journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Consent to examination or treatment

CLIN-0001-v5.3

Status: Ratified
Document type: Policy

Contents

1 Introduction....4
2 Why we need this policy....4
2.1 Purpose....4
2.2 Objectives....4
3 Scope....5
3.1 Who this policy applies to....5
3.2 Roles and responsibilities....5
4 Policy....6
4.1 Consent....6
4.2 Context of consent....6
4.3 Documentation....8
4.4 Seeking consent....9
4.4.1 Seeking consent generally....9
4.4.2 Single stage process....9
4.4.3 Two or more stage process....10
4.4.4 Seeking consent for information sharing....11
4.4.5 Seeking consent for anaesthesia....11
4.4.6 Emergencies....12
4.5 Treatment of children....12
4.6 Treatment of 16- and 17-year-olds who are able to consent to treatment....13
4.7 Treatment of 16- and 17-year-olds who are unable to consent to treatment....13
4.8 Providing information....14
4.9 Completing consent forms....15
4.10 Responsibilities for seeking consent....15
4.11 Attendance by students and trainees....16
4.12 Refusing treatment....16
4.13 Advance statements and decisions....17
4.14 Patients who refuse blood or blood components....17
4.15 Tissue....18
4.16 Clinical photography and video recordings....18
5 Mental Health Act 1983....19
5.1 Consent to treatment and the Mental Health Act 1983....19
5.2 Capacity and the Mental Health Act 1983....19
5.3 Treatment and the Mental Health Act 1983....19
5.4 The Mental Health Act 1983 three month rule....21
6 Definitions....22
7 Related documents....23
8 How this policy will be implemented....23
8.1 Training needs analysis....23
9 How the implementation of this policy will be monitored....23
10 References....24
11 Document control (external)....24

Appendix 1 - Equality Analysis Screening Form.....26
Appendix 2 – Approval checklist 29

1 Introduction

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

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

The Mental Health Act 1983
The Mental Capacity Act 2005
The Children Act

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) recognises that patients have a fundamental right to determine what happens to their own bodies.

This policy aims to support Our Journey to Change by enabling our staff to deliver outstanding and compassionate care that is sensitive to the needs of patients, supports individual choice and respect rights. It will also outline guidance for staff that will help work collaboratively with a range of services to deliver the best possible care.

2 Why we need this policy

2.1 Purpose

Consent forms part of the Care Quality Commission's (CQC) fundamental standards.

This document informs practitioners of the:

Standards in Tees, Esk and Wear Valleys NHS Foundation Trust which ensure that professionals follow national guidance on consent;
Guidance on consent relevant to patients detained under the Mental Health Act 1983 (MHA).

2.2 Objectives

- As a provider of healthcare, TEWV will ensure that consent is obtained lawfully.

3 Scope

3.1 Who this policy applies to

This policy applies to all staff employed by TEWV who are involved in providing care and treatment. It outlines the legal structures which staff have to work within when delivering care or treatment.

3.2 Roles and responsibilities

Role	Responsibility
All clinical staff	Ensure they have consent or another form of authority before providing care or treatment to a patient
Responsible clinicians	A patient's RC has specific responsibilities for authorising treatment under the Mental Health Act

4 Policy

4.1 Consent

Consent is a patient's agreement for a health professional to provide care.

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

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

Consent can be given:

In writing,
Verbally, or
Indicated non-verbally.

4.2 Context of consent

Consent can take a range of forms, from the active request by a patient for a particular treatment to the passive acceptance of a health professional's advice.

In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it.

In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them.

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

Some patients are well informed about their illness and may request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making'; the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

A person is presumed to have the capacity to make a treatment decision unless they have an impairment or disturbance in the functioning of their mind or brain, and this impairment or disturbance means they cannot make the treatment decision at the time it needs to be made because they are unable to:

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

You must follow the principles set out in the Mental Capacity Act 2005 when determining whether an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves.

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

A patient who lacks capacity can be given treatment if it is in their best interests in accordance with the MCA, as long as the patient has not made a valid and applicable advance decision.

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

4.3 Documentation

Consent is often wrongly equated with a patient's signature on a consent form.

A patient's signature on a form 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. 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 withdraw consent after they have signed a form: the signature is not a binding contract.

