Lincolnshire Community Health Services NHS Trust

Policy for Consent to Examination or Treatment

Reference No:	P_CIG_05
Version:	5
Ratified by:	Lincolnshire Community Health Services NHS Trust Board
Date ratified:	08 January 2019
Name of originator/author:	Named Nurse for Safeguarding
Name of responsible committee/individual:	Safeguarding and Patient Safety Group
Date issued:	January 2019
Review date:	January 2021
Target audience:	All Staff
Distributed via:	Website

Lincolnshire Community Health Services NHS Trust

Policy for Consent to Examination or Treatment

Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1		New Policy	Sept 2010	Risk Manager
2		Renumbered from CIG003a to P_CIG_05	January 2012	Corporate Assurance Manager
3		P3 reference to LCHS MCA and DoLS policy and procedures P6 update section 1.3 in relation to capacity and consent P11 reference to Fraser guidelines attached as appendix. Reference to safeguarding 3.2 update PALS info P13 4 update Quality and Scrutiny Group Remove 7.3 Remove appendix C,D & F	August 2014	Head of Safeguarding
4		Full Policy review and update	August 2016	Head of Safeguarding
4.1		Minor administrative/formatting updates	February 2018	Corporate Assurance Team
5		Full Policy Review	November 2018	Gemma Cross, Named Nurse for Safeguarding
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Lincolnshire Community Health Services NHS Trust
Policy for Consent to Examination or Treatment

Policy Statement

Background

The Department of Health has issued a range of guidance documents on consent which have informed the policy of expected practice requirements for consent. This policy sets out the standards and procedures which aim to ensure that health professional are able to comply with the guidance. This policy should be read in conjunction with NHS Lincolnshire Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure for LCHS (P_CS_42) and Planning for Future Care Guidance (Adult): Advance Care Planning, Advance Decisions to Refuse Treatment & DNACPR (G_CS_11).

Statement

This policy sets out the standards and procedures in Lincolnshire Community Health Services NHS Trust which aim to ensure that health professionals are able to comply with the guidance. 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 patient or client.

Responsibilities

All staff are required to ensure that the policy is adhered to. The health professional carrying out a specific procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done. The policy covers:-

- Adults and competent children;
- Parental consent for a child or young person;
- Adults unable to consent;
- Photography/ video recording.

Training

Training on consent is available as:

- Staff Induction.
- Professional updates.
- Procedure specific training is available via local lead clinicians

Dissemination

The policy will be disseminated to all staff via the public website, staff intranet, and will be discussed with staff as part of their team meetings.

Resource Implication

Failure to obtain or record consent could lead to legal challenge.

Resource implications in the implementation of this policy are primarily in relation to training implications.

Lincolnshire Community Health Services NHS Trust
Policy for Consent to Examination or Treatment
Contents

Contents

1. Introduction

1.1 Why consent is crucial

Lincolnshire Community Health Services recognises that patients have a fundamental legal and ethical right to determine what happens to their own bodies and how information about them is used. Valid consent to treatment is therefore 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. Patients who lack capacity have a right to receive treatment when it is then their best interests, even when they object providing there is no legal basis for not doing so (such as a valid and applicable Advance Decision to Refuse Treatment or conflict with the decision of a person who holds Personal Welfare Lasting Power of Attorney or Court Deputyship for personal welfare decisions.)

1.2 This policy

The Department of Health has issued a range of guidance documents on consent (see Appendices), and these should be consulted for details of the law and expected practice requirements on consent. This policy sets out the standards and procedures for use in Lincolnshire Community Health Services, which aim to ensure that health professionals are able to comply with the guidance. 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 patient or client.

1.3 Definitions

Valid Consent

For the consent to be valid, the patient must:

- Have the mental capacity to take the particular decision;
- Have received sufficient information;
- Not be acting under duress.

The validity of consent does not depend upon the form in which it is given. It can be verbal, implied or written. Implied consent is not in itself sufficient to demonstrate an understanding about the proposed intervention without evidence that sufficient information has been provided to a capacious patient. Acquiescence, where the person does not know what the intervention entails, is not consent.

