Lancashire Care NHS
NHS Foundation Trust

CONSENT TO EXAMINATION AND TREATMENT POLICY

POLICY REFERENCE NO	CL002
DATE RATIFIED *(this version)*	March 2015
NEXT REVIEW DATE	October 2018
APPROVED BY	Clinical Policy Council
ACCOUNTABLE DIRECTOR	Executive Director - Director of Nursing & Medical Director
POLICY AUTHOR	Trust Solicitor Mental Health Legal Officer MCA Practitioner Clinical Policy & Compliance Lead

Policy Statement/Key Objective:

To ensure that care is provided in partnership with patients respecting their preferences and choices.
Staff will be informed of their responsibilities with regard to obtaining valid consent for all treatments, procedures and investigations.

Executive Summary

Subject	Consent to examination and treatment	
Applicable to	All health care staff who provide clinical care	
Key Policy Issues	To ensure that care is provided in partnership with patients respecting their preferences and choices Staff will be informed of their responsibilities with regard to obtaining valid consent for all treatments, procedures and investigations.	
Original Issue Date	March 2002	
Issue date *(this Version - including any minor amendments)*	May 2015	
Dates Policy Reviewed *(include all previous dates of review)*	March 2004, Feb 2005, June 2011, March 2013, Minor amendment May 2015, Minor Amendment Oct 2015	
Next Review Date	March 2018, extended until October 2018	
Policy written by *(state title only)*	Trust Solicitor Mental Health Legal Officer MCA Practitioner Clinical Policy & Compliance Lead	
Policy Lead *(state title only)*	Director of Nursing and Medical Director	
In Consultation with	Trust Solicitor & Legal Team MCA Practitioner Hempsons – Legal Advisors to the Trust	
Monitoring Arrangements	See Section 7	
Approved by *(state group)*	Clinical Policy Council	
Authorised by *(state senior accountable person e.g. Network or Clinical Director)*	Director of Nursing	
Related Procedural Documents	CL026&26a Physical Health care Policy and Procedure CL027 Clinical Record Keeping Policy CL039 Guidance on Preparing an Advanced Statement CL046 &46a Electro Convulsive Therapy Policy & Protocols. CL048 Mental Capacity Act Implementation Policy MHA policies and procedural documents	
Related CQC Lines of enquiry *(check all that apply)*	Safe ☒	Caring ☒
	Effective ☒	Responsive ☒
	Well-led ☒	

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1.0 Introduction

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person.

This principle reflects the right of patients to determine what happens to their own bodies and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by the patient and action by their professional body.

A very recent significant change in informed consent case law from the reasonable doctor standard to what might be termed a reasonable patient standard; the importance of providing patients with accurate, up to date information about their upcoming medical or surgical procedure is now greater than ever.

2.0 Scope

This document is relevant to all LCFT health care staff (including students) who carry out interventions including: assessment, examination, providing treatment or personal care for a patient. It covers the entire range of interventions from procedures and treatments which involve serious consequences to assistance with basic care needs.

3.0 Duties

The Chief Executive
Has overall accountability for ensuring correct patient consent is taken. The responsibility for ensuring correct patient consent procedures are followed is delegated to the Medical Director. Where nursing or Allied Health Professionals take consent, the responsibility for ensuring correct patient consent procedures are followed is delegated to the Director of Nursing.

The Medical Director
The Medical Director is the professional lead for medical staff within the Trust and as such will promote and monitor compliance with the Trust Consent to Examination and Treatment Policy.

The Director of Nursing
Is the professional lead for nursing and has overall professional regard for Allied Health Professional staff within the Trust and as such will promote and monitor compliance with the Trust Consent to Examination and Treatment Policy.

Consultant Medical Staff
All medical consultants will ensure that correct patient consent is taken. Where they delegate consent taking to another member of their team, they will ensure that team members receive appropriate training and that team members are competent to take consent.

Clinical Directors
Are responsible for clinical standards within their Network and as such will promote and monitor compliance with the Trust Consent to Examination and Treatment Policy.

Health care staff (including students)
All staff have a responsibility for ensuring that the principles outlined within this document are universally applied. This policy applies to all members of staff who are involved in taking consent.

4.0 Definitions

Mental Capacity is the ability of an individual to make a particular decision for him/herself at the relevant time. It is decision specific. Someone who is unable to do one or more of the following will lack the capacity to make the particular decision at that time: -

- understand information given to them to make a particular decision
- retain that information long enough to be able to make the decision
- use or weigh up the information to make the decision
- communicate their decision by any means

- **The Mental Capacity Act (2005)** is the legal framework which governs the care and treatment provided to people who lack capacity to make decisions for themselves.
- **An Advance Decision** is a decision to refuse treatment which is made at a time when the person has capacity to make the decision and will come into effect in the event that the person loses his/her capacity. If the Advance Decision relates to life-sustaining treatment, it must be in writing, witnesses and explicitly state that the Advance Decision applies to life-sustaining treatment.
- **Lasting Power of Attorney** (LPA) is a form of legal authority that one person (doner) gives to another person (donee). The LPA allows the donee to make decisions on behalf of the doner the event that s/he loses capacity.
- **The Court of Protection** is the specialist Court which deals with the affairs of adults who may lack capacity to make decisions for themselves.
- **The Mental Health Act (1983)** is the legal framework which applies to people receiving care and treatment for mental health problems. The Act also contains the powers which enable some patients to be compulsorily detained in hospital and given treatment for mental disorder without consent.
- **Parental Responsibility** is the power to make decisions in relation to a child, including decisions about whether or not a child should receive medical treatment.
- **Zone of Parental Control**
  A concept introduced in the Mental Health Act revised Code of Practice which suggests that certain decisions cannot be made by the person with parental responsibility. It would always be advisable to seek advice from the Trust Solicitor for any cases which may engage the Zone of Parental Control.

- **Gillick Competence** is the test applied to help assess whether a child has the maturity to make his/her own decisions and whether s/he can understand the implications of her decision. There is no specific age when a child becomes competent to consent to treatment; it depends on the individual child and the complexity of the treatment being proposed.

