate even if not married to the mother. Prior to 1 December 2013 only the mother can consent unless the father has acquired this right either through a court or legal agreement with the mother. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check. The Trust Safeguarding Children Team should be contacted for advice

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

9.14 **Consent issues for children in care**

9.14.1 Children in care broadly fall into two categories:

- i. Those children where there is a voluntary agreement between the Local Authority and the parent;
- ii. Those children where the court has granted either an Interim or Full Care Order to the Local Authority.

9.14.2 In all cases the parental responsibility remains with the parents, however, under a Care Order that responsibility is shared with the Local Authority – the consent forms are held by Children's Social Care.

9.14.3 When a child is accommodated those adults with parental responsibility sign an agreement which includes consent for routine, planned and emergency medical and dental treatment, including routine childhood immunisations.

9.14.4 For staff completing Initial and Review Health Assessments it is good

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practice to gain consent on an individual basis where the child is competent to do so. There is a section on the relevant forms to record this. In all other cases the Local Authority should provide evidence that consent has been gained.

9.15 Provision of Information

9.15.1 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). 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.

9.15.2 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.

9.15.3 A record of the information provided to patients (including both discussions and written information) must be documented. The consent form should be used as a means of documenting the provision of information.

9.15.4 The following sources of patient information are available in this Trust:

- Trust staff will be aware of sources of information in their own clinical area and of other approved Trust sources of information relevant to their own department. The Trust will endeavour to make available printed information for patients on all procedures, assessments and treatments commonly undertaken by Trust clinicians (for details regarding the development management of Patient Information, including version control and archiving arrangements are described within the 'Producing Information for Service Users and Carers Guidance'). Visiting specialist clinicians will be asked to provide patient information relevant to their own specialty.
- clinicians may also wish to consider using the patient information leaflets provided by Doctor Online at nww.doctoronline.nhs.uk. This is the most comprehensive, peer-reviewed patient information service in the country with over 1,300 leaflets, covering 92% of presentations.
- most GP practices locally have access to the patient information Leaflets on their clinical system.

- 9.15.5 The approved sources of information within this Trust are:
- specialist leaflets approved by Trust senior managers or visiting specialists held in out-patient departments
 - patient information leaflets developed internally in accordance with the Trust Guidelines on Producing Information for Service Users and Carers.
- 9.15.6 It is important to assess the patient's ability to understand the significance of the information and every attempt must be made to aid their understanding. This includes patients with any type of disability and not just those with language problems. Consideration should be given to the use of other communication aids for example symbols, photographs, Braille, and aids such as hearing loops. Where English is not the first language the need for interpreters must be considered (please refer to the Professional Interpreters and Translation Services Policy).
- 9.15.7 The Trust has access to British Sign Language interpreters as well as to Professional Interpreters and Translation Services. The Trust aims to provide all written material in other languages or formats on request.
- 9.15.8 With the patient's agreement, the presence of a friend, relative or advocate during the discussion may be helpful. Information leaflets should be used and the assistance of other members of staff, such as specialist nurses, should be sought to help provide information.
- 9.15.9 Copies of the Department of Health's "Reference Guide to consent for examination or treatment (second edition)", are available from <https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

9.16 Provision for patients whose first language is not English

- 9.16.1 This Trust 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.
- 9.16.2 Information on how to contact Professional Interpreters and Translation Services, including 1:1 interpreters, is available on request from the Trust Headquarters (see Professional Interpreters and Translation Services Policy).

9.17 Access to more detail or specialist information

- 9.17.1 Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. The Trust has made the following arrangements to assist patients to obtain such information:
- Patient Advice and Liaison Service (Tel: 01278 432022)

- Direct Online (Tel: 0845 4647)
- National Electronic Library for Health via the website www.nelh.nhs.uk

9.17.2 There are a number of specialist advocacy services available to patients:

- Mental Health Advocacy
- Age Concern
- Citizen's Advice Bureau
- Independent Complaints and Advocacy Service

9.18 Access to health professionals between formal appointments

9.18.1 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 take 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).

9.18.2 Contact details of a relevant member of the health care team should be provided in the event a patient wishes to ask further questions.

9.19 Open access clinics

9.19.1 Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. The member of staff must ensure that the patient has all the information they need before proceeding with an investigation or treatment. Patient information is available for this purpose.

9.20 Refusal of Treatment

9.20.1 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*. The situation for children is more complex: see relevant sections above, and the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

9.20.2 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, this should be recorded on the form.

9.20.3 Where a patient has refused a particular intervention, it is important that this is restricted to the intervention that they have refused and that any other appropriate care to which they have consented continues to be provided. It is the professional's responsibility to inform the patient that 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.

- 9.20.4 If a patient consents to a particular procedure but refuses certain aspects of the intervention, the possible consequences must be explained to the patient. However if it is considered that the patient's partial refusal to an intervention compromises the safety of the procedure the member of staff is not obliged to perform it but should seek support from a senior clinician. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, the patient must be transferred to the care of that health professional.

