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NHS Foundation Trust

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	V04.3	Update	Sept 16	Amalgamation of App 3 – CYPS Consent Form 2 and 3 to App3–Consent Form 2
	V04.4	Update	Sept 17	Update due to clinical transformation

This policy supersedes the following documents which must now be destroyed:

Reference Number	Title
NTW(C)05 – V04.3	Consent to Examination and Treatment Policy

Consent to Examination or Treatment Policy

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A	Equality Impact Assessment tool	22
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Appendices listed separately to policy				
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Appendix 1	Consent: Patients and doctors making decisions together. GMC 2008	2	Sep 17	Jan 19
Appendix 2	Reference Guide to Consent	2	Sep 17	Jan 19
Appendix 3	**Consent Forms:-**			
	Consent form 1 - Patient agreement to investigation or treatment	2	Sep 17	Jan 19
	Consent form 1B - ECT (Electroconvulsive Therapy) requires review	2	Sep 17	Jan 19
	Consent form 2 – Children and Young People Service (CYPS) Consent Form	3	Sep 17	Jan 19
	Consent form 3A –Client/patient/parental agreement to video/audio recording	2	Sep 17	Jan 19
	Consent form 3B - Client/patient/carer parental agreement to research	2	Sep 17	Jan 19
	Consent form 4 A- Adults who lack the capacity to consent	2	Sep 17	Jan 19
	Consent form 4b - ECT Adults who lack the capacity to consent to ECT (**as per NTW(C)51 - Electroconvulsive Therapy Policy**)	3	Sep 17	Jan 19
Appendix 4	The Legal Aspects of the Care and Treatment of Children and Young People With Mental Disorder: A guide for Professionals. NIMHE 2009	2	Sep 17	Jan 19
Appendix 4a	Flowchart – Mental Health Act – Code of Practice (MHA-CoP) Figure 7: Informal admission and treatment of under16s	2	Sep 17	Jan 19
Appendix 4b	Flowchart - MHA CoP - Figure 9: Informal Treatment of 16 and 17 year old	2	Sep 17	Jan 19
Appendix 4c	Flowchart – Figure 8 – Informal Admission 16-17year olds	2	Sep 17	Jan 19
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Appendix 5	Definition of Terms	2	Sep 17	Jan 19
Appendix 6	Leaflets–Consent; plus 'Easy to Read' versions – V03 - linked to Patient Information Centre	2	Sep 17	Jan 18

Practice Guidance Notes – listed separate to policy				
PGN No:	**Description**	**Issue No:**	**Issue Date**	**Review Date**
CET-PGN-01	**CHAPERONE Guidance PGN**	**V01 – Issue 2**	**Sep 17**	**Aug 19**

1. Introduction

1.1 Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) recognises that patients have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between health professionals and patients.

1.2. Health professionals in this Trust should comply with the standards and procedures in this policy which should be applied in conjunction with the principles set out in Consent: Patients and Doctors Making Decisions Together; General Medical Council – Appendix 1, Reference guide to consent for examination or treatment, Second edition – Appendix 2 and the Mental Health Act (MHA) Code of Practice (CoP) 2015.

1.3. While this policy is primarily concerned with healthcare and refers to health professionals, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or service user.

1.4 In this policy reference to an adult patient means a patient of 18 years or above, 'young person' for 16/17 year olds and a child is person who is under the age of 16.

2. Purpose

2.1 The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures within the Trust, which aim to ensure that health professionals are able to comply with the guidance. Unlike similar policies for acute Trusts, this policy also incorporates the guidance on consent that is relevant to service users detained under the Mental Health Act 1983.

2.2 The Trust believes that valid consent is essential for all forms of health care provided by the Trust. The approach to obtaining consent should meet the standards set out in this document, in all areas of the Trust. The Trust expects that only the forms in Appendix 3 will be used for obtaining written consent. It must be remembered that there are special considerations to be made for children, young people, patients without capacity and those subject to the Mental Health Act 1983 (MHA 1983).

3. Consent

3.1. "Consent" is the voluntary and continued 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. Before providing care or treatment, a health professional should be satisfied that the patient has given their valid consent. Consent will only be valid if it is given freely and not under duress by a properly informed patient who has capacity to give consent. Consent can be given in writing, verbally or even indicated non-verbally.

