Leicestershire Partnership NHS Trust

Consent to Treatment or Examination Policy

This Policy sets out the standards and procedures to ensure that health professionals comply with consent guidance.

Key words: Consent, Examination, Treatment

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KEY REQUIREMENTS

The NHS as part of its definition of Consent states the following:

“For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.”

The key requirements then of this Policy is to ensure that its content provides staff with the tools, knowledge, and skills to comply with that statement and to ensure that knowledge extends to incidents where consent cannot be given under these conditions.

TARGET AUDIENCE:

The content of this Policy applies to permanent employees of Leicestershire Partnership NHS Trust (LPT) and those working on behalf of the Trust in any other capacity, i.e., bank, agency, voluntary staff, students etc. (this list is not exhaustive).

SUMMARY & AIM

This policy provides guidance on consent and obtaining consent for patient interactions at LPT.

It is essential to obtain consent from a patient and to involve patients in their care and treatment. Individual practitioners must take responsibility for obtaining the appropriate consent from a patient but are encouraged to seek advice and use national guidance in conjunction with the LPT consent policy.

All practical efforts must be made to ensure that a patient is providing valid consent for an intervention and this consent must be sought by the clinician carrying out the intervention.

Although this policy acts as a guide the expectation is that staff at LPT will contact appropriate staff for advice if they are unsure about consent. This is likely to be their line manager in the first instance or on call manager/ on call consultant out of hours and on call directors and legal team if required.

In a situation where a Patient is refusing urgent/ emergency physical health treatment or transfer to Acute care, this should be discussed with the Consultant/ On call Consultant who will consider treatment under the Mental Health Act/ Mental Capacity Act and confirm and record the plan.

If EMAS staff attend and are unsure about transferring a patient who is refusing to go, please contact the Consultant/On call Consultant/ Manager on Call to discuss a plan for transfer and treatment. Capacity assessment for decisions relating to treatment or transfer remain with the clinical team responsible for the patient. EMAS will support the assessment and document their understanding but will not override the clinical team's judgement unless there is an immediate risk requiring emergency intervention.

It is important to note that the position concerning consent and refusal of treatment for those patients under the age of 18 is different from the position for adults and where treatment is being refused.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children.

You must be aware that not all parents have parental responsibility for their children.

1.0 Quick look summary

Consent to treatment means a person must give permission before they receive any type of medical treatment, test, or examination. This must be done based on an explanation by a clinician. Consent from a patient is needed regardless of the procedure, whether it's a physical examination or something else. The principle of consent is an important part of medical ethics and international human rights law.

The policy sets out the law and associated guidance in respect of consent to treatment in general.

The two main legislative mechanisms are the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA). Although both of these Acts of Parliament could apply to those under the age of 18 years, the Children Act 1989 and the Family Law Reform Act 1969 are also key pieces of legislation when it comes to the treatment of children.

The policy covers each legal perspective in situations involving adults and children, but each case will have its own unique characteristics.

This policy should be read in conjunction with the following policies:

- Mental Health Act Procedural Document,
- Deprivation of Liberty Act Safeguards Policy and Procedures,
- Safeguarding & Public Protection Policy & Procedures,
- Covert Administration of Medicines,
- Mental Capacity Act Policy (2005),
- Care Coordination Policy.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
3	March 2012	
4	12.9.2012	Additional content added to ensure the Trust complies with NHSLA criteria 5.3.
5	28.2.2013	Amendments incorporated to NHSLA (NHS Litigation Authority) Monitoring Section
6	15.10.14	Clarified an individual's duty to obtain consent (section 1.1) Consent for anesthesia removed (section 4.3) Clarified simultaneous T2 and T3 (section 9.2) Tissue section (section 10)

		removed. Latest policy format utilised
6.4	February 2015	Inclusion of further sections
6.7	April 2015	Inclusion of legal information and minor amendments
7	February 2020	General review Removal of Clozapine statement Update to titles
8	April 2024	General review and transferred to new policy format
9	June 2024	General review following comments by policy group.
10	February 2026	Inclusion re Responsibility for Mental capacity assessment re transfer to Acute hospital following information shared by EMAS.

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1.2 Key individuals involved in developing and consulting on the document.

Key individuals involved in developing the document.

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1.3 Governance

Level 2 approving Delivery Group	Quality Forum/CEG
Level 1 Committee to Ratify Policy	Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favorable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity. In carrying out its functions, LPT must have due regard for the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development and review.

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 1) of this policy.

1.6 Definitions that apply to this policy.

Advance Directive	An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision that allows an individual to detail in advance their right to refuse a specific type of treatment at some time in the future.
Consent	A patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must: - be competent to take the particular decision. - have received sufficient information to take it and not be acting under duress.
Parental Responsibility	Parental responsibility is defined in s 3(1) Children Act 1989 as being: "All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property". The term 'parental responsibility' attempts to focus on the parent's duties towards their child rather than the parent's rights over their child.
ECT	Electro Convulsive Therapy, a procedure for which formal written consent is required. ECT is governed by the Electro Convulsive Therapy Clinical Guidelines within LPT.
Gillick or Fraser Competent	Following the case of Gillick-v-West Norfolk and Wisbech AHA [1986] AC 112, the Courts have held that children who have sufficient understanding and intelligence to

	enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being 'Gillick or Fraser competent.' Gillick competency -assessing competence if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge. The Fraser guidelines apply specifically to advice and treatment about contraception and sexual health. They may be used by a range of healthcare professionals working with under 16-year-olds, including doctors and nurse practitioners.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Mental Capacity	The law says that capacity i.e., the ability to make an informed decision for oneself, must be assumed, unless proven otherwise. This means that a diagnosis of a particular condition, type of behaviour, age or appearance cannot automatically mean you lack capacity. Lack of capacity may not be a permanent condition. Assessments of capacity should therefore always be time and decision specific. The Mental Capacity Act 2005 (MCA).

1.7 Abbreviations that apply to this policy

MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
ICH-GCP	International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) Good Clinical Practice (GCP) guidelines
ECT	Electro Convulsive Therapy
EMAS	East Midlands Ambulance Service
SOAD	Second Opinion Appointed Doctor
AC	Approved Clinicians
BNF	British National Formulary
RC	Responsible Clinician
CTO	Community Treatment Orders
Form T1	Regulation 27(1)(b) Mental Health Act 1983 Section 57 — Certificate of consent to treatment and second opinion
Form T2	Regulation 27(2) Mental Health Act 1983 Section 58(3)(a) — Certificate of consent to treatment
Form T3	Regulation 27(2) Mental Health Act 1983 Section 58(3)(b) — Certificate of second opinion
Form T4	Regulation 27(3)(b) Mental Health Act 1983 Section 58A(3) — Certificate of consent to treatment (patients at least 18 years old)
Form T5	Regulation 27(3)(b) Mental Health Act 1983 Section 58A(4) — Certificate of consent to treatment and second opinion (patients under 18)
Form T6	Regulation 27(3)(b) Mental Health Act 1983 Section 58A(5) — Certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment)

2.0 Purpose and Introduction/Why we need this policy.

This Policy provides for the overall framework of guidance and support required to enable staff working for, or on behalf of the Trust to undertake their responsibilities in accordance with legal requirements, current national guidelines and recognised good practice in achieving the Trust vision in creating high quality and compassionate care for all.

Individual practitioners must take responsibility for obtaining the appropriate consent from a patient but are encouraged to seek advice and use national guidance in conjunction with the LPT consent policy. Consent is a fluid concept that is decision and time- specific, much like capacity. All practical efforts must be made to ensure that a patient is providing valid consent for an intervention and this consent must be sought

by the clinician carrying out the intervention. Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery.

While there is no English statute setting out the general principles of consent, case law ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, if healthcare professionals (or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved. Poor handling of the consent process may also result in complaints from patients through the NHS complaints procedure or to professional bodies. A person who lacks capacity to consent does not consent to treatment, even if they cooperate with the treatment or actively seek it.

Staff with responsibility for the assessing, recording, and implementing the content of this Policy, i.e., consent, should therefore be afforded the necessary tools and information to enable them to do so in a competent and professional manner. It is the responsibility of the professional in charge of the particular treatment to establish the valid authority to treat, and for the professional administering the treatment to be satisfied that such authority exists.

Although this policy acts as a guide the expectation is that staff at LPT will contact appropriate staff for advice if they are unsure about consent. This is likely to be their line manager in the first instance or on call manager/ on call consultant out of hours and on call directors and legal team if required.

3.0 Policy Requirements

Policy requirements are in line with legislative, good practice and national guidelines for the assessment of a service users' capacity and provision of consent or otherwise.

4.0 Duties within the Organisation

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively, including this, the Consent Policy.

The Quality and Safety Committee, as a **Trust Board Sub-committee**, has the responsibility for ratifying policies and protocols. Its sub-group, **Quality Forum** has responsibility for considering and agreeing this policy.

Executive Directors and **Heads of Service** are responsible for ensuring that comprehensive arrangements are in place regarding adherence to this policy and how Consent procedures are managed within their own Department or Service in line with the guidelines in this policy. They will ensure that team managers and other

management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction. These arrangements will include ensuring that all staff have access to this policy and maintaining a system for recording that policies and procedures have been distributed to and received by staff within the Department / Service and for having these records available for inspection upon request for audit purposes.

Managers and Team leaders are responsible for providing advice and support to staff on consent issues/concerns raised within their service areas and are responsible for ensuring all clinical staff have been trained to the required standards. They are responsible for ensuring that the Consent Policy is followed and understood as appropriate to each staff member's role and function.

- This information must be given to all new staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes policies and procedures.
- Ensuring that the staff understand how and where to access current policies and procedures; via Intranet/ e-source.
- Ensuring that a system is in place for their area of responsibility that keeps staff up to date with the Consent Policy and any recommended training related to it.

All staff (including seconded staff) should be aware that despite the above responsibilities of senior staff, every staff member has a professional responsibility to have an understanding of consent in their day-to-day clinical practice and to follow the guidance of their professional body, the Department of Health as well as local trust policies. The consent procedures pertaining to the Mental Health Act are detailed in Appendix 4- the Self-Harm Refusal of Treatment Flowchart.

5.0 Consent

5.1 What is and is not consent.

'Consent' is a patient's agreement for a health professional to provide care. The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice.

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

Clinical staff must ensure that consent has been sought and obtained before any care,

intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

For consent to be valid, patients must:

- have the capacity to make the decision.
- have been offered sufficient information to make an informed decision.
- be acting voluntarily and free from undue pressure; and
- be aware that they can refuse

5.2 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 being sought at the point the procedure will be carried out, this will naturally 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.

Staff who are not capable of undertaking the procedure are not authorised to gain consent for that procedure.

Doctors and healthcare professionals must obtain consent from patients who have the capacity to give it any time they wish to initiate an examination, treatment, or any other intervention. The only exceptions to this are in emergencies where it is not possible to obtain consent, or when the law prescribes otherwise, such as when compulsory treatment for a patient's psychiatric disorder is authorised by mental health legislation.

Doctors, healthcare professionals and other approved staff on a study delegation log (such as Clinical Research Practitioners and similar delivery staff) must ensure that patients asked to consider taking part in research are given clear information, presented in a way they can understand. Patients should be made aware that they are being asked to take part in a research project and that the results are not predictable.

Participant Information Sheets and Participant Consent Forms are independently approved by the Health Research Authority (which may include NHS Ethical Review) for each research study, with standard templates available.

Staff receiving consent for research should be ICH-GCP trained (mandatory for clinical trials of medicinal products) and have successfully undergone training in receiving informed consent, and additional training for participants lacking capacity where needed.

It is also necessary to seek a patient's consent for students or other observers to be present during a consultation or treatment. The professional carrying out the consultation should explain to the patient that an observer would like to sit in on the consultation, who that person is and why they would like to observe. Patients should feel able to say no, knowing that it will not impact on their treatment in any way.

5.2.1 Single Stage Process

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

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

5.2.2 Two or More Stage Process

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

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in 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. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example, beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

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

5.3 Emergencies

In emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given but should not affect its quality. Dependent on the nature of the emergencies, Clinicians can act in the best interest of the patients unless they have an advanced directives denying lifesaving intervention.