It is rarely a legal requirement to seek written consent, (the MHA 1983 requires written consent in certain circumstances) but is good practice in situations where:

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 treatment involves the use of unlicensed medication. This is frequently the case within Children and Young People's Services where a locally developed consent form has been agreed for this purpose;
the procedure involves general/regional anaesthesia or sedation;
providing clinical care is not the primary purpose of the procedure;
there may be significant consequences for the patient's employment, social or personal life;
the treatment is part of a project or programme of research approved by this Trust;

Completed forms must be filed in the patient's paper case notes. Any changes made to a form after it has been signed must be initiated and dated by both patient and health professional.

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

If you are performing a significant procedure, you must document both a patient's agreement to the intervention and the discussions which led up to that agreement. Either use a consent form (with further detail in the electronic patient record if necessary) or document consent in the electronic patient record.

Standard consent forms and forms for adults who are unable to consent for themselves are available from the trust intranet. There are five versions of the standard consent form:

Form 1 for adults or competent children.

Form 1 B for adults or competent children for ECT.
Form 2 for parental consent for a child or young person.
Form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care.
Form 4 for adults who lack the capacity to consent.

Using form 3 is optional. It may be appropriate where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

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

The assessment of the patient's capacity MCA1;
Why the health professional believes the treatment to be in the patient's best interests (MCA2); and
The involvement of people close to the patient.

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

4.4 Seeking consent

4.4.1 Seeking consent generally

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

When a patient formally gives their consent to a particular intervention, this is the endpoint of the consent process. 'Seeking consent' is a process of information giving, discussion and decision-making. 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.

4.4.2 Single stage process

It may be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, a 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 consent and the procedure can go ahead immediately. Usually, consent will be given orally.

If a proposed procedure carries significant risks, you must seek written consent. You must consider whether the patient has understood the information needed for them to make their decision. If you believe the patient understands and consents, you may then proceed.

4.4.3 Two or more stage process

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

1. Providing information, discussing options and initial (oral) decision;
2. Confirming that the patient still wants to go ahead.

The consent form must document 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 out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure;
- new information becomes available regarding the proposed intervention (e.g. new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period between the time when consent was sought and when the intervention is undertaken.

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

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

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

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

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

4.4.4 Seeking consent for information sharing

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

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

You must be clear that you will review the situation at regular intervals or if circumstances change, and that they can change their minds at any stage. Please refer to the Confidentiality and Sharing Information policy for further detail.

4.4.5 Seeking consent for anaesthesia

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

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

The anaesthetist must document the discussion with the patient and their consent in the anaesthetic record, in the patient's notes on electronic patient records or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she must make sure that the patient has given consent to that form of anaesthesia.

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

4.4.6 Emergencies

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

4.5 Treatment of children

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

Chapter 19 of the MHA Code of Practice gives further guidance on key factors to be considered, including:

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

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

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

4.6 Treatment of 16- and 17-year-olds who are able to consent to treatment

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

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

Treatment with consent – if the young person is capable of giving consent and does so, then treatment may be given.
Treatment under the Mental Health Act 1983 – Consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met.
Application to the court – If the criteria for detention under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.
Life threatening emergencies – where the young person's refusal would be likely to lead to their death or to severe permanent injury they may be admitted to hospital without consent.

You should exercise caution in cases where a young person or child refuses treatment.

You should contact the Mental Health Legislation department for advice.

Such cases can be controversial and raise complex legal issues. You should have regard to chapters 19, 23, 24, 25 and 26 of the MHA 1983 Code of Practice.

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

If the young person does not give consent to the proposed treatment, the MHA 1983 Code of Practice advises against relying on the consent of a person with parental responsibility in order to treat the young person.
Although, in the past, courts have found that parental consent can override a young person's refusal in non-emergency cases, the trend in recent cases has been to reflect greater autonomy for children and young people who are able to make health-related decisions for themselves.

4.7 Treatment of 16- and 17-year-olds who are unable to consent to treatment

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

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

The MCA 2005 will not apply if:

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

Unless it is not practicable or appropriate, you must consult those with parental responsibility on whether the proposed treatment is in the young person's best interests.

Treatment on the basis of parental consent – In some circumstances young people lacking capacity may be admitted to hospital and / or treated on the basis of parental consent. This can only be relied upon if the decision falls within the 'scope of parental responsibility' and the parents are acting in the young person's best interests.