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

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

3.4 In determining whether an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, health professionals will apply the principles set out in the Mental Capacity Act 2005 (MCA) and the Mental Capacity Act 2005 Code of Practice. It is the responsibility of the person carrying out the intervention to assess and determine capacity. It is important to remember that no-one other than a person who has authority under a Lasting Powers of Attorney (LPA) or is a deputy appointed by the Court, can give consent on behalf of an adult patient. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, as long as the patient has not made a valid and applicable Advance Decision.

3.5 When treating patients who may lack capacity, health professionals should give careful consideration to the Mental Capacity Act 2005 Code of Practice and the Trust's policy NTW(C)34 Mental Capacity Act Policy. When deciding in Best Interest consideration should be given to the person's past and present wishes and feelings, any beliefs and values that would influence the decision in question and any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

3.6 An individual is presumed to have the capacity to make a treatment decision unless they have impairment or disturbance in the functioning of the mind or brain; and this impairment or disturbance mean they can't make the treatment decision at the time it needs to be made because they are unable to:

- understand the information relevant to the decision, or
- retain the information, or
- use or weigh the information as part of the process of making the decision, or
- communicate the decision (whether by talking, using sign language, or by any other means)

4. Documentation

4.1. 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 consent. It is up to individual professionals to decide which interventions they consider significant enough to record discussions and decisions. Within the MHA 1983 there are statutory forms which must be completed when assessing and recording consent.

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

4.3. It is rarely a legal requirement to seek written consent, (the Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances) 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 this Trust

4.4 Completed forms should be kept with the patient's records. 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.

4.5. It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past); it would be helpful to do so.

4.6. Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix 3 and are available from the trust intranet. There are three versions of the standard consent form:

- form 1 for adults or competent children;
- form 2 for parental consent for a child or young person; and
- Form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care.

4.7 The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

4.8. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with:

- the assessment of the patient's capacity;
- why the health professional believes the treatment to be in the patient's best interests as detailed in the MCA Code of Practice; and
- the involvement of people close to the patient.

4.9 The standard consent forms (1, 2 and 3) should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

4.10 Where ECT is being considered for both capacitated and incapacitated patients, specific forms are available at Appendix 3, Form 1b and Form 4B.

5. Seeking Consent

5.1 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.

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

5.3 Single stage process - In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally. It would be good practice to always record this consent process either by use of the form or entry into health record.

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

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

5.5. 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;
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period between the time when consent was sought and when the intervention is undertaken

5.6. 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?"

5.7. 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.

5.8. The patient's consent may be obtained by post and this gives the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure on a patient must ensure that, immediately before the procedure, the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time to consider any additional information.

5.9 Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:

- listen to patients and respect their views about their health
- discuss with patients what their diagnosis, prognosis, treatment and care involve
- share with patients the information they want or need in order to make decisions
- maximise patients' opportunities, and their ability, to make decisions for themselves
- respect patients' decisions

6. Seeking Consent for Anaesthesia

6.1. Where 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. However, in elective treatment it is not acceptable for the patient to receive no information about 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 general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic.

6.2 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 (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

6.3. 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. Emergencies

7.1. 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. Treatment of children

8.1. When treating children, health professionals should take particular care to ensure that they are familiar with the relevant law and should consider carefully whether the child is competent to give his or her consent to the treatment. Extensive guidance is provided at Appendix 4 in the document 'The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals'.

8.2 Chapter 19, MHA Code of Practice 2015 sets out some key factors for consideration including:

- parental responsibility and decisions within the 'scope of parental responsibility
- assessing the competence of children and the capacity of young people to make decisions about admission and/or treatment
- when informal admission may be appropriate and when the MHA 1983 should be used
- specific provisions relating to the treatment of children and young people under the Act

8.3 If the child is not competent to give consent, then the health professional may give treatment on the basis of parental consent from the person with 'parental responsibility', usually the person's parents. Parental Consent should not be relied upon when the child is competent or the young person has the capacity to make the particular decision.