In the absence of valid consent, an intervention may be lawful:

- Under the Mental Capacity Act 2005.
- Under the Mental Health Act 1983.
- With the consent of someone who holds parental responsibility (where the decision is ‘within the scope’ of parental responsibility).
- Following a decision of the Court of Protection or the High Court

Where an adult patient lacks the mental capacity, to make the decision at the time it needs to be made, **no-one else can give consent** on their behalf, unless they have Lasting Power of Attorney (LPA) for Health and Wellbeing in which they become the decision maker, and consent as if they were the patient. In cases where no one holds a valid LPA, treatment may be given if it is in their best interests in line with the Mental Capacity Act (2005), as long as it has not been refused in advance, in a valid and applicable Advanced Decision to Refuse Treatment (ADRT).

For further details on ADRTs please refer to the Planning for Future Care Guidance (Adult) Advanced Care Planning, Advanced Decisions to Review Treatment Policy (G_CS_11);

https://staff.lincolnshirecommunityhealthservices.nhs.uk/application/files/9815/4521/0523/G_CS_11_Planning_for_Future_Care_Guidance_Adult_Advance_Decisions_to_Refuse_Tr....pdf

1.4 Advocacy

In certain cases, it may also be appropriate to instruct an Independent Mental Capacity Advocate (IMCA);

- The person is aged 16 or over
- A decision needs to be made about either a long-term change in accommodation or a serious medical treatment
- The person lacks capacity to make the specific decision, and there is no one independent of services, such as a family member of friend who is 'appropriate to consult'.

In Lincolnshire, Total Voice provide the IMCA service, information is available here: http://www.totalvoicelincolnshire.org/

1.5 Guidance on consent

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

- *Reference guide to consent for examination or treatment* (2nd edition, 2009) provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available from Department of health www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

- *12 key points on consent: the law in England* has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis and is attached at Appendix A.

  http://www.health.wa.gov.au/mhareview/resources/documents/UK_DoH_twelve_key_points.pdf

- Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at

www.doh.gov.uk/consent, www.nhs.inform.co.uk/rights/publications/leaflets and www.nhs.uk/consent-to-treatment/page

1.6 Documentation

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

1.7 Written consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.
It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply:

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

Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialed and dated by both patient and health professional.

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

1.8 Procedures to follow when patients lack capacity to give or withhold consent

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). In addition, an assessment of the patient's mental capacity should be made using the 2 stage capacity assessment. The assessment and checklist should record why the health professional believes the treatment to be in

the patient's best interests, and the involvement of people close to the patient, or Independent Mental Capacity Advocate (IMCA) where appropriate. See section 1.4 for details of Advocacy.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment is potentially serious, a court declaration may be sought. Please contact the Corporate Safeguarding team for further advice in these situations.

1.9 Availability of forms

Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix B There are three versions of the standard consent form:

Form 1 for adults or competent children, requiring anesthesia
Form 2 for parental consent for a child or young person and
Form 3 for patient/parental agreement for procedures where conscious not impaired
Form 4 for adults who are unable to consent for investigation or treatment.
The use of form 3 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 anesthesia 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.

2. When should consent be sought?

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

2.1 Single stage process

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

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

2.2 Two or more stage process

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

and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in outpatients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team **must** check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

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

2.3 Seeking consent for anesthesia

Where an anesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anesthesia until their pre-operative visit from the anesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anesthesia. Patients should therefore either receive a general leaflet about anesthesia in outpatients, or have the opportunity to discuss anesthesia in a pre-assessment clinic. The anesthetist should ensure that the discussion with the patient and their consent is documented in the anesthetic record, in the patient's notes or on the consent form. Where the clinician providing the care is personally responsible for anesthesia (e.g. where local anesthesia 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 anesthesia.

In addition, where general anesthesia 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 anesthetist and dentist will therefore share that responsibility.

