Consent to Examination or Treatment Policy
**Policy Title:** Consent to Examination or Treatment Policy

**Executive Summary:**
It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. This policy sets out the Trust requirements in relation to obtaining consent prior to carrying out procedures.

**Supersedes:** V2

**Description of Amendment(s):**
- Introduction of a registration process for all Trust policies and procedures,
- Changes to organisational responsibilities in relation to this policy
- Inclusion of updated appendices required due to the changing needs of the Trust.

**This policy will impact on:**
All Trust policies and procedure documents
Local Specialist Policies (font and control page)

**Financial Implications:**
Limited financial impact - unless failure to comply with policy leads to successful claims of clinical negligence which affect the Trust’s claims history and NHS Litigation Authority contributions.

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**APPROVAL RECORD**

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**Consultation:**
Director of Corporate Affairs & Governance
Governance Managers

**Approved:**
Risk Management Sub-Committee

**Received for information:**
Integrated Safeguarding Meeting
Matrons
1. **Policy Statement**
   It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. Any healthcare professional (or other healthcare staff) who do not respect this principle may be liable both to legal action by the patient and to action by their professional body. Employing bodies may also be liable for the actions of their staff.

   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.

2. **Purpose**
   This document provides guidance on English law concerning consent to physical interventions on patients – from major surgery and the administration or prescription of drugs to assistance with dressing – and is relevant to all healthcare practitioners (including students) who carry out interventions of this nature. Guidance is provided on the legal requirements for obtaining valid consent and on the situations where the law recognises exceptions to the requirement to obtain consent.

3. **Scope**
   This policy applies to all permanent, locum, agency and bank staff who carry out any interventions on living patients (including physical interventions and drug treatment).

4. **Definitions**
   **Consent** is 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.

   **Mental Capacity**: 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. Further guidance can be found in the Trust's Mental Capacity Act Policy

5. **Roles and responsibilities**
   **5.1 Chief Executive**
   The Chief Executive has overall responsibility for ensuring that the Trust has appropriate policies in place and that robust monitoring arrangements are in place.

   **5.2 Medical Director**
The Medical Director has the delegated responsibility for ensuring that appropriate arrangements are in place for the taking of consent to ensure patients are informed effectively and that informed consent is obtained.

5.3 Consultants
Are responsible for a patient’s care have a duty to ensure that:
- The consent process specific to their specialty interventions has been appropriately developed
- All participating staff are fully informed on the process, and that regular updates are provided when any changes/amendments have been required.
- Members of their team are appropriately trained for the process and, therefore, can be allocated responsibility for completing consent, escalate any concerns or questions with which they do not feel able to deal with adequately to the consultant or nominated deputy
- Prior to the commencement of a procedure, and to the initiation of any form of sedation or anesthesia the person who will perform the procedure has ensured that the consent process has been fully completed.

5.4 Staff taking Consent/Performing the Procedure
Staff must ensure that:
- The consent process and the procedure have been appropriately explained and that all questions have been answered.
- Any questions which they cannot answer are escalated to the Consultant or, in his/her absence another senior colleague

5.5 Staff who are not capable of performing the procedure but who are authorised to obtain consent
Staff who have been appropriately trained may be allocated responsibility for explaining the intended procedures to the patients, and ensuring that they are comfortable to sign the consent form. In any circumstances where the patient has either concerns that they cannot answer, or if for some reason they have concerns about the patient’s condition, they should contact a medical colleague to help address these issues. In complex circumstances this may mean that the consultant or a senior member of the medical team must become engaged in the process.

5.6 Staff involved in the patient care pathway
All staff who are involved in the admission, assessment, preparation, explanation and transfer of patients have a responsibility for ensuring that:
- The consent process has been fully followed and that patients have been informed of any risks/benefits
- The consent process had been completed before a patient’s transfer to theatre is undertaken or any sedative medication is administered
- Should they have any concern about a patient’s competency they should formally raise this for assessment before consent or any procedure is undertaken.

6.0 Implementation
The consent process is detailed fully in appendix 1.

7.0 Monitoring and Audit
Monitoring and audit will involve:
- Examining the number of consent related incidents reported.
- Measuring the percentage of compliance with the consent process via the Consent Audit.
- Recording the percentage of consent training completed by staff via bi-monthly update to the Risk Management Sub-Committee provided by the Legal Services Manager.

8.0 Review
This policy will be reviewed every 3 years by the Legal Services Manager.
Appendix 1 – The consent process

1. What consent is and isn’t

“Consent” is 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.

Consent is not valid if obtained by fraudulent means.

The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional’s advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, ‘seeking consent’ is better described as ‘joint decision-making’: the patient and health professional need to come to an agreement on the best way forward, based on the patient’s values and preferences and the health professional’s clinical knowledge.

In general, where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves no one else can give consent on someone else’s behalf. However treatment may be given if it is in their best interests, as
long as the requirements of the Mental Capacity Act 2005 are adhered to and it has not been refused in advance in a valid and applicable advance directive or advance decision.