9.21. Advance Decisions to refuse treatment

- 9.21.1 An advance decision may be made by anyone aged 18 years or over when they have the capacity to do so. An advance decision is a declaration about which treatments the person does not wish to have at a point in the future when they lack the capacity to consent. There is a distinction between an advance statement, which is a statement of treatment preference, and an advance decision, which is a refusal of treatment. The former has no statutory force but should be taken into account when determining what treatment is in the patient's best interests, while the latter has statutory force and must be respected.
- 9.21.2 An 'advance decision' only applies to healthcare matters and can be made by anyone with capacity to make the decisions covered by the 'advance decision' if they are aged 18 or over. Healthcare professionals must follow an 'advance decision' if it is valid and applies to the particular circumstances. It can only be a refusal of medical treatment. An advance decision cannot insist on a particular form of treatment, nor can it cover basic or essential care aimed at keeping patients comfortable – e.g. oral nutrition/hydration, warmth, shelter or actions to keep them clean and free from distress.
- 9.21.3 Advance decisions to refuse offers of life sustaining treatment must be in writing, signed and be very specific about what treatment is being refused. If there is any doubt about the validity or applicability of such an advance decision it is permissible to provide the minimum treatment required to keep the person alive whilst an urgent decision is sought from the Court of Protection about withholding treatment.
- 9.21.4 Healthcare professionals must take all practical and appropriate steps to determine whether an 'advance decision' exists. The actions taken and the time spent will vary according to the seriousness of the proposed treatment. Further information relating to advance decisions and advance statements can be found in the MCA Code of Practice.

9.22 Tissue

- 9.22.1 The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) now forms part of the Human Tissue Act 2004. This act makes it clear that living patients must consent to the retention and use of their organs and tissues for particular

purposes beyond diagnosis and treatment. Consent is also required from a nominated representative or qualifying relative of deceased patients, if they have expressed their consent prior to death.

9.22.2 The Act lists the scheduled purposes for which consent is required:

Part 1: purpose generally requiring consent where the tissue is from the living or deceased

- Anatomical examination - *re required witnessed consent in writing before death*
- Determining the cause of death – *exception where a post mortem is ordered by the coroner*
- Establish after a person's death the efficacy of any drug or other treatment administered to him – for example, *hospital post mortem*
- Obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person) – for example, *genetic information*
- Public display – *requires witnessed consent in writing before death.*
- Research in connection with disorders or the functioning of the human body
- Transplantation – *includes all bodily material such as blood, bone marrow, skin, tissue and organs*

Part 2: purpose requiring consent where the tissue is from deceased persons

- Clinical audit
- Education and training relating to human health – *includes training in research techniques*
- Performance assessment – such as, *testing medical devices*
- Public health monitoring
- Quality assurance

Further information is available on the Department of Health website.

9.23 Clinical Photography and Conventional or Digital Video Recordings

9.23.1 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.

9.23.2 Where photographic and video recordings may be used for any purpose other than the patient's care or the audit of that care the express consent of the patient or a person with parental responsibility for the patient must be sought. Consent must be recorded in writing using the Trusts "Consent for Photography" consent forms, 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 Somerset Partnership NHS Foundation Trust 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, it must not be used, even if a person with parental responsibility consents. The patient should also be given a copy of the patient information leaflet available in service areas requiring written consent (More details Appendix B)

- 9.23.3 If a photographic or video recording is to be made of a patient specifically for education, publication or research purposes, written consent must be sought (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.
- 9.23.4 The situation may sometimes arise where it is desirable 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, the recording can be made but consent must be sought as soon as the patient regains capacity. However, the recording must not be used until consent has been given, and if the patient does not consent to any form of use, the recording must be destroyed.
- 9.23.5 If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, agreement should be sought from some-one close to the patient. No recording should be made which might be against the interests of the patient. A recording should not be made if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent. Please refer to Photographic Identification Policy for further details and consent form.
- 9.23.6 The Mental Health Act Code of Practice(2015) states in relation to taking photographs of detained patients:

“(...) In case they fail to return from leave, an up-to-date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patient’s consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA)).” (MHA Code of Practice paragraph 27.22.)

10 ASSESSING CAPACITY TO GIVE OR WITHHOLD CONSENT

- 10.1 The person responsible for assessing capacity will be the person responsible for providing treatment or organising care for the patient. Although the concept of capacity is inevitably complex, for the purposes of the MCA the person lacks capacity if, at the time the decision needs to be made, he or she is unable to make or communicate the decision because of ‘an impairment of, or disturbance in, the functioning of the person’s mind or brain’ and the

impairment or disturbance is sufficient that the person lacks the capacity to make that particular decision. This could be the result of a variety of factors including mental illness, learning disability, dementia, brain damage or intoxication.