2.4 Emergencies

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

2.5 Children under 16

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

2.51 Children under the age of 16 are not automatically presumed to be legally capable of making their own decisions about their healthcare. However, under 16's may be capable of giving valid consent to a particular treatment or intervention if they have 'sufficient understanding and maturity to enable him or her to understand fully what is proposed.' This is known as being *Gillick* competent. There is no specific age at which a child under 16 becomes capable of consenting to a particular treatment. It depends on the child and the seriousness and complexity of the treatment proposed. *Gillick* competence and Fraser guidelines are not one and the same. The 'Fraser guidelines' set out by Lord Fraser in the *Gillick* case specifically concern contraceptive advice given by medical practitioners and should be followed when considering starting a child under 16 on contraception.

2.52 If a child under 16 is not '*Gillick* competent' to give consent for themselves, consent should be sought from a person with parental responsibility. People with parental responsibility for a child include: the child's mother, the child's father if married to the mother at the child's conception, birth or later, the Local Authority if the child is subject to a Care Order, or a person named in a Residence Order in respect of the child.

2.53 Historically, a child's refusal of treatment (including refusal by a 16 or 17 year old or a *Gillick* competent child), could be overruled by someone with parental responsibility. However, the modern approach (post Human Rights Act 1998) is that it is wise to seek legal advice if a competent under 18 year old is refusing consent to treatment in order to determine whether it is lawful to treat them in the face of their refusal. If detention under the Mental Health Act is not legally appropriate, an application to Court may be required.

2.54 The concept of Gillick competence reflects a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus a child under 16 may have the capacity to consent to some interventions but not to others. The child's capacity to consent should be assessed carefully in relation to each decision that needs to be made.

In some cases, for example because of a developmental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly Gillick competent at the time that they need to take a relevant decision.

If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared.

Professionals working with children need to consider how to balance children's rights and wishes with their responsibility to keep children safe from harm. Underage sexual activity should always be seen as a possible indicator of child sexual exploitation and sexual activity with a child under age 13 is a criminal offence and should always result in a safeguarding

children referral in line with LCHS Safeguarding Children Policy and Procedures and notification to the police.
https://www.lincolnshirecommunityhealthservices.nhs.uk/application/files/7915/2931/9266/PSG_03_Safeguarding_Children_Policy.pdf

3. Provision of information

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their Condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

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

The following sources of patient information are available in Lincolnshire Community Health Services NHS Trust

- Access to patient information leaflets from the practice or clinician. These may be computer generated, as an utilisation of Clinical Knowledge Summaries (formally Prodigy) (computerised decision aid for GPs/nurse practitioners and independent prescribers).
- Leaflets and other health promotional materials taking into consideration for provision of information to those with sensory impairment are available from Lincolnshire Knowledge and Resource Service

3.1 Provision for patients whose first language is not English

- Lincolnshire Community Health Services are committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use family or friends to interpret for family members who do not speak English. If the patient insists that their family/friend translates for them this should clearly be documented. Children should never be used to translate. It is important to consider safeguarding as part of your assessment in these situations.

- To be able to give valid consent, the person needs to understand the nature and purpose of the investigation or treatment. The information needs to be given in a way that will help the person understand the specific decision to be made and its implications. This could include pictures, simple words, clear terminology and where

required the use of interpreters, including British Sign Language (BSL).

Details of how to arrange translation or British Sign Language services please access the staff intranet or follow this link:

https://staff.lincolnshirecommunityhealthservices.nhs.uk/links-and-contacts/translation-services

4. Who is responsible for seeking consent?

The Medical Director has overall responsibility for this policy, and for ensuring that all clinicians understand the procedure. The Medical Director will ensure that the content of this procedure is part of clinical induction for all new staff. The Medical Director is accountable to the Board of Directors on matters relating to patient consent and is lead for the CQC standard on consent.

Clinicians are responsible for ensuring that they obtain consent from each patient and that the patient has sufficient information on the benefits, risks and alternatives of the proposed treatment on which to make an informed decision. Clinicians are responsible for recording that consent has been discussed and the outcome recorded, and for ensuring that records of any concerns relating to consent are kept up to date

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. Any clinician carrying out a procedure must be conversant with the technique and capable of providing information on informed consent. Only a clinician conversant with a procedure will be able to achieve consent.

Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this must be done by the health professional responsible. However, teamwork 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. All members of the team who are required to participate in obtaining procedure-specific consent must have received training to ensure they are able to give sufficient information to gain informed consent. Any change in practice must be approved by the Quality and Scrutiny Group. Any procedure specific training required to ensure competence will be provided by the lead clinician responsible for delivering the treatment who must be satisfied that the individual seeking consent for the treatment is suitably informed and able to answer questions. If issues are raised that the individual is not able to answer these should be referred back to the lead clinician.

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 as identified in the specialist area they work in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit annually.

4.1 Completing consent forms

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health

professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

If the patient signs the form in advance of the procedure (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.

All staff involved in obtaining consent or providing treatment are accountable both legally and professionally for their actions. However, the person actually providing the treatment must satisfy themselves that valid consent has been given before carrying out the treatment.

4.2 Refusal of treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983 (amended 2007)*.

The law assumes capacity unless it can be demonstrated otherwise. The fact that a refusal to consent to examination/treatment may be considered to be unwise, does not necessarily mean that the person lacks capacity to make the decision.

It is crucial that any refusal is explicitly documented within the patient notes.

4.3 Religious Beliefs and Culture

Religious beliefs and culture must be taken into account when consenting for treatment and this must be explored with the patient. Patients who are Jehovah's Witnesses may carry a 'Healthcare Advance Directive' document setting out their wishes based on their beliefs and restrictions on what treatment they are willing/ able to consent to.

5. Tissue

The Human Tissue Act 2004 came fully into force on 1 September 2006. It sets out the legal framework for the storage and use of tissue from the living and for the removal, storage and use of tissues and organs from the dead, including 'residual' tissue following clinical and diagnostic procedures. The Human Tissue Act makes consent a legal requirement for the removal, storage and use of human tissue or organs and sets out whose consent is needed in which circumstances. The Act also established the Human Tissue Authority (HTA). The HTA is also responsible for approving the transplantation of organs from living donors and bone marrow and peripheral blood stem cells from adults who lack capacity to consent and children who lack the competence to consent. Further guidance and HTA Code of Practice is available from HTA's website www.hta.gov.uk

5.1 Public Health Surveillance

Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.

5.2 Quality Assurance

Department of Health believes that tissue samples may be used for quality assurance purposes without requiring specific patient consent *provided* there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised. Instances where pathology and hematology samples are submitted form primary and community care the whole of the sample is used for investigation.

6. Clinical photography and conventional or digital video and audio recordings

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.

Staff should refer to the Lincolnshire Community Health Services NHS Trust Clinical Technology Standards Policy;

https://www.lincolnshirecommunityhealthservices.nhs.uk/application/files/3815/3434/0536/P_IG_29_Clinical_Technology_Standards_Policy.pdf

6.1 Recordings for education, publication or research purposes

When seeking consent for research, the clinician must give information in the same way as for other treatments, ensuring the patient is fully informed of the intended use.

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

If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients

must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

6.2 Patients who are temporarily unable to give consent to recordings

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

Sections 30 to 34 of the Mental Capacity Act 2005 govern the conduct of research involving patients who lack the capacity to consent. Any clinician proposing research in these circumstances must comply with these sections. Prospective researchers also have a legal duty to have regard to the Mental Capacity Act Code of Practice.

7. Training

Training is available on obtaining consent for Lincolnshire Community Health Services NHS Trust staff, covering both basic training on the law of consent, and training on any specific procedures used in this organisation and procedure specific training on consent for staff to whom the consent process is delegated and who are not capable of performing the procedure are provided via:-

- Staff induction
- Professional updates
- Procedure specific training is available via local lead clinicians or the Clinical Practice Education Team.

Those health professionals who themselves do not carry out specific procedures, but who provide information to patients as part of the decision making process, are required to act in accordance with their professional code of conduct, National Best Practice Guidelines and local Trust protocols.

8. Informed consent for research

The gaining of informed consent for research is an important starting point for all studies involving human subjects. There is a clear distinction between informed consent to research and informed consent to a clinical or therapeutic procedure. Most of the activities performed in the health care setting have a beneficial aim, even if the outcome is not proven. The aim of research is very much the same but with one main difference. The individual involved in research may not benefit personally and may even be inconvenienced. This is the main reason why there is greater emphasis placed on the strict guidelines for informed consent for research.