8.4 When babies or children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, health professionals should remember that, in law, such consent is required although consent may be given in advance. Where a child is admitted, the health professional should discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

8.5 Treatment flowchart for children is shown in Appendix 4a

8.6 Further guidance in relation to consent to treatment for Children and Young People within Community Services is provided at Appendix 4d

8.7 In relation to providing sexual health services to children, specific guidance is provided with the Trust's NTW(C)04 – Safeguarding Children Policy, practice guidance note, SC-PGN-05 – Working with sexually active children under 16-safeguarding guidance.

9. Treatment of Young People, 16 and 17 year olds who are able to consent to treatment

9.1 Section 8 of the Family Law Reform Act 1969 provides that 16 and 17 year olds have the right to consent to their treatment and such treatment can be given without the need to obtain the consent of a person with parental responsibility.

9.2 Young people who are able to consent to their treatment for mental disorder may be given such treatment in the following circumstances:

- **Treatment on the basis of the young person's consent**: If the young person is capable of giving valid consent and does so, then treatment may be given
- **Treatment under the Mental Health Act 1983**: Consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met
- **Application to the court**: If the criteria for detention under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.

- **Life threatening emergencies**: where the young person's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent

9.3 Health professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Health professionals should have particular regard to chapters 19, 23, 24, 25 and 26 of the MHA 1983 CoP.

9.4 Relying on parental consent is not advisable:

- If the young person does not give consent to the proposed treatment the MHA Code advises against relying on the consent of a person with parental responsibility in order to treat the young person

- Although in the past, courts have found that parental consent can override a young person's refusal in non-emergency cases, the trend in recent cases has been to reflect greater autonomy for children and young people who are able to make health-related decisions for themselves

9.4 Treatment flowchart for 16 and 17 year olds is shown in Appendix 4b.

10. Treatment of 16 and 17 year olds who are unable to consent

10.1 Young people who are unable to consent to the proposed treatment for mental disorder may be treated without their consent in the following circumstances:

- **Treatment relying on the MCA 2005***:* a young person who lacks capacity within the meaning of the MCA 2005 may be treated without their consent (if this is in the young person's best interests and the other principles of the MCA 2005 are followed)

- The MCA 2005 will not apply if:
    - The admission would involve a deprivation of liberty.
    - The young person does not lack capacity within the MCA 2005

- Unless it is not practicable or appropriate, those with parental responsibility should be consulted on whether the proposed treatment is in the young person's best interests

- **Treatment on the basis of parental consent***:* In some circumstances young people lacking capacity may be admitted to Hospital and/or treated on the basis of parental consent. This can only, however be relied upon if the decision falls within the 'scope of parental responsibility' and the parents are acting in the Young Persons best interests

- **Use of the Mental Health Act 1983***:* If the MCA 2005 does not apply and the decision does not fall within the zone of parental control, consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met

- **Application to the court***:* If the MHA is not applicable, it may be necessary to seek authorisation from the court

- **Life threatening emergencies***:* where the young person's refusal would be likely to lead to their death or to severe permanent injury she or he may be admitted to hospital and treated without consent.

11. Provision of Information

11.1 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). Drawings, diagrams and models may be used to facilitate this process where appropriate. Patients also need to know the scope of the intended treatment and 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. The information given should be related to the particular patient, the particular treatment by someone with relevant clinical knowledge and practice.

11.2 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. 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 the treatment, including the likelihood of its success and any alternatives to it. The patient should always be encouraged to make the decision for him or herself although 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. A record should be kept of information provided to patients. 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.

11.3 A range of information and leaflets relating to available services, consent and treatment are available from the Patient Information Centre, Stephenson Court, St Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne, NE3 3XT Telephone 0191 223 2545/46 Fax 0191 223 2547. This information is also accessible on the Trust Website: http://www.ntw.nhs.uk/pic/

11.4 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. In order to safeguard the consent process, unless the health professional is fluent in the patient's language, an interpreter should always be used when seeking consent from the patient. It is not appropriate to use children to interpret for family members who do not speak English.

11.5 Details for Trust-wide access to interpreters, use the following link: Interpreting Service

11.6 Similarly consideration should be given to other communication barriers which could be assisted with specialist services and/ or equipment (i.e. signing, speech and language therapists).