- 10.2 The assessment of capacity, therefore, focuses on the specific decision that needs to be made at the specific time the decision is required. It does not matter if the incapacity is temporary, or the person retains the capacity to make other decisions, or if the person's capacity fluctuates, although if the impairment is temporary and the decision can realistically be put off until such time as the person is likely to regain capacity, then it should be deferred.
- 10.3 Capacity should not be confused with a professional's assessment of the reasonableness of the person's decision. Patients must be allowed to make unwise decisions and their decision should be respected as long as they have the capacity to do so.
- 10.4 The test for capacity is a functional one. Professionals should never express an opinion without carrying out a proper examination and assessment of the person's capacity to make the decision. Regard should be paid to:
1. Whether the person is able to understand the information (relevant to the decision which needs to be made).
 2. Whether they are able to retain the information related to the decision.
 3. Whether they are able to use or weigh that information as part of the process of making the decision.
 4. Whether they are able to communicate that decision
- 10.5 Assistance should be given to the person to help them make a decision. Where the person fails one or more parts of the test, then they do not have the relevant capacity and the entire test is failed in relation to the particular decision needing to be made.
- 10.6 If a decision that appears irrational is based on a misperception of reality, as opposed to a different value system to that of the practitioner, then the patient may not be able to comprehend, weigh or make use of the relevant information and hence may lack the capacity to make the decision in question.
- 10.7 Clearly, difficult judgements will still need to be made, particularly where there is fluctuating capacity or where some capacity is demonstrable but its extent is uncertain. When a capacity test is applied in relation to the decision that needs to be made, the reasons why capacity was in doubt and details of the assessment process, including what help was provided to enable the patient to make his or her own decision should be recorded on the consent and capacity assessment form on RiO, which is located in the 'mental state examination' folder within the RCPA. The Act requires that any decision that a person lacks capacity must be based on a 'reasonable belief' backed by objective reasons. Notes made on RiO should reflect this principle.
- 10.8 The care plan for those lacking capacity to consent will follow from the assessment of the individual's capacity relevant to the care or treatment being proposed. Where the care-plan is of a multi-disciplinary nature, professionals concerned with individual aspects of treatment or care should, on a consent and capacity assessment form on RiO, contribute their own capacity

assessment in relation to the relevant parts of the care plan. Where the decisions about care or treatment are significant, help in the assessment of capacity may be sought from relevant professionals (e.g. doctors or psychologists), but the final decision on capacity rests with the person wishing to make the decision or perform an action on behalf of someone lacking capacity.

10.9 Practitioners must ensure that assessments of capacity form a regular part of the review procedure.

10.10 All staff providing pre-arranged care or treatment for a person lacking the capacity to consent should take reasonable steps to ensure the individual does in fact lack capacity. Where a member of staff believes the individual has the capacity to refuse, they should not provide the care or treatment against the individual's wishes. If the care or treatment is being provided as part of the individual's care plan, which was produced in the belief that the individual lacks the capacity to consent, and the provider of care or treatment believes the individual to have the capacity to refuse and they do refuse, they should, if attempts to get consent by informing the individual of the benefits of the care or treatment fail, immediately refer the matter to the individual's care-coordinator or doctor responsible for the individual's treatment.

10.11 In situations where a patient's capacity fluctuates, practitioners should encourage patients, when they retain capacity, to provide an advance statement of treatments they would prefer should they lose capacity; or an advance decision refusing specific treatments. Any advance statement should be taken into account when determining best interests.

10.12 **Assessing Best Interests**

10.12.1 The principle of 'best interests' applies to anyone making decisions or acting for anyone lacking the capacity to make the decision or act for themselves. Given the variety of interventions that can be covered by the MCA, it understandably avoids a definition of best interests. In its place is a statutory checklist of common factors that must be taken into account. The 'best interest checklist' appears on RiO within the consent and capacity form, and should be completed when determining best interests. It is a list of possible relevant factors taken from the Code of Practice, which are:

a) Have all relevant circumstances been considered

The MCA defines 'relevant circumstances' as those of which the person making the determination is aware and which it would be reasonable to regard as relevant.

If someone acts or makes a decision in the reasonable belief that what they are doing is in the best interests of the person who lacks capacity, provided they have followed the checklist, they will have complied with the best interests principle set out in the MCA.

b) Is it likely the person will regain capacity in relation to the matter in question? If so, when is that likely to be?

With the right support the person may be able to regain capacity and make the decision for him or herself, or the effects of illness or medication may abate sufficiently for sufficient capacity to be regained. In emergency

situations, however, it may not be possible to wait for the person to be in a position to decide for him or herself.

- c) In so far as it is reasonably practicable, has the person been encouraged and helped to participate in the decision making process?

Even if the person lacks capacity to make the decision, they may have views on matters affecting the decision, and on what outcome would be preferred.

- d) In so far as it is reasonably ascertainable, have the person's past and present wishes and feelings, and beliefs and values which would be likely to influence the decision if the person had capacity, been considered?

How much someone can learn about a person's past and present views will depend on the circumstances and the time available. 'Reasonably ascertainable' means one has considered all possible information in the time available. The person may have held strong views in the past, which could have a bearing on the decision now to be made.

Information about past and present wishes and feelings might be obtained from a written statement of preference made before losing capacity or, if the person has not been able to express themselves in words in the past, through expressions of pleasure or distress.

A person's beliefs and values influence the decisions they make.