Where consent cannot be obtained, doctors should provide treatment that is immediately necessary either to preserve life or to prevent a serious deterioration in the patient's condition. The only exception to this is where there is clear evidence of a valid and applicable advance decision to refuse the treatment in question.

In a situation where a Patient (either informal or under MHA) is refusing physical health treatment or transfer to Acute care, this should be discussed with the Consultant/ On call Consultant who will consider treatment under the Mental Health Act/ Mental Capacity Act and confirm and record the plan.

If EMAS/ Ambulance staff attend for a patient who is already in a hospital or inpatient care environment, capacity assessment for decisions relating to treatment or transfer remain with the clinical team responsible for the patient. EMAS will support the assessment and document their understanding but will not override the clinical team's judgement unless there is an immediate risk requiring emergency intervention. If unsure about transferring a patient who is refusing to go, please contact the Consultant/On call Consultant/ Manager on Call to discuss a plan for transfer and treatment.

If legal advice is required, the Director/ On call Director will facilitate contact.

5.4 Provision of Information

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments / investigations and their risks and benefits (including the risks / benefits of doing nothing). It should be recorded in the health care records what information has been provided (e.g. leaflets) in the patient's health care records.

They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example, a blood transfusion, or the removal of tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

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

The following sources of patient information are available in the Trust:

- Braille
- Large Print Information Sheets.
- Easy Read
- Tape recording of consultation.
- Taped and Audio facilities.

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

Translation and interpreting services are available from: Ujala Resource Centre, St Peter's Health Centre 0116 295 4747

5.5 Informed Consent and the Duty to Warn

Following the Supreme Court decision in Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] clinicians need to make patients aware of any "material risks".

i.e. risks involved in proposed treatment which:

1. A reasonable person in the patient's position would be likely to attach significance to; or

2. The doctor is or should be aware that the particular patient would be likely to attach significance to, taking into account factors such as the nature of the risk, the effect of its occurrence on the patient's life and the importance to the patient of the beneficial aim of the treatment.

Clinicians have a duty to inform patients of any reasonable alternatives to the treatment proposed.

While the goal is not to overwhelm patients with information, clinicians need to demonstrate that they have had a dialogue with patients where the risks of a treatment and reasonable alternatives have been discussed. Instead of an individual clinician deciding what risks a patient may find important, it is better to make the patient aware of all the risks, however unlikely, so that the patient can make a truly informed decision.

5.6 Documentation

For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement.

It is important that each group of health care professionals charged with obtaining consent are:

- Consistent in the form of words used in the documentation that indicates that the patient has given oral consent (if a consent form is not being used)
- in general agreement as to what procedures require oral as opposed to written consent and that there is consistency in this approach.

For medication for a mental disorder, despite the law allowing treatment without consent for three months, there must be a consideration at the first consultant review of a patient about the patient's capacity to consent to their treatment. This must be documented in the patient's notes using the MHA consent to treatment form.

Standard consent forms and forms for adults who are unable to consent for themselves are available to download on the Department of Health website. There are three versions of the standard consent form: form 1 for adults or competent children, form 2 for parental consent for a child or young person, and form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anesthetist will be involved in their care. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

There are specific forms for medication following three months of treatment (currently T2 forms for patients with capacity who consent or T3 forms for patients who lack capacity or have capacity but refuse treatment). T2 forms are available from the Mental Health Act office and Second Opinion Appointed Doctor (SOAD) requests are made online through the CQC website (Care Quality Commission).

5.7 Completing Consent Forms

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

If the patient signs the form in advance of the procedure, 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 to provide the second signature, as long as they have access to appropriate colleagues to answer questions, they cannot handle themselves.

If a health professional obtains consent where it has not been authorised this should be reported as an incident. The incident should be managed through the Disciplinary Policy and Procedure and a referral made to the General Medical Council (GMC) using the required form where appropriate.

5.8 Written Consent

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

- The treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- The procedure involves general/regional anesthesia or sedation.
- Providing clinical care is not the primary purpose of the procedure.
- There may be significant consequences for the patient's employment, social or personal life.
- The treatment is part of a project or programme of research approved by the Trust following HRA and Ethical Approval.

Formal written consent is required for Electro Convulsive Therapy (ECT), and this is governed by the Electro Convulsive Therapy Clinical Guidelines within LPT.

Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialed and dated by both patient and health professional. It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample.

However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example, if they have declined, or become very distressed about, similar care in the past) it would be helpful to do so.

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005.

5.9 Refusal of Treatment

It must not be assumed that the person who refuses treatment lacks capacity even if the professionals demonstrate that the treatment is in the person's best interests. It must be demonstrated that the person:

A. Lacks capacity and the treatment is in the person's best interests.

For the treatment to take place in compliance with the law. A person is allowed by Mental Capacity Act 2005 to make an 'unwise decision' to refuse treatment. Please refer to LPT Safeguarding and Public protection Policy and Mental Capacity Act (2005) Policy.

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act 1983. (This might apply to patients detained under the Mental Health Act in in-patient CAMHS (Children and Adolescent Services) – seek advice in these types of cases). The situation for children is more complex: see the Department of Health's Seeking consent: working with children for more detail. The following paragraphs apply primarily to adults.

If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

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

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal (for example, a Jehovah's witness who may agree to a procedure but refuses a blood transfusion which may be required as a consequence of that procedure). If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You 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, you must on request be prepared to transfer the patient's care to that health professional.

If a patient has self-harmed and is refusing treatment/ transfer to Acute care, staff are to seek advice from the Doctor/Consultant (on call /on call manager out of hours). If the patient continues to refuse treatment/ transfer, the Dr must seek advice from the consultant (On Call out of hours). If the patient continues to decline treatment/ transfer to acute hospital and the clinician is of the opinion is that treatment/ transfer is in the best interest of the patient, legal advice must be sought and is available/ accessible through the Legal team or on call director (out of hours).

5.10 Capacity

For a person to have capacity, he/she must be able to comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question and must be able to use and weigh this information in the decision–making process. Patients also need to be able to communicate their decision.

The Mental Capacity Act 2005 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.

Where there are grounds to question whether the patient has the capacity to make the decision in question, an assessment is required. This is a matter for clinical judgement, guided by professional practice and subject to legal requirements. To demonstrate capacity to consent to treatment, individuals should be able to:

- understand the information relevant to the decision
- retain the information relevant to the decision
- use or weigh the information, and
- communicate the decision (by any means).

In England, Wales, and Northern Ireland, a person lacks capacity if their inability to do these things is caused by an impairment or disturbance in the functioning of the mind or brain.

Where it is deemed that a patient lacks capacity to consent to treatment, treatment may be given if it is in their best interest as long as it has not been refused in advance in a valid and applicable Advance Directive. Please see Section 8 of this policy and refer to MCA policy.

5.11 Open Access Clinics

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

Patients attending open access clinics should contact them direct for further information relating to any proposed treatment.

6.0 Children and Consent

It is important to note that the position concerning consent and refusal of treatment for those patients under the age of 18 is different from the position for adults and where treatment is being refused.

6.1 Treatment of Young Children

When babies or young children are being cared for in hospital, it will not usually seem practicable to seek their parent's consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent what routine procedures will be necessary and ensure that you have their consent for these interventions in advance. 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.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children, for example, unmarried fathers do not automatically have such responsibility although they can acquire it if:

- They are registered as the child's father.
- There is an agreement made with the child's mother providing for him to have parental responsibility for the child.
- There is a successful application to the court by the father for parental responsibility.

A mother automatically has parental responsibility upon the birth of the child. The child's father will have parental responsibility if he was married to the mother at the time of the child's birth, if he later marries the mother, (for children born after 1 December 2003), he is named on the birth certificate, he enters a parental responsibility agreement with the mother; or is awarded parental responsibility by the Court via parental residency or residence order. It should also be noted that anyone can obtain parental responsibility if they are granted a residence, special guardianship, or adoption order by the Court. If in doubt about whether an individual has parental responsibility, legal advice should be sought.

If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check (Please refer to section 9.8 of this policy for further guidance).

Children under 16 – the concept of "'Gillick/Fraser' competence"

In 1983 the judgement from Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security: HL 17 Oct 1985, laid out criteria for establishing whether a child under has the capacity to provide consent to treatment; the so-called 'Gillick test'. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options.

If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.

If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment.

6.2 Fraser Guidelines

The 'Fraser guidelines' specifically relate only to contraception and sexual health. They are named after one of the Lords responsible for the Gillick judgement but who went on to address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent. The House of Lords concluded that advice can be given in this situation as long as:

1. He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment.
2. He/she cannot be persuaded to tell her parents or to allow the doctor to tell them.
3. He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment.
4. His/her physical or mental health is likely to suffer unless he/she received the advice or treatment.
5. The advice or treatment is in the young person's best interests.

Health professionals should still encourage the young person to inform his or her parent(s) or get permission to do so on their behalf, but if this permission is not given, they can still give the child advice and treatment. If the conditions are not all met, however, or there is

reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.

Fraser guidelines originally just related to contraceptive advice and treatment but, following a case in 2006, they now apply to decisions about treatment for sexually transmitted infections and termination of pregnancy.

6.2.1 Under 13

There is no lower age limit for Gillick competence or Fraser guidelines to be applied. That said, it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent's involvement. When it comes to sexual health, those under 13 are not legally able to consent to any sexual activity, and therefore any information that such a person was sexually active would need to be acted on, regardless of the results of the Gillick test.

6.2.2 16–17-year-olds

Young people aged 16 or 17 are presumed in law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults and referred to above should be used. If the requirements for valid consent have been met, it is not legally necessary to obtain consent from a person with parental responsibility, but good practice directs that in the case of a patient aged 16 to 17 the family should be involved in the decision-making process, unless the young person specifically wishes to exclude them.

6.3 Child or Young Person with Capacity Refusing Treatment

In England, Wales, and Northern Ireland, a competent refusal by a patient under 16 can be overruled by a court. Healthcare professionals faced with an informed refusal of a treatment they believe to be in the patient's best interests, for example, a refusal of lifesaving treatment or treatment that would prevent permanent injury, should take legal advice.

Treatment may be provided, despite refusal by those with parental responsibility, in

three circumstances:

- in an emergency where treatment is clearly in the child's or young person's best interests.
- a competent young person consents to treatment, or
- the court approves treatment.

7.0 Consent to Treatment Procedures for Patient Detained Under Mental Health Act 1983 (Amended 2007)

The Mental Health Act 1983 (Amended 2007) permits some medical treatment for mental disorder to be given without consent, however, wherever practicable, the patients consent should still be sought before the treatment is given.

7.1 Key Principles of Consent and the Mental Health Act 1983

Neither the existence of mental disorder nor the fact of detention under the Mental Health Act should give rise to an assumption of incapacity. The person's capacity must be assessed in relation to the particular decision they are being asked to make.

Consent or refusal to consent to treatment should be recorded in the patient's electronic records, as should an assessment as to the patient's capacity to consent.

If a patient withdraws consent, the clinician in charge of the treatment should review the treatment and consider whether to provide alternative treatment, give no further treatment or proceed with treatment in the absence of consent under the Mental Health Act (where appropriate).

The responsibility for ensuring that a treatment plan is in place lies with the Responsible Clinician. Treatment plans are essential for patients who are being given treatment for mental disorder under the Mental Health Act 1983. The treatment plan should form part of the care plan under the Care Programme Approach, be recorded in the patients' electronic records and should include immediate and long-term goals and treatment methods. The plan should be reviewed regularly and in conjunction with the patient and with carers where appropriate.