11.7 Patients may sometimes request more detailed information about their condition or about a proposed treatment than can be provided in general leaflets. This should always be provided whenever practicable by the appropriate practitioner.

11.8 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.

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

12. Completing Consent Forms

12.1 The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the health care professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

12.2 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.

13. Responsibilities for Seeking Consent

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

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

13.3 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 that exceed that competence
- If you feel that you are being pressurised to seek consent when you do not feel competent to do so this should be addressed through line management

14. Attendance by Students and Trainees

14.1 Where a student or trainee health professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the health professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

14.2 In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Again, consent should be recorded in the patient's notes.

14.3 A patient's explicit consent should be obtained prior to any occasion when a student or trainee is going to be present during an examination or when treatment is to be given. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

15. Refusal of Treatment

15.1 If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. 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. An adult patient who has capacity can refuse any treatment, except in circumstances governed by the **Mental Health Act 1983.** The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the Mental Capacity Act 2005 must be applied.

15.2 An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so.

15.3 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, the health professional (and where possible the patient) should note this on the form.

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

15.5 If a patient consents to a particular procedure but refuses certain aspects of the intervention, the health professional must explain to the patient the possible consequences of their partial refusal. If the health professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on request be prepared to transfer the patient's care to that health professional.

16. Advance Statements and Decisions

16.1 Legally an advance decision is a refusal of treatment made, in advance, at a time when the adult has capacity to make it, and made in accordance with the provisions of the MCA 2005. A patient may make an advance decision about their care and treatment to apply when they no longer have capacity. This is a decision to refuse treatment, if it is both valid and applicable for the purposes of the Mental Capacity Act 2005, then health professionals must not provide treatment.

16.2 Advance statements are not binding on the health professionals but are indicative of the patient's wishes and should not be ignored. If a patient has specified in an advance statement that they want a particular treatment, their wishes will be relevant in so far as it indicates the patient's preferences, but the health professional is not bound to provide that treatment and may act in accordance with his or her clinical judgement. Advance statements will be very relevant in assessing best interests of the person.

16.3 More details of advance decisions and statements in outlined in the Trust's policy, NTW(C)34 – Mental Capacity Act, practice guidance note, MCA-PGN-02 - Advance Decision to refuse Treatment and Advance Statements, and the MCA 2005 Code of Practice.

17. Patients who Refuse Blood or Blood Components

17.1 The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. Some patients (e.g. Jehovah's Witnesses) may be prevented by their religious convictions from accepting blood or blood components (red cells, white cells, plasma and platelets), even when these are considered necessary to sustain life. All health professionals must respect this choice. To administer blood to an adult who has refused to accept it may be unlawful and could lead to criminal and, or civil proceedings.

17.2 Further information can be accessed via JPAC – Joint UK Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee:

- JPAC - Better Blood Transfusion

18. Tissue

18.1 The removal, storage and use of human tissue is now regulated by the Human Tissue Act 2004. Where human tissue which is defined as material which has come from a human body and consists of, or includes, human cells (but does not include cell lines or hair and nails from living people) is removed, the Act provides that certain specified activities (including research) as set out in Schedule 1 require the consent of the patient. Consent must be given by an appropriate person and penalties of up to three years imprisonment or a fine, or both, can be imposed for failure to obtain or misuse of consent. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990.

18.2 When dealing with tissue samples health professionals should be familiar with the Codes of Practice and guidance issued by the Human Tissue Authority. These are available on their website at www.hta.gov.uk.

19. Clinical Photography and Conventional or Digital Video Recordings

19.1 Video recordings of treatment may be used both as a medical record or treatment aid in themselves, and as a tool for teaching, audit or research. The purpose and possible future use of the video must be clearly explained to the person, before their consent is sought for the recording to be made. If the video is to be used for teaching, audit or research, patients must be aware that they can refuse without their care being compromised and that when required or appropriate the video can be anonymised. As a matter of good practice, the same principles should be applied to clinical photography. If patients do not have capacity to consent they cannot be used for teaching or research purposes, the Mental Capacity Act 2005 has clear boundaries and guidance in this area. Please see the Trust's NTW(O)45 – Visual Imaging and Audio Policy.