Evidence of a person's beliefs and values can be found in things like their cultural background, religious beliefs, political convictions or past

- e) In so far as it is practicable and appropriate to consult, have the views of anyone named by the person as someone to be consulted, anyone engaged in caring for the person or interested in their welfare, any holder of a Lasting Power of Attorney (LPA) granted by the person or deputy appointed by the Court of Protection, been sought in relation to what would be in the person's best interests and in matters relating to c) (above)?

Decision makers must show they have thought carefully about whom to speak to. If it is practicable and appropriate to speak to the above people, they must do so and take their views into account. The decision maker should try to find out what the people consulted think is in the person's best interests and whether they can give information on the person's wishes and feelings, beliefs and values.

Where an attorney has been appointed under an LPA or Enduring Power of Attorney (the old power preceding LPAs which is still applicable but only to financial matters) or a deputy has been appointed by a court, they must make the decisions on any matters they have been appointed to deal with. Attorneys and deputies should also be consulted, if practicable and appropriate, on other issues affecting the person who lacks capacity.

- f) In relation to life-sustaining treatment, is the treatment motivated by the desire to bring about the person's death?

All reasonable steps should be taken to prolong life and healthcare professionals must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. As with all decisions, before deciding to withdraw or withhold

life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist (accessible in RiO) should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

- g) Is the determination being made merely on the basis of the person's age or appearance; or a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests?

10.12.2 'Appearance' is a broad term and refers to all aspects of physical appearance, including skin colour, mode of dress and any visible medical problems, disfiguring scars or other disabilities. A 'condition' can cover physical disability, learning disability, age related illness or temporary conditions like drunkenness or unconsciousness. 'Behaviour' refers to behaviour that might seem unusual to others, such as talking too loudly or laughing inappropriately.

10.12.3 Where the care plan is of a multi-disciplinary nature, professionals concerned with individual aspects of treatment or care should contribute their own best interests assessment in relation to the relevant parts of the care plan.

10.12.4 It should be remembered that a valid advance decision, in relation to the treatment proposed, precludes the need for a best interest assessment. Advance decisions only apply to medical treatment.

10.12.5 A decision-maker may be faced with people (staff or family members and carers) who disagree about what is in a person's best interests. The first approach should be to review all elements of the best interest checklist (in Rio) with everyone involved, including the person who lacks capacity. If disagreement continues, the decision-maker will need to weigh up the views of different parties but ensure that the interests of those consulted do not overly influence the process of working out a person's best interests. Where there is serious disagreement and the decision(s) needing to be made will have a major impact on the life of the person lacking capacity, consideration should be given to convening a case conference, involving an advocate, attempting mediation or getting a second opinion.

10.12.6 Practitioners should ensure that assessments of best interests are a regular part of the review procedure.

10.13 Independent Mental Capacity Advocates

10.13.1 The aim of the Independent Mental Capacity Advocacy (IMCA) service is to provide independent safeguards for people who lack capacity to make certain important decisions. The role of the IMCA will be similar to that of a concerned relative of the person lacking capacity. In Somerset the service is provided by an independent provider commissioned by Somerset County Council.

- 10.13.2 An IMCA must be requested, and then consulted, for people who lack capacity and have no appropriate family or friends to support them, have not previously named someone who could help with a decision or made a relevant Lasting Power of Attorney or Enduring Power of Attorney and
1. An NHS body is proposing to provide serious medical treatment, or
 2. An NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in either a hospital or care home, and they will stay in hospital for longer than 28 days or in a care home for more than 8 weeks.
- 10.13.3 Where serious medical treatment or a stay in hospital beyond 28 days is proposed, it is the responsibility of the doctor responsible for the care of the patient to ensure the IMCA service is contacted.
- 10.13.4 The IMCA service has a right to see all relevant records relating to the patient and to meet the patient in private. They will also talk with the staff proposing treatment or care. The IMCA view should be taken into account, as practitioners would take the views of relatives into account, but the final decision in determining 'best interests' rests with the practitioner wishing to provide treatment or care.
- 10.13.5 As well as the statutory requirement to involve the IMCA service, care coordinators may request an IMCA to be involved in a care review when there are no family or friends to consult or adult protection case when the person is or has been abused or neglected by another person, or the person is abusing or has been abused by others. An IMCA should only be contacted if it is felt their involvement would be of possible benefit to the person lacking capacity. The care coordinator should be clear on the parameters of the IMCA role in non-statutory involvement.

10.14 Emergency situations

- 10.14.1 Where urgent decisions need to be made, and it is not practicable to consult the individual, ascertain best interests through the 'checklist' process, request an IMCA or determine whether an advance decision or Lasting Power of Attorney exists, action should be taken in what is immediately perceived to be in the person's best interests.
- 10.14.2 In emergency situations, staff should try to communicate with the individual and keep them informed of what is going on.
- 10.14.3 Emergency procedures done without consent must be recorded on RiO, with reasons given as to why the processes of the Mental Capacity Act could not be followed.
- 10.14.4 Procedures to assess capacity, obtain consent or complete the best interest checklist should be initiated as soon as it is practicable to do so.