Treatment under the Mental Health Act 1983 – If the MCA 2005 does not apply and the decision does not fall within the 'scope of parental responsibility'; consideration will need to be given as to whether the criteria for detention under the MHA 1983 are met.

Application to the court – If the criteria for detention under the MHA 1983 are not met, it may be necessary to seek authorisation from the court.

Life threatening emergencies – where the young person's refusal would be likely to lead to their death or to severe permanent injury they may be admitted to hospital without consent.

4.8 Providing information

Providing information is central to the consent process.

Before patients can make a decision about treatment, they need understandable information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). Drawings, diagrams and models may be used to facilitate this process where appropriate. Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary as part of the procedure, 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. The patient should always be encouraged to make the decision for him or herself although there will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

Tees, Esk and Wear Valleys NHS Foundation Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. To safeguard the consent process, an interpreter must be used when seeking consent from the patient.

It **is not** appropriate to use children to interpret for family members who do not speak English.

Guidance on translation and interpretation services can be found in the Translation and Interpretation Policy.

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

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

After an appointment with a health professional in primary care or in out-patients, patients often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure.

Do not assume that the attendance of a patient at a clinic implies consent to particular treatment.

Do ensure that the patient has the information they need before proceeding with an investigation or treatment.

4.9 Completing consent forms

The standard consent form has space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so because they:

carry out the procedure themselves, or
have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

Inappropriate delegation (e.g., where the health care professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

4.10 Responsibilities for seeking consent

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.

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

It is a health professional's own responsibility to:

ensure that colleagues who seek consent on their behalf are competent to do so; and work within their own competence, and not to agree to perform tasks that exceed that competence.

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

4.11 Attendance by students and trainees

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

If a student proposes to conduct a physical examination that is not part of the patient's care, it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place.

A patient's explicit consent should be obtained before any occasion when a student or trainee will be present during an examination or when treatment is to be given. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment.

Written consent must be obtained if students or trainees will be present during examination or treatment using sedation or anesthesia.

4.12 Refusing treatment

For the process of seeking consent to be meaningful, refusal must be one of the patient's options. An adult patient who has capacity can refuse any treatment, except in circumstances governed by the *MHA 198*3. The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA 2005 must be applied.

An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the

decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so.

After discussing treatment options, if a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the health professional (and where possible the patient) should note this on the form.

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

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

4.13 Advance statements and decisions

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

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

More details of advance decisions and statements in outlined in the Trust's Advance decisions to refuse treatment and statements made in advance procedure and the MCA Code of Practice.

4.14 Patients who refuse blood or blood components

The same legal principles apply to any patient who refuses treatment whether out of religious convictions or otherwise. Some patients (e.g. Jehovah's Witnesses) may be prevented by their religious convictions from accepting blood or blood components (red cells, white cells, plasma and platelets), even when these are considered necessary to sustain life. All health professionals must respect this choice.

To administer blood to an adult who has refused to accept it may be unlawful and could lead to criminal and/or civil proceedings.

Further information can be accessed via UK Blood Transfusion and Tissue Transplantation Services.

4.15 Tissue

The removal, storage and use of human tissue are regulated by the Human Tissue Act 2004.

Where human tissue is removed, the Act provides that certain specified activities (including research) as set out in Schedule 1 require the consent of the patient. Consent must be given by an appropriate person and penalties of up to three years imprisonment or a fine, or both, can be imposed for failure to obtain or misuse of consent. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990.

If you are dealing with tissue samples you must be familiar with the Codes of Practice and guidance issued by the Human Tissue Authority. These are available on their website at HTA - The Human Tissue Authority.

4.16 Clinical photography and video 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.

Video recordings, clinical photography and/or radiographs may sometimes be needed following injuries sustained in an accident or assault. Health professionals should be satisfied that the patient has been given sufficient information for valid consent, making it clear that the recording could be used during legal proceedings, as part of a medical record, or possibly as a tool for teaching, audit or research. The need to obtain consent applies equally if the patient has requested the recording, photograph or radiograph.

Making and Using Visual and Audio Records of Patients, GMC, 2002 and the Trust's policy Visual and Audio Recordings in Clinical Procedures give detailed advice in the use of recordings when treating or assessing patients.