5.0 The Policy

The Department of Health, General Medical Council and other regulatory and professional bodies have published guidance documents on consent which set out the current law and good practice. A list of these documents can be found at section 8.0 of this policy. LCFT employees and students should be aware of the guidance that relates to their own professional bodies and practice areas.

5.1 Valid Consent

For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. If the person does not know what the intervention entails, any consent to treatment they have provided will not be valid.

- **Voluntary**: the decision to consent or not consent to treatment must be made alone, and must not be due to pressure by a health care professional, friends or family.
- **Informed**: the person must be given full information about what the treatment involves, including the benefits and significant possible adverse outcomes or risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead. Health care professionals should not withhold information just because it may upset or unnerve the person

"The doctor is... under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a ***reasonable person in the patient's position would be likely to attach significance to the risk****, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it".* MDU, 16th March 2015

- **Capacity**: the person must be capable of giving consent, which means they understand the information relevant to the decision, retain that information, use or weigh that up as part of the decision making process and communicate the decision by any means.

5.2 Who can give Consent?

- A patient aged 16 years or over with capacity to provide consent for the intervention.
- A child under 16 years with sufficient understanding and intelligence to understand fully what is being proposed. (In certain, very limited circumstances, a competent child's refusal to consent to treatment may be

over-ridden by the person or organisation with Parental Responsibility for the child).
- Where a child is not Gillick competent, the person or organisation with Parental Responsibility.
- An individual who has been given the authority either under a Lasting Power of Attorney or as a Deputy appointed by the Court of Protection to make decisions on behalf of the incapable patient.

5.3 How to obtain Consent

Consent should be obtained by the health care professional directly responsible for the intervention being undertaken, such as the nurse arranging a blood test, the nurse-prescriber prescribing new medication or the consultant planning the treatment. Consent is a continuous process rather than a single event and should be rechecked.

Consent can be given:

- verbally
- non-verbally, for example, raising a hand to indicate they are happy for a nurse to take a blood sample
- in writing, by signing a consent form

If someone is going to have major medical intervention, such as an operation, their consent should be obtained well in advance so they have sufficient time to consider information about the procedure and ask questions.

To consent to a treatment or procedure, the person needs to be fully informed about the treatment and understand why it is considered necessary including:

- the type and extent of the treatment being proposed
- the advantages and disadvantages of the treatment
- any alternative treatments that might be available
- any significant possible adverse outcomes or risks and side-effects and make a record of the information given.
- the person's right to change their mind and withdraw consent at any time.

Health care professionals should not withhold information just because it may upset or unnerve the person. Even if the person specifically requests not to be told about the extent or likely outcome of their condition, the health care professional has a duty to provide the patient with:

- a basic overview of their condition
- the likely outcome of their condition
- their treatment options

Treatment given to a capable person without his/her valid consent is unlawful and could give rise to:

- Criminal proceedings
- A claim for damages
- Disciplinary proceedings either internal or with a regulatory body

5.4 Refusal to Consent

If the person has capacity and makes a voluntary and informed decision to refuse a particular treatment, or decides to withdraw consent, their decision must be respected. This is still true even if their decision would result in their death, or the death of their unborn child. The health care practitioner should ensure that his/her advice to the patient about the consequences of refusing treatment is fully documented in the patient's notes.

Where a competent adult refuses to consent to treatment, it is particularly important to ensure that they understand the implications and risks of their decision. The refusal does not absolve practitioners from their duty of care to the person and advice should be given about alternative forms of treatment. The clinician's obligation is to make their knowledge available to the person who has to make a decision. The person will not always choose the option the health care professional expects.

5.5 Documenting Consent

Whilst consent must always be obtained, it is not always necessary to document a patient's consent to routine and low risk interventions such as providing personal care or taking a blood sample.

For more involved interventions 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 is advisable to document the key elements of your discussion, any specific request by the patient, any written/audio information that you have given to the patient and details of any decisions that were made by the patient in his/her clinical notes.

It is good practice to obtain written consent from the patient if the intervention involves significant risks, side-effects or complications. Individual services within LCFT may have devised Consent forms which are specific to the more complex interventions that the service provides. Your Service Manager will be able to inform you whether or not Consent Forms are used in your particular service and if so, for which intervention. Where a service wishes to use a consent form to record written consent and has not yet developed a form, template forms can be found via the links below. Any consent forms that services have developed or may develop in the future must be approved by either the Trust Solicitor or the Mental Health Legal Officer phil.hesketh@lancashirecare.nhs.uk.

- Form 1 for people aged 16 years and over with mental capacity and people under 16 years of age who are Gillick competent
- Form 2 for a child under 16 years of age who is not Gillick competent
- MCA Mental Capacity Assessment form for those people who lack capacity to consent

5.6 Use of Interpreters

This Trust is committed to ensuring that patients receive the information they need and are able to communicate appropriately with health care staff. The services of an interpreter may be required if the patient is unable to speak English or has hearing difficulties. It is not appropriate to use children to interpret for family members.

Interpreter Services: must always be used in situations where there is doubt about the communication between patients and providers/clinicians. In the first instance, contact the telephone interpreting service for an initial communication by telephone, whilst face-to-face interpretation is arranged. See the LCFT intranet Equality and Diversity resource page: Sourcing Interpreters and Translation

Using adult family members and friends as interpreters:

This is inappropriate and carries the risk of the patient misunderstanding what is being said to them, which reduces their opportunity to make an informed decision about their health care, which could result in the patient receiving inappropriate health care/treatment. This clearly is a risk to patient confidentiality and leaves the individual patient, practitioner and the Trust at risk.