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

3. Reference guide to consent for examination or treatment
provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies may be accessed on the internet at www.dh.gov.uk/consent and clicking on ‘Consent Key Documents’.

4. Twelve key points on consent: the law in England has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis. Further copies are available from www.dh.gov.uk/consent

Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at www.dh.gov.uk/consent and clicking on ‘Consent Key Documents’

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

6. 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.

7. 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 information stage(s), as well as the confirmation stage.

### Seeking consent: remembering the patient’s perspective

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.

8. Seeking consent for anaesthesia and sedation
Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient’s notes or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that procedure.

In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Note: Details of who can take consent from a patient cannot be exhaustive, the crucial point to be taken from this policy is that patient consent is required on every occasion a healthcare professional wishes to initiate an examination or treatment or any other intervention, except in emergencies or where the law prescribes otherwise (such as where compulsory treatment is authorised by mental health legislation).

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

10. Additional procedures
During an operation it may become evident that the person could benefit from an additional procedure that was not within the scope of the original consent. If it would be unreasonable to delay the procedure until the person regains consciousness (for example because there is a threat to the person's life) it may be justified to perform the procedure on the grounds that it is in the person’s best interests. However, the procedure should not be performed merely because it is convenient. For example, a hysterectomy should never be performed during an operation without explicit consent, unless it is necessary to do so to save life.

If a person has refused certain additional procedures before the anaesthetic (for example, specifying that a mastectomy should not be carried out after a frozen section biopsy result), then this must be respected if the refusal is applicable to the circumstances. The GMC guidance states that it is good practice to seek the views of the patient on possible additional procedures when seeking consent for the original intervention.

11. Treatment of children and young people
Where a child is admitted, you should discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these
interventions in advance. When babies or young children are being cared for in hospital, it may not seem practicable to seek their parents’ 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. 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. Parental responsibility is defined in the Children Act (1989) as: “All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to a child and his property” (Children Act 1989, section 3 (1)).

You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers will have such responsibility if jointly registered with the mother on the birth certificate, but not otherwise). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check. Please see Appendix 5 for definitive guidance re children and young people.

12. Duration of consent
In general, when a person gives valid consent to an intervention that consent remains valid for an indefinite duration, unless it is withdrawn by the person. However, if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken, the General Medical Council (GMC) guidance states that a doctor or member of the healthcare team should inform the patient and reconfirm their consent.

The clinician should consider whether the new information should be drawn to the attention of the patient and the process of seeking consent repeated on the basis of this information. Similarly, if the patient’s condition has changed significantly in the intervening time it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention may also have changed.

If consent has been obtained a significant time before undertaking the intervention, it is good practice to confirm that the person who has given consent (assuming that they retain mental capacity) still wishes the intervention to proceed, even if no new information needs to be provided or further questions answered.

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

14. 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 good practice to seek written consent where 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 anaesthesia or sedation
- Providing clinical care is not the primary purpose of the procedure, e.g. research trials, student observation
- There may be significant consequences for the patient’s employment, social or personal life, e.g. HIV and Hepatitis B testing, pregnancy testing, stress testing.
- The treatment is part of a project or programme of research approved by this Trust

Attending for a procedure and proffering an arm or removing clothing implies consent for the majority of the population. However, there are times when people may be directed or instructed what to do, without fully understanding why, or what is happening.

In the case of people with a learning disability, who present as inpatient, at outpatient clinics, the Emergency Department, community clinics and surgeries, they may not always arrive fully understanding why or what they are there for.

In these cases it is important to establish a person’s preference regarding treatment and their capacity to consent. This should include their level of understanding, their ability to retain the information and their ability to express their choice. This is important even in the most common procedures, (such as the taking of blood pressure, an injection, taking of blood and cytology).

Completed consent 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 initialled 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.

15. Availability of forms
There are four versions of the consent form (see Appendix 3):
Form 1: for adults or competent children,
Form 2: for parental consent for a child or young person
Form 3: for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. 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 anaesthesia and do not need to make any advance decisions about additional
procedures because they will be in a position to make any such decisions at the time if necessary.
Form 4: for adults who are unable to consent to investigation or treatment.

The Trust also uses pre printed consent forms that are procedure specific. A list of procedure specific consent forms is in appendix 3

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

Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgment 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 in their health record. If a hazard that should have been mentioned is not mentioned, the law will impose an obligation to compensate if that hazard occurs.

Recent court judgements (e.g. Chester vs Afshar [2002]) have reinforced the importance of identifying serious risk to the patient, even if that risk is relatively rare. This applies especially if the patient may choose an alternative treatment or no treatment at all if made aware of the risk.

17. Patient Information Leaflets
Patient information leaflets/fact sheets are a useful means of providing information on the procedure and the risks, benefits, alternatives and sources of information, as they can take them away with them and consider the implications of the required treatment.

Information leaflets/fact sheets do not negate the clinician's responsibility to provide a verbal explanation of much of the same information. For example, the clinician will clearly need to explain why one procedure has been suggested over the alternatives in a particular client's specific case.

When providing patient information as part of the consent process, the use and provision of the relevant leaflet must be clearly documented in the patient's health record.