Once potential research subjects have received comprehensive information, which they understand, they should then be free to decide whether to participate in the

research or not. That decision should be their decision and their decision alone. The subject should be free to make that decision without any undue coercion from any other party.

9. Monitoring Compliance

Consent will be reviewed as part of the Lincolnshire Community Health Services NHS Trust records management audit included within the annual audit programme. The audit will be conducted within the local team as part of the 'Take Five' record keeping audit, and the results of the audit to be taken to the Lincolnshire Community Health Services NHS Trust the Quality Assurance Group on an annual basis. The Heads of Service will be responsible for the development of an action plan which will be monitored by the Quality Assurance Groups.

Minimum requirement to be monitored	**Process for monitoring e.g. audit**	**Responsible individuals/ group/ committee**	**Frequency of monitoring/audit**	**Responsible individuals/ group/ committee (multidisciplinary) for review of results**	**Responsible individuals/ group/ committee for development of action plan**	**Responsible individuals/ group/ committee for monitoring of action plan**
The organization has an approved and documented process for dealing with issues relating to consent	Quality Scrutiny Group	Clinical Governance Managers Quality Scrutiny Group	Monthly	Quality and Scrutiny Group Quality and Risk Committee	Clinical Governance and Risk Managers Quality Scrutiny Group	Quality Scrutiny Group Quality and Risk Committee

Appendix A

Twelve key points on consent: the law in England

When do health professionals need consent from patients?

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

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

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

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

Can children give consent for themselves?

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

Who is the right person to seek consent?

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

What information should be provided?

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

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

Does it matter how the patient gives consent?

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

also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusal of treatment

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

Adults who are not competent to give consent

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

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

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment, 2nd edition (2009)* from the NHS Response Line 08701 555 455 and at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

Appendix B
Current forms in use in this Trust- see attached

Consent form 1	Patient agreement to investigation or treatment
Consent form 2	Parent (or person who has parental responsibility) agreement to investigation or treatment for a child or young person
Consent form 3	Patient (or person who has parental responsibility) agreement to investigation or treatment (procedures where consciousness not impaired).
Consent form 4	Form for adults who are unable to consent to investigation or treatment
Consent form 5	Photography

LCHS

consent form 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

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

Patient's first names .....

Date of birth .....

Responsible health professional .....

Job title .....

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

Male Female

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

To be retained in patient's notes

Patient identifier/label

Name of proposed procedure or course of treatment (include brief explanation if

.....

.....**medical term not clear) .....**

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

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

.....

The intended benefits .....

.....

.....

.....

Unavoidable or frequently occurring risks

Any extra procedures which may become necessary during the procedure

▫ blood transfusion……

.....

▫ other procedure (please specify) ……

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

▫ The following leaflet/tape has been provided .....

This procedure will involve:

▫ general and/or regional anesthesia ▫ local anesthesia ▫ sedation

Signed_____ Date .. ..

Name (PRINT) ..... Job title .....

Contact details (if patient wishes to discuss options later) .....

Statement of interpreter (where appropriate)

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

Signed ..... Date .....

Name (PRINT) .....

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

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

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

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

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

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

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried**

.....
.....
.....**out** without further discussion. .....

Patient's signature ..... Date .....

Name (PRINT).....

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

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

Name (PRINT).....

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

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

Signed _____ Date.. .....

Name (PRINT) ..... Job title .....

Important notes: (tick if applicable)

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

Guidance to health professionals (to be read in conjunction with

consent policy) **What a consent form is for**

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

The law on consent

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

Who can give consent

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

When NOT to use this form

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

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

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do so under a Lasting Power of Attorney or as a court appointed deputy.

Information

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

LCHS

consent form 2

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

Patient details (or pre-printed label)

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

Patient's first names.....

Date of birth .....

Age .....

Responsible health professional .....

Job title .....

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

Male Female

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

To be retained in patient's notes
Patient identifier/label

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

.....
.....

