Our Ref: LW/lmw/FOI.284.23
Date: 4th October 2023

Laurie Wrench
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
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Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 7th September 2023**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

please can you disclose any policies and/or guidance and/or any other documentation you hold relating to training in informed consent for doctors working at your hospital. In particular, we are interested in any policies/guidance/documentation which address the following:

1. Whether training in informed consent is mandatory for doctors working within your hospital**.**
   Doctors in the Trust are not offered separate mandatory training in "informed consent". Seeking informed consent is covered in our Trust Policy, please see Appendix 1 attached (currently under review). Additional to this consent is covered in both the Mental Capacity Act and Mental Health Act pieces of national legislation, which all doctors receive regular updates in as part of their continual professional development. Consent is also covered in research training for principal investigators.

2. Who provides/funds training in informed consent for doctors working at your hospital.
   N/A

3. What a doctor must do to fulfil any training requirements relating to informed consent.
   N/A

   If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision.

The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Laurie Wrench
Deputy Director of Governance

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Document level: Trustwide
Code: 4.25
Issue number: One

Consent/Competence Policy

Lead executive	Executive Medical Director
Authors details	Medical Director Mental Health Law Team Manager

Type of document	Policy
Target audience	**Healthcare Professional / Staff Responsibility** It is the healthcare 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 and safe to do so. • Work within their competence and not to agree to perform tasks which exceed that competence. • Ensure that they are fully aware of their Professional Body's advice relating to consent. That they adhere to relevant legislation, Mental Health Act, Mental Capacity Act, Equality Act and GDPR.
Document purpose	Patients have a fundamental legal and ethical right to determine what happens to them. North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to ensuring that service users consent is obtained before commencing treatment, interventions or providing care. This policy sets out the legal standards and procedures in relation to seeking, obtaining and recording consent.

Approving meeting	Quality Committee Trust Board	Meeting date	7th November 2019 28th November 2019
Implementation date	30th November 2019	Review date	31st October 2023

Trust documents to be read in conjunction with	
MHA16	Mental Capacity Act Policy.
	The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals', NIMHE, 2009.
1.55	Advance decisions to refuse treatment and statements made in advance procedure
	The NHS Accessible Information Standard

Document change history		Version	Date
What is different?	Complete re-write of policy and change of ownership from Nursing Director (previously 4.25) to Medical Director (now 1.89).		
Appendices / electronic forms	Forms for completion are contained within the electronic patient record.		
What is the impact of change?			

Training requirements	Face to face and e-learning

Document consultation	
Directorates	North Staffs Community Directorate, Stoke Community Directorate, Specialist Directorate via representation at the Consent Steering Group. PLAG
Corporate services	Trust Mental Health Law Governance Group, membership has representatives from each Directorate.
External agencies	None.

Financial resource implications	None.

External references
Code of Practice, Mental Health Act 1983, TSO 2015
Reference Guide to the Mental Health Act 1983, TSO 2015
Mental Capacity Act 2005, Code of Practice, TSO, 2007

Monitoring compliance with the processes outlined within this document	The Mental Health Law Governance Group will, on behalf of the hospital managers, monitor compliance with this procedure and will routinely commission an audit of compliance.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g. consider impact on younger people/ older people) – **Disability** (remember to consider physical, mental and sensory impairments)	No No	

– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)		
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	~~Yes~~ / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	~~Yes~~ / No	
What is the level of impact?	Low / medium / high	

CONTENTS

1. Introduction / background

1.1 As both a legal and ethical principle, consent must be obtained before an act of care or treatment (including assessment and examination) is provided to a person.

Care and treatment can only be provided to a person with their informed consent or with some other specific legal authority. For example, an act of care or treatment that has **not been consented** to could be authorised by:

- The Mental Health Act 1983
- The Mental Capacity Act 2005
    - Lasting Power of Attorney
    - Court of Protection
- The Children Act

1.2 The Trust recognises that patients have a fundamental right to determine what happens to their own bodies and care regime.