7.2 Part IV of the Mental Health Act 1983

Part IV of the Mental Health Act 1983 relates to treatment for mental disorder for those patients liable to be detained in hospital and covers those patients liable to be detained under the following sections:

- Section 2: Admission for assessment
- Section 3: Admission for treatment
- Section 36: Remand of accused person to hospital for treatment.
- Section 37: Powers of courts to order hospital admission or Guardianship
- Section 37/41: (as above – additionally with restriction on discharge etc)
- Section 38: Interim hospital order
- Section 44: Committal to hospital under section 43
- Section 45a: Power of higher courts to direct hospital admission
- Section 47: Removal to hospital of persons serving sentences of imprisonment etc.
- Section 47/49: (as above – additionally with restrictions on discharge etc)
- Section 48: Removal to hospital of other prisoners
- Section 48/49: (as above – additionally with restrictions on discharge etc)
- Section 17e: Community Treatment Orders recalled to hospital (see Part 4a for Section 17a)

Patients not covered by Part IV of the Act are those patients detained under the following sections:

- Section 4: Admission for assessment in cases of emergency
- Section 5: Sections 5(2) & 5(4) Emergency holding powers.
- Section 35: Remand to hospital for report on accused's mental condition
- Section 135(1:) Warrant to search for and remove patients – sub-section (1) specifically.
- Section 136: Removal of mentally disordered persons without a warrant
- Section 17a: Conditionally discharged patients who have not been recalled to hospital (See part 4A Below).

7.3 Definition of 'Medical Treatment' under the MHA 1983 – section 145

Medical treatment is defined in section 145(1) of the Mental Health Act 1983 as including 'nursing, psychological intervention and specialist Mental Health habilitation, rehabilitation and care'.

Section 145(4) makes it clear that medical treatment for mental disorder means treatment 'for the purpose of alleviating or preventing a worsening of a patient's mental disorder or one or more of its symptoms or manifestations'. The Mental Health Act Code of Practice (2015) states that 'it should never be assumed that any disorders or patients are inherently or inevitably untreatable'.

Medical treatment must be appropriate, taking into account the nature and degree of the person's mental disorder and all their particular circumstances; the treatment must also be available. This 'applies to those liable to be detained under sections 3, 36, 37 (or 37/41), 44, 45A, 47, 47/49, 48, 48/49 and those patients on a Community Treatment Order. It also applies to those patients who were originally detained under the Criminal Procedure (Insanity) Act 1964 prior to the amendment of that Act on 31st March 2005.

Part IV applies to all forms of treatment for mental disorder however, certain types of treatment are subject to special rules – see below. All certificates authorising treatment must be emailed to the Mental Health Act Office: lep-tr.mentalhealthact@nhs.net who will upload this to the patient's electronic record. The MHA Office sends out reminders promptly as detailed in Appendix 3 to this document.

Part IV – Sections Explained and Relevant Forms

7.4 Section 57 – Treatment Requiring Consent and a Second Opinion

Section 57 of the Act relates to those treatments that require both the consent of the patient and a second opinion from a SOAD and provided for by the CQC.

Treatments covered by section 57 currently cover neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive. Section 57 is applicable to both informal and detained patients and certificates authorising section 57 type treatments must be authorised using form T1. A T1 certificate will become invalid if the patient no longer consents or no longer has the capacity to consent to the treatment.

7.5 Section 58 – Treatment Requiring Consent or a Second Opinion

Section 58 of the Act relates to those treatments requiring consent of the patient or a second opinion from a Second Opinion Appointed Doctor.

Treatment currently covered by section 58 is medication for mental disorder after three months of medication for mental disorder first being administered during an unbroken period of compulsion.

A period is not unbroken because a patient moves from a section 2 to a section 3, nor is a period unbroken if a person becomes a Community Treatment Order patient and then is recalled back to Hospital and has their Order revoked.

If, after 3 months of administration of medication, a patient has capacity and consents to the treatment, a form T2 is completed by either the approved clinician in charge of the treatment or a Second Opinion Appointed Doctor.

If the patient withdraws consent or loses capacity to give consent, the T2 is no longer valid and cannot be relied upon as authority to treat.

If the patient refuses to consent to the treatment after 3 months of administration, or does not have the capacity to consent, or withdraws consent or loses capacity, a form T3 must be signed by a Second Opinion Appointed Doctor if he/she believes it is appropriate for the treatment to be given (see also s62).

As to if the patient has or lacks capacity to make the decision to accept medication, this must be documented on the appropriate Trust form on SystmOne (see Appendix 6 to this document).

All certificates must set out the forms of treatment to which they apply. All drugs should be listed (including “as required” drugs), either by their name or their class as described by the British National Formulary (BNF). If the drugs are described by class, the certificate should state how many of each drug within the class is authorised and whether any are particularly excluded (e.g. Clozapine). Maximum dosage and route must also be set out.

If, once section 58 is applicable, medication is prescribed that is not covered on the certificate then it should not be given until a fresh certificate is authorised or unless section 62.

It is the responsibility of the administering professional to check the medication authorised on the certificate against the prescription chart each time the medication is given, satisfy themselves that the certificate remains applicable and raise any issues of incompatibility immediately with the Responsible Clinician (RC).

Treatment certificates may be time limited; however, if no specified time for validity of the certificate is recorded on the form, it is important that the clinician in charge of the treatment reviews it at regular intervals. A T2 form will require review on an annual basis if not subject to any other relevant change (see below).

A T2 certificate will need to be changed if the approved clinician who issued the certificate stops being the approved clinician in charge of the treatment. A T3 certificate will need to be updated if the certificate was given on the basis that the patient had capacity to consent and was refusing and either the patient is now consenting, or the patient has lost capacity. The T3 certificate will also need to be changed if the patient did not have the capacity to consent and has regained capacity.

7.6 Section 58A – Electro-convulsive Therapy, etc.

Section 58A – this section also covers treatment requiring consent or a second opinion but the current relevant treatment in section 58A is Electro Convulsive Therapy (ECT) together with medication administered as part of ECT.

Section 58A cannot be used if the detained patient has capacity to consent to treatment and has not done so; a Second Opinion Appointed Doctor cannot authorise ECT in the face of a capable refusal unless it is an emergency. In other words, section 58A can only be given with either the patient's valid consent or with a Second Opinion Appointed Doctor's certificate when the patient lacks capacity, and it does not conflict with a valid advance decision to refuse the treatment, or conflict with a decision made by a lasting power of attorney or a deputy from the Court of Protection or a decision from the Court of Protection.

The use of section 58a in relation to people under the age of 18, whether detained or not can only be given electro-convulsive therapy if they have consented to it and a Second Opinion Appointed Doctor has certified (Form T5) that the patient can understand the nature, purpose and likely effects and it is appropriate that the treatment be given.

When a person under 18 is not capable of consenting, a Second Opinion Appointed Doctor certifies (Form T6) that the patient is not capable of understanding the nature, purpose and likely effects of ECT but it is appropriate that the treatment is given and it would not conflict with a decision made by a deputy appointed by the Court of Protection (for 16 & 17 year olds only) or a decision by the Court of Protection preventing the treatment being given (advance decisions to refuse treatment and lasting power of attorneys do not apply to those under the age of 18.

Certificates by Approved Clinicians or Second Opinion Appointed Doctors confirming that the patient has given valid consent are made using form T4. A certificate by a Second Opinion Appointed Doctor stating that the treatment is appropriate in the case of a patient who does not have the capacity to give consent is made using form T6.

A T4 certificate must be changed, if the Approved Clinician who issued the certificate stops being the Approved Clinician in charge of the treatment, or if any time limit expires.

A T4 or T6 certificate issued by a Second Opinion Appointed Doctor will become invalid if any time limit expires, if the patient was consenting and is no longer consenting or has lost the capacity to consent; if the patient lacked capacity to consent and has now regained capacity or if it is discovered that the incapacitated patient has made an advanced decision to refuse treatment which would conflict with the treatment, or an attorney, deputy or the Court of Protection makes a decision that treatment should not be given.

7.7 Section 62 Urgent Treatment

Sections 57 and 58 will not apply if the treatment:

- Is immediately necessary to save a patient's life;

- Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others

For Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.

If section 62 is to be used as authority to treat, the treatment can continue for as long as it remains immediately necessary; if it is no longer immediately necessary, the normal requirement for a certificate will apply.

If section 62 is used as authority to treat, the Approved Clinician in charge of the treatment should complete the relevant section 62 form – see Appendix 7.

7.8 Section 63 – Other treatments that do not require the patients consent.

Specifically, this covers all medical treatment for mental disorder which is not covered by sections 57, 58 or 58A; providing it is given under the direction of the Approved Clinician in charge of the treatment.

This includes treatment of the conditions that are a symptom or manifestation of the mental disorder as noted in the B v Croydon Health Authority case in (1995).

This includes physical treatment for conditions that could be a symptom or manifestation of a mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder, feeding by naso-gastric tube of a patient with anorexia nervosa or treatment for an overdose).

7.9 The Second Opinion Appointed Doctor (SOAD) Certificates for Section 57/58/58A.

When the Second Opinion Appointed Doctor carries out the assessment, she/he will expect to discuss the treatment plan with two statutory consultees who have been professionally concerned with the patient's medical treatment. One must be a nurse and one must be neither a nurse nor a doctor (it could be an occupational therapist, social worker, psychologist, pharmacist etc.)

It is for the Second Opinion Appointed Doctor to be satisfied about the validity of the person's profession and/or opinion. The name and designation of the two statutory consultees must be recorded on the request form.

The Second Opinion Appointed Doctor will also expect to see the clinical records and interview the patient.

It is a legal requirement that the reasons as to why the patient should have the treatment be communicated to him/her. It is the responsibility of the clinician in charge of the treatment to communicate the results of the visit to the patient and this must be documented either within the electronic progress notes or an explanation given as to why if it has not been done and when the position will be reviewed.

7.10 Section 61 & 64H – Review of Treatment

Where treatment is being given in accordance with a Second Opinion Appointed Doctor's certificate, it is a requirement for the Approved Clinician in charge of the treatment (usually the RC) to complete a review of treatment and document it on the form and send to the CQC in these situations detailed below:

- Non-restricted patient - T3 certificate – when the renewal form is furnished (not the time of expiry).
- Restricted patient – T3 certificate – 6 months after the date of the order (not the admission date), then each time that the RC is required to send a report to the Secretary of State for Justice which is a minimum of every 12 months.
- Community Treatment Order (CTO) patient – CTO extension is furnished and during the preceding period the patient had been recalled to hospital AND was treated under the authority of the CTO11 because the SOAD had authorised treatment on recall AND the patient lacked capacity or refused that treatment at the time.
- At any other time as required by the CQC.

7.11 Part 4A of the Mental Health Act 1983

Part 4A of the Act applies to those patients' subject to Community Treatment Orders (CTO) who have not been recalled to hospital and it also brings in aspects of the Mental Capacity Act 2005 (MCA).

The requirements of Part 4A of the Act are firstly, that the person giving the treatment must have the authority to do so, and secondly, if the treatment in question is either medication (section 58 type treatment) or Electro Convulsive Therapy (section 58A type treatment), then a certificate requirement must also be met.

There are different rules for Part 4A patients who have capacity to consent to specified treatments and those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria set out in section 17E.

The Part 4A rules recognise and incorporate aspects of the MCA including advance decisions and persons appointed to make surrogate decisions such as a donee of a lasting power of attorney or a court appointed deputy. It should be noted in these cases that the MCA may not generally be used to give CTO patients any treatment for mental disorder other than where a donee, deputy or Court of Protection order provides consent.

It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient, the MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is 'Gillick competent".

Part 4A patients over the age of sixteen who lack capacity, may be given specified treatments on the authority of an attorney or court appointed deputy or by order of the Court of Protection. If over sixteen, treatment cannot be given where a deputy (or a lasting power of attorney donee if over eighteen) refuses on the patient's behalf.

If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under the MCA (see also 5.2). If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in section 64G of the Act, which reflect the similar scheme in the MCA. This is that the relevant professional believes that the patient lacks capacity, the treatment is immediately necessary (see below) and that any force used is a proportionate response to the likelihood of harm being suffered. The alternative mechanism is via recall to hospital.

In an emergency, treatment for Part 4A patients who have not been recalled and who lack capacity, can be given by anyone (it need not be an Approved Clinician or the Responsible Clinician) but only if the treatment is immediately necessary to:

- Save the patient's life.
- Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.
- Alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- Prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

For Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.