5.7 Adults who lack capacity (the incapable patient)

(*see also related document CL048 Policy for the implementation of the Mental Capacity Act and obtaining authorisation for deprivation of liberty*)

A person aged 16 or over is presumed in law to be competent to give consent for their own treatment and associated procedures unless it is established that they lack capacity to give consent.
The Mental Capacity Act 2005 (MCA 05) defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary. A person lacks capacity if:

- they have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and
- that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made
- they are unable to make a decision if they cannot understand, retain , use or weigh up the information and communicate the decision

The level of capacity a person must possess will vary according to the nature of the decision. For example a greater level of capacity will be needed to consent to complex interventions or decisions which involve serious consequences compared with capacity required to consent to examination of a pressure ulcer.

A patient's capacity may fluctuate over time therefore it is necessary to assess capacity at the time consent is required. It is good practice for a person's capacity to be kept under constant review.

A mental disorder does not necessarily mean that a person lacks capacity. A person detained under the Mental Health Act (MHA 1983) might remain capable so that consent will still be required before any treatment is given. Even if the treatment is for a mental disorder and can be given to the patient against their wishes, the patient should be given opportunity to consent

It is the practitioner who is in charge of the intervention that is responsible for making sure all the consent requirements are fulfilled. Therefore it is this person who should also assess the person's capacity to consent.

In certain circumstances an Independent Mental Capacity Advocate (IMCA) must be instructed and that role would fall to the decision maker. However an IMCA would only engage if the person was 'unbefriended' (no family member or others to consult with) and in the following circumstances

a) Where serious treatments are being considered. b) Patient will be in hospital longer than 28 days. c) Accommodation move to care home for more than 8 weeks.

Where the above criteria are met, an IMCA must be instructed.

If there are doubts or disagreements about a patient's capacity that cannot be resolved, seek advice from the Trust Solicitor. In some cases, the matter may need to be referred to the Court of Protection.

5.7.1 Lasting Power of Attorney [1]

A Lasting Power of Attorney (LPA) is a legal document by which one person gives someone else the power or authority to make decisions about them. The person that creates the LPA is called the 'donor' and the person to whom the power is given to is called the 'attorney' or the 'donee.'

The decisions an attorney/donee can make under a LPA are often about the donor's property and finances, but they can also relate to their welfare and health care. It is important to check the scope of the attorney/donee's authority before relying on their decision. The scope of the authority will be described in the LPA. It will either be a general authority allowing the attorney to make wide-reaching decisions about the donor's health and welfare or it will be limited to specific matters.

If you are caring for or treating a patient who has an LPA, you should ask to see the formal LPA document and ensure that a copy is included within the patient's clinical records.

In order to make a LPA, a person must be at least 18 years of age and capable;

(MCA 2005 s 9.10.11)[1]

A person can nominate more than one attorney. A donor can give full (general) powers or limit the scope of decisions that an attorney/ donee can make on his/her behalf;
Having created a LPA, a donor may revoke it, but only if they still have the capacity to do so.

In order to be valid, a LPA must be (a) in a particular form and (b) registered with the Office of the Public Guardian. An attorney/donee under a LPA can only make welfare decisions when the donor lacks (or the attorney reasonably believes him to lack) capacity. When making welfare and health decisions about the donor, an attorney/donee must do so in the donor's best interests. If you have any concerns or doubts about the validity of an LPA, you can refer the matter to the Office of the Public Guardian.

5.7.2 Court Appointed Deputy

The Court of Protection has the power to nominate a Deputy to make decisions on behalf of people who lack capacity. The Court will state what decisions the Deputy has the power to make and these will be set out in a Court Order.

It is the responsibility of the Court appointed Deputy to notify health care providers that s/he has been appointed and to explain the scope and nature of their authority.

If you are providing care or treatment to an incapable person who has a Court appointed Deputy, ensure that a copy of the Court Order which sets out the scope of the Deputy's authority is included in the patient's clinical records. You should read the Court Order carefully to ensure that the Deputy has the authority to make the decision in question.

The Office of the Public Guardian is responsible for supervising Deputies.

5.7.3 Advance Decisions

A capable person may give or withhold their consent to medical treatment. That is so whether the treatment is to be given to the person now or in the future.

An Advance Decision is a decision made at the time when the patient has capacity to refuse health care treatment in the event that s/he loses capacity in the future. Provided that the Advance Decision is valid and applies in the circumstances that exist, an Advance Decision is binding.
In order for an AD to be valid a person must be capable when it is made and at least 18-years of age at the time the AD was made.

An Advance Decision:

- may only refuse health care treatment. It cannot be used to compel treatment;
- must specify the treatment that is refused (even if it does so in lay terms);
- may limit the circumstances in which it is to apply;
- will only apply when the person making it lacks capacity

An Advance Decision would no longer be valid if:

- It was withdrawn by the maker while still capable
- the maker subsequently made an LPA giving an attorney authority to consent or refuse health care treatment unless the maker limited the power of the LPA not to overrule the Advance Decision.

An Advance Decision can be made orally unless it relates to life-sustaining treatment. It is good practice for a practitioner to make an entry within the patient's clinical records if the patient indicates that s/he wishes to make an Advance Decision.

Special rules apply to an Advance Decision to refuse life-sustaining treatment. The rules are that the Advance Decision:

- must be in writing;
- must contain a statement by the maker that it is to apply to that treatment even if their life is at risk;
- must be signed, either by (a) the maker or (b) someone else, in the maker's presence and by their direction;
- the signature must be witnessed.

5.7.4 Advance Statement

An Advance Statement is a statement of preference about how the person would like to be treated. It is different to an Advance Decision which relates to a decision to refuse treatment. An Advance Statement is not legally binding. However information about a person's wishes with regard to health and social care should be considered in their best interest if the person becomes incapable and it is good practice to make an entry in the patient's clinical records of their treatment preferences.

5.8 Children and Young People

The law relating to Children and Young People is complex. Practitioners are encouraged to consult guidance listed at section 8 References which provide a more comprehensive account of the legal position than can be offered within the limits of this Trust-wide policy. If, after consulting the guidance and senior colleagues, practitioners have concerns about particular cases, they should ask their Service Manager to obtain legal advice from the Trust Solicitor.