2. Policy synopsis

2.1 Consent forms part of the Care Quality Commission's (CQC) fundamental standards.
This document informs practitioners of the:

- Trust Standards which ensure that professionals follow national guidance on consent.
- Guidance on consent to patients detained under the Mental Health Act 1983 (MHA).
- NB – this policy does not cover guidance for people who lack capacity to consent – for this you would need to refer to the Trust Mental Capacity Act Policy – MHA16.

3. Policy

3.1 Definition of informed consent:

For the purpose of this policy informed consent is an individual's permission for care delivery with the full knowledge of the possible consequences, risks and benefits and alternatives to the care proposed.

3.2 Consent:

Before providing care or treatment a health professional must be satisfied either that the patient has given their valid consent or some other lawful authority exists.

Consent is only valid if it is given freely and not under duress by a properly informed patient who has capacity to give consent.
Consent can be:

- Written Consent
- Verbal (has to be explicit, decision and time specific)

- Non-verbal consent (implied or implicit) is not legally compliant post GDPR (May 2018).

NB - Capacity: the person must be capable of giving consent, which means that they understand and remember the information given to them, and use or weigh up the relevant details to make an informed-decision. They must also be able to communicate their decision.

3.3 Context of Consent:

Consent can take a range of forms, from the active request by a patient for a particular treatment 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.

As a health professional, by law, you must provide the patient with sufficient information to enable them to make an informed decision. This information must be provided in a form which meets the information and communication support needs of those with a disability or, impairment or sensory loss. Please see the NHS Accessible Information Standard for further information.

At the end of the seeking consent process, the patient will either be consenting or not, there is nothing in-between.

3.4 Lacking Capacity to Consent

A person is presumed to have the capacity to make a treatment decision unless they have impairment or disturbance in the functioning of their mind or brain, and this impairment or disturbance means they cannot 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 an informed decision (whether by talking, using sign language or by any other means)

All professionals must follow the principles set out in the Mental Capacity Act 2005 when determining whether persons aged 16 or over lack the mental capacity (either temporarily or permanently) to give or withhold consent for themselves.

Only a person who has authority under a Lasting Power of Attorney or is a deputy appointed by the Court of Protection can give consent on behalf of an adult patient.

The Office of the Public Guardian maintains registers of:

- lasting powers of attorney (LPA)
- enduring powers of attorney (EPA)
- deputyship court orders

Anyone can apply for a search of these registers.

What you can find out by completing Form OPG100

You can find out:

- if there is a registered lasting power of attorney (LPA), enduring power of attorney (EPA) or deputyship court order
- the registration date of the LPA or EPA, or date of court order
- the name of the person the LPA, EPA or deputyship order is about
- the date of birth of the person the LPA, EPA or deputyship order is about
- the names of attorneys or deputies
- whether decisions relate to property and finances or health and welfare
- whether there are any restrictions on the power of attorney or court order
- how attorneys or deputies are appointed to act
- whether the LPA, EPA or deputyship order is registered, cancelled, revoked or expired
- the expiry date of deputyship orders, where relevant

What you cannot find out

You cannot find out about:
LPAs or EPAs we are currently registering
applications for deputyship court orders that are in progress

A patient who lacks capacity can 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.

When treating patients who may lack capacity, health professionals should give careful consideration to the MCA, the MCA Code of Practice and Mental Capacity Act Policy, NICE guidance and associated procedures.

3.5 Responsibilities for seeking consent:

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

Where verbal or non-verbal consent is sought at the time of treatment, this will 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.

It is a health professional's own responsibility to:

- ensure that when seeking consent they are competent to do so; and
- work within their own competence, and not to agree to perform tasks that exceed that competence.

If a professional feels that they are being pressurised to seek consent when they do not feel competent to do so this should be escalated via line management processes.

3.6 Attendance by students and trainee's

If a student or trainee health professional is undertaking examination or treatment of the patient – for example taking a blood sample for testing – assuming the student is trained in the procedure, the fact 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 is good and ethical practice to do so and consent will still be required.

If a student proposes to conduct a physical examination that is not part of the patient's care, 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.