In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision, or a decision made by a person authorised on the patient's behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting CTO patient, who doesn't have capacity, without first recalling them to hospital.

In non-emergency situations (excluding Electro Convulsive Therapy for which reference should be made to paragraphs 25.19 - 25.25 of the Code of Practice and to the Trust's Electro Convulsive Therapy Policy) a patient may lack capacity and object to treatment but, where physical force is not required, he or she can be treated with medication for mental disorder in the community.

For the first month, no certificate is required, however, during this time, an assessment of capacity to consent must be made by the Approved Clinician in charge of the treatment which should be documented on the trusts form on SystmOne (see appendix 6). After the first month, a Second Opinion Appointed Doctor must certify that such treatment is appropriate on a Part 4A certificate (form CTO11) for a person who is judged to be lacking capacity. If a person has capacity and is consenting to treatment in the community, the Approved Clinician in charge of that treatment should complete form CTO12 certifying the patient has capacity and is consenting. If a person is judged to have capacity but is refusing treatment in the community, the Second Opinion Appointed Doctor will visit to consider certifying on form CTO11 that certain treatment proposed for the patient whilst in the community is appropriate even though such certification provides no authority to give it if the patient is refusing; and/or certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital.

The Second Opinion Appointed Doctor will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply.

The arrangements surrounding the Second Opinion Appointed Doctor's examination will be complicated by the fact that the patient is in the community so an appropriate person should be asked to confirm arrangements with the Second Opinion Appointed Doctor and coordinate the process. This will usually be the care coordinator.

Other than in exceptional circumstances, Second Opinion Appointed Doctor examinations will be arranged in a hospital or clinical setting. If the Responsible Clinician agrees that it is necessary to visit a community treatment order patient in a hostel or home, the Second Opinion Appointed Doctor will always be accompanied by an appropriate member of the care team, who will act as one of the statutory consultees. At least one statutory consultee shall not be a Doctor and neither of the

statutory consultee's can be either the Responsible Clinician or the Approved Clinician in charge of the treatment in question – see Code of Practice at 25.54.

When a patient on a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients. If treatment does not include psychotropic medication or Electro Convulsive Therapy and a patient with capacity consents to it, it may be given under the direction of the Responsible Clinician.

If a Second Opinion Appointed Doctor has approved any treatment (on form CTO11) in the event of the patient's recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the Second Opinion Appointed Doctor has indicated otherwise, the certificate will authorise treatment (other than Electro Convulsive Therapy) whether the patient has or does not have capacity to refuse it.

On recall and revocation, treatment that was already being given as described on form CTO11 (but not authorised for administration on recall), may continue to be given if the Approved Clinician in charge of the treatment considers that stopping it would cause the patient serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment (there is no new "three month rule" for section 58 type treatment if the CTO is revoked). This can include previously authorised Electro Convulsive Therapy treatment. For those patients who continue to have capacity and to consent to treatment on recall, the CTO12 will provide authority to continue with that treatment. In the event that a patient loses capacity or is not consenting then consideration will need to be given to whether the criteria for the use of section 62 is applicable. Responsible clinicians must record details of why it was necessary to continue treatment without a certificate and how long it took to obtain a new certificate.

It is not good practice on recall or after revocation, to rely on a certificate that was issued while a patient was detained prior to going onto supervised community treatment even if it remains technically valid. A new certificate should be obtained.

7.12 Section 64H – Review of Part 4A treatment

Where treatment is being given in accordance with a Second Opinion Appointed Doctor's Part 4A certificate, the Approved Clinician in charge of that treatment is required to provide a written report on that treatment and the relevant patient's condition at any time if requested by the Care Quality Commission.

Please refer to the LPT Mental Health Act Procedural Document.

8.0 Consent and the Mental Capacity Act 2005

The MCA 2005 came into force in October 2007 and regulates care and treatment for those people who lack capacity (where the Mental Health Act 1983 does not apply). It

generally applies to people over the age of 18 but some parts apply to young people aged between 16 and 18.

The MCA 2005 essentially codified common law rights of autonomy and bodily integrity. It allows for others to make decisions on behalf of the person without capacity (lasting power of attorney, deputies appointed by the Court of Protection etc.) and allows for people to make decisions in advance as to which treatments they do not want in the event that they lose capacity ('advance decision to refuse medical treatment').

The MCA 2005 also provides protection for those carers/professionals caring for people who lack capacity provided the care that is carried out is in their best interest (section 5) and if restraint is used, then that restraint is a proportionate response to the likelihood and seriousness of harm which might occur if the person was not restrained (section 6).

A person must always be presumed to have capacity unless it can be established otherwise. A person cannot be treated as lacking capacity if they make a decision that seems unwise or irrational, unless it can be established that capacity is lacking (see below).

8.1 Test for Capacity

The MCA 2005 defines someone 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 the mind or brain. It does not matter if this is a permanent or temporary disturbance.

An assessment of capacity is based on the person's ability to make a specific decision at the time it needs to be made, not their ability to make decisions in general. A person may have the capacity to make one decision but not another.

A person is deemed to be lacking capacity if the person cannot do one or more of the following:

- Understand the information that is given to them relevant to the decision that they are being asked to make.
- Retain that information for long enough to make the decision.
- Use or weigh up the information as part of the decision-making process.
- Communicate the decision - every effort must be made to assist the person to communicate in whatever mode they can.

And the above is a consequence of an impairment or disturbance of the mind or brain.

If the person is assessed to lack capacity to make a specific decision, this must be documented in the patient's records as to how this assessment was reached and by whom. There is no statutory form required to be completed when using the MCA 2005.

8.2 General Documentation of Consent, Capacity and Best Interests.

Different units in SystmOne have different templates for recording consent, capacity and best interest decisions and services should ensure that staff are aware of how to access these and when to complete them. The standard Consent for Treatment, Intervention & Examination template is available on the LPT Patient Registration Template available in all Trust SystmOne units. This template supports the documentation in the electronic patient record for consent for treatment, examination and photography. This template also includes a quick link to the Mental Capacity Act & DoLS template. See Appendix 9 for DMH templates. See Appendix 11 for DMH Templates

8.2 Advance decisions to refuse Medical Treatment

Under the MCA 2005, all persons over the age of 18, whether in receipt of health services or not, can make a legally binding advance decision to refuse treatment, if, at that point, they have capacity to do so. This would be a decision to refuse particular treatment in anticipation that at some point in the future the person may lose the capacity to refuse the treatment.

Advance decisions to refuse treatment may be given verbally or in writing (in the case of life sustaining treatment, they must be made in writing). If it is valid and applicable, the advance decision to refuse treatment has the same effect as a contemporaneous decision to refuse treatment and must be followed.

A person's treatment decision can be overridden in some limited circumstances. For example, when a patient is detained under the Mental Health Act 1983, the contents of any advance decision relating to a refusal of treatment for mental disorder may be overridden by virtue of the provisions in Part IV of the Act in most cases. Additionally, an advance decision must be valid and application to take effect in the relevant circumstances.

Note that there is an important legal distinction between a written statement expressing treatment preferences, which a health care professional must take into account when making a best interest decision on behalf of an incapacitated patient (sometimes known as an advance statement or directive), and a valid and applicable advance decision to refuse treatment which healthcare professionals must follow.

8.3 Lasting Power of Attorney & Court Appointed Deputies

The Mental Capacity Act allows a person with capacity to appoint someone to make

their health and welfare decisions at any point in the future when they lose capacity. This is known as a lasting power of attorney and dependent on what powers have been granted and when, the donee of a personal welfare lasting of power of attorney can make healthcare decisions which would be as valid as if the person had made the decision themselves.

Deputies are those people appointed by the Court of Protection to make decisions on behalf of the incapacitated person. The powers of a court appointed deputy may be limited in scope, so it is important to ascertain what decision-making powers this person has.

With the exception of Electro Convulsive Therapy, donee's and deputies may not give or refuse consent to treatment on a patient's behalf if that treatment is covered by Part IV of the Mental Health Act (although they could with an incapacitated Community Treatment Order patient under Part 4A of the Mental Health Act – see section 4.5). Nor may they take a decision which will conflict with decisions that a Guardian (for a person under a Mental Health Act Guardianship Order) has a lawful right to make.

Being subject to the Mental Health Act 1983 does not mean a person cannot make a lasting power of attorney if they have capacity to do so. The donee of a lasting power of attorney and court appointed deputies may also have the power to apply to the First Tier Tribunal (mental health) for the patients discharge from detention, guardianship, or a community treatment order.

The rights of the nearest relative under the Mental Health Act are not affected because the person also has a court appointed deputy or a lasting power of attorney. The donee of a lasting power of attorney or deputy may not exercise the rights of the nearest relative (unless of course, they are also themselves the nearest relative).

If there are any doubts as to the rights of a donee of a lasting power of attorney or a court appointed deputy, it is advisable to seek help from the local Mental Health Act office (details of each locality office can be found at appendix 5).

8.4 Independent Mental Capacity Advocate (IMCA)

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

8.5 Court of protection

The MCA 2005 established the Court of Protection which deals with decision-making

for adults lacking capacity. It deals with serious decisions affecting personal welfare matters, including healthcare which were previously dealt with in the High court. It has the same rights, powers, privileges, and authorities as the High Court. Where there are disagreements between the treating team and the donee of a Lasting Power of Attorney or a Deputy regarding a best interest decision, this needs to be escalated to the Court of Protection for a decision and the Trust's legal team will support this process.

8.6 Treatment for Physical Disorder and the Mental Capacity Act

Except in certain circumstances governed by the Mental Health Act 1983 (see Section 5.2.2), if an adult with the capacity to make the decision refuses treatment for a physical disorder, practitioners must comply with the person's decision. If a refusal is ignored, they will be treating the person unlawfully.

The exception, governed by the Mental Health Act 1983, is if the physical treatment is part of or ancillary to treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder, feeding by naso-gastric tube of a patient with anorexia nervosa or treatment for an overdose). In these cases, the ancillary treatment may be given under the authority of section 63 of the Mental Health Act 1983.

For a person who lacks capacity, treatment for physical disorder may be given under the authority of the MCA if it is in the persons best interest and would not conflict with an advance decision to refuse medical treatment or a decision by a donee of a lasting power of attorney or a Court of Protection or a deputy decision. The MCA applies to persons detained under the Mental Health Act 1983 in relation to physical disorders, just as it does to informal patients.

8.7 Best Interests and protection from liability

Section 5 of the MCA 2005 states that as long as acts or decisions are made in the best interests of the person who lacks capacity, the decision maker or carer will be protected from liability. The Act does not give a definition as to what "best interests" means as it encompasses a wide range of decisions and care acts, but section 4 sets out a checklist and states that the care giver/ decision maker must take into account all the relevant circumstances when coming to a decision as to whether the care/ decision is in the person's best interest include finding out if possible, the person's views before they lost capacity and taking into account their current preferences and wishes.

Unless the person has an attorney or deputy, the final responsibility for determining what is in a person's best interest will rest with the relevant health professional. However, the health professional must consult with those close to the patient (e.g.

spouse/partner, family and friends, carer, supporter, or advocate) as far as is practicable and as appropriate.

Section 6 of the MCA 2005 explains that carers can carry out personal care, healthcare, and treatment of incapacitated patients if it is in their best interests, and that this may even extend to the restraint of a person.

However, any action in respect of restraint on a person who lacks capacity will only be lawful if the person taking the action believes the restraint is necessary to prevent harm to the person who lacks capacity and the amount or the type of restraint and the length of time of restraint must be a proportionate response to the likelihood and seriousness of the harm. In other words, if restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum force for the shortest time possible.

8.8 Deprivation of Liberty

On 1st April 2009, Deprivation of Liberty Safeguards (DOLS) came into effect. This means that if an incapacitated person will be cared for in a manner which amounts to a deprivation of their liberty, authorisation for this must be obtained from a "supervisory body" (i.e. the local authority) or, if the deprivation falls outside of the scope of the safeguards, then authority must be obtained from the Court of Protection. This does not apply to persons detained in Hospital under the Mental Health Act 1983.