5.8.1 Young People Aged 16–17

The law presumes that 16 and 17 year olds have capacity to make decisions about their own health care and treatment. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, in certain, very limited circumstances, the **refusal** of a capable young person (aged 16–17) may be overridden by either a person with parental responsibility or a court.

In order to establish whether a young person aged 16 or 17 has the capacity to consent to the proposed intervention, the criteria set out in the Mental Capacity Act as for adults should be used If however they are unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, then consideration should be given to whether they satisfy the Gillick competency test. It may be unclear whether a young person lacks capacity within the meaning of the Act. When in doubt, seek advice from senior colleagues, Safeguarding or the Trust Solicitor.

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If the 16/17-year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process provided that the young person consents to their information being shared.

5.8.2 Children under 16 – The Concept of Gillick Competence

There is no particular age when a child becomes competent to consent to treatment; it depends both on the child and on the seriousness and complexity of the treatment being proposed. The concept of Gillick competence is said to reflect 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 (competency) to consent should be assessed carefully in relation to each decision that needs to be made.

In some cases, a child's mental or emotional 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.

Where advice or treatment relates to sexual health services, the health care professional should encourage the child to inform his or her parent(s), or allow the medical professional to do so. If however the child cannot be persuaded, advice and/or treatment should still be given if the health care professional considers that the child is very likely to begin or continue to have sexual intercourse with or without advice or treatment, and that unless they receive the advice or treatment then the child's physical or mental health is likely to suffer.

Although a child or young person may have the capacity to give consent, this is only valid if it is given voluntarily. This requirement must be considered carefully. Children and young people may be subject to undue influence by their parent(s), other carers or a sexual partner (current or potential), and it is important to establish that the decision is that of the individual him or herself.

Where a child under the age of 16 is not Gillick competent, consent can be given on their behalf by any one person or organisation with parental responsibility or by the Court. As is the case where patients are giving consent for themselves, those giving consent on behalf of child patients must have the capacity to consent to the

intervention in question, be acting voluntarily and be appropriately informed. The power to consent must be exercised according to the 'welfare principle': that the child's 'welfare' or 'best interests' must be paramount. It is good practice to involve the child as much as possible in the decision-making process.

5.8.3 Refusal of Treatment by a Competent Child or Young Person

Where a young person of 16 or 17 who has the capacity to consent to treatment or a child under 16 who is assessed as Gillick competent, refuses treatment that could save his/her life or prevent a serious deterioration in his/her health, it may be possible to override his/her refusal.

The law on overriding a child or young person's competent refusal to accept treatment is complex. Legal advice should be obtained by practitioners if they consider that treatment would be in the best interests of a child or young person who is refusing that treatment.

5.9 Patients Detained under the Mental Health Act

Introduction- A general rule is that clinical staff must understand where the authority to treat a patient is coming from. This rule applies even if the patient is detained under the Mental Health Act 1983 or informal or at home.
Some authority to treat under the Mental Health Act also requires addition certification from a second opinion doctor (SOAD) before the authority is lawful.

Since 2007 the Mental Capacity Act has an important part to play within the rules of consent under the MHA.

The parts of the Mental Health Act that relate to consent can be found in Part IV and Part 4A but just as importantly this policy emphasises the need for all staff to embrace the guiding principles found in chapter 1 of the Mental Health Act 1983, Code of Practice when considering consent under the MHA.

Part IV and Part 4A of the MHA lay down the statutory rules for consent and giving treatment under the Act. However some of the shorter sections are outside of the remit of Part IV or Part 4A. This means that patients on short sections or in the community not recalled and who have capacity cannot be treated under the MHA without the patient's valid consent or other lawful authority.
For the purposes of this part of the policy, part 4 refers to all 'detained patients' except sections 4, 5, 35, 37(4), 45A(5), 135 and 136.
Part 4 does not apply to conditionally discharged patients or SCT patients not recalled to hospital. Part 4 also has special provisions regarding ECT to under 18s (s58A) and section 57 treatments that apply to both detained and informal patients.
Part 4A provisions apply to Supervised Community Treatment patients except when they are recalled to hospital.
Clinical staff of the Trust must bear in mind that the giving of treatment to informal patients or patients on the shorter sections named above without proper authority could be constituted as an assault and result in legal action against individuals or the Trust.

If the patient is 16 or over and lacks capacity to consent, then treatment may be given under best interest under the Mental Capacity Act. In any case where the Mental Capacity Act is being used, it is essential to assess capacity and follow the MCA code of practice best interest checklist before undertaking treatment. Clear records of assessment and best interest process must be kept. See MCA policy for guidance.

As with advocacy under the MCA above, the Trust will always support the use of advocacy as a mean to supporting the rights of patients and ensuring they 'have a voice'. Since 2009 statutory advocates must be instructed under the MHA where the criteria is met. The Trust encourages this under its Open Advocacy Protocol (MHA024/1). The appropriate advocate under the MHA would be an Independent Mental Health Advocate (IMHA).

Medical Treatment under the Mental Health Act 1983- Medical treatment under the Act has a broad definition and includes the following 3 key parts-

1. **nursing, psychological interventions, habilitation, rehabilitation and care**. This means that subject to the requirements of section 57, 58 and 58A, a broad range of treatment can be given to detained patients for their mental disorder without consent under Part 4.

2. Section 63 clarifies this position in stating that treatment is given under the direction of the Approved Clinician in charge of the treatment. In Lancashire Care NHS Foundation Trust, the Approved Clinician will be the nominated (Responsible Clinician) Consultant Psychiatrist for the patient.
3. However that treatment can only be given if the purpose of that treatment is to alleviate, or prevent a worsening of, a patient's mental disorder, or one or more of its symptoms or manifestations. (s145) If the treatment does not relate to mental disorder in some way it cannot be authorised under the MHA. It is the responsibility of the Approved Clinician to be satisfied the treatment is covered by the MHA.

Where the patient who is informal or on a short term section and has capacity and is not consenting, then there is no statutory authority to treat.