The following sources of patient information are available in this Trust, to ensure that information is available in many formats and readily available,

- A growing library of approved patient information leaflets (EIDO), about specific illnesses, investigations and treatments is available via the trust intranet and throughout wards, departments and outpatient areas
• Health promotion literature is also available as above

In addition:
• A reader’s panel of local patients and public monitors the standard of health literature which is produced in-house being made available to patients at this Trust
• Patient information can be produced in a range of formats including audio, large print and other languages
• Hand held Communicators are available in patient areas, as are low visual aids.
• British Sign Language is available for deaf patients and written information can be provided in large print or Braille for those with sight loss.

Further information and advice can be obtained from the Equality & Patient Experience Manager (01625 663981 – office hours).

18. Provision for patients whose first language is not English

This Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

The Trust has put in place interpreting and translation services. Patients needing a foreign language interpreter can now have instant access 24/7 to a qualified interpreter on the phone at any time during the day or night and face to face interpreters can be arranged when required.

More details can be found in the Interpretation Policy on the Trust internet.

19. Provision for patients with hearing or sight loss

This Trust is committed to ensuring that patients with hearing or sight loss receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to rely on children or family members to interpret or communicate to patients.

British Sign Language is available for deaf patients and written information can be provided in “easy read”, large print or Braille for those with sight loss.

Further information and advice can be obtained from the Equality & Patient Experience Manager (01625 663981 – office hours).

20. Provision for patients with cognitive impairment

For concerns about the ability of a patient with cognitive impairment to understand the information being given, Patient information can be obtained in “easy read” and the trust ids developing a range of photo journeys. Further advice can be obtained from the Equality & Patient Experience Manager (01625 663981 – office hours).

21. Access to more detail or specialist information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. The treating clinician should be prepared to provide more detailed information on request.
22. Access to health professionals between formal appointments
After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). To ensure patients can easily follow up any queries, there is a section on the Form 1 and Form 2 consent forms for the health professional to fill in their contact details.

In compliance with cancer treatment guidelines, all patients are given contact details, including the number of the appropriate health professional, prior to treatment.

23. 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.

24. Who is responsible for taking 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 health professional carrying out the procedure that 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 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.

25. Delegated consent
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. This is known as delegated consent; the clinician has been given delegated authority to obtain consent.

Each specialty wishing to delegate the responsibility for obtaining informed consent for specific procedures must:
- Have a Standard Operating Procedure (SOP) which outlines to whom training for delegated consent will be provided and recorded
- Identify the procedures for which delegated consent is undertaken by those who are not capable of performing that procedure
- Develop a procedure specific training package for undertaking delegated consent for that particular procedure.
The delegating clinician must remember that they retain accountability for the information provided to the patient at all times, even if they have not personally provided it.

Where the healthcare professional 'confirming' consent is unable to answer specific patient queries, they should contact the healthcare professional carrying out the procedure (or where not possible a colleague competent to undertake such a procedure) to ensure the information is provided in a timely manner.

Procedures are in place to ensure that the health professionals 'confirming' the patient's consent have access to appropriate colleagues where they are personally not able to answer any remaining questions. All Consultants carry a pager or mobile phone, the numbers for which are registered with the Trust's Main Switchboard and made known to delegates for immediate advice. Where the Consultant is away from the Trust site, the team must have a nominated second Consultant, within the specialty or a closely related specialty, agreed as a proxy, to provide advice on the patient's Consultant's behalf.

26. Responsibility of health professionals
It is a health professional's own responsibility to:
- Ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent and trained to do so; and
- Work within their own competence and not to agree to perform tasks which they are not competent to carry out.

If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered.

27. Refusal of Treatment
If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the Mental Health Act 1983. 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. For the young patient who is not deemed to be Gillick competent, refer to the parent/carer.

28. Advance decisions to refuse treatment
A person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of common law, and the Mental Capacity Act 2005 puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable.

Healthcare professionals must follow an advance decision if it is valid and applicable, even if it may result in the person's death. If they do not, they could face criminal prosecution or civil liability. The Mental Capacity Act 2005 protects a health professional from liability for treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable. The Act also protects healthcare professionals from liability for the
consequences of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision. If there is genuine doubt or disagreement about an advance decision’s existence, validity or applicability, the case should be referred to the Court of Protection. The court does not have the power to overturn a valid and applicable advance decision. While a decision is awaited from the courts, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the patient’s condition.

If an advance decision is not valid or applicable to current circumstances, healthcare professionals must consider the advance decision as part of their assessment of the person’s best interests. Advance decisions made before the Mental Capacity Act came into force may still be valid if they meet the provisions of the Act. There are transitional arrangements for advance decisions to refuse life-sustaining treatment made before 1 October 2007. Further information is available on the Department of Health website.

Some healthcare professionals may disagree in principle with a person’s right to refuse life-sustaining treatment. The Mental Capacity Act does not change the current legal position. Healthcare professionals do not have to act in a way that goes against their beliefs. However, they must not simply abandon patients or cause their care to suffer. A patient should have the option of transferring their care to another healthcare professional or, if the patient lacks capacity, arrangements should be made for the management of the patient’s care to be transferred to another healthcare professional.