A patient's consent should be obtained before any occasion when a student or trainee will 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.

3.7 Providing information

Providing information is central to the consent process.

Before patients can make a decision about treatment, they need understandable 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. 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 (if applicable), and how they can expect to feel afterwards.

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.

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. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

The 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. To safeguard the consent process, an interpreter must 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.

Guidance on interpretation and translation services can be found on the Trust intranet site within the Diversity tab.

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

Patients may request more detailed information about their condition or proposed treatment than can be provided verbally and in leaflets. This must be provided whenever practicable.

It is important that professionals do not assume that the attendance of a patient at a clinic implies consent to particular treatment and therefore professionals must ensure that the patient has the information they need before proceeding with an assessment, investigation or treatment.

Accessible standards information / easy read will accessed via CAT as they become available.

3.8 Seeking Consent:

3.8.1 Seeking consent generally:

When seeking consent,
You must take reasonable care both to provide sufficient and relevant information before seeking consent, and also to meet the continuing obligation to provide the patient with sufficient information about the proposed treatment and any alternatives to it.

Case law (Montgomery v Lanarkshire case March 2015) says whether “a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”

Remember when confirming the patient's consent and understanding, ask questions that require more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind.

A person carrying out a procedure on a patient must ensure that, immediately before the procedure or implementation of treatment, the patient has understood the information and that they still give their consent. If the patient has queries or concerns they must be given time to consider any additional information.

Whatever the context in which 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 need in order to make an informed decisions;
- share with patients any risks and consequences of having or not having specific interventions;
- maximise patients' opportunities, and their ability, to make decisions for themselves, this includes having someone with them, if they wish, to support them.
- respect patients' decisions.

When a patient formally gives their consent to a specific intervention and a specific time, this is the endpoint of the consent process. 'Seeking consent' is a legal requirement. This 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.

3.8.2 Single stage process:

It may be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, a doctor may suggest a particular medication and explain how it might help the patient's condition and whether there are any significant risks. If the patient consent's treatment can go ahead immediately. In most cases consent will be given verbally, however there are some exceptions, for example, ECT.

3.8.3 Two or more stage process:

In most cases where written consent is being sought, treatment options will be discussed well in advance of the actual procedure being carried out. This may be on just one occasion or it might be over a series of consultations with a number of health professionals.

The consent process will therefore have at the least the following stages:

1. Providing information, discussing options and initial (oral) decision;
2. The consequences (risks including the likelihood of success and any alternatives and what will happen if the treatment does not go ahead;
3. To freely give their opinion (not coerced, therefore acting voluntarily); and
4. Confirming that the patient still wants to go ahead.

The consent form must document the information stage(s), as well as the confirmation stage.

3.9 Obtaining written consent

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 the initial consultation or when they arrive for treatment.

If a form is signed before patients arrive for treatment, 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 (e.g. 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.

3.10 Seeking consent for information sharing

Obtaining informed and explicit consent is also essential for information sharing and should be obtained from the start.

Service users must know and understand as far as possible how their information is to be used, shared and stored (there should be 'no surprises') and they should understand the implications of their decision, particularly where refusing to allow information to be shared is likely to affect the care they receive.

You must be clear that you will review the situation at regular intervals or if circumstances change, and that they can change their minds at any stage.

Please refer to the 7.01 - Confidentiality of Patient and Employee Information Policy for further detail.

3.11 Seeking consent for anesthesia

Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon or doctor prescribing ECT) to seek consent for anaesthesia, having discussed the benefits and risks.

In elective treatment patients must either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. It is not acceptable for the patient to only receive information about anaesthesia at their pre-operative visit from the anaesthetist.

The anaesthetist must document the discussion with the patient and their consent in the anaesthetic record, in the patient's notes on the Electronic Patient Record 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 they must make sure that the patient has given consent to that form of anaesthesia.

If general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council requires dentists to make sure that the patient has all the necessary information. In such cases, the anaesthetist and dentist will share that responsibility.