Emergency treatment without consent (medical necessity) or not covered by the MCA would be under common law only. Clinical staff should take legal advice in these circumstances if the treatment is believed to be important. During office hours contact the Trust solicitor Helen Smith at helen.smith@lancashirecare.nhs.uk telephone 07904663182. Out of office hours contact the network specific senior manager on call.
Where the patient is under 18, people with parental responsibility may give consent if the treatment is within the zone of parental control. See chapter 36 MHA Code of Practice. In section 131, the Act refers to informal young adults (16/17) who have capacity and do not consent to admission. People with parental responsibility cannot override this decision if the person is being admitted for the

treatment of mental disorder. Similarly someone with PR cannot override a 16/17 year old with capacity who agrees to admission. Subsequent treatment could be consented to by the 16/17 year old. If a 16/17 year old is not consenting to informal admission and treatment detention under the MHA must be carefully considered.

Mental Capacity under the MHA 1983

Prior to the Mental Capacity Act 2005 capacity was defined in common law as an understanding of the nature, purpose and likely effects of the treatment. Since the Mental Capacity Act, capacity and the assessment of capacity is defined in sections 2 and 3 of that Act. Part 4 of the Mental Health Act does not specifically refer to the Mental Capacity Act but the new Code of Practice and CQC state that any reference to capacity must be as per the Mental Capacity Act. The newer Part 4A of the Mental Health Act (treatment in the community) specifically states that any reference to capacity must be as per the Mental Capacity Act.
Capacity therefore only refers to people aged 16 or over and cannot be used for children. The common law standard of 'Gillick Competence' is the test to be used for children under 16.

See Appendix 1 for further details of consent under the MHA.

5.10 Research: Tissue

The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) is set out in the Human Tissue Act 2004.

At present, this Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during procedures to be used for education or research purposes. Any research undertaken must be compliant with the standards set out in the Research Governance Framework for Health and Social Care (DH 2005) and the researcher must obtain ethical approval and Trust approval prior to commencement of the study. Patients must also be able to record any objections to particular uses or use of particular tissues.

Explicit consent is not necessary for public health surveillance using the unlinked anonymous method.

Section 251of the NHS Act 2006 enables the use of confidential patient information in the interest of patients or the wider public good. Powers under section 251 can provide a basis in law for patient identifiable information to be disclosed to specified bodies, (e.g. cancer registries), for specific purposes. In such cases the Trust requires that this is endorsed by and support obtained from the National Information Governance Committee which is part of the independent statutory body the Care Quality Commission.

5.11 Clinical Photography and Conventional or Digital Video Recordings

Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as x-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that

they make clear in advance if any photographic or video recording will result from that procedure.

Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. In such cases you must explain to the patient why a recording would assist their care, what form the recording will take and that it will be stored securely. When seeking consent to make a recording, explain that any secondary use e.g. audit, will only be done in an anonymised or coded form.

The one exception to this principle is where photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be identified, 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 there is any risk that the patient might be identified. 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.

6.0 Training

Training with regards to the implementation of this policy will be provided by the Trust on 5 levels.

- Level 2 Mental Capacity Act 2005
- Consent to treatment for all clinical staff
- Consent and the Mental Health Act 1983
- Consent in specialist areas of the Trust
- E Learning (This is currently limited to the MHA at level 1)

The Trust Training Matrix proposes that 'consent' should be mandatory training and attended every 3 years. This includes all qualified staff and Health Care Assistants in mental health who have contact with patients where decisions about examination, treatment, personal care, finances etc. is required.

There are regular sessions at level 2 for MCA available on a monthly basis. The Mental Health Legal Officer also provides training on consent on request from managers and team leaders.

7.0 Monitoring

Standard	Time frame/ format	How	Whom
Staff who carry out interventions including: assessment, examination, providing treatment or personal care for a patient will be appropriately trained regarding consent.	Initially at induction then as per the Trust's mandatory training matrix appropriate to role	The education and training department will be responsible for administrating the promotion, attendance record at sessions and will provide contemporaneous feedback to managers about training attendance data. ESR will be populated with a record of individual staff training status.	Education and training lead. Line manager to check individual staff training records during supervision / PDR
Only service approved forms or approved generic forms will be used for interventions that services have deemed require written consent must be obtained	For each intervention that has been categorised by the service lead as requiring written consent	During QSEEL assessment of patient records During any agreed service clinical record keeping audit	Team leader Nominated auditor
Patients will receive sufficient information and advice from staff who provide care to enable them to make an informed decision	At every intervention	All patient reported incidents and feedback with regard to consent will be investigated and followed up.	Team leaders

8.0 References

Department of Health (2009) Reference guide to consent for examination or treatment (2nd edition)
Mental Capacity Act 2005 Code of Practice
Mental Health Act 1983 Code of Practice (2015)
https://www.gov.uk/**government**/.../**research**-**governance**-**framework**
GMC Consent: Patients and doctors making decisions together (June 2008)
GMC 0-18 years: guidance for all doctors
www.gmc-uk.org/guidance
http://www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=11930
MDU Guidance and Advice

Appendix 1
Consent and the Mental Health Act 1983

Introduction

A general rule is that clinical staff must understand where the authority to treat is coming from. It may simply be from the patient with capacity (common law). If the patient is not consenting, the authority may be from the Mental Health Act. Remember that some authority to treat under the Mental Health Act also requires addition certification from a SOAD before the authority is lawful. If the patient lacks capacity to consent then the Mental Capacity Act may give the authority to treat.

Clinical staff of the Trust must bear in mind that giving treatment to informal patients or patients on the shorter sections without proper consent could be constituted as an assault and result in legal action against individuals or the Trust.

If the patient is over 16 and lacks capacity to consent, then treatment may be given under the Mental Capacity Act. Where the Mental Capacity Act is being used, it is essential to assess capacity and follow the MCA code of practice and 'best interest' checklist before undertaking treatment. Clear records of capacity assessment and the best interest process must be kept. See MCA policy for guidance.

Where the patient who is informal or on a short term section and has capacity and is not consenting, then there is no lawful authority to treat.