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

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient, and document in their health record, the possible consequences of their partial refusal. 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. Further guidance can be found in the Trust’s Mental Capacity Act Policy.

29. Mental Capacity
The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision for himself if he is unable to:
• Understand the information relevant to the decision
• Retain that information
• Use or weigh the information as part of the process of making the decision
• Communicate the decision

The assessment of capacity should be made by the practitioner in charge of the patient’s medical treatment. Although a psychiatric opinion may be helpful, it should not in itself be regarded as conclusive.

NOTE: Every adult is assumed to be capable. The default position, therefore, is that all adults have capacity until they are proven otherwise

30. Third party consent and advanced decisions
As a general rule, one adult may not provide consent for the medical treatment of another adult. There are two exceptions under the Mental Capacity Act 2005:
• Lasting Power of Attorney (LPA): the person is instructed under an LPA, validly made by the patient while they were still capable and which relates to their health and social care.
• Court of Protection: the person is a Deputy appointed to make decisions on behalf of the patient.

An advance decision (AD) is a refusal of healthcare treatment made when the person is capable. It will only apply when the person lacks capacity. If it is valid and applicable (i.e. it mentions the proposed treatment and circumstances), it will take precedence over consent given by an LPA appointed prior to the AD or Court of Protection Appointed Deputy. It need not be in writing unless it is refusing life-sustaining treatment, in which case it must be signed and witnessed. An AD that otherwise would be valid and applicable will not be so if:
• The patient has withdrawn the AD
• There are reasonable grounds for believing that circumstances exist that the person did not anticipate when the AD was made and that would have affected the decision.
• A LPA has been appointed since the AD
• Since making the AD, the patient has done something inconsistent with it.

Existing Advance Directives (from before the Mental Capacity Act 2005 came into force) are still valid unless they have subsequently been withdrawn.

31. Advocacy – Independent Mental Capacity Advocacy (IMCA)
In some circumstances, an advocate will have to be appointed for a patient who lacks capacity:
• The patient is to have ‘serious medical treatment’ (see below);
• The patient is to be in hospital for more than 28 days or in a care home for more than 8 weeks; or
• The local authority is to arrange for the patient to be accommodated for more than 8 weeks.

A ‘serious medical treatment’ will involve providing, withdrawing, or withholding treatment in circumstances where:
• A single treatment is proposed and there is a fine balance between its benefits and burdens (and risks);
• There is a choice of treatments but a decision as to which one to use is finely balanced; or
• What is proposed would be likely to involve serious consequences for the patient.
32. Procedures to follow when patients lack capacity to give or withhold consent
Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient’s capacity, why the health professional believes the treatment to be in the patient’s best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient’s notes.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient’s situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult’s best interests. Where the consequences of having, or not having, the treatment is potentially serious, a court declaration may be sought. The Legal Services Manager should be consulted in these cases. They can be contacted on: 01625 66 1768 in office hours, out of hours advice should be sought from the on call manager via switchboard. Further guidance can be found in the Trust’s Mental Capacity Act Policy.

33. Referral to court
The Mental Capacity Act established the Court of Protection to deal with decision-making for adults (and children in a few cases) who may lack the capacity to make specific decisions for themselves. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. In cases of serious dispute, where there is no other way of finding a solution or when the authority of the court is needed in order to make a particular decision or take a particular action, the court can be asked to make a decision. The Legal Services Manager should be consulted in these cases. They can be contacted on: 01625 66 1768 in office hours, out of hours advice should be sought from the on call manager (who may instruct out of hours solicitors by referring the matter to the Executive on call).

34. Research
The Mental Capacity Act sets out a legal framework for involving people who lack the capacity to consent to taking part in research. Anyone setting up or carrying out such research will need to make sure that the research complies with the provisions set out in the Act and will need to follow the guidance given in chapter 11 of the Mental Capacity Act (2005) Code of Practice. The Act does not include clinical trials, which are covered by the Medicines for Human Use (Clinical Trial Regulations) 2004.

35. Subsequent Removal of Tissue
The Human Tissue Act 2004

The 2004 Act makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or the deceased for specified health-related purposes and public display. It also covers the removal of such material from the deceased. (It does not cover removal of such material from living patients – this continues to be dealt with under the common law and the Mental Capacity Act 2005.)

The 2004 Act regulates removal, storage and use of human tissue. This is referred to in the Act as ‘relevant material’ and is defined as material that has come from a human body and consists of, or includes, human cells. Cell lines are excluded, as is hair and nail from living people. Live gametes and embryos are excluded as they are already regulated under the Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology Act 2008.

Human Tissue Act 2004 lists the purposes for which consent is required in Schedule 1, and they are referred to as ‘scheduled purposes’. The consent required under the Act is called ‘appropriate consent’, which means consent from the appropriate person, as identified in the Act. Where there has been a failure to obtain or misuse of consent, penalties of up to three years imprisonment or a fine, or both, are provided for in the Act.