19.2 Occasionally, video recordings, clinical photography and/or radiographs may be required following injuries sustained as the result of an accident or an assault. Health professionals should be satisfied that the patient has been given sufficient information for valid consent, making it clear that the recording could be used during legal proceedings, as part of a medical record, or possibly as a tool for teaching, audit or research. The need to obtain consent applies equally if the patient has requested the recording, photograph or radiograph. Please see the Trust's NTW(O)45 – Visual Imaging and Audio Policy.

19.3 The GMC guidance (Making and Using Visual and Audio Records of Patients 2002) gives detailed advice in the use of recordings when treating or assessing patients. Further information can also be found in the Information Commissioners "Use and Disclosure of Health Data: Guidance on the Application of the Data Protection Act 1998" May 2002.

20. Consent and the Mental Health Act 1983

20.1 As a mental health trust it is important that we operate to high standards and within the law, in providing a service. This is also an area subject to frequent scrutiny by the Care Quality Commission (CQC).

20.2 The sections contained in Part 4 of the Mental Health Act 1983 are concerned with the treatment of patients suffering from mental disorder. All persons involved with this process should be familiar with the following publications:

- Mental Health Act 1983 (as amended 2007) (MHA)
- Code of Practice to the MHA 1983 (2015) (CoP)
- Reference Guide to the Mental Health Act 1983 (2015)

20.3 It is the Approved Clinician (AC) who must ensure that there is compliance with the MHA provisions relating to medical treatment. This policy must be used in conjunction with the CoP.

20.4 Clinicians authorising or administering treatment without consent under the MHA 1983 are performing a function of a public nature and are therefore subject to the provisions of the Human Rights Act. In some instances, competing human rights will need to be considered, which may require finely balanced judgements. Such decisions and the reasons for them should be clearly documented.

21. Capacity and the Mental Health Act 1983

21.1 Capacity to consent continues to be applicable for those patients subject to MHA. The RC should make an assessment of capacity to consent to the proposed treatment at the earliest opportunity; this should be recorded in the patient's record.

21.2 Capacity should be re assessed 'as appropriate' and a clear record made each time there is requirement to complete a form T2 in compliance with Section 58. An entry should be made in the patient's progress notes stating that an assessment of capacity has been undertaken.

22. Treatment and the Mental Health Act 1983

22.1 Part 4 of the MHA applies to all forms of medical treatment for mental disorder. However, certain types of treatment are subject to special rules set out in sections 57, 58, and 58A described below.

22.2 **Section 57** - Treatments requiring a patient's consent and a second opinion:

- This section applies to both detained and informal patients
- It stipulates that no patient may be subject to psychosurgery or the implantation of female hormones into a man for the purpose of reducing sexual drive without the patients express consent and a second opinion
- The second opinion is to be provided by a doctor appointed by the CQC
- Treatments given under this section require careful consideration because of the ethical issues and possible long-term effects
- Advice should be sought from the Mental Health Act Department of the Trust, as procedures for implementing this section must be agreed between the CQC and the Trust

22.3 **Section 58** – Treatments requiring the patient's consent or a second opinion:

- This section applies to all patients liable to be detained except for those detained under sections 4, 5(2) or 5(4), 35, 135, 136, 37(4),45A(5); conditionally discharged restricted patients, CTO patients not recalled to hospital.

- It covers the administration of medication for mental disorder (unless included in section 57 or 58A treatment) if three months or more have lapsed since medication for mental disorder was first given to the patient during an unbroken period of compulsion ("medication after three months").
- If the above criteria apply then the RC must personally seek the consent of the patient in order to continue with the proposed treatment.
- The patient must have the capacity to make the decision.