Having an authorisation to deprive someone of their liberty does NOT automatically also allow the treatment of that person. Treatment that is proposed following a deprivation of liberty authorisation may only be given with the persons consent (if they have the capacity to make this decision) or in accordance with the MCA 2005.

If a patient on a mental health inpatient ward lacks capacity and is objecting to their care and treatment, consideration must be given to treatment and detention under the Mental Health Act 1983 rather than the Mental Capacity Act 2005.

8.9 Children and young people

The legal position relating to treatment of children and young people varies from adults with regards to certain sections of the Mental Health Act 1983. Other legislation which may be applicable includes the Children Acts 1989 and 2004; the MCA 2005 and the Family Law Reform Act 1969. In this policy, children refer to those under the age of 16 and young people refers to those aged 16 and 17.

When taking decisions about children and young people, it is important to establish whether they have the capacity or competence to consent to the treatment and whether they are actually consenting. As the rules relating to treatment of young people and children can often appear quite confusing, it is always preferable to seek advice from the local Mental Health Act office if unsure of legal authority to treat.

8.10 Treatment for mental disorder and the informal child or young person

Treatment can be given to an informal child or young person if they have the competence or capacity to consent and they are consenting to it. If the child or young person is informal and they lack capacity, then a person with parental responsibility may give consent on their behalf if it falls within the scope of parental responsibility.

The Mental Health Act Code of Practice advises that parental consent should not be relied on for authority to treat if the child or young person has capacity and is not consenting.

If the young person of 16 or 17 lacks capacity then it may be possible to treat them in accordance with the MCA 2005 (however, this cannot be relied on to authorise treatment if the treatment would result in the person being deprived of their liberty; also the MCA will only apply if section 2(1) is fulfilled – that is that the person lacks capacity because of an impairment or a disturbance in the functioning of the mind or brain. If they are unable to make a decision for some other reason, for example because they are overwhelmed by the implications of the decision, the Act will not apply to them).

It is prudent to refer any disagreements (regarding capacity or best interests and treatment issues of the child/ young person) between a family and the clinical team to the Trust's legal team to seek clarification in the first instance on the legal position of the Trust. It may be deemed advisable following this consultation to seek a declaration from the Court to resolve the matter.

9.0 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. The one exception to this principle is set out in paragraph 3 below. If you

wish to use such a recording for education, publication, or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

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

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

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

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent. Where children may be involved, seek advice from Children's Services on photography and video recording confidentiality and consent, copyright, and storage for specific policies.

10.0 Training

LPT recognises the importance of consent education and training. Following training needs analysis, all clinical staff require formal training on consent. The level of training required is as follows:

New Starters - receive basic training in consent issues as part of their induction via Role essential Training (in the Record Keeping session, Mental Capacity Act & Mental Health Act)

Existing Staff - receive updates via Clinical Mandatory Training (in the Record Keeping session, Mental Capacity Act Training & Mental Health Act).

Medical Staff not directly employed by LPT must provide evidence of yearly consent training from their direct employer.

Training needs are identified and addressed in Appendix 2 'training template'.

In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role essential training.

The course directory e- source link will identify who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

A record of the event will be recorded on u-Learn.

The governance group responsible for monitoring the training is the Patient and Carer Experience Group.

11.0 Monitoring and Compliance

The primary responsibility for ensuring all clinical staff have been trained to the required standard lies with the Managers. All consent training is logged on to the LPT trust wide mandatory training database. LPT formally monitors compliance via the Performance Review process which takes place across all localities and their services.

The risks associated with the consent process are monitored via a number of routes: All patient safety incidents and complaints relating to the consent process are monitored via LPT clinical governance processes and areas of concerns escalated via CEG directorate reporting. Regular monitoring audits (MHA and care planning) will be undertaken to monitor compliance with this policy to ensure that the appropriate process is followed for obtaining consent and that this is recorded.

This policy is compliant with standard 5.2 (Patient Information & Consent). To understand how this standard is monitored, refer to the table in Appendix 3. The audit will use an approved methodology and will be performance managed by the Patient and Carer Experience Group.

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
	Review of patient safety incidents and complaints relating to consent	Incident and compliant analysis as part of CEG reporting	HoN via CEG reporting	CEG (reported as and when)
	Process for obtaining consent	Record Keeping/Care Planning Monitoring Audit	Service Directors DMT/MHA GDGD	Directorate Monthly, Q&S DMT with assurance through MHA GDG Bimonthly
	How information is provided to patients to support their decision making, including risks, benefits, and alternatives where appropriate	Record Keeping Audit	Matrons/ Service Leads	Directorate Monthly, Q&S DMT with assurance through CEG
	How the discussion and provision of information to patients is recorded	Record Keeping Audit	Matrons	Directorate Monthly, Q&S DMT with assurance through CEG
	Process for recording that consent has been given	Record Keeping Audit	Matron	Directorate Monthly, Q&S DMT with assurance through CEG

12.0 References and Bibliography

Department of Health 2009 Reference Guide to consent for examination or treatment 2nd Ed https://assets.publishing.service.gov.uk/media/5a7abdcee5274a34770e6cdb/dh_103653__1_.pdf

Nice guideline (NG 204) 2021 Babies, Children and young people's experience of Healthcare https://www.nice.org.uk/guidance/ng204/chapter/Recommendations

Mental Capacity Act 2005 Code of Practice Third Impression 2007 https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf

Mental Health Act 1983:Code of Practice 2015 https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF

Consent for Children-Gillick v West Norfolk and Wisbech Area Health Authority [1986] https://www.healthcareethicsandlaw.co.uk/consent-healthcare-ethics-law/gillickcompetence

The Children Acts 1989 https://www.legislation.gov.uk/ukpga/1989/41/contents

The Care Act 2014 https://www.legislation.gov.uk/ukpga/2014/23/contents

Care Quality Commission Regulation 11:need for consent https://www.cqc.org.uk/guidance-providers/regulations/regulation-11-need-consent

General Medical Council (GMC) (Dec 2024) Decision making and consent https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent

Nursing &Midwifery Council The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Health & Care Professions Council (2024) Standards of conduct, performance and ethics https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics-2024.pdf

Health Research Authority (2023) UK Policy Framework for Health and Social Care Research https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/uk-policy-framework-health-and-social-care-research/

Leicestershire Partnership NHS Trust Mental Capacity (2024) https://www.leicspart.nhs.uk/wp-content/uploads/2024/11/Mental-Capacity-Act-2005-Policy-v9-Exp-March-2027.pdf

13.0 Fraud, Bribery and Corruption Consideration

The Trust has a zero-tolerance approach to fraud, bribery, and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or

receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

15.0 Appendix

15.1 Appendix 1 - Due Regard Screening Template

Section 1	
Name of activity/proposal	Consent to Examination or Treatment Policy
Date Screening commenced	April 2025
Directorate / Service carrying out the assessment	Clinical Effectiveness Group
Name and role of person undertaking this Due Regard (Equality Analysis)	Zayad Saumtally
Give an overview of the aims, objectives, and purpose of the proposal:	
AIMS: Policy provides guidance on consent and obtaining consent for patient interactions at LPT.	
OBJECTIVES: This purpose of this policy and related documents is to ensure that all permanent employees including medical staff who work for LPT including those on bank, agency or honorary contracts are clear of their responsibilities around gaining consent to treatment and provide a clear assurance framework for the LPT board.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact, please give brief details**
Age	It has neutral impact on all the protected characteristics
Disability	
Gender reassignment	

Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4

If this proposal is low risk, please give evidence or justification for how you reached this decision:

Decision at the Clinical Effectiveness Group

Signed by reviewer/assessor	Zayad Suamtally	**Date**	September 2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Zayad Suamtally	Date	September 2025

15.2 Appendix 2 - Training Requirements (TNA)

Training Required	YES✓ and is already being. Provided and developed as listed in Section 11.0	YES
Training topic:	Consent	
Type of training: (see study leave policy)	✓Mandatory (must be on mandatory training register) Role specific Personal development	
Division(s) to which the training is applicable:	✓Adult Mental Health & Learning Disability Services ✓Community Health Services ✓Enabling Services ✓Families Young People Children ✓ Hosted Services	
Staff groups who require the training:	New Starters - receive basic training in consent issues as part of their induction via Clinical Mandatory Training (in the Record Keeping session) Existing Staff - receive bi-annual updates via Clinical Mandatory Training (in the Record Keeping session)	
Regularity of Update requirement:	Bi-annual updates via Clinical Mandatory Training (in the Record Keeping session).	
Who is responsible for delivery of this training?	Learning and Development	
Have resources been identified?	To be addressed	
Has a training plan been agreed?	To be addressed	
Where will completion of this training be recorded?	ULearn	
How is this training going to be monitored?	L&D Reports	
Signed by Learning and Development Approval	Alison O Donnell	

Name and Date:	

15.3 Appendix 3 - The NHS constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers Answer yes/no to all

Respond to different needs of different sectors of the population yes/no

Work continuously to improve quality services and to minimise errors yes

Support and value its staff yes/no

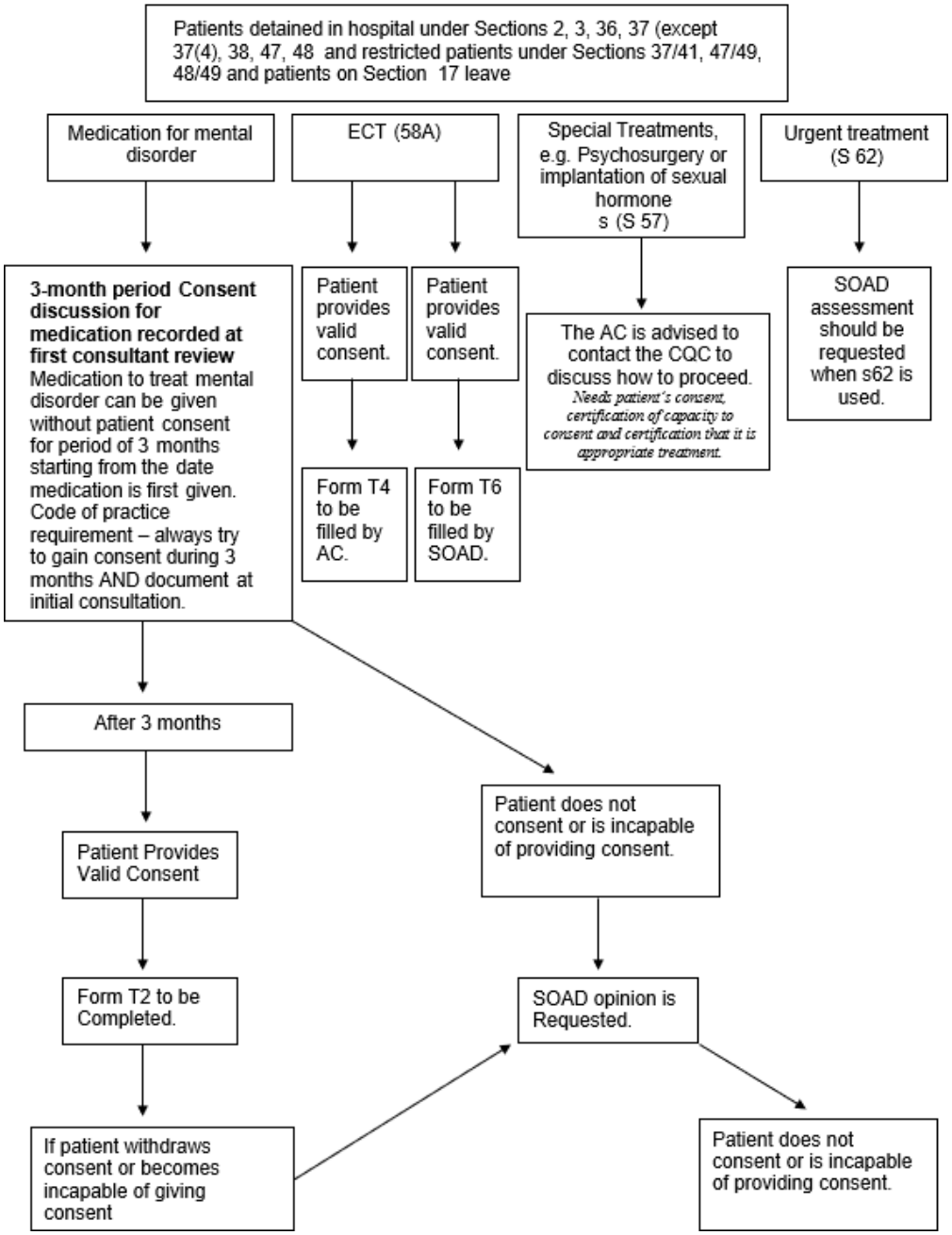
Work together with others to ensure a seamless service for patients yes