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

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

explained: The intended benefits .....

Significant, unavoidable or

.....
.....
.....
frequently occurring risks

Any extra procedures which may become necessary during the procedure

▫ blood transfusion .....

.....
▫ other procedure (please specify) .....

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

▫ The following leaflet/tape has been provided .....

This procedure will involve:

▫ general and/or regional anesthesia ▫ local anesthesia ▫ sedation

Signed:…… Date……...

Name (PRINT) .....Job title .....

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

Statement of interpreter (where appropriate)

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

Signed ..... Date .....

Name (PRINT).....

Top copy accepted by patient: yes/no (please ring) Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page

2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

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

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

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

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

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

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

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

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

Name ..... Signature .....

Date.....

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

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

Signed_____ Date.. .……

Name (PRINT) ..... Job title ……

Important notes: (tick if applicable)

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

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

This form

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

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. If children are not able to give consent for themselves, some-one with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment.

Where a young person of 16 or 17 or a Gillick competent child under 16, refuses treatment, it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child. (Gillick v West Norfolk and Wisbech AHA (1986) AC 112).

As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance *Seeking consent: working with children.* Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

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

Information
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks.

In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent
See the Department of Health publications *Reference guide to consent for examination or treatment* and *Seeking consent: working with children* for a comprehensive summary of the law on consent also available at www.doh.gov.uk/consent or www.nice.org.uk/about/nice-communities/public-involvement/your_care

LCHS

consent form 3

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

Patient details (or pre-printed label)

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

Patient's first names.....

Date of birth .....

Responsible health professional .....

Job title .....

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

Male Female

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

To be retained in patient's notes

NHS Lincolnshire consent form 3 Patient/parental agreement to investigation or treatment (procedures where consciousness not impaired)

Patient identifier/label

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

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

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

.....

.....

explained: The intended benefits

.....

.....

Significant, unavoidable and frequently occurring risks

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

The following leaflet/tape has been provided .....

Signed: Date ..... .

Name (PRINT) ..... Job title .....

Statement of interpreter (where appropriate)

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

Signed .....Date..... .

Name (PRINT).....

Statement of patient/person with parental responsibility for patient I agree to the procedure described above.

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

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

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

Name (PRINT) .....Relationship to patient .....

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

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

Signed_____ Date .....

Name (PRINT) ..... Job title .....

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

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

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

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

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

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

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

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

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

The law on consent

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

LCHS

consent form 4

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

Patient details (or pre-printed label)

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

Patient's first names.....

Date of birth .....

Responsible health professional .....

Job title .....

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

Male Female

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

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

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

B Assessment of patient's capacity

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

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

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

C Assessment of patient's best interests

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

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

The treatment cannot wait until the patient recovers capacity because:

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

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer or supporter) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

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

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

Any other comments (including any concerns about decision)

Name..... Relationship to patient.....
Address (if not the same as patient.....

Signature ..... Date

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)
LI Yes LI No
Details:

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

Details:

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

Signature of health professional proposing treatment
The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their

knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.
Signature: _____ Date_____

Name (PRINT) .....Job title ……

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

Signature: Date .. ..

Name (PRINT) .....Job title ……

E The patient has an attorney or deputy

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

Signature of attorney or deputy

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

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

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

Name (PRINT) ..... Role……

Guidance to health professionals (to be read in conjunction with Consent Policy)

This form should only be used where it would be usual to seek written consent but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983 (Amended 2007)*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity to consent, but has made a valid advanced decision to refuse treatment that is applicable to the proposed treatment then you must abide by that refusal. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.dh.gov.uk/consent).

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

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005. More information about the Act is given in the Code of Practice **www.gov.uk/government/publications/mental-capacity-act-code-of-practice** Treatment can be given to a patient who is unable to consent, only if:

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

Capacity

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

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

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

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

Best interests
The Mental capacity Act requires that a health professional **must** consider all the relevant circumstances relating to the decision in question, including as far as possible considering:

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

When determining what is in the person's best interests' a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.