Emergency treatment without consent and not covered by the MHA or MCA should only be considered after taking legal advice. Where there is some doubt of capacity and in life saving circumstances emergency treatment can be given until the capacity issue is resolved or resolved by a court of law.

Where the patient is under 18 and lacks capacity/competence, people with parental responsibility may give consent if the treatment is within the zone of parental control. Be aware of informal young adults (16/17) who have capacity and do not consent to admission, consideration of detention under the MHA may have to be considered as people with parental responsibility cannot override this decision if person is being treated for mental disorder.

Capacity under the MHA Prior to the Mental Capacity Act 2005 capacity was defined in common law. Since the Mental Capacity Act, capacity and the assessment of capacity is defined in section 2 and 3 of that Act.

Part 4 of the Mental Health Act does not specifically refer to the Mental Capacity Act but the MHA Code of Practice and CQC state that any reference to capacity must be as per the Mental Capacity Act. See MHA Code of Practice chapter 24.

The newer Part 4A of the Mental Health Act (treatment in the community) specifically states that any reference to capacity must be as per the Mental Capacity Act.

Capacity therefore only refers to people aged 16 or over and cannot be used for children. The common law standard of 'Gillick Competence' is the test to be used for children under 16.

Medical Treatment under the Act - Medical treatment under the Act is a

broad definition and includes nursing, psychological interventions, habilitation, rehabilitation and care. This means that subject to the requirements of section 57, 58 and 58A, a broad range of treatment can be given to detained patients for their mental disorder without consent under Part 4. (section 63)
Section 63 also states that treatment is given under the direction of the Approved Clinician in charge of the treatment. In Lancashire Care NHS Foundation Trust, the Approved Clinician will be the nominated (Responsible Clinician) Consultant Psychiatrist for the patient.
However that treatment can only be given if the purpose of that treatment is to alleviate, or prevent a worsening of, a patient's mental disorder, or one or more of its symptoms or manifestations. MHA (s145) also Code of Practice chapter 23.

Special Rules under Part 4
Section 57 Section 57 currently relates to two treatments, neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive. Both of these treatments are rare and the section applies to all patients both detained and informal. The main requirements are that only patients who have capacity to consent and in fact do consent can have the treatment.
The second main requirement is that a Second Opinion Doctor (SOAD) and two other people (not medical practitioners) appointed by the Commission must examine the patient and certify in writing that the patient does in fact have capacity and has consented to the treatment. The SOAD must also state that the treatment is appropriate. Code of Practice chapter 24.

Section 58 For the time being only medication for mental disorder is regulated by this section. Section 58 allows medication to be given for 3 months to a detained patient without consent with or without capacity. This policy reinforces the principle of clinicians seeking the patient's consent in the first place regardless of the fact that treatment can be given without consent.
This policy recognizes this as good practice following the principles of the Code of Practice and CQC guidance.

The 3 month period commences when medication is first given not when the detention starts although this is usually the same day. Remember the three month period is not affected by either:

- Change or renewal of the detention order
- Withdrawal of consent
- Change in treatment
- Discontinuation of treatment

Prior to the end of the 3 month period, the Approved Clinician in charge of the treatment must examine the patient and confirm that the patient has capacity and has consented to the specified treatment. If the patient does not have capacity or is refusing the treatment then a SOAD must examine the patient and after consulting with professionals who know the patient, must state that the treatment is appropriate and can go ahead.
Like section 57, there are statutory forms that must be completed and scrutinized by the Trust before the treatment is authorized.

In addition to the statutory forms, the Trust has implemented an additional form to record the communication to the patient of the SOAD's assessment and decision. This includes any decision not to disclose to the patient.

Section 58A Section 58A was introduced via the Mental Health Act 2007. This section applies only to ECT and medication administered as part of ECT.
Section 58A introduced elements of the Mental Capacity Act in to the giving of ECT in that a patient with capacity cannot be given ECT under this section without his/her consent.
Where a patient does not have capacity then a SOAD must certify this fact and agree the treatment is appropriate. The SOAD must also confirm that the treatment does not conflict with an advanced decision, or a decision made by a person with Lasting Powers of Attorney or a person appointed by the Court of Protection.
Section 58A also made different provision for people under 18. In effect all persons under 18 detained or otherwise, must be examined by a SOAD to confirm that child/young adult has competence/capacity and that the person is consenting. Where the person is unable to consent, the SOAD must state that the treatment is appropriate. As the Mental Capacity Act is in evidence in this section, the SOAD must confirm there is no conflict as specified in the paragraph above for young adults (16/17 years old). As in sections 57 and 58, there are statutory forms that must be completed before treatment can proceed. The Trust has its own consent form for ECT Electro Convulsive Therapy Policy & Protocols (CL046 & CL046a) and this must be used in all cases except where ECT is being given under section 62. The Trust is committed to maintaining the highest standards for the administration of ECT and will therefore work towards maintaining the standards laid down by the Royal College of Psychiatrist (ECT Approval Scheme). Code of Practice chapter 24.

Section 59 Treatment plans are essential for both informal and detained patients. Responsible Clinicians and Approved Clinicians should co-ordinate the formulation of a treatment plan in consultation with their professional colleagues.
The Treatment plan should include both immediate and long term goals, clear indications of the treatment proposed, and when the review of the treatment plan will take place. For Electro Convulsive Therapy (ECT) the proposed maximum number of applications must be included.
For the situation where patients who lack capacity to consent, are informal and are assessed to require ECT, they should be considered for detention under section 3 of the Mental Health Act so that the benefits of the Mental Capacity Act can be considered and the protection and safeguards of the Mental Health Act including a statutory second opinion doctor, access to a statutory advocate, nearest relative rights and appeal mechanisms to a court of law etc. can be assured.

The giving of ECT treatment under the Mental Capacity Act 2005 is far from ideal and should only be considered after very careful consultation with colleagues and legal advisor and only if the Mental Health Act is not actioned by the 3 MHA assessors.