Full details on the requirements of the Human Tissue Act 2004 and the Human Tissue Authority’s codes of practice can be found at www.hta.gov.uk.

36. Post mortems
Attitudes towards post mortem examination, in particular the removal of organs and tissue and the use of tissue after death, differ greatly. When death has occurred unexpectedly or as a potential consequence of procedures / interventions undertaken, referral should be made to the Coroner who has responsibility for deciding whether a post mortem should be performed. Although a full explanation should be provided to the relatives and consent should be requested for such procedures, post mortems in appropriate circumstances are a legal requirement they can be undertaken without consent.

It may also occasionally be relevant to discuss the potential of a post mortem (and even agree consent if this is their preference) with a patient who is known to be terminally ill if there is knowledge that they would wish this to be performed for the benefits of others.

If a family refuses consent for a post mortem for religious or other reasons and there are reservations/concerns about whether death may have been influenced by procedures or interventions the doctor responsible for the patient’s previous care should consult with the Coroner.

For religious or other reasons, it may be essential that the funeral takes place as soon as possible and therefore the post mortem needs to be undertaken as promptly as possible. The implications of this should be discussed sensitively and openly, with every effort made to meet the family’s requirements without compromising the outcome. If the post mortem is to be a ‘coroner’s’ post mortem
the issues should be discussed with them. Appendix 3 gives guidance on religion-specific post mortems.

37. Clinical Photography and Conventional or Digital Video Recordings
Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must be clearly explained to the person before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised. GMC guidance gives more detailed advice, including situations when permission is not required and about obtaining consent to use recordings as part of the assessment or treatment of patients and for training and research. Please see the Standard Operating Procedure for Photographing & Video Recording of Patients: Confidentiality, Consent and Storage for more guidance.

38. Training
Generic consent training is provided as per the Training Needs Analysis and an elearning module for Consent (including the Mental Capacity Act) is provided for online training.

Training records
Training records for general consent training are maintained by ESR.

39. Procedure specific training
Clinicians seeking to delegate the role of obtaining consent to junior staff (medical or nursing) have a responsibility to ensure that those to whom they wish to delegate are competent in the general principles of consent and in the specific details of the proposed procedures for which that consent is to be taken.

Each consultant or specialty wishing to devolve the responsibility for obtaining informed consent for specific procedures must develop a procedure specific training package for consent to that particular procedure. Details of specialty consent training is recorded and retained in the individual's personnel file. The delegating clinician must remember that they retain accountability for the information provided to the patient at all times; even if they have not personally provided it. However, the primary responsibility for ensuring that knowledge of consent principles and law is possessed by an individual clinician lies with the clinician themselves.

Nurses are authorised to undertake specific procedures for which consent is required. In this instance, they must demonstrate the appropriate level of competency (Appendix 4). The completed competency statements should be retained in the staff members personnel file.

40. Identifying staff who are not capable of performing the procedure but are authorised to take consent
Each consultant/specialty wishing to delegate consent to junior staff who are not capable of performing the procedure, must have in place a standard operating protocol (SOP). The contents of the SOP will vary from specialty to specialty but should include: the types of procedure for which delegated consent is appropriate; the level/staff group to which delegation is given; and the training that is provided.

41. How the Trust follows up where an individual has obtained consent without the authorisation to do so
If it is identified that an individual has obtained consent without the authorisation to do so a Datix incident report will be completed and escalated as per the incident management process. For medical staff guidance in the Maintaining High Professional Standards Policy will be followed, for nursing/other health professional staff the disciplinary policy will be followed.

42. How the Trust notifies the GMC via the required form, of any individual who has obtained consent without the authorisation to do so. The guidance in the Maintaining High Professional Standards Policy will be followed for notifying the GMC.
APPENDIX 2

QUICK REFERENCE GUIDE

12 KEY POINTS ON CONSENT: THE LAW IN ENGLAND

When do health professionals need consent from patients?
1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

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

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

What information should be provided?
7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?
9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid -- the point of the form is to record the patient’s decision, and also increasingly the discussions that have taken place. Trusts or organisations may have a policy setting out when you need to obtain written consent.

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

Adults who are not competent to give consent
11. No-one can give consent on behalf of an incompetent adult. However, a patient may still be treated if this would be in their best interests. ‘Best interests’ go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to provide information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences.
12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an ‘advance refusal’), and if these circumstances arise, this refusal must be abided by.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available at [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent).
APPENDIX 3

CONSENT FORMS

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

Consent Form 1 - Patient agreement to investigation or treatment.
This form deals with people who have the capacity to consent to treatment. It should not be used if the patient is 18 years or over and lacks the capacity to give consent.

Consent Form 2 - Parental agreement to investigation or treatment for a child or young person.
This form is to be used when a parent (or person who has parental responsibility) is providing consent.

Consent Form 3 - Patient/parental agreement to investigation or treatment (Procedures where consciousness not impaired)

Consent Form 4 - Form for adults who are unable to consent to investigation or treatment

These links identify the templates (DoH) that are in use in the Trust. Wards/Departments will have stocks of these documents for completion by staff.