22.4 **Section 58A** – Treatments requiring consent and / or a second opinion:

- This section applies to all patients aged under 18 (whether or not they are detained) and all patients liable to be detained except for those detained under sections 4, 5(2) or 5(4), 35, 135, 136, 37(4),45A(5); conditionally discharged restricted patients, and SCT patients
- It covers electro-convulsive therapy (ECT) and treatments specified in the regulations (at the time of publication this is medication administered as part of ECT). Recorded on Form 1B.
- A detained patient aged 18 or over may only be given 58A treatment if the patient has capacity (certified by an AC or SOAD) and has consented to it, or, the patient does not have capacity, and it is appropriate treatment, and there is no refusal under the MCA, and this is certified by a SOAD.
- Patients aged under 18 may not be given 58A treatment unless; the child has competence and has consented to it, and, the treatment is appropriate, and is certified by a SOAD; or, the child does not have competence, the treatment is appropriate, and, (patient 16 or 17 years old) there is no refusal under the MCA, and this is certified by a SOAD.
- Further guidance regarding ECT and its legal provisions can be found in the Mental Health Act 1983 Code of Practice

22.4 **Part 4A** – apply to CTO patients not recalled to hospital.

- Medical treatment for mental disorder may not be given (by anyone in any circumstances) to CTO patients who have not been recalled to hospital unless the requirements of Part 4A are met
- Part 4A requires authority (i.e. consent or MCA provision) and (if a 58 or 58A type treatment) a SOAD certificate to confirm the treatment is appropriate.

22.5 **Section 63** - Treatments that do not require the patient's consent are all medical treatments for mental disorder given by or under the direction of the patient's RC and which are not referred to in sections 57, 58 and 58A. This includes nursing, care, habilitation, and rehabilitation given under medical direction. It is however good practice to try and gain the patient's consent to care in these categories.

22.6 **Section 62** - Sections 57 and 58 do not apply if the treatment in question is:

- immediately necessary to save the patient's life;
- a treatment which is not irreversible, but which is immediately necessary to prevent a serious deterioration of the patient's condition;
- a treatment which is not irreversible or hazardous, but which is immediately necessary to alleviate serious suffering by the patient; or
- a treatment which is not irreversible or hazardous, but which is immediately necessary to prevent the patient from behaving violently or being a danger to himself or to others, and represents the minimum interference necessary to do so

22.7 **Section 58A** does not apply to ECT if the ECT falls within the first two categories above. Regulations about other section 58A treatments can say which of the categories of immediate necessity above apply in each case.

23. The Mental Health Act 1983 Three-Month Rule

23.1 The three month rule legally authorises a doctor to prescribe and a nurse to administer medication for mental disorder to patients detained under the Mental Health Act 1983 if they refuse or are incapable of giving valid consent. The three month period commences with the date of the first dose of medication during any continuous period of detention, even if the medication has been changed or is not given continuously. This includes any medication given under Section 2. During this period it remains good practice to try and gain the patients consent to treatment.

23.2 Following the three month period, medicines for the treatment of mental disorder can be given to the patient either with the patient's consent as recorded by the patient's RC on Form T2 or, in the absence of the patient's consent, only if authorised under a Form T3 completed by a Second Opinion Appointed Doctor (SOAD). It is the responsibility of the RC to contact the CQC to gain the second opinion; this task will be undertaken by the MHA

24. Training

24.1 Training details are available from the Training and Development Department. There are two training sessions pertinent to this policy, these are provided by the trust as part of a rolling programme of training and are summarised below.

- Mental Health Act 1983
- Mental Capacity Act 2005

24.2 Specific training may be developed and delivered locally or to defined groups of staff depending upon organisational need. All training content must be agreed with the Mental Health Legislation Development Lead.

25. Definitions of Terms

25.1 Terms are defined in Appendix 5, further defining can be found in the MHA code of practice.

25.2 Abbreviations used are shown below.

- AC - Approved Clinician
- AMHP - Approved Mental Health Professional
- CPA - Care Programme Approach
- CAMHS - Children and Adolescent Mental Health Services
- CQC - Care Quality Commission
- CAF - Common Assessment Framework
- CTO - Community Treatment Order
- IMCA - Independent Mental Capacity Advocate
- IMHA - Independent Mental Health Advocate
- LA - Local Authority
- RC - Responsible Clinician
- SOAD - Second Opinion Appointed Doctor

26. Identification of Stakeholders

26.1 This is an existing policy under review, which has been circulated for consultation to the following for a **two week consultation period**