Help keep people healthy and work to reduce health inequalities yes/no

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes/no

15.4 Appendix 4 – Flowchart of Consent procedures related to the Mental Health Act

Flowchart of Consent procedures related to the Mental Health Act



15.5 Appendix 5 – MHA Reminders

Part IV of the Act- Consent to Treatment Provisions – Section 58

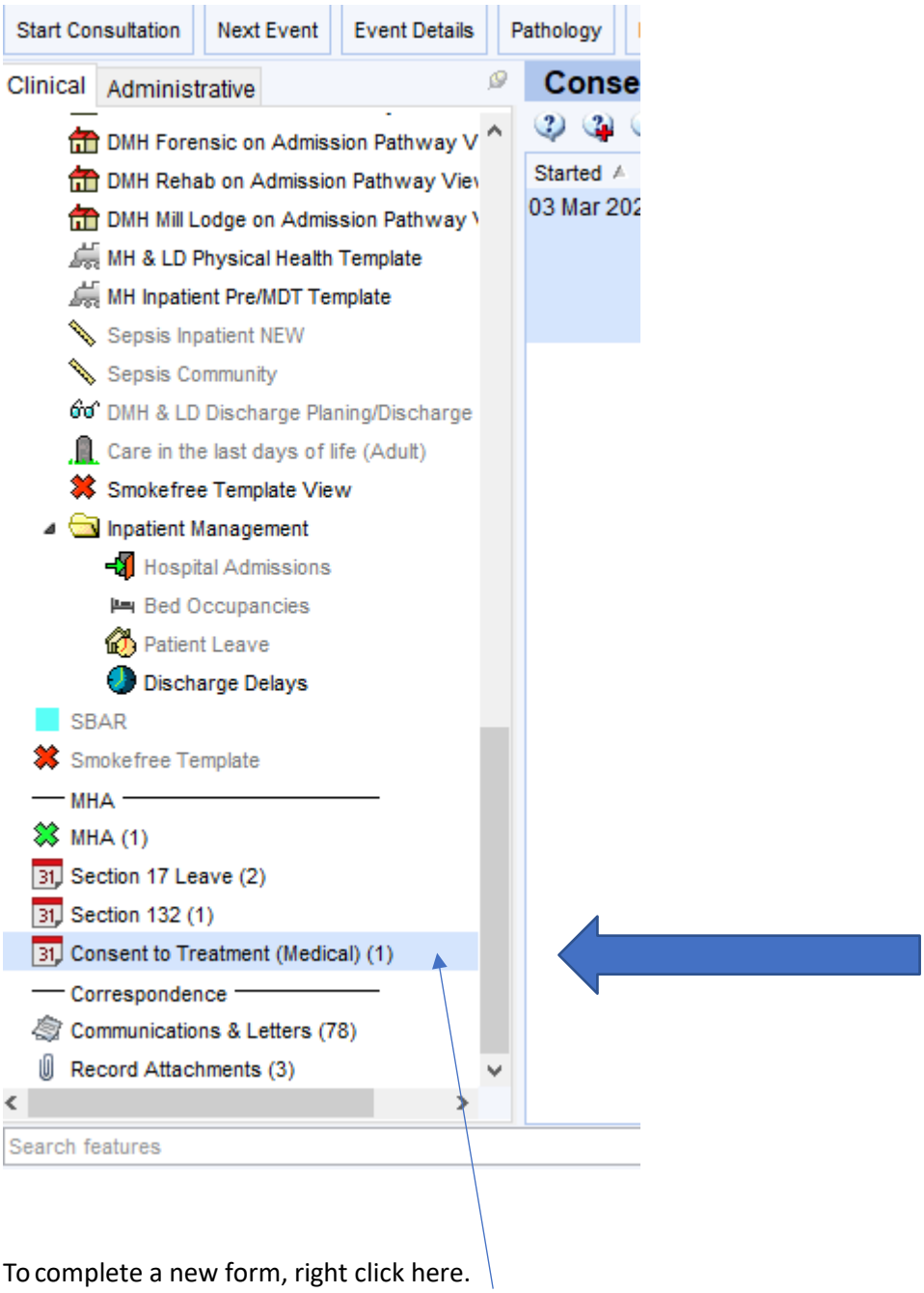
https://www.legislation.gov.uk/ukpga/1983/20/part/IV

COMMUNICATION FROM MHAO	REMINDER PERIOD	ACTION EXPECTED OF RC	RESPONSE REQUIRED FROM RC	TIMESCALE
The RC is notified by email of the requirements of Part IV of the Act:				
Section 3 & 37	6 weeks prior to due date - 1 month and 1 week prior to due date	Assess the patient's capacity and understanding and agreement to receiving treatment.	Completed T2 or C6 Where a C6 is completed, it remains the responsibility of the RC to request a SOAD.	Prior to due date
Section 17a	One month and 1 week prior to due date	Assess the patient's capacity, understanding and agreement to receiving treatment.	Completed CTO12 or C6 - Where a C6 is completed, it remains the responsibility of the RC to request a SOAD.	Prior to due date
Transfer of patient's care (as above unless patient is already subject to Section 58 in which case the following applies)	Immediate reminder	Assess the patient's capacity, understanding and agreement to receiving treatment.	As above dependent on detaining section	With immediate effect
Recall/and or revocation under section 17a	Immediate reminder	Assess the patient's capacity, understanding and agreement to receiving treatment	Completed T2 or C6 - Where a C6 is completed, it remains the responsibility of the RC to request a SOAD.	With immediate effect or as advised by MHAO

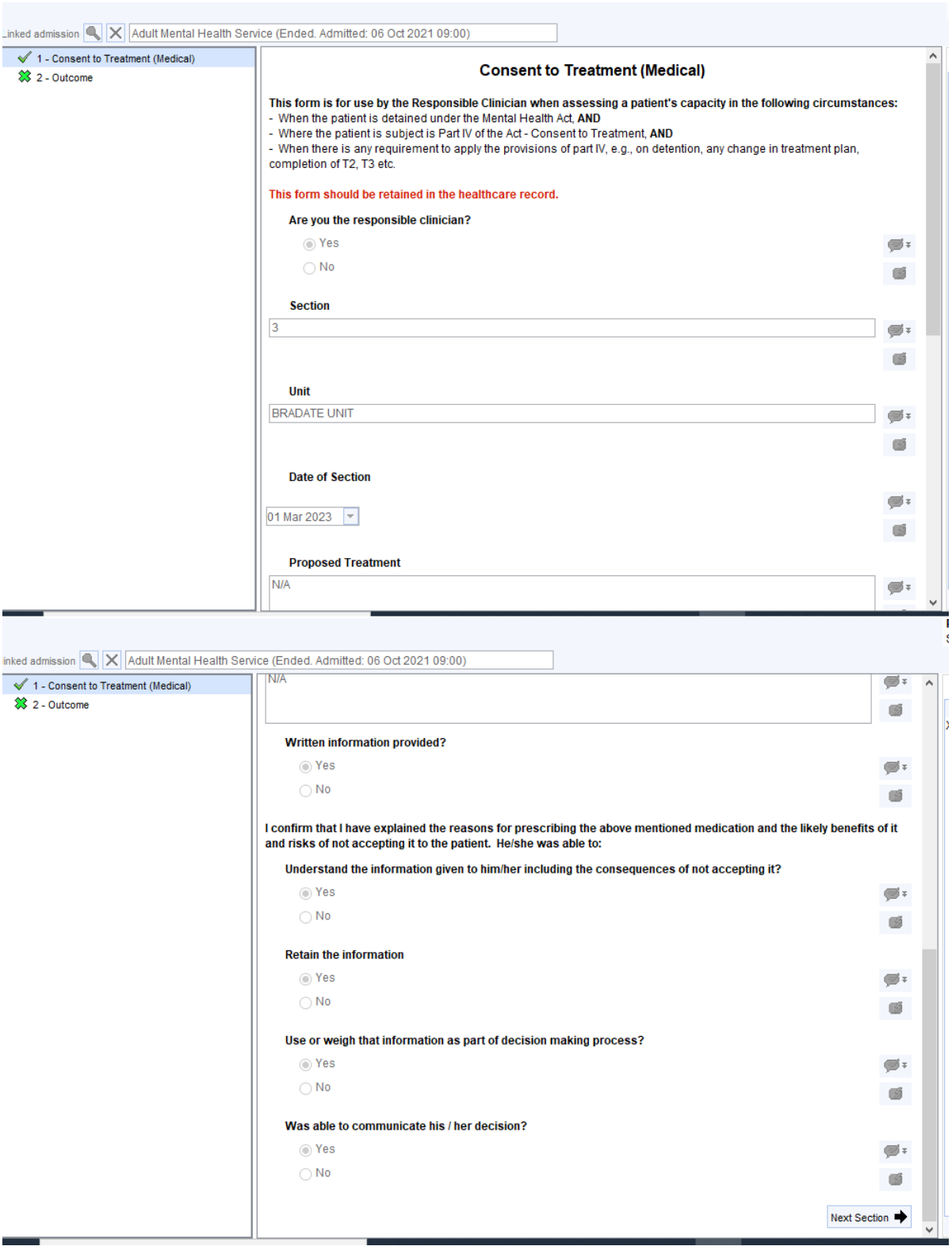
15.6 Appendix 6 – DMH Consent to Treatment (Medical) Form on SystmOne

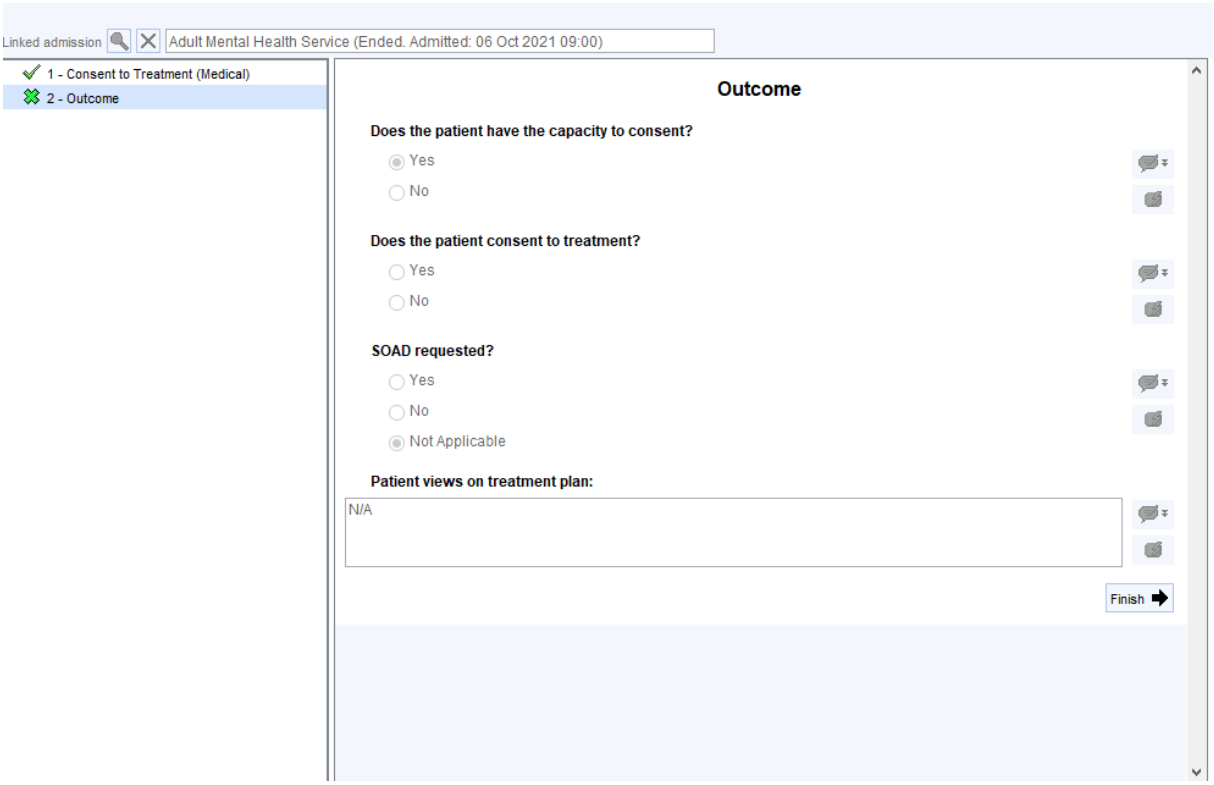
Consent to Treatment (Medical) Form on SystmOne

The Consent to Treatment (medical) form can be located on the clinical tree as shown below.