3.12 Emergencies

In emergencies, the two stages (discussing options and confirming that the patient wishes to go ahead) will follow straight on from each other. Documenting any discussion and the patient's consent on their electronic care record might be more appropriate than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but must not affect its quality.

4. Written Consent

4.1 Consent is often wrongly equated with a patient's signature on a consent form / care plan. A signature on a form or care plan may be evidence that patient has agreed to the relevant care / treatment, but it is not *proof* of valid consent.

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:

- ECT
- Withdrawal and withholding of life prolonging treatment.
- 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').

- Written consent, including the person's hand written signature, required for specific medications to be prescribed and/or dispensed.
- The procedure involves general / regional anesthesia 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.

It is not usually 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 believe 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 is advisable to do so.

If you are performing a significant procedure, you must document both a patient's agreement to the intervention and the discussions which led up to that agreement.

Either use a consent form (with further detail in the electronic care record if necessary) or document consent in the electronic care record.

4.2 Minimum standard for documenting consent

The Trust's minimum documentation standard is as follows:-

- Consent to an assessment of care needs is obtained and recorded by the appropriate professional during the core assessment into North Staffordshire Combined Healthcare NHS Trust services.
- Consent to treatment, for example: medication, therapies and clinical interventions is obtained and recorded by the appropriate professional whilst the service user is in the care of North Staffordshire Combined Healthcare NHS Trust services
- Consent to hospital admission.

NB – there are other forms of consent which will be routinely obtained and reflected within the clinical records of the professionals involved in the individuals care. For example; supporting an individual's personal hygiene; supporting an individual to attend community based activities; obtaining consent to enter a person's home for a review.

5. Treatment of Children

Under 16 legislation and 16–17 year olds has different legislation.
13–15 year olds may have competency of some decisions.

5.1 When treating children, you must ensure you are familiar with relevant law and consider carefully whether the child is competent to give their consent to the treatment.

Extensive guidance is provided in 'The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals',

Chapter 19 of the MHA Code of Practice (2015) gives further guidance on key factors to be considered, 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 MHA 1983

If the child is not competent to give consent, you may give treatment on the basis of parental consent from the person with parental responsibility; this is usually the person's parents. Although the MCA does not apply to under 16's, case law and judges are using the MCA mental capacity process as a guide to assessing and determining competency. September 2019 - Supreme Court judgment regarding 16 – 17 changes parental responsibility in some circumstances.

Parental consent should not rely upon when the child is competent or the young person has the capacity to make the particular decision.

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. However, you should remember that, in law, this consent is required but may be given in advance.

Where a child is admitted, you must discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, you 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. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

5.2 Gillick / Fraser Competence or Competence

The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17. The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the MCA, while the test for children under 16 is determined by considering whether they are 'Gillick competent' also known as the 'Fraser Guidelines'. Gillick competency and Fraser Guidelines refer to a legal case which looked specifically at

whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. (Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984]).

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.

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. As a result the child's competence to consent should be assessed carefully in relation to each decision that needs to be made.

5.3 Assessing Competence

Practitioners with expertise in working with children and young people should be consulted in relation to competence assessments. In general a competence decision should be made by the member of staff who is proposing the particular intervention/treatment that a decision needs to be based upon.

The assessment of competence in under 16's should be appropriate to the child's age. For example, routine assessments of competence would not be expected in the case of 8 and 9 year olds, but would be more usual for children aged 13, 14 and 15.

When considering whether a child has the competence to decide about the proposed intervention, practitioners should 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)?

Although the MCA does not apply to under 16's, case law and judges are using the MCA mental capacity process as a guide to assessing and

determining competency. September 2019 - Supreme Court judgment regarding 16 – 17 changes parental responsibility in some circumstances.

Staff should also consider if a child has developed the necessary intelligence and understanding to make that particular decision or if their mental disorder adversely affects their ability to make the decision.

Assessments of competence should be clearly recorded in the child's clinical record and reviewed at key stages of their intervention / treatment. Staff should also document information they have given the child, the reasons / nature of the treatment, the child's views / feedback and the alternatives, disadvantages, advantages of the treatment / intervention offered.