- Corporate Decision Team
- Local Negotiating Committee
- North Locality Care Group
- Central Locality Care Group
- South Locality Care Group
- Business Delivery Group
- Safer Care Group
- Medical Directorate
- Nursing Directorate
- Trust Allied Health Profession Services

- Communications, Finance, IM&T,
- Commissioning and Quality Assurance
- Staff-side
- Workforce and Organisational Development
- Internal Audit

27 Equality and Diversity Assessment

27.1 In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

28 Monitoring and Compliance

28.1 Monitoring and compliance will be undertaken in accordance with the Policy Monitoring Tool, Appendix C.

28.2 This policy will be monitored by the Mental Health Legislation Committee. If at any stage there is an indication that the target date of November 2015 cannot be met, then the Medical Directorate Committee will consider the implementation of an action plan.

29 Standards / Key Performance Indicators

29.1 This policy will be operated in compliance with Consent: Patients and Doctors Making Decisions Together; General Medical Council - Appendix 1; Reference Guide for Consent to Examination or Treatment; Welsh Assembly – Appendix 2. Code of Practice for MHA 1983;

30 Fair Blame

30.1 The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

31 Policy Leaflets

31.1 Any information given to patients needs to be in an accessible format, accurate and 'branded' correctly. Northumberland, Tyne and Wear NHS Foundation Trust (the Trust) follows the process around production of this information as outline in the Trust's NTW(O)03 – Accessible Information for Patients, Carers and Public Policy.

32 Fraud, Bribery and Corruption

32.1 In accordance with the Trust's policy NTW(O)23 – Fraud, Bribery and Corruption, all suspected cases of fraud and corruption should be reported immediately to the Trust's Local Counter Fraud Specialist or to the Executive Director of Finance.

33 Associated Documentation

- NTW(C)07 - Promoting Engagement with Service Users
- NTW(C)17 – Medicine Management Policy and practice guidance notes
- NTW(C)34 - Mental Capacity Act Policy and PGN:
  - MCA-PGN-02 – Advance Decision to Refuse Treatment and Advance Statements
- NTW(C)47 – Community Treatment Order Policy

- NTW(O)01 – Development and Management of Procedural Documents
- NTW(O)03 – Production of Accessible Info; for Patient, Carer and Public

34 References

- Mental Health Act 1983 Code of Practice TSO, 2015.
- Reference Guide to the Mental Health Act 1983 TSO, 2015.
- Mental Health Act Manual, Richard Jones, 2015.
- Mental Capacity Act 2005 Code of Practice, TSO, 2007.
- Mental Capacity Act Deprivation of Liberty Safeguards Code of Practice. TSO 2008

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix A

Equality and Diversity Impact Assessment Screening Tool

Equality Analysis Screening Toolkit			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Locality**
Kerry Graham	October 2015	November 2018	
Policy to be analysed		**Is this policy new or existing?**	
NTW(C)05 – Consent to Examination and treatment Policy		Existing	

What are the intended outcomes of this work? Include outline of objectives and function aims

The Department of Health has issued a range of guidance documents on consent, and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in Northumberland, Tyne and Wear NHS Foundation Trust, (the Trust) which aim to ensure that health professionals are able to comply with the guidance. Unlike similar policies for acute Trusts, this policy also incorporates the guidance on consent that is relevant to service users detained under the Mental Health Act 1983. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the service user.

The Trust believes that valid consent is essential for all forms of health care provided by the Trust. The approach to obtaining consent should meet the standards set out in this document, in all areas of the Trust. The Trust expects that only the forms in Appendix 3 will be used for obtaining written consent.

Associated documentation:

- NTW(C)07 Promoting Engagement with Service Users
- NTW(C)17 – Medicine Policy and pgns
- NTW(C)34 Mental Capacity Act Policy and PGN;
  - MCA-PGN-02 – Advance Decision to Refuse Treatment and Advance Statements
- NTW(C)47 Community Treatment Order Policy
- NTW(O)03 – The Production of Accessible Information for Patient, Carer and Public

Who will be affected? e.g. staff, service users, carers, wider public etc

Protected Characteristics under the Equality Act 2010. The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them

Disability	Importance of reasonable adjustments to ensure informed consent have been acknowledged
Sex	
Race	Interpretation needs have been acknowledged
Age	