Any certificate of consent to treatment obtained for the purpose of section 57, 58 or 58A can relate to a plan of treatment which can involve one or more of the treatments specified under the same section and can include a time-scale for the administration of the treatments.If a plan of treatment is being considered the appointed SOAD will consider the whole plan and accept or reject it as a whole. Drug categories should be recorded in terms used in the British National Formulary

categories.
An outline of the plan will appear on the certificate (T2) and should be described in detail in the patient's medical notes. Anyone responsible for administering treatment under the Act must have sight of not just the prescription chart, but any other authority to treat including MHA statutory treatment forms (Forms T1 to T6 or CTO 11 for SCT patients recalled/revoked). Sight of these forms should be read and verified at each treatment application. If the T2 Form has been signed by the Approved Clinician and not a SOAD, then a new T2 Form must be signed every time the Approved Clinician changes or the consent will not be valid.
Certificates given when the patient did not have capacity (Form T3) must be replaced by a Form T2 if the patient regains capacity and consents or a new SOAD visit and Form T3 if the patient regains capacity and is not consenting. Where consent fluctuates, it may be appropriate to continue treating under the authority of Form T3.
Changes of medication to another BNF group or not authorised on the current Form T3 must have a further SOAD visit and new Form T3. There is no guidance on how long Form T3 is valid. The CQC advise that forms should not normally be extant for more than two years. This policy therefore enforces the rule that any Form T3 being unchanged and in use for 18 months will be followed by a request for a SOAD visit to issue a new Form T3.

Section 60 as in common law, the Mental Health Act recognizes the right to withdraw consent to treatment and examination at any time. This would only apply to treatment where consent forms part of the authority to treat. Examples would be section 57 and 58A treatments where there must be patient consent even if detained under the Act. The Act also recognizes that where a second opinion (SOAD) certificate has been issued because the patient did not have capacity, the patient could withdraw consent if he/she regained capacity and then refused treatment.
This section does not override the need to give treatment under section 62 (urgent treatment) below.

Section 61 This section directs the Responsible Clinician to complete a report (section 61 Review of Treatment Form previously MHAC1) on the current treatment being given to a detained patient and the patient's condition.
The report is given on a non- statutory form devised by CQC when:

- The section is renewed
- For restricted patients at the end of the first six months and on subsequent occasions that a report is furnished to the Secretary of State
- At any other time if so required by the CQC

On the submission of the report to CQC, the consent to continue treatment must be assumed unless CQC subsequently gives notice of withdrawal of consent.

Section 62 This section states that section 57, 58 and 58A do not apply in cases of urgency. Urgency in the Act refers to treatments that are **immediately necessary.**
There are four situations that describe immediately necessary where treatment

can be given to a 'detained patient' without the formality of sections 57, 58 & 58A. These situations are-

- To save a patient's life.
- To prevent a serious deterioration of the patient's condition
- To alleviate serious suffering.
- To prevent the patient from behaving violently or being a danger to himself or others.

The latter 3 situations must not be irreversible or hazardous.

With regards to ECT (s58A), only the first 2 bullet points apply. Clinicians considering ECT under section 62 for capacious patients refusing ECT must first consider if the SOAD will certify the treatment. This may result in a full course of ECT not being possible.
There are no statutory forms for section 62 but clinicians considering section 62 must complete the Trust standard form Appendix 2 to verify that treatment was given on an urgent basis under this section.

- The fact that sections 57, 58 and 58A do not apply does not mean that the treatment can automatically be given under this section. Although section 62 does include treatment under a plan of treatment it still must be **immediately necessary.** It is important therefore that treatment is reviewed on a very regular basis and not allowed to 'drift along'.

To ensure section 62 is applied in a lawful manner, section 62 for ECT should be reviewed and new forms signed before **each treatment**. For medication, treatment should be reviewed and new forms signed on a **weekly basis**. The Trust cannot envisage or support any circumstance that would allow section 57 treatments to be given under section 62 however rare these treatments might be contemplated.

Section 62A This section was introduced by the Mental Health Act 2007 and is specifically intended to deal with the authority to treat patients who are recalled to hospital under section 17E (SCT) or have their SCT revoked under section 17F.

Although this is a complicated section it is important that staff understand the law clearly to prevent risk to the Trust for unlawful treatment of recalled or revoked patients. Basically recalled & revoked patients are subject to the same s58/58A rules as other detained patients but can only be given treatment without consent if the following rules apply.

Medication:

- A SOAD section 58 certificate is not needed if less than 1 month has passed since going on SCT or still within 3 months since treatment originally started prior to going on to SCT.

- A SOAD section 58 certificate is not needed if treatment required explicitly authorised on recall on Part 4A certificate (CTO 11).

- Treatment required is not explicitly authorised on recall/revoke on part

4A certificate then treatment on certificate can be given if discontinuing it would cause serious suffering pending SOAD request for visit.

- If there is no Part 4A certificate in place but an appropriate Part 4 certificate that was in place prior to discharge to SCT is the last certificate issued, then this is likely to be still technically valid. A SOAD visit should be requested urgently.
  Note- You should be aware that the Trust regards the use of previous Part 4 certificates as not good practice. Without a current and valid certificate, the Trust would suggest the RC considers the powers of section 62A(6A) i.e. to discontinue the treatment would cause serious suffering. If this is not appropriate then use of section 62 would be a final option in these cases. Where there is doubt then discuss with the Trust Solicitor or Mental Health Legal Advisor.

- Section 62 can be used but the rules for urgent treatment must be met.

- If none of the above applies including section 62, then there is no authority to treat without the patient's consent.

ECT:

- A SOAD section 58A certificate is not needed if ECT treatment required explicitly authorised on recall on Part 4A certificate (CTO 11).

- If there is no Part 4A certificate in place but an appropriate Part 4 certificate that was in place prior to discharge to SCT is the last certificate issued, then this technically can be used. A SOAD visit should be requested urgently.
  Note- You should be aware that the Code of Practice and the CQC suggest this is not good practice although legally valid. The Trust does not condone poor practice and therefore would suggest the use of section 62 in these cases.