A detailed review will not be required if there has been no substantial change in the competence of the child to make a decision about a particular intervention / treatment. However, evidence that a review has taken place must be documented.

6. Treatment of 16 and 17 year olds who are able to consent to treatment

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

Young people who are able to consent to their treatment for mental disorder may be given treatment in these circumstances:

- Treatment with consent – if the young person is capable of giving 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 they may be admitted to hospital without consent.

Every practitioner should be legally competent and compliant. In unusual and/or complex situations and where there are short or longer term risks legal advice can be sought from the Trust Legal Team or Mental Health Law Team.

Such cases can be controversial and raise complex legal issues. Please refer to chapters 19, 23, 24, 25 and 26 for the MHA 1983 Code of Practice.

There are circumstances where you should not rely of parental consent:

- If the young person does not give consent to the proposed treatment, the MHA 1983 Code of Practice 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.

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

7.1 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 lead to a deprivation of liberty
- The young person does not lack capacity within the meaning of the MCA 2005

Unless it is not practicable or appropriate, you must consult those with parental responsibility 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 be relied upon if the decision falls within the 'scope of parental responsibility' and the parents are acting in the young person's best interests.
- **Treatment under the Mental Health Act 1983** – If the MCA 2005 does not apply and the decision does not fall within the 'scope of parental responsibility'; 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 they may be admitted to hospital without consent.

8. Professionals completing consent forms:

8.1 The standard consent form has 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 because they:

- Carry out the procedure themselves, or
- 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.

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.

The professional recording consent decisions in the electronic patient record must clearly demonstrate what information has been provided to the person, ie, risks/benefits/consequences, what the persons views were, and how the final decision was achieved.

9. Refusing treatment:

It is a person's right to withdraw their consent at any time refusal of treatment is different.

9.1 For the process of seeking consent to be meaningful, refusal must be one of the patient's options. An adult patient who has capacity can refuse any treatment, except in circumstances governed by the Mental Health Act 1983 (as amended in 2007). 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.

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 they have capacity to do so.

After discussing treatment options, if 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.

Where a patient has refused a particular intervention, the health professional must continue to provide any other care to which the patient has consented. They must also ensure the patient knows they are free to change their mind and accept treatment if they later wish to do so. The patient must be informed if delay may affect their treatment choices.

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, they are 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, they must on request, be prepared to transfer the patient's care to that health professional.

NB: There must be clear narrative and rationale for decision making within the consent / capacity form within the patient's electronic patient record, as outlined above for all refusals or withdrawal of consent.

10. Advance statements and decisions:

10.1 A patient may have made an advance decision about their care and treatment to apply when they no longer have capacity. If this is a decision to refuse a specified treatment, and is both valid and applicable for the purposes of the MCA 2005, then health professionals must not provide treatment.

Advance statements are indicative of the patient's wishes and must not be ignored. If a patient has specified in an advance statement that they want a particular treatment, the patient's preferences must be considered when identifying best interests. The health professional is not bound to provide that treatment and may act in accordance with their clinical judgement.

More details of advance decisions and statements is outlined in the Trust's Policy number 1.55 for Advance Statements and Advanced Decisions to Refuse Treatment and the MCA Code of Practice.

11. Clinical photography and video recordings

11.1 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.

Video recordings, clinical photography and/or radiographs may sometimes be needed following injuries sustained in an accident or 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.

Making and Using Visual and Audio Records of Patients, GMC, 2002 and the Trust's Policy number 4.33 for the use of Clinical Photography and Conventional or Digital Video Recordings give detailed advice in the use of recordings when treating or assessing patients.

12. Mental Health Act 1983

12.1 Consent to treatment and the Mental Health Act 1983

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

The sections contained in Part 4 and Part 4A of the MHA 1983 is 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 (MHA).
- Mental Health Act 1983 Code of Practice (MHA CoP).
- Reference Guide to the Mental Health Act 1983 (Reference Guide).

The Approved Clinician (AC) in charge of the treatment in question must ensure compliance with the MHA provisions relating to medical treatment.