10.15 Lasting Powers of Attorney

- 10.15.1 Lasting Powers of Attorney (LPA) replace Enduring Powers of Attorney (EPA) and, for the first time, can cover personal welfare (e.g. day-to-day care, who the donor might contact, and arrangements and decisions about health matters) as well as financial welfare. Existing EPAs will continue. An LPA cannot give attorneys the power to demand specific forms of medical treatment.
- 10.15.2 To be valid an LPA must be registered with The Office of the Public Guardian (OPG). An unregistered LPA will not give the attorney any legal powers to make a decision for the donor of the LPA. Where a LPA exists, the member of staff wanting to make a decision about care or treatment should first assure themselves that the individual does lack the capacity to make the decision for him or herself and then, if they do, that the LPA is valid for that particular decision and no advance decision has been made after the LPA was registered.
- 10.15.3 The decision of the LPA holder must be respected, unless there are significant concerns relating to the decision being motivated by LPA holder's best interests and not the donor's best interests.
- 10.15.4 When a care plan is being prepared, professionals must consult the LPA holder and get their agreement to those elements of the plan covered by the LPA. The care plan cannot be implemented without the LPA holder's agreement. The relevant professional should record the agreement of the LPA holder on the plan.
- 10.15.5 Anyone acting under a LPA is constrained by the basic principles of the MCA and must act in the best interests of the LPA donor. Practitioners can, if necessary, challenge the LPA holder's decision(s) in the Court of Protection (via the OPG). They should also approach the OPG should they feel that the LPA is being operated in a way that is not in the individual's best interests. Except in the case of very serious abuse or exploitation, where action may need to be taken quickly, every effort should be made to resolve the situation. If the situation is irresolvable, the person who would provide the treatment or organise the care is responsible for ensuring the OPG is contacted.

10.16 Resolving Difficulties

- 10.16.1 Disagreement may occur around the person's capacity to make a decision, or what is in their best interests (including financial best interests). The disagreement will usually be between professionals or between professionals and family members.
- 10.16.2 All disagreements between professionals should be resolved quickly and informally. The care coordinator should convene a case conference if a serious decision with significant consequences needs to be made on behalf of someone lacking capacity (e.g. residential care, or serious medical treatment) and there are unresolved conflicting views amongst professionals. While the case conference should aim to reconcile differences and provide a consensus view of what is in the person's best interests, the final decision rests with the professional making the decision.
- 10.16.3 Where family members, or others concerned about the person's welfare, disagree with our assessment of capacity or interpretation of best interests, our first actions should be to try to resolve the matter informally. If resolution is not possible, a case conference should be convened by the care

coordinator and the family, and/or concerned others, invited. If the matter cannot be resolved, consideration should be given to involving an independent advocate (or IMCA service if the non-statutory criteria are met). If no agreement can be reached, family members or others should be reminded by the care coordinator of the NHS and local authority complaints procedures and of their right to approach the Court of Protection, via the OPG.

- 10.16.4 In circumstances where we have serious concerns about the care or treatment by family members, or others, of an individual lacking capacity, we should try to resolve the matter through working constructively with the family or others (this may involve a case conference convened by the care coordinator). If we are unable to resolve the matter and serious concerns persist, the care coordinator should try to identify a way forward by discussing the matter with the OPG.
- 10.16.5 In complex cases with serious cumulative concerns and doubts about the correct course of action, or where the decision proposed on behalf of a person lacking capacity is likely to have very serious consequences for the individual, the matter should be discussed with the OPG by either the care coordinator in the case of serious cumulative concerns, or the person making the decision when serious consequence is an issue. The OPG may facilitate access to the Court of Protection with a view to the appointment of a Court Appointed Deputy to oversee either financial or personal welfare matters, or the Court making a declaration regarding treatment.
- 10.16.6 Where the protection of the incapacitated person's finances is an issue, the local authority policy document 'Assisting service Users with their Finances' should be consulted. Social workers, or AMHPs, should be asked to advise on the appropriate intervention. It may be appropriate for the local authority to act as deputies (the new term for receivers) under the MCA.

10.17 Deprivation of Liberty (DoL)

- 10.17.1 It is sometimes in their best interests to impose restraints on the liberty of individuals who lack capacity. The Act defines restraint as the use (or threat) of force to make someone do something they are resisting, or a restriction on their movements whether they are resisting or not. When doing either of these things, practitioners will not be liable to prosecution if they believe the restraint is necessary to prevent harm to the person lacking capacity and that the type of restraint and the time it lasts is a proportional response to the likelihood and seriousness of harm.
- 10.17.2 The use of restraint under the MCA is only to prevent the person harming him or herself. Where the person lacks capacity and there is a risk of them harming others, for example at the acute stage of an illness, staff may, under common law, take appropriate and necessary action to prevent the harm being done.
- 10.17.3 Although the use of restraint is permitted under the MCA, and protection is afforded practitioners who use restraint, there is no protection when the restraint amounts to a deprivation of the person's liberty.
- 10.17.4 See the Trust's Deprivation of Liberty Safeguards (DoLS) policy for details about how to identify a deprivation of liberty and then what actions to take to ensure no breach of The Human Rights Act occurs. The DoLS policy also

includes information about the interface between the MCA, DoLS and the MHA.