The Trust also has a number of pre printed procedure specific consent forms available for use. These forms provide ready prepared detail on the risks associated with specific procedures.

The current list includes the following (this is not an exhaustive list – clinical staff should check local documentation to identify if there is a pre printed procedure specific consent form available):

- Appendicectomy
- Cataract surgery with lens implant
- Closure of loop illeostomy/loop colostomy
- Colonoscopy
- ERCP
- Examination under anaesthetic of rectum
- Femoral hernia repair
- Flexible sigmoidoscopy
- Gastroscopy
- Haemorrhoidectomy
- Incision and drainage of abscess
- Laparoscopic +/- conversion to open bowel resection
- Laparoscopic cholecystectomy
- Laparoscopic inguinal hernia repair +/- conversion to open mesh repair
• Laporoscopic nissen fundoplication
• Lateral internal sphincterotomy
• Mastectomy
• Oesophageal stent insertion
• Open incisional hernia repair
• Open incisional hernia repair
• Open inguinal hernia repair
• Parathyroidectomy
• Paraumbilical hernia repair
• Removal of skin lesion
• Reversal of hartmanns procedure
• Staging laparoscopy for cancer
• Surgery for anal fistula
• Surgery for pilonidal sinus
• Thyroidectomy
• Varicose vein surgery
• Wide local excision
<table>
<thead>
<tr>
<th>RELIGION</th>
<th>REQUIREMENTS</th>
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<tbody>
<tr>
<td>Ba’hai</td>
<td>No specific objections or requirements</td>
</tr>
<tr>
<td>Buddhist</td>
<td>No specific objections or requirements</td>
</tr>
<tr>
<td>Christian</td>
<td>Only if required by coroner</td>
</tr>
<tr>
<td>Scientists</td>
<td>Only if required by coroner</td>
</tr>
<tr>
<td>Christians</td>
<td>No specific objections or requirements</td>
</tr>
<tr>
<td>Hindu</td>
<td>Considered distasteful, so only if required by Coroner</td>
</tr>
<tr>
<td>Islam</td>
<td>Only if required by Coroner. The family of the deceased may request that an</td>
</tr>
<tr>
<td></td>
<td>Iman (religious leader) be present during the post mortem. In this instance</td>
</tr>
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<td></td>
<td>time must be allowed for the Iman to arrive before commencing the post</td>
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<td></td>
<td>mortem. This may have a potential conflict with the religious preference of</td>
</tr>
<tr>
<td></td>
<td>burial being undertaken within a time limit and should be discussed / agreed</td>
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<td></td>
<td>with family members. The family may request that any organs removed should</td>
</tr>
<tr>
<td></td>
<td>be returned to the body after examination</td>
</tr>
<tr>
<td>Jehovah’s</td>
<td>Usually only if required by Coroner,</td>
</tr>
<tr>
<td>witness</td>
<td></td>
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<tr>
<td>Judaism</td>
<td>Only if required by coroner.</td>
</tr>
<tr>
<td>Mormon</td>
<td>No specific objections or requirements</td>
</tr>
<tr>
<td>Rastafarianism</td>
<td>Only if required by coroner</td>
</tr>
<tr>
<td>Sikhism</td>
<td>No specific objections or requirements</td>
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APPENDIX 5

CONSENT TO EXAMINATIONS OR TREATMENT OF CHILDREN & YOUNG PEOPLE
(Up to age 18)

NHS Trusts’ policies on consent must specifically address the needs of children and young people (Department of Health 2004). This appendix should be read in conjunction with the main body of the policy.

Consent has to be explicit, treatment specific and involve the child or young person.

Contents of this Appendix:

2. Persons who may have parental responsibility.
4. In Loco parentis (In place of parents).
5. Competent 16 & 17 year olds.
7. Children deemed not to be Gillick –Competent (aged under 16)
8. Refusal of Consent by a child.
10. Teenage Sexual Health.
12. Referral of Children from Third Parties.
1. **Consent Procedure for children and young people.**

Verbal or written consent must be obtained from one of the following and recorded in the patient’s Health Records:

- the parent or person with parental responsibility
- competent 16 & 17 year old
- competent child under 16 (in line with Fraser guidelines/Gillick ruling)

Details of all screening, assessments, examinations, investigations, invasive or non-invasive treatments and procedures must be recorded in the health records together with details of any advice and information leaflets given to the patient and parent.

It is good practice to have consent paperwork in place for specific regularly occurring situations. The NHS recommended forms are not always appropriate.

Consent may be implied if, after received advice on the screening / assessment / examination to be carried out, the parent / person with parental responsibility and/or child present themselves for it to take place.