- Section 62 can be used but the rules for urgent treatment must be met.

(Where the patient has capacity and is not consenting to ECT note comments under section 58A above)

Any patient who has his/her SCT revoked returns to a section 3/37 status. However there is no new three month rule for section 58 purposes. Unless no certificate is required as above or a certificate is in place as per above (not certificate given prior to SCT) a SOAD visit and certificate is required immediately.

Section 63 This section is a 'catch-all' for those treatments that are not covered by sections 57, 58 or 58A. This section allows treatment to be given under the direction of the Approved Clinician (RC in LCFT). As the definition of treatment under section 145 is a broad definition this section covers such treatment as nursing care, psychological therapies and ancillary treatment related to the treatment of the mental disorder. This would also include nasogastric feeding,

the taking of blood for Clozaril treatment and physical treatments that have a relationship in law to the mental disorder. This would include the physical treatment of a wound caused by self harm due directly to the mental disorder. Many of these treatments require the cooperation of the patient and under the Guiding Principles of the Act it is important that Trust staff ensure patients' involvement in treatment decisions is given full support despite the fact that consent is not required under this section.

Supervised Community Treatment (SCT) Part 4A

Introduction The 2007 Mental Health Act amended the current Act to introduce Supervised Community Treatment (SCT). In doing so a new treatment Part (Part 4A) was introduced to address consent and certification in the community. Part 4A introduces many elements of the Mental Capacity Act that encourages more decision-making to be made by the patient. Consent to treat in the community again has the elements of authority and certification.

The requirements of Part 4A are that no one can be treated in the community without their consent unless they are recalled to hospital. For patients who lack capacity, treatment can only be given in their best interest.

In order to meet the requirements of Part 4A then it is clear that a starting point is to decide if the patient has capacity or not. If the principle is to follow the Mental Capacity Act then we must assume that the patient has capacity unless the professionals treating the patient have some doubt. If there is doubt then the 'decision-maker' (treating clinician) must undertake and record a capacity test as per section 2 of the Mental Capacity Act.

Section 64B/64C These sections apply to most SCT patients (over 16) in the community being treated for mental disorder. The first thing is the patient must have capacity and the patient consents. The patient's consent is the authority to treat and no certificate is required for section 58 treatments within the first month of going on to SCT.

A certificate is also not required if the period is still within the first three months of commencing treatment since detention started.

A certificate is required after 1 month of being in the community. If the patient has capacity and is consenting then the certificate (CTO 12) is provided by the Responsible Clinician. If the patient lacks capacity or has capacity and is not consenting then the certificate (CTO11) can only be provided by a SOAD examining the patient and stating the treatment is appropriate.

It is also important to note that for section 58A treatments (ECT), that a CTO11 is required immediately. There is no time limit.

Under this section treatment can be given while awaiting a SOAD certificate if the treatment is immediately necessary. However treatment cannot be given to a capacious refusing patient under this section.

Section 64D This section applies to adult patients who lack capacity and their capacity is assessed as per section 2 of the Mental Capacity Act. Treatment is given on the basis of best interest and it is Trust policy to use the assessment and best interest check list in the Trust's MCA policy document.

Although the patient does not have capacity it is important to assess that the patient does not object to treatment and force is not used to give treatment. All treatments

under this section have to be given under the direction of an Approved Clinician (community Responsible Clinician CRC).

This section requires the same SOAD certification as in section 64B above but the SOAD is not testing for capacity, only stating that the treatment is appropriate.
This section also requires the Responsible Clinician to ensure that there is no conflict with an advanced decision or against the wishes of a person with Lasting Powers of Attorney/Deputy of the Court of Protection.

Section 64E This section applies to children under 16 and is the same as section 64B/64C except the Mental Capacity Act does not apply. This means that any reference to capacity means competency as per 'Gillick Competency'. As with capacious adults, treatment cannot be given to a child in the community who is competent to consent and does not consent.
Whilst on SCT, persons with parental responsibility cannot consent or refuse treatment for a child. SOAD certification required as section 64B above.

Section 64F relates to children without competence. The Act states that reasonable steps are taken to establish competence and hold a belief that the patient is not competent to consent. As with adults, an assessment is required but as this is under a standard of common law there is no clear legal framework as set down in the Mental Capacity Act or MCA Code of Practice. However guidance is available from the Department of Health and the British Medical Association.
The policy expects that assessment of competency would be given under the direction of the Responsible Clinician. The assessor must be qualified and experienced in the assessment of competence in children.
If the patient is not objecting, treatment can be given in their best interest but not using force. SOAD certification required as above as section 64D above.

Section 64G As in section 62 in Part 4, Part 4A has an Immediate Necessary (Urgent) section allowing treatment in the community that is seen as urgent. This would be for treatment that has authority (patient's consent) but perhaps does not have SOAD certification. Unlike section 62, treatment cannot be given to a capacious/competent patient under this section without the patient's consent.

A further difference to section 62 is that section 64G specifies that a proportionate amount of force might be used to give the treatment if that prevents harm to the patient. Clearly if the amount of force required is disproportionate or raises risks to the staff who may have to give the treatment then consideration to recalling the patient to hospital has to be considered. There is no statutory form for this section but the Trust has an internal form that must be completed when this section is being implemented.

Appendix 2
Clinical entry to communicate the results of the SOAD visit: Code of Practice 24.62

Certificate of Second Opinion – 58(3) (b)

Following the recent examination of ……. ……..
on, ……. by a SOAD.

I have/have not* discussed the following:

The results of the SOAD visit and the reasons for the treatment prescribed.

Reasons for non-disclosure of the treatment plan to the patient *(please indicate)*

(i) on the SOAD's recommendations

(ii) disclosure would be likely to cause serious harm to the patient's physical or mental health.

(iii) other:

……

……

Observations and comments have been recorded in a clinical entry on electronic clinical record dated:

……..

Signed: …….
(Approved Clinician)

I agree with the above record.

Signed……
(Detained person)

Date: ……..