11. TRAINING REQUIREMENTS

- 11.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- 11.2 All practitioners responsible for the implementation of the Mental Capacity Act 2005 and its Code of Practice, or Part IV of the Mental Health Act 1983 and its Code of Practice, should ensure they are aware of information which will enable them to follow this policy and guidance. This entails making oneself aware of:
- I. The 5 'statutory principles' underpinning the Mental Capacity Act 2005.
 - II. How to implement and record the capacity test.
 - III. Areas where help can be given to enable people to make their own decisions.
 - IV. How to determine and record best interests.
 - V. The role of the IMCA service and how to access it.
 - VI. Advance decisions and the roles of Lasting Power of Attorney holders and deputies of the Court of Protection.
 - VII. The role of the Court of Protection and when to approach the OPG.
 - VIII. The provisions of Part IV and 4A of the Mental Health Act 1983 and the Code of Practice relating to the Act.
 - IX. Practice implications regarding 'deprivation of liberty'.
 - X. The interface between the MHA and MCA
 - XI. The limits of one's professional responsibilities
- 11.3 Specific training will be provided by the Training Department and will include basic training on the law of consent and training on any specific procedures used within the Trust. This will be coordinated by the training department in partnership with relevant managers and clinicians.
- 11.4 Consent will only be gained by staff that are competent to perform the procedure for which the consent is being obtained or where they have been identified by their line manager.
- 11.5 Consent seminars and training events for appropriate staff will be arranged on a regular basis. These seminars will be provided by suitably qualified Trust personnel and external speakers and will cover all areas of consent relevant to Trust staff and the services that they provide.
- 11.6 Issues around consent are covered in other training sessions that include intervention or assessment such as record keeping, blood transfusion and Intravenous drug therapy and cannulation training (further details is

accessible to staff in the Training Prospectus).

12. EQUALITY IMPACT ASSESSMENT

- 12.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

13. MONITORING COMPLIANCE AND EFFECTIVENESS

- 13.1 As described within the Learning Development and Mandatory Training Policy, compliance of attendance and evaluation of consent training will be monitored by the Workforce Governance Group and compliance reports will be provided to Managers each month.
- 13.2 Particular service areas record keeping audit ensures consent is included as part of the clinical audit standards (Refer to Record Keeping Policy). Record keeping audits are undertaken by clinical staff for their own area or service. Consent is included as part of these record keeping audits. The reports will be discussed at the Clinical and Social Care Effectiveness (CSCE) Group who report biannually to the Clinical Governance Group using the Governance Group reporting template accessible in the Risk Management Strategy. Where deficiencies are identified action plans will be produced and monitored by the relevant Best Practice Groups who have undertaken the record keeping audit. The CSCE group will escalate significant risks/areas of concern within the biannual report to the Clinical Governance Group.
- 13.3 Each Lead responsible for the following areas will inform the relevant governance group each quarter of any potential actions or recommendations that are required:
- complaints relating to matters of consent
 - PALS enquiries relating to matters of consent
 - adverse incidents relating to matters of consent
 - evaluations of mandatory training on consent

14 COUNTER FRAUD

- 14.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

15 RELEVANT CARE QUALITY COMMISSION (CQC) REGULATIONS

- 15.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 16:	Receiving and acting on complaints
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

15.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

15.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

16 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

16.1 References

0-18 years Guidance for all Doctors, (General Medical Council, 2007)
Code of Professional Conduct, (Nursing and Midwifery Council)
Consent Guidance: patients and doctors making decisions together, (General Medical Council, 2008)
 Department of Health, 2004. The Human Tissues Act. London: DH.
 Department of Health, 2005. The Mental Capacity Act. London: DH.
 Department of Health, 2015. Code of Practice: Mental Health Act 1983. London: DH.
 Department of Health, 2009. Reference guide to consent for examination and treatment. 2nd ed. London: DH.
 NHSLA Risk Management Standards 2012-2013 for NHS Trusts providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care
Safeguarding Children and Young people: roles and competences for health care staff: Intercollegiate Document, (RCPCH, 2010)
Seeking Consent: working with children, (DoH, 2001)
Standards for Children and Young People in Emergency Care Settings, (RCPCH, 2012)
Working Together to Safeguard Children, (DCFS, 2010, 2013)

16.2 Cross reference to Other Procedural Documents

Advance Decisions / Statement of Treatment Preferences Policy
 Clinical Supervision Policy
 DNAR (Do Not Attempt Resuscitation) Policy
 Deprivation of Liberty Safeguards Policy
 ECT Policy

Learning Development and Mandatory Training
Photographic Identification Policy
Physical Assessment and Examination of Service Users Policy
Physiological Observations Policy for Inpatients and Minor Injury Units
Producing Information for Patients and Carers Guidance
Professional Interpreting and Translation Service Policy
Record Keeping and Records Management Policy
Recovery Care Programme Approach (RCPA) Policy
Resuscitation Policy
Safeguarding Children Policy
Safeguarding Vulnerable Adults Policy and Process

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

17 APPENDICES

17.1 For the avoidance of any doubt, the appendices in this policy constitute part of the body of this policy and shall be treated as such.