The Act also requires that, as far as possible, health professionals must consult other people, if it is appropriate to do so, and to take into account of their views as to what would be in the best interest of the person lacking capacity as someone to be consulted and anyone engaging in caring for patient and their family and friends.

Independent Mental capacity Advocate (IMCA)

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

Lasting Power of Attorney and Court Appointed Deputy

A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests.
The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no way of settling the matter in the best interests of the person lacking capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it the deputy rather than the health professional who makes the treatment decision and the deputy must make decisions in the patient's best interests.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions

affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Cases involving:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- all other cases where there is a doubt or dispute about whether a particular treatment will be

in a person's best interest (including cases involving ethical dilemmas in untested areas)

should be referred to the Court for approval. The Court can be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advanced decision to refuse treatment.

LCHS

consent form 5

Form for Photography

Patient details (or pre-printed label)

I have no object to myself/child being videoed/photographed.

I do/do not agree to either video/photographs being used for publication or training purposes.

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

Patient's first names.....

Date of birth .....

Responsible health professional .....

Job title .....

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

Male Female

Special requirements .....

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

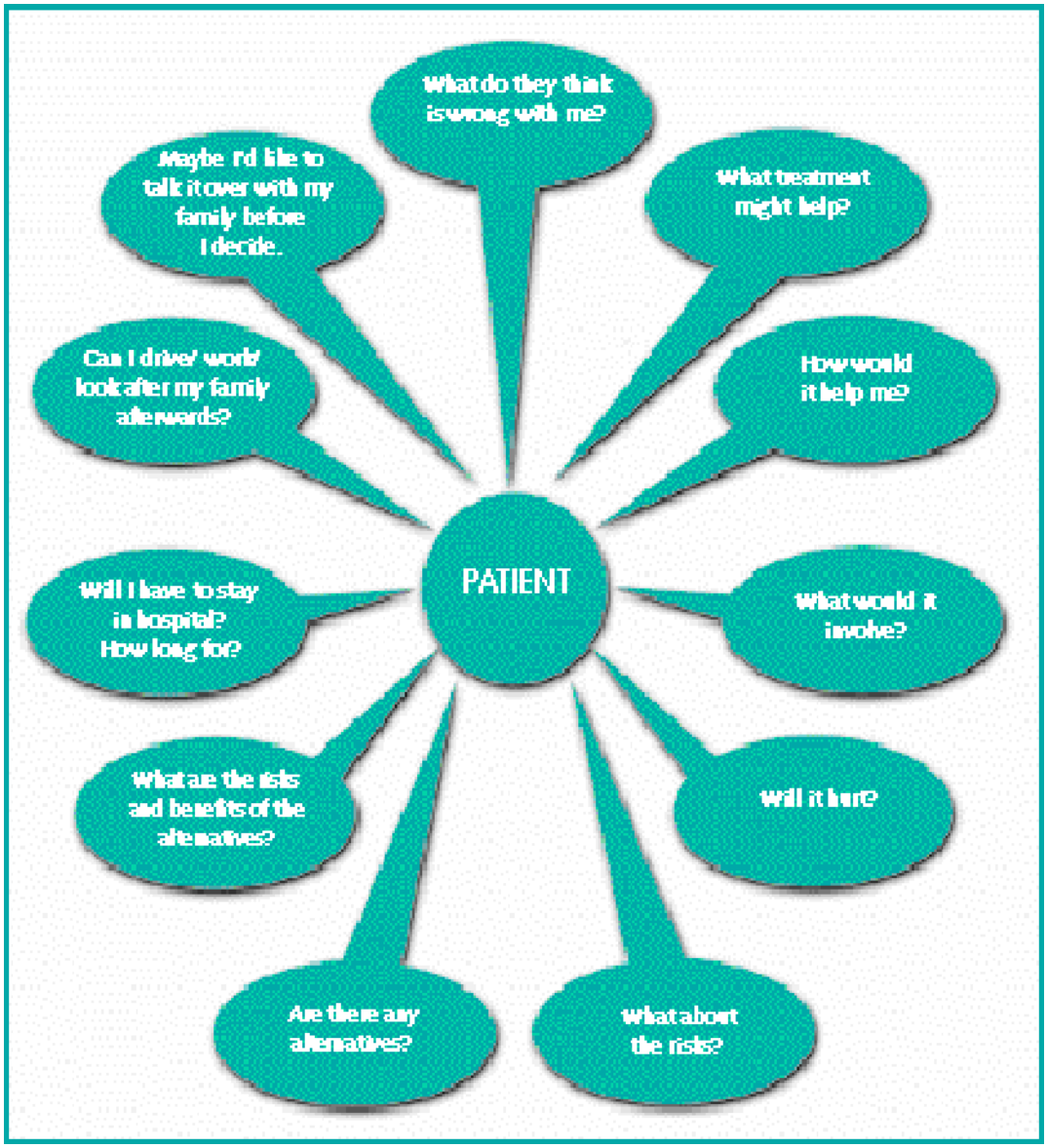
Signature_____ Date .. ..