2. **Persons who may have parental responsibility.**

The Children Act 1989 sets out persons who may have parental responsibility. These include:

- The child’s mother
- The child’s father, if he was married to the mother at the time of birth
- Unmarried fathers, who can acquire parental responsibility in several different ways:
  - For children born before 1 December 2003, unmarried fathers will have parental responsibility if they:
    - Marry the mother of their child or obtain a parental responsibility order from the court
    - Register a parental responsibility agreement with the court or by an application to court
  - For children born after 1 December 2003, unmarried fathers will have parental responsibility if they:
    - Register the child’s birth jointly with the mother at the time of birth.
- Re-register the birth if they are the natural father
- Marry the mother of their child
- Obtain a parental responsibility order from the court
- Register with the court for parental responsibility

- The child's legally appointed guardian - (Under section 5 of the Children Act 1989, courts may appoint a guardian for a child who has no parent with parental responsibility. Parents with parental responsibility may also appoint a guardian in the event of their own death)

- A person in whose favour the court has made a residence order concerning the child

- A local authority designated in a care order in respect of the child a local authority or other authorised person who holds an emergency protection order in respect of the child. Section 2(9) of the Children Act 1989 states that: a person who has parental responsibility for a child ‘may arrange for some or all of it to be met by one or more persons acting on his or her behalf. Such a person might choose to do this, for example, if a childminder or the teaching staff of a boarding school have regular care of their child’. As only a person exercising parental responsibility can give valid consent, in the event of any doubt then specific enquiry should be made. Foster parents do not automatically have parental responsibility. (DH 2009).

In an emergency, it is justifiable to treat a child who lacks capacity without the consent of a person with parental responsibility, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child.

Where there is doubt about whether a parent is acting in the interest of the child or young person, then the healthcare practitioner would be unwise to rely on the parent’s consent, for example if a child alleges abuse and the parent supports psychiatric treatment for the child. The Government’s guidance Working Together to Safeguard Children (2010) covers situations involving parental consent where abuse or neglect is suspected.

In order to consent on behalf of a child, the person with parental responsibility must themselves have capacity. Where the person with parental responsibility
for a child is themselves under 18, they will only be able to give valid consent for the child’s treatment if they themselves are competent according to Fraser guidelines.

3. **Consent for Looked After and Cared for Children.**

A discussion should take place with the child’s carer regarding the most appropriate way of communicating with the child’s social worker. Where it is possible, medical consent should be obtained from the child’s birth parent. Where it is not possible to obtain informed consent from the birth parents the child’s social worker will need to contact their local authority locality manager in order that arrangements for informed consent can be made and suitable arrangements made.

4. **In Loco parentis (In place of parents).**

This assumes custodial/parental responsibility and authority and forms the basis of a duty of care the same as that of a parent in relation to the child. Although this can be established by written contract it is often assumed in common situations e.g. siblings, teachers. They will have limited rights to act *in loco parentis* until the person with parental responsibility can be contacted. Reasonable effort must be made to make contact with parents and make reasonable decisions based on the circumstances of the case for the purpose of safeguarding or promoting the child’s welfare.

5. **Competent 16 & 17 year olds.**

Young people aged 16/17 may have the mental capacity to consent to treatment but they are not necessarily able to refuse treatment. A refusal can be overruled and all that is required to proceed is a valid consent and this may be obtained from:

- A holder of parental responsibility OR
- The Court (in contrast to adults) can consent on behalf of those patients who are 17 and under

Careful consideration needs to be given to the circumstances of a refusal by a patient under 18 years old. There may be circumstances where a minor is mature for their age and would forcibly resist treatment. In such cases or in the cases of
any doubt, legal advice should be obtained as to the lawfulness of proceeding in the face of a minor’s refusal, even if a holder of parental responsibility is in favour of the treatment. This is particularly the case if any force might have to be used.

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

A young person under 16 years may consent to medical treatment if he/she is judged to be competent to give that consent. It is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lord’s ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security. These are commonly known as the Fraser Guidelines:

- the young person understands the health professional’s advice;
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- unless he or she receives contraceptive advice or treatment, the young person’s physical or mental health or both are likely to suffer;
- the young person’s best interests require the health professional to give contraceptive advice, treatment or both without parental consent.

Although this ruling was around sexual health advice it has now been accepted that it can be applied to any situation requiring consent. (Gillick 1985).

The healthcare professional must be able to justify that the young person has sufficient maturity to understand the nature, purpose, hazards and benefits of the treatment in order to give a valid consent. A young person may have the capacity to consent to an uncomplicated procedure but not to a more complex one, e.g.
request for emergency hormonal contraception as opposed to termination of pregnancy.

A child’s request for confidentiality must be respected even when this includes refusing permission to discuss the treatment with his/her parents. However, the healthcare professional should seek to persuade such a young person to tell his/her parents or allow the healthcare professional to do so. If the healthcare professional is to proceed with the treatment without parental involvement he/she must be able to justify that the best interest of the child are being served. When such situations arise, it may be helpful to obtain advice from senior colleagues.

In the majority of cases where there are no issues between child and parent, it is advisable to obtain both the child’s and the parental consent.

Problems may arise if assessment of competence is disputed by parents/guardians. Some parents believe that children under the age of 16 should not have the right to consent to any treatment on their own behalf. This is not a correct statement of law. The test is not one a parent can make. Where such a disagreement arises, the health professional should explain the legal position to the parent.

7. **Children deemed not to be Competent (aged under 16).**
   
   In the case of a child who is under 16 and not Gillick competent, a valid consent to proceed with treatment must be obtained from a holder of parental responsibility.