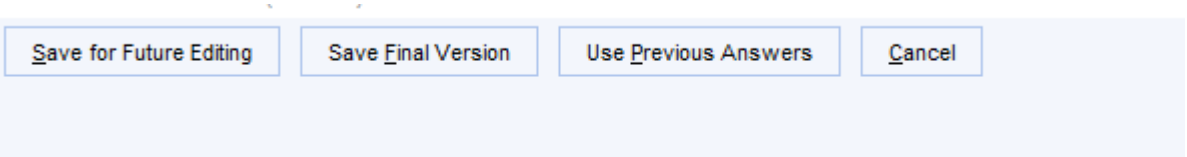


To complete a new form, right click here.

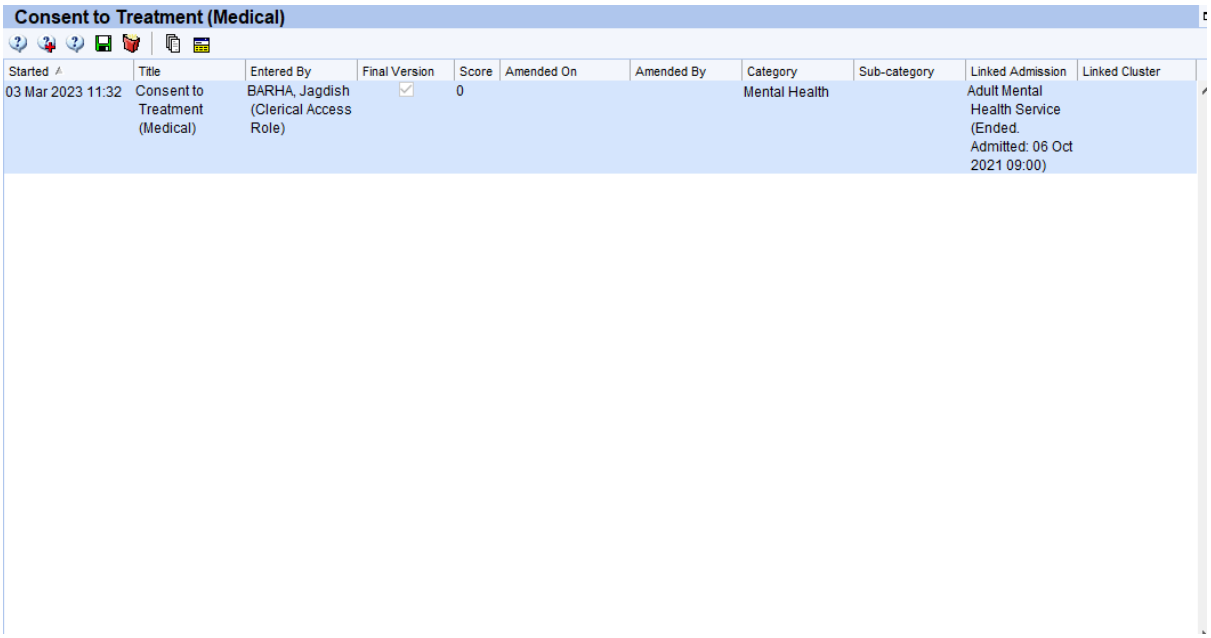


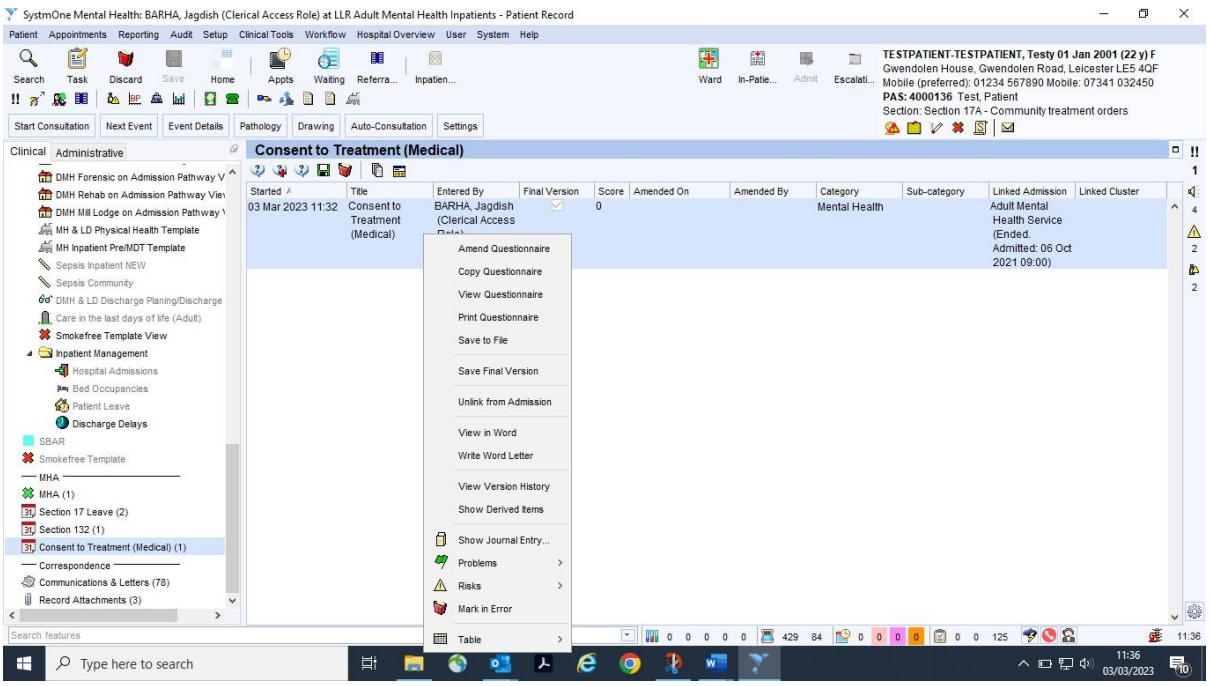


Upon completing the form, choose one of the following options –



The form will then be available to view as below -





15.7 Appendix 7 - URGENT TREATMENT OF PATIENTS DETAINED IN HOSPITAL: SECTION 62 OR 64 OF THE MENTAL HEALTH ACT 1983 (AS AMENDED)

This form must be completed by the Approved Clinician in charge of the patient's treatment if it is necessary to provide treatment as a matter of urgency.

Patient's Name:

NHS Number: DOB:

Inpatient - Section 62 ☐

Community - Section 64 ☐

(Full Name and Address of RC/AC):

I have assessed the above-named patient, and have concluded that they require emergency treatment under section 62/64 because: (delete the statement which does not apply)

(a) he/she/they are capable of understanding the nature, purpose and likely effects of the treatment outlined below and has refused consent.
OR
(b) he/she/they are not capable of understanding the nature, purpose and likely effects of the treatment outlined below.

The proposed treatment is as follows: (please describe the treatment or course of treatment):

Please state why the treatment is immediately necessary:

And the length of time for which the treatment is to be given.

At least one of the following criteria must be met before urgent treatment may be given: (please tick box)

(PLEASE NOTE - FOR ECT ONLY BOX 1 OR BOX 2 APPLY)

☐ The treatment is immediately necessary to save the patient's life.

☐. The treatment, not being irreversible, is immediately necessary to prevent a serious deterioration of the patient's condition.

☐ the treatment, not being irreversible or hazardous, is immediately necessary to alleviate serious suffering by the patient.

☐ the treatment, not being irreversible or hazardous, is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to him/herself or to others.

Signed (Approved Clinician in charge of treatment)

Date

I FURTHER CONFIRM A SOAD HAS BEEN REQUESTED: (Please complete the details of second opinion appointed doctor).

DATE REQUESTED:

SOAD REFERENCE NUMBER:

(Provided by the CQC)

THE COMPLETED FORM SHOULD BE IMMEDIATELY EMAILED TO THE MENTAL HEALTH ACT OFFICE – lep-tr.mentalhealthact@nhs.net

Department of Health & Social Care

Form T2 - Regulation 27(2) Mental Health Act 1983

Section 58(3)(a) — Certificate of consent to treatment

I [PRINT full name, address and, if sending by means of electronic communication, email address],

the approved clinician in charge of the treatment described below/a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD) <delete the phrase which does not apply> certify that.

[PRINT full name and address of patient]

(a) is capable of understanding the nature, purpose and likely effects of: [Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.]

[If you need to continue on a separate sheet please indicate here and attach that sheet to this form.]

AND

has consented to that treatment.

Signed [ ] Date [ ]

Mental Health

www.gov.uk/dhsc

Department of Health & Social Care

Form CTO12 - Regulation 28(1A) Mental Health Act 1983

Section 64C(4A) – Certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate)

(To be completed on behalf of the responsible hospital)

I [PRINT full name, address and, if sending by means of electronic communication, email address]

am the approved clinician in charge of the treatment of [PRINT full name, address of patient]

who is subject to a community treatment order.

I certify that this patient has the capacity/is competent to consent <delete the one that is not appropriate>

and has consented to the following treatment.

The treatment is:

[Give description of treatment or plan of treatment]

If you need to continue on a separate sheet, please indicate here [] and attach that sheet to this form]

Signed [ ] Date []

Mental Health

www.gov.uk/dhsc

Department of Health & Social Care

Form T4 - Regulation 27(3)(b) Mental Health Act 1983

Section 58A (3) — Certificate of consent to treatment (patients at least 18 years old)

THIS FORM IS NOT TO BE USED FOR PATIENTS UNDER 18 YEARS OF AGE

I [PRINT full name, address and, if sending by means of electronic communication, email address],

the approved clinician in charge of the treatment described below/a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD) <delete as appropriate> certify that.

[PRINT full name and address of patient]

who has attained the age of 18 years,

(a) is capable of understanding the nature, purpose and likely effects of: [Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.]

[If you need to continue on a separate sheet please indicate here and attach that sheet to this form]

AND

(b) has consented to that treatment.

Signed [ ] Date [ ]

Mental Health

www.gov.uk/dhsc

15.8 Appendix 8 - How to seek a Court Declaration

In-hours (08.30-17.00)

Applications are to be initiated by the Medical Director
Applications process:

- The attending doctor/Consultant would need to get a formal second opinion from another doctor/Consultant first,
  - Only if both agree that a Court Declaration is required, should the Medical Director be contacted to initiate the application.