Appendix A	Current forms used in the Trust
Appendix B	Useful contact details and how to seek a court declaration
Appendix C	Who can consent?
Appendix D	Seeking Consent: Remembering the Patient's Perspective

**CURRENT FORMS IN USE IN THIS ORGANISATION
IN THIS SECTION**

- Consent Form 1** Patient agreement to investigation or treatment
- Consent Form 2** Parental agreement to investigation or treatment for a child or young person
- Consent Form 3** Patient/parental agreement to investigation or treatment
- Consent Form 4** Form for adults who are unable to consent to investigation or treatment

Patient consent for clinical photography/video recording. Please refer to the Photographic Identification Policy which includes the consent form.

Information for Patients There is a patient information leaflet 'About the Consent Form.' Copies available from the intranet.

All consent forms will be available from procurement.

Consent Form 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names

Date of birth

Responsible health professional.....

Job title

NHS number (or other identifier).....

Male

Female

Special requirements

(eg other language/other communication method)

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

.....
.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits

Serious or frequently occurring risks

Any extra procedures which may become necessary during the procedure
o blood transfusion.....
o other procedure (please specify)

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

o The following leaflet/tape has been provided

This procedure will involve:

o general and/or regional anaesthesia o local anaesthesia o sedation

Signed:..... Date ..
Name (PRINT) Job title

Contact details (if patient wishes to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date
Name (PRINT)

Top copy accepted by patient: yes/no (please ring)

Statement of patient

Patient identifier/label

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.....

.....
.....

Patient's signatureDate.....

Name (PRINT).....

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature Date.....

Name (PRINT).....

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed:..... Date

Name (PRINT) Job title

Important notes: (tick if applicable)

See also advance directive/living will (e.g. Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign /date here)

Guidance to health professionals (to be read in conjunction with consent policy)

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.

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 is not legally competent to give consent, you should use form 4 (form for adults who are unable 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 this form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do 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 'significant, unavoidable 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.

Consent Form 2

Parental (or person who has parental responsibility) agreement to investigation or treatment for a child or young person

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names

Date of birth

Age

Responsible health professional.....

Job title

NHS number (or other identifier).....

Male

Female

Special requirements

(e.g. other language/other communication method)

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits.....

Significant, unavoidable or frequently occurring risks

Any extra procedures which may become necessary during the procedure

blood transfusion.....

other procedure (please specify).....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient and his or her parents.

The following leaflet/tape has been provided

This procedure will involve:

general and/or regional anaesthesia local anaesthesia sedation

Signed:.....

Date

Name (PRINT) Job title

Contact details (if child/parent wish to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed

Name (PRINT)

Top copy accepted by patient: yes/no (please ring)

Patient identifier/label

Statement of parent/parental responsibility

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form and **I confirm** that I have 'parental responsibility' for this child.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I have been told about additional procedures which may become necessary during my child's treatment. I have listed below any **procedures which I do not wish to be carried out** without further discussion.....
.....

Signature Date.....
Name (PRINT)
Relationship to child.....

Child's agreement to treatment (if child wishes to sign)

I agree to have the treatment I have been told about.

Name Signature
Date

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child have signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish the procedure to go ahead.

Signed:..... Date
Name (PRINT) Job title

Important notes: (tick if applicable)

- See also advance directive/living will (e.g. Jehovah's Witness form)
- Parent has withdrawn consent (ask parent to sign /date here).....

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as a shorthand for 'person with parental responsibility'. Where children are legally competent to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a competent child wishes them to do so.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that 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. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised. Where a young person or 16 or 17 or a Gillick competent child under 16, refuses treatment, it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child's mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement (although this may change in the future).

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 children and their parents when making up their minds about treatment. 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.

Guidance on the law on consent

See the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.doh.gov.uk/consent).

Patient identifier/label

Consent Form 3

Patient/parental agreement to investigation or treatment

(Procedures where consciousness not impaired)

Name of procedure (include brief explanation if medical term not clear)

.....
.....

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits.....

Significant, unavoidable or frequently occurring risks.....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The following leaflet/tape has been provided

Signed Date

Name (PRINT) Job title

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed Date..... Name (PRINT).....

Statement of patient/person with parental responsibility for patient

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature Date

Name (PRINT) Relationship to patient

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed:..... Date

Name (PRINT) Job title

Top copy accepted by patient: yes/no (please circle)

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. **It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – 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 also have every right to change their mind after signing the form.

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, if they wish. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf. 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 (see also ‘This form’ above)

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

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 this form on behalf of an adult who is not legally competent to consent for himself or herself.

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 about treatment. 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 overleaf or in the patient's notes.

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).

Consent Form 4

Form for adults who lack the capacity to consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names

Date of birth

Responsible health professional.....

Job title

NHS number (or other identifier).....

Male

Female

Special requirements

(e.g. other language/other communication method)

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

.....
.....
.....
.....

(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B Assessment of patient’s capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because of an impairment of the mind or brain or disturbance affecting the way their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following:

- o **understand information about the procedure or course of treatment**
- o **retain that information in their mind**
- o **use or weigh that information as part of the decision- making process, or**
- o **communicate their decision (by talking, using sign language or any other means)**

Further details for example, how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.