5 Mental Health Act 1983

5.1 Consent to treatment and the Mental Health Act 1983

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

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

Mental Health Act 1983 (MHA).
Mental Health Act 1983 Code of Practice (MHA CoP).
Reference Guide to the Mental Health Act 1983 (Reference Guide).

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

This policy **must** be used in conjunction with the MHA CoP.

5.2 Capacity and the Mental Health Act 1983

Capacity to consent continues to apply to those patients subject to the MHA 1983. The AC in charge of the proposed treatment must assess capacity to consent at the earliest opportunity; this must be recorded in the electronic patient records on Form MCA 1.

Capacity should be re assessed and recorded on Form MCA1 and a clear record made in the electronic patient records each time there is a requirement to complete a T1 or T2 Form in compliance with Section 58.

5.3 Treatment and the Mental Health Act 1983

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

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

This section applies to both detained and informal patients

No patient may be subject to psychosurgery or the implantation of hormones for the purpose of reducing sexual drive without the patient’s express consent and a second opinion;
The second opinion must be provided by a doctor appointed by the CQC;

Treatments given under this section require careful consideration because of the ethical issues and possible long-term effects;
Advice must be sought from the MHL department of the Trust as procedures for implementing this section must be agreed between the CQC and the Trust.

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

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

It covers the administration of medication for mental disorder (unless included in section 57 or 58A treatment) if three months or more have lapsed since medication for mental disorder was first given to the patient during an unbroken period of compulsion ("medication after three months").
If the above criteria apply then the AC in charge of the treatment in question must personally seek the consent of the patient in order to continue with the proposed treatment.
The patient must have the capacity to make the decision.
Where the patient does not consent, or lacks the capacity to consent, the treatment in question cannot be given without the approval of a SOAD.

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

This section applies to all patients aged under 18 (whether or not they are detained) and all patients liable to be detained except for those detained under sections 4, 5(2) or 5(4), 35, 135, 136, 37(4),45A(5); conditionally discharged restricted patients, and CTO patients.

It covers electro-convulsive therapy (ECT) and treatments specified in the regulations (at the time of publication this is medication administered as part of ECT).
A detained patient aged 18 or over may only be given 58A treatment if the patient has capacity (certified by an AC in charge of that element of treatment or SOAD) and has consented to it, or, the patient does not have capacity, and it is appropriate treatment, and there is no refusal under the MCA, and this is certified by a SOAD.
Patients aged under 18 may not be given 58A treatment unless; the child has capacity and has consented to it, and, the treatment is appropriate, and is certified by a SOAD; or, the child does not have capacity, the treatment is appropriate, and, (patient 16 or 17 years old) there is no refusal under the MCA, and this is certified by a SOAD.

Part 4A – applies to CTO patients not recalled to hospital.

Medical treatment for mental disorder **may not** be given (by anyone in any circumstances) to CTO patients who **have not** been recalled to hospital unless the requirements of Part 4A are met.

- Part 4A requires authority (i.e. consent or MCA provision) and (if a 58 or 58A type treatment) a treatment certificate:
  - Where the patient has capacity / is competent to consent, this will be a CTO 12 completed by the approved clinician in charge of the treatment;
  - Where the patient lacks the capacity / is not competent to consent, this will be a CTO 11 completed by a SOAD.
- For detailed information see Tees, Esk and Wear Valleys NHS Foundation Trust Policy MHA/0010 Community treatment orders

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

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

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

Section 58A **does not** apply to ECT if the ECT falls with the first two categories above. Regulations about other section 58A treatments can say which of the categories of immediate necessity above apply in each case. At the time of publication, only the first two categories in paragraph 16.56 above apply.

5.4 The Mental Health Act 1983 three month rule

The three month rule legally authorises the prescription and administration of medication for mental disorder to patients detained under the MHA 1983 even if they refuse, or are incapable of giving, valid consent. The three month period commences with the date of the first dose of

medication administered during any continuous period of detention, even if the medication has been changed or is not given continuously. This includes any medication given under Section 2.

During this period it remains good practice, and is a requirement of the MHA CoP para 24.41, to assess the patient's capacity to consent to the treatment, to try and gain the patient's consent to treatment and to record the outcome of both.