Gender reassignment (including transgender)	
Sexual orientation	
Religion or belief	
Marriage and Civil Partnership	
Pregnancy and maternity	
Carers	
Other identified groups	

How have you engaged stakeholders in gathering evidence or testing the evidence available?
Through standard policy process procedures
How have you engaged stakeholders in testing the policy or programme proposals?
Through standard policy process procedures
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:
Appropriate policy review author/team
Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic	
Eliminate discrimination, harassment and victimisation	
Advance equality of opportunity	
Promote good relations between groups	Policy is neutral in its impact
What is the overall impact?	Policy is neutral in its impact
Addressing the impact on equalities	This policy does not unlawfully discriminate against equality target groups

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?

If yes, has a Full Impact Assessment been recommended? If not, why not?

Manager's signature: **Kerry Graham** **Date: Oct 15**

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix B

Communication and Training Check list for policies

Key Questions for the accountable committees designing, reviewing or agreeing a new Trust policy

Is this a new policy with new training requirements or a change to an existing policy?	Existing Policy
If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.	Part of rolling training programme for Mental Health Act and Mental Capacity Act.
Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice? Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHS Resolutions etc. Please identify the risks if training does not occur.	Staff are not kept up to date in application of trust policies
Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.	All care staff prescribing and implementing care in all service areas.
Is there a staff group that should be prioritised for this training / awareness?	Awareness of policy and practice.
Please outline how the training will be delivered. Include who will deliver it and by what method. The following may be useful to consider: Team brief/e bulletin of summary Management cascade Newsletter/leaflets/payslip attachment Focus groups for those concerned Local Induction Training Awareness sessions for those affected by the new policy Local demonstrations of techniques/equipment with reference documentation Staff Handbook Summary for easy reference Taught Session E Learning	Training sessions provided as part of a rolling programme as detailed below.
Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.	Mental Health Legislation Development Lead; Executive Director of Nursing and Operations Medical Director

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix B – continued

Example Training Needs Analysis

Staff/Professional Group	Type of training	Duration of Training	Frequency of Training
Professionally qualified care staff who provide care for service users and need to consider consent issues	Consent to treatment under the Mental Health Act 1983		3 yearly
Professionally qualified care staff who provide care for service users	Awareness of the Mental Capacity Act 2005 and its use in practice		3 yearly
Professionally qualified care staff who provide care for service users	Awareness of advance decisions / statements under the Mental Capacity Ac		3 yearly

Copy of completed form to be sent to:

Training and Development Department,
St. Nicholas Hospital

Should any advice be required, please contact:- 0191 245 56770 (internal 56770)

Northumberland, Tyne and Wear NHS Foundation Trust

Appendix C

Monitoring Tool

Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

NTW(C)05 – Consent to Treatment and Examination Monitoring Framework			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implemented and monitored;** (this will usually be via the relevant Governance Group).
1.	Consent to Medication for Patients detained under MHA Approved Clinician completion of T2 (Certificate of Consent to Treatment) SOAD completion of T3 (Certificate of Second Opinion Doctor) within 3 months of commencement of treatment	¼ report from MH Legislation Lead	Medical Directorate Committee. Group Quality and Performance Sub-Group - Effective
2.	Consent for ECT Completion of Form 1b-Consent of Adult Patient for ECT. Completion of Form 4b-Best Interest Decision for Adult Patient lacking Capacity to Consent to ECT Forms checked at work up and prior to each treatment by Clinician proposing Treatment	Electronic incident form completed for all patients who do not have mandatory consent forms Safeguard Report	ECT Clinical Standards Group Group Quality and Performance Sub-Group - Effective

NTW(C)05 – Consent to Treatment and Examination Monitoring Framework			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implemented and monitored;** (this will usually be via the relevant Governance Group).
3.	Training in MHA/MCA/DoLS 90% of Clinical Staff will have undertaken NTW training - 3 yearly	Workforce Section of the Integrated Performance Report and Workforce Performance Dashboard Quarterly Performance Report Performance Managers Monthly	Trust Quality and Performance Committee Group Quality and Performance Meetings

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Group in line with the frequency set out.