.....
.....
.....

C Assessment of patient’s best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person’s past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient’s best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:.....

.....

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:.....

.....
.....
.....

D Involvement of the patient’s family and others close to the patient

Unless the person has an attorney or deputy, the final responsibility for determining whether a procedure is in an incapacitated patient’s best interests lies with the health professional performing the procedure. 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 is practicable and as appropriate. “Best interests” go far wider than “best medical interests”, and include factors such as the patient’s wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

Independent Mental Capacity Advocate (IMCA)

For decisions about the serious medical treatment, where there is no one appropriate to consult other than paid staff, has an Independent Mental Capacity Advocate (IMCA) been instructed?

Yes No

Details:

.....
Signature..... Date.....

I/We have been involved in a discussion with the relevant health professionals over the treatment of.....(patient’s name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

.....
.....
.....

NameRelationship to patient.....

Address (if not the same as patient).....

.....
Signature Date.....

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)

Yes No

Details:
.....

E The patient has an attorney or deputy

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the Attorney or Deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Signature of attorney or deputy

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney/ as a Court Appointed Deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (See section C) and believe the procedure to be in the patient's best interests.

Any other comments (including the circumstances considered in assessing the patient's best interests)

.....

.....

.....

Signature..... Date.....

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature:..... Date

Name (PRINT) Job title

Where second opinion sought, s/he should sign below to confirm agreement:

Signature:..... Date

Name (PRINT) Job title

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

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

- the patient must lack the capacity to give or withhold consent to this procedure AND
- the procedure is in the patient's best interests.

Capacity

A person who lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that effects the way their mind or brain works which means 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 quite able to take other more straight-forward decisions or parts of decisions. Capacity may 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.

Best interests

The Mental Capacity Act 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
- the 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 of 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.

Independent Mental Capacity Act (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*.

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 had the authority to make decisions about life-sustaining treatment. 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.

The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no other way of settling the matter in the best interest of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather than the health professional that will make the treatment decision and the deputy must make decisions in the patient's best interests.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Cases involving:

- Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- Cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
- Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- All other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests (include cases involving ethical dilemmas in untested areas) should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

USEFUL CONTACTS HOW TO SEEK A COURT DECLARATION

Contact the Director of Nursing and Patient Safety via the contact details below who will liaise with the Trust solicitors on your behalf:

Director of Nursing and Patient Safety
Somerset Partnership NHS Foundation Trust
2nd Floor, Mallard Court
Express Park
Bridgwater
Somerset
TA6 4RN

For direct enquiries please contact:

Telephone 01278 432000

During Out-Of-Hours contact the Clinical on Call Manager or the Director on call.

APPENDIX C

WHO CAN CONSENT?

		Able to give valid consent	Others able to consent instead	Best interest consent issues	Can refuse treatment
Adults	<i>Competent</i>	Yes Consent is the only basis on which treatment of a competent adult can occur	No No one else can give consent on behalf of an adult	No A competent adults best interests are irrelevant	Yes “..for reasons which are rational or irrational or for no reason (Sidaway)
	<i>Incompetent</i>	No No incompetent person can give a valid consent,	Yes The holder of a relevant lasting power of attorney, or a deputy appointed by the Court of Protection to make the decision in question	Yes In the absence of a lasting power of attorney or deputy best interest is the only basis on which an incompetent adults can be treated	No No incompetent person can withhold consent, but a valid and applicable advance decision can be sufficient to withhold consent.
16 and 17 year olds	<i>Competent</i>	Yes Without the need for consent with a person with parental responsibility	Yes Person with parental responsibility (in some circumstances- seek legal advice) or courts	Yes “..the child’s welfare shall be the court’s paramount consideration (Children’s Act)	No The competent minor who withholds consent can be overruled by a person with parental responsibility (in some circumstances seek legal advice) or the
	<i>Incompetent</i>	No No incompetent person can give a valid consent	Yes Person with parental responsibility (in some circumstances - seek legal advice)	Yes “..the child’s welfare shall be the court’s paramount consideration (Children’s Act)	No No incompetent person can withhold consent, and advance decisions cannot be made by anyone under the age of 18.

Under 16 year olds	<i>Competent (N.B the MCA does not apply, a child is either 'Gillick competent' or not)</i>	Yes But where ever possible consent from someone with parental responsibility should be sought	Yes Person with parental responsibility (in some circumstances- seek legal advice)	Yes “..the child’s welfare shall be the court’s paramount consideration (Children’s	No The competent minor who withholds consent can be overruled by a person with parental responsibility(in some
Under 16 year olds	<i>Incompetent (N.B the MCA does not apply, a child is either 'Gillick competent' or not)</i>	No No incompetent person can give valid consent	Yes Person with parental responsibility (some decisions may fall outside the remit of parental consent- seek legal advice if in	Yes “..the child’s welfare shall be the court’s paramount consideration (Children’s Act)	No No incompetent person can withhold consent. Those with parental responsibility may be able to refuse consent- seek legal advice.

SEEKING CONSENT: REMEMBERING THE PATIENT'S PERSPECTIVE