When medication for mental disorder is first prescribed there must be an assessment of capacity regarding the medication/s recorded on Form MCA1 in the electronic patient records**.** There must also be an entry regarding whether the patient has capacity and is consenting or refusing to consent, or, lacks capacity and is compliant or objecting to the treatment.

After the initial three month period, medicines for the treatment of mental disorder can be given to the patient either with the patient's consent as recorded by the patient's AC in charge of that element of treatment on Form T2 or, in the absence of the patient's consent, only if authorised under a Form T3 completed by a SOAD. It is the responsibility of the AC in charge of that element of treatment to contact the CQC to gain the second opinion.

6 Definitions

[This section is a list of the terms used in this policy and what they mean]

Term	Definition
Approved Clinician (AC)	A suitably experienced and qualified professional from either a medical, psychological, nursing, social work or occupational therapy background who has been approved by a regional panel as having Approved Clinician status. A patient's Responsible Clinician (RC) is the Approved Clinician who is in overall charge of their care.
Care Quality Commission (CQC)	The independent body responsible for monitoring the operation of the MHA 1983 (previously the responsibility of the Mental Health Act Commission (MHAC)). The CQC is an integrated health and adult social care regulator, bringing together existing health and social care regulators into one regulatory body.
Court of Protection	The specialist court set up under the MCA 2005 to deal with all issues relating to people who lack capacity to make decisions for themselves.
Deputy	A person appointed by the Court of Protection under the MCA 2005 to take specified decisions on behalf of someone who lacks capacity to take those decisions themselves.
Human Tissue	Material which has come from a human body and consists of, or includes, human cells (but does not include cell lines or hair and nails from living people)

Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Care Quality Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given.

7 Related documents

Mental Health Act Code of Practice
Mental Capacity Act Code of Practice

8 How this policy will be implemented

- This policy will be published on the intranet and Trust website
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff	Mandatory MHL e-learning	3 hours	Every 2 years

9 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Clinical teams to ensure authorisation for treatment has been identified and documented	Team managers to audit patient records	Report to relevant governance group where appropriate.
2	MHA treatment certificates are obtained within time scales	MHL team monitor compliance	Reported back to clinical teams if internal issues are identified.

10 References

Mental Health Act Code of Practice
Mental Capacity Act Code of Practice

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	18 October 2023
Next review date	14 December 2025
This document replaces	Consent to examination or treatment policy CLIN-0001-v5.2
This document was approved by	MHLC
This document was approved	31 August 2023
This document was ratified by	Management Group
This document was ratified	18 October 2023
An equality analysis was completed on this policy on	09 August 2022
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
5	13 March 2019	The policy has undergone a full revision and consultation with minor amendments throughout.	Withdrawn
5	21 Sept 2020	Review date extended by six months.	Withdrawn
5.1	17 June 2021	Information leaflet given to patients in form 1b has needed to be updated. Minor amendments to wording on form 1b. As part of the updates, the existing policy was transferred onto new policy template. Sections 7.1 and 8 have been included.	Withdrawn
5.2	14 Dec 2022	3 yearly review with minor changes:- • Template has been updated to new format with additional reference to Our Journey to Change.	Withdrawn

		• Minor grammatical changes. • Hyperlinks have been updated.	
5.3	18 Oct 2023	Minor wording changes: • In sections 4.3, 4.4.5, 4.4.6, 5.2 and 5.4 “Paris” has been changed to “electronic patient record”. • In section 5.3 “MHA Department” has been changed to “MHL Department”	Published

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Mental Health Legislation
Title	Consent to Examination or treatment policy
Type	Policy
Geographical area covered	Trust wide
Aims and objectives	Consent forms part of the Care Quality Commission's (CQC) fundamental standards. The consent to examination or treatment policy informs practitioners of the: • Standards in Tees, Esk and Wear Valleys NHS Foundation Trust which ensure that professionals follow national guidance on consent; • Guidance on consent relevant to patients detained under the Mental Health Act 1983 (MHA).
Start date of Equality Analysis Screening	01/07/2022
End date of Equality Analysis Screening	02/08/2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All patients Clinical staff
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO**

	• **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Legislation and associated codes of practice
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	This policy is based on UK legislation that undergoes a robust engagement and consultation process.

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No

Describe any training needs for Trust staff	NA
Describe any training needs for patients	NA
Describe any training needs for contractors or other outside agencies	NA

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	NA	