NB - This policy must be used in conjunction with the MHA and the MHA CoP

12.2 Capacity and the Mental Health Act 1983

Capacity to consent continues to apply to those patients subject to the MHA 1983. The AC in charge of the proposed treatment must assess capacity to consent at the earliest opportunity/first review in ward round; this must be recorded on the appropriate consent forms in the electronic patient record.

If a change in consent or capacity is indicated this must be re-assessed and recorded on the appropriate consent form in the electronic patient record as well as each time there is a requirement to complete or review consent to treatment certificates to be compliant with Section 58 requirements.

12.3 Treatment and the Mental Health Act 1983

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.

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

This section applies to both detained and informal patients

- No patient may be subject to psychosurgery or the implantation of hormones for the purpose of reducing sexual drive without the patient's express consent and a second opinion;
- The second opinion must 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 must be sought from the MHA department of the Trust as procedures for implementing this section must be agreed between the CQC and the Trust.

12.5 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, Community Treatment Order (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 AC in charge of the treatment in question 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.
- Where the patient does not consent, or lacks the capacity to consent, the treatment in question cannot be given without the approval of a Second Opinion Appointed Doctor (SOAD).

12.6 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 CTO 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).
- A detained patient aged 18 or over may only be given 58A treatment if the patient has capacity (certified by an AC in charge of that element of treatment 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 capacity and has consented to it, and, the treatment is appropriate, and is certified by a SOAD; or, the child does not have capacity, 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.

12.7 Part 4A – 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 treatment certificate:
    - Where the patient has capacity / is competent to consent, this will be a CTO12 completed by the approved clinician in charge of the treatment;
    - Where the patient lacks the capacity / is not competent to consent, this will be a CTO11 completed by a SOAD.

- For detailed information see Trust Policy MHA01 Community Treatment Orders.

12.8 Section 63 – Treatment that does not require the patient's consent

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.

12.9 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.

Section 58A **does not** apply to ECT if the ECT falls with 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. At the time of publication, only the first two categories in paragraph 16.56 above apply.

12.10 The first three months of detention under the Mental Health Act 1983

The three month rule legally authorises the prescription and administration of medication for mental disorder to patients detained under the MHA 1983 even if they refuse, or are incapable of giving, valid consent. The three month period commences with the date of the first dose of medication administered 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, and is a requirement of the MHA CoP para 24.41, to assess the patient's capacity to consent to the treatment, to try and gain the patient's consent to treatment and to record the outcome of both.

When medication for mental disorder is first prescribed there must be an assessment of capacity regarding the medication/s recorded in the consent form in the electronic patient record, including the rationale for your decision making process. After the initial 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 AC in charge of that element of treatment on Form T2 or, in the absence of the patient's consent, only if authorised under a Form T3 completed by a SOAD. It is the responsibility of the AC in charge of that element of treatment to contact the CQC to gain the second opinion.

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Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There **is no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There **is** specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	3 yearly	Face to face or e-learning	✓
Training Grade Doctor	✓	3 yearly	Face to face or e-learning	✓
Locum medical staff	✓	3 yearly	Face to face or e-learning	✓
Inpatient Registered Nurse	✓	3 yearly	Face to face or e-learning	✓
Inpatient Non-registered Nurse				
Community Registered Nurse	✓	3 yearly	Face to face or e-learning	✓
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist	✓	3 yearly	Face to face or e-learning	✓
Therapist	✓	3 yearly	Face to face or e-learning	✓

Clinical bank staff regular worker	✓	3 yearly	Face to face or e-learning	✓
Clinical bank staff infrequent worker	✓	3 yearly	Face to face or e-learning	✓
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Consent is covered in all mental health law training delivered in the Trust, including face to face mandatory sessions, specific speciality and team sessions and e-learning packages.

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

It has been highlighted by the Mental Health Act reviewer from the Care Quality Commission during several recent visits to the Trust that our Consent processes within the Trust need to be strengthened to improve our record keeping.

Any other additional information

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Completed by	Samantha Dawson	Date	31.10.2019