8. **Refusal of Consent by a competent child.**
   
   The law is not clear. There is no logical reason why a child who has capacity to consent to treatment should not also have an equal right to refuse that treatment. Others can override a young persons wish to refuse treatment, even if they are 16/17 years of age. There have been several court cases, which indicate that a child who refuses treatment can have that refusal overturned by a parent or guardian if it is in the best interests of the child to do so. This power to overrule must be exercised on the basis that the welfare of the child is paramount. This does not just mean physical health.
Where there is a difference of opinion between child and parents or between parents this should be clearly recorded in patient’s notes. If staff are faced with a situation in which a child refuses treatment that may endanger life or health, they should take legal advice.

9. **Attending without a Parent (aged 15 and under).**
   When a child attends without a parent or legal guardian, efforts should be made to contact them and obtain oral consent, which is then recorded in the health records. In the case of a competent young person (see section 6) contacting the parent should be done with the child’s consent, although it would be lawful to proceed on the basis of the competent child’s consent to treatment alone if necessary. In this case a full note should be made of the factors taken into account by the healthcare professional in making his or her assessment of the child’s capacity to give a valid consent. If the child who is alone is unable to give consent and the parent or legal guardian cannot be contacted, then in an emergency, immediately necessary treatment must be given in the best interests of the child. Full account of attempts to obtain consent and of the urgency of the treatment required, should be made in the health records.

10. **Teenage Sexual Health.**
   It is recognised that competent young people under 16 years seek advice in variety of settings and will sometimes not give their permission to parental contact in order to obtain consent. As previously stated, healthcare professionals working with these patients should seek to persuade them to inform a parent.

   However, where treatment is required in the best interest of the patient and parental consent cannot be obtained; the treatment should be carried out, e.g. the provision of contraception, treatment of sexually transmitted infections.

   Sexual health practitioners should always be aware that there may be child protection issues to consider when young people seek advice for sexual health issues.

   Termination of pregnancy requires the signature of 2 doctors who will determine independently the competency of young person.
11. **Safeguarding children & Consent.**

Where any examinations or photographs of children in child protection cases maybe required this must be discussed with the on call consultant paediatrician. This accepts the principles recommended in item 75 of the Laming Report. However there may be circumstances where the consent of a holder of parental responsibility cannot be obtained because that person may be the potential abuser of the child or because obtaining the consent might interfere with the investigation of a serious crime. In such circumstances Social Services must be closely involved and a court order may be necessary. However if there is an urgent need for medical attention, which cannot be delayed, then treatment should take place in the best interests of the child. If possible a written supporting opinion from another senior clinical colleague should be obtained to support the urgency of the situation and need for treatment. The clinician must be able to justify his or her decisions.

12. **Referral of Children from Third Parties.**

Non-emergency referrals of children between agencies, e.g. Education, Social Services, must not be accepted unless consent, preferably in writing, has been obtained from the parent or legal guardian, or from the child if deemed to be competent. It is the responsibility of the referrer to ensure this but if the department receiving the referral are unsure they should seek clarity before accepting.

The written or oral consent obtained should be recorded in the Health Records.

**APPENDIX 5**

Equality Analysis (Impact assessment)
1. What is being assessed?

Consent to Examination or Treatment Policy

Details of person responsible for completing the assessment:

- John Glynn
- Legal Services Manager
- Governance

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. This policy sets out the Trust requirements in relation to obtaining consent prior to carrying out procedures.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

All clinical staff will need to be aware of this document and the requirements to take consent prior to carrying out ant procedures on patients

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □ No X
Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to race with regards to this process. Staff will follow the trust interpretation and translation policy to ensure patients can understand the information given to them, this is detailed in the policy.

__________________________________________________________________________

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes □ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to gender with regards to this process.

__________________________________________________________________________

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to disability with regards to this process. Staff will follow the trust interpretation policy to ensure patients can understand the information given to them, and this is detailed in the policy. For patients with cognitive impairment such as learning disabilities staff will follow the Mental Capacity Act policy. There is a separate consent form in the policy.

__________________________________________________________________________

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes □ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to age with regards to this process. There is specific guidance and a separate form for children and young people.

__________________________________________________________________________

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes □ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to sexuality with regards to this process.

__________________________________________________________________________

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes □ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to religion with regards to this process. There is a specific consent form regarding post mortem and religion belief in the policy.
CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☐ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to carers with regards to this process.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No X

Explain your response:
This policy will be used for the management of the consent process. There is no discrimination in relation to others with regards to this process.

4. Safeguarding Assessment - CHILDREN
a. Is there a direct or indirect impact upon children? Yes ☐ No X

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children
This policy will be used for the management of the consent process and specific arrangements are in place herein to ensure that children are consented lawfully and safeguarded by the process.

5. Relevant consultation
Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations, etc?

Governance Managers; Risk Management Sub-Committee; Integrated Safeguarding Meeting, and Matrons.

6. Date completed: 31st March 2016
Review Date: March 2019

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
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8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead: lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 1.4.16