Out-of-hours (17.30 - 08.30)
Applications are to be initiated by the On-call Manager or On-Call Executive Director. Applications are to be made:

- Only after a full assessment of the patient's capacity to give consent has

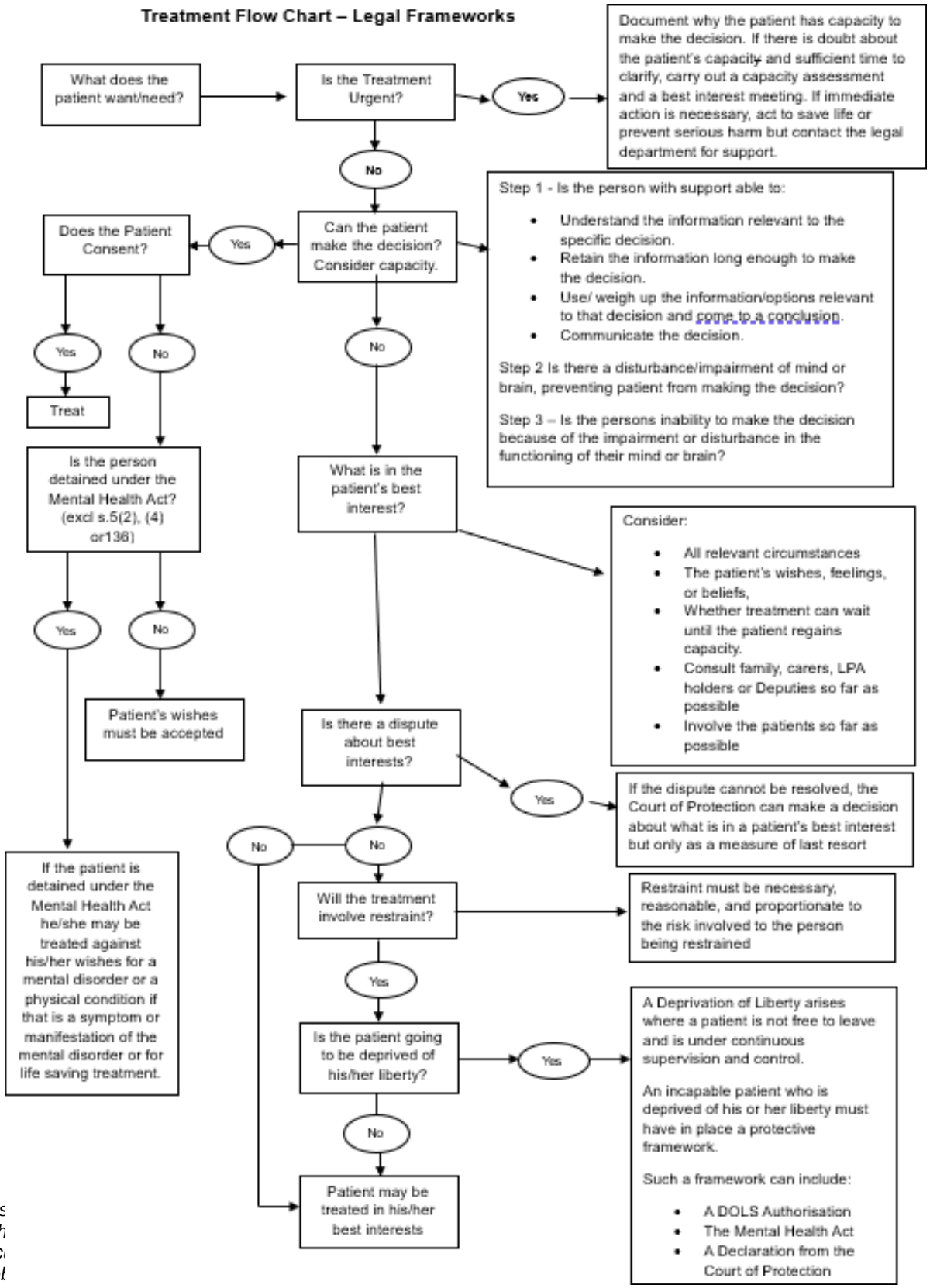
been made by the clinical team, (and teams of the psychiatric on-call team where appropriate).

- Or because the patient is mentally incapacitated or is a child under the age of 16 and the parents
- Or because the guardian has refused to consent to treatment.

Where agreement has been reached that an application to the court, to obtain consent from a judge, is the only course of action open to staff, the Trust's solicitors are to be notified, (a 24-hour service is provided) so that this can be sought.

The telephone number is Bevan Brittan: 0870 1941000

15.9 Appendix 9 – Treatment Flow Chart



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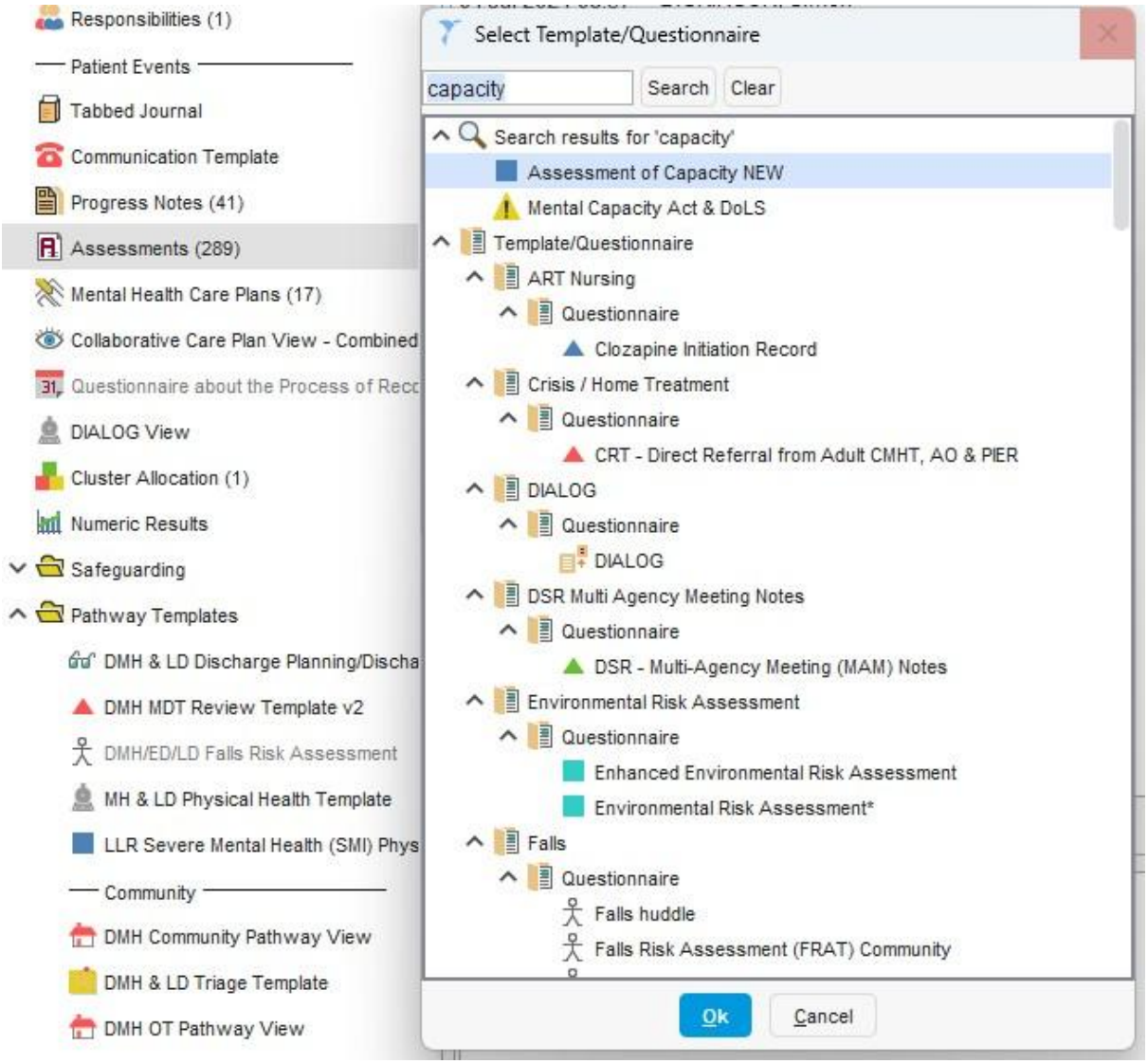
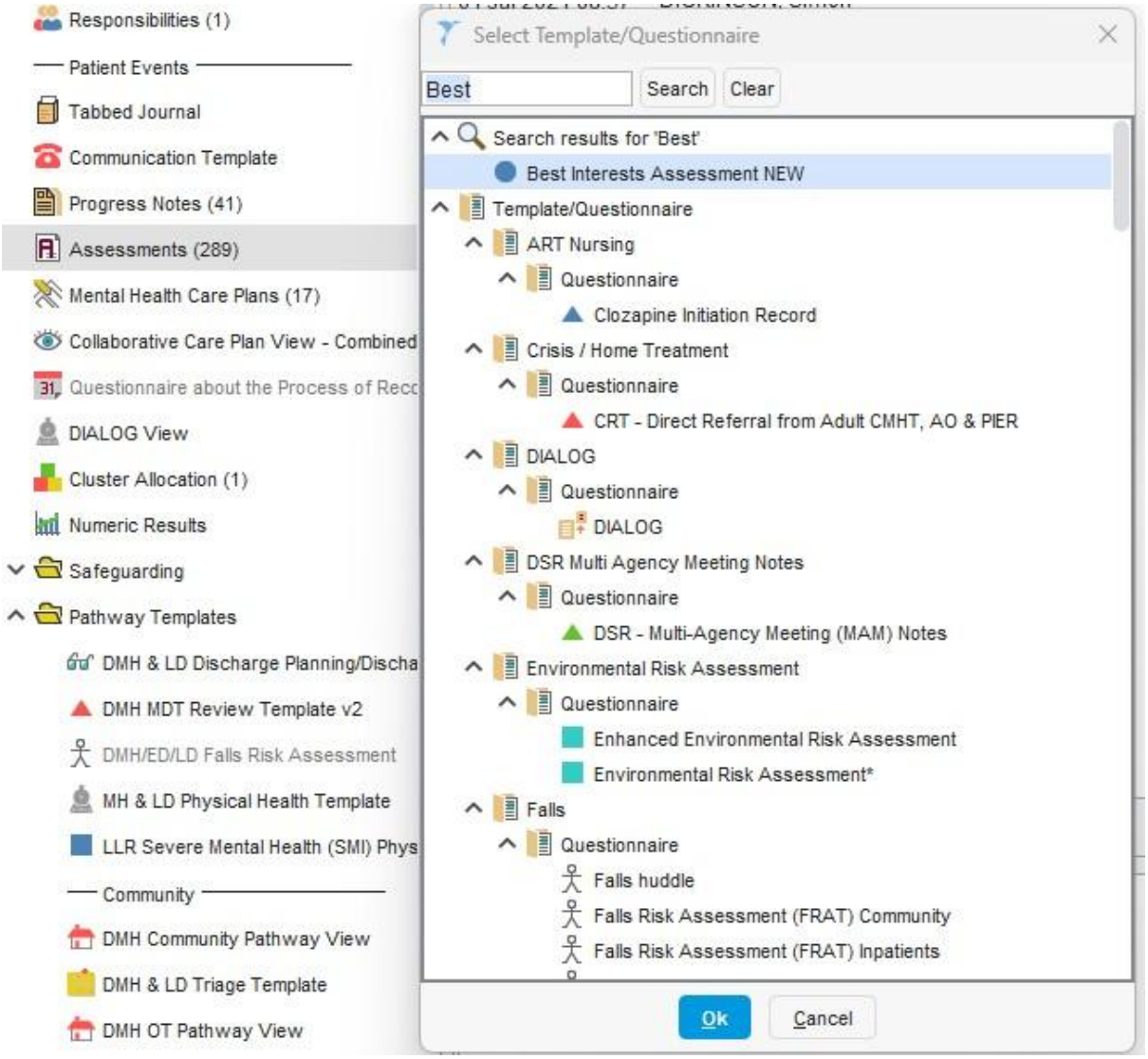
15.10 Appendix 10 – DMH SystmOne Unit templates

In the SystmOne electronic patient record, the assessment of capacity should be recorded on the template “Assessment of capacity NEW”, which is accessed from the “Assessments” tab on the clinical tree and can be found by searching for “capacity”.



Any Best Interest Decisions should be recorded on the “Best Interest Assessment NEW” template, also accessed from the “Assessments” tab on the clinical tree and can be found by searching for “Best Interest”:



15.11 Appendix 11 - Consent for Treatment SystmOne Intervention & Examination Template