Name (PRINT) ..... Job title .....

To be retained in patient's notes

Appendix C

Seeking consent: remembering the patient's perspective



Appendix D

What is Gillick competency? What are the Fraser guidelines?

Written and compiled by the NSPCC Safeguarding Information Service (December 2009)

When deciding whether a child is mature enough to make decisions, people often talk about whether a child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. This factsheet briefly explains the meaning of these terms.

What do 'Gillick competency' and 'Fraser guidelines' refer to?

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-yearolds
without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

In 1982 Mrs Victoria Gillick took her local health authority (West Norfolk and Wisbech Area Health Authority) and the Department of Health and Social Security to court in an attempt to stop doctors from giving contraceptive advice or treatment to under 16-year-olds without parental consent.

The case went to the High Court where Mr Justice Woolf dismissed Mrs Gillick's claims. The Court of Appeal reversed this decision, but in 1985 it went to the House of Lords and the Law Lords (Lord Scarman, Lord Fraser and Lord Bridge) ruled in favour of the original judgement delivered by Mr Justice Woolf:

"...*whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent."*

Fraser Guidelines

Please follow the Fraser Guidelines and complete the checklist below in all cases.

The young person signing this form must be able to understand the advice given and have sufficient maturity to understand all implications* ☐

The young person cannot be persuaded to inform his/her parent/carer that advice on contraception has been sought. ☐

The young person is very likely to have sexual intercourse with or without contraceptive advice or treatment. ☐

The young person's mental or physical health or both might suffer unless he/she receives contraceptive advice/treatment. ☐

It is in the young person's best interest to receive the advice or treatment even without parental/carer consent. ☐

Is the worker satisfied that these guidelines are being met? ☐

*Staff must work within these guidelines to ensure that the young person is able to understand the contraceptive choices available and their consequences. This includes the implications and risks of sexual
relationships.

Signature of Worker: ……..

Print Name: …….

Date: …….

I understand that information about me will be stored in accordance with the Data Protection Act
1989.

Signature of Young Person: …….

Print Name: …….

Date: …….

Name of Policy/Procedure/Function*	
Policy for Consent to examination or treatment	
Equality Analysis Carried out by:	**Gemma Cross**
Date: November 2018	
Equality & Human rights Lead:	**Rachel Higgins**
Director\General Manager:	**Susan Ombler**

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	This policy aims to ensure that health professionals are able to comply with the guidance for consent and examination. The document is primarily concerned with healthcare; however 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 client.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	No		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Gemma Cross		
Date:		November 2018		

Section 2

Equality analysis

Title:
Relevant line in:

What are the intended outcomes of this work? *Include outline of objectives and function aims*
Who will be affected? *e.g. staff, patients, service users etc*

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.*
What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*
Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*
Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

Engagement and involvement

Was this work subject to the requirements of the Equality Act and the NHS Act 2006 (Duty to involve) ? (Y/N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the policy or programme proposals?

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

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.

Eliminate discrimination, harassment and victimisation

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Advance equality of opportunity

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Promote good relations between groups

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

What is the overall impact?

Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?

Addressing the impact on equalities

Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*
Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

For the record
Name of person who carried out this assessment:
Date assessment completed:
Name of responsible Director/ General Manager:
Date assessment was signed: