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1. **Introduction**

This policy aims to provide a robust framework for good practice in relation to obtaining consent for treatment. It informs health care professionals of the legal and ethical requirements in gaining consent either verbal, non-verbal, or written for any intervention.

The main principle of this policy is to ensure that patients with capacity have the right to choose, and that care offered and provided is person centred. For patients who lack capacity either temporarily or permanently, that they are offered care and treated in their “best interest” with dignity and respect.

Implementation of the policy assures the Board that consent is being sought in a manner compliant with National Health Service guidelines and National Patient Safety agency advice.

This policy should be read in conjunction with a number of policy’s and procedures relating to clinical interventions such as infection prevention and control policy, the incident reporting policy, patient identification policy, Risk Management strategy, Mental Capacity Act 2005. The range of policies and procedures are extensive and specific policies and procedures relating to specific interventions should be consulted in conjunction with this policy.

**2 Developmental process**

**2.1 Identification of need**

It is a requirement of providing care to an individual that appropriate and adequate information is provided to enable them to make a decision on what treatment they wish to accept. The Department of Health have developed a standard consent policy which can be adapted locally to fit the needs of the service.. The policy needs to be read in conjunction with a number of local policies and procedures relating to specific clinical interventions.

**2.2 Stakeholders**

The organisation recognises that policies need to be developed in consultation and communication with a range of stakeholders. The following list identifies some of the groups consulted during the development of this policy, but is not an exhaustive list.

|  |  |
| --- | --- |
| **Stakeholder** | **Interest** |
| **Executive Management Team** | **Approval, consultation** |
| **Medical Director** | **Initiation, Lead, development receipt and circulation** |
| **Director of Nursing, Governance and****and Patient Safety** | **Initiation, Lead, development receipt and circulation** |
| **Medical staff** | **Consultation** |
| **Allied Health Professionals** | **Consultation** |
| **Nursing staff** | **Consultation** |
| **Patient Safety group** | **Consultation** |

* 1. **The Risk of Not Having this Policy in Place**
	2. Failure to comply with this policy may result in the following risks arising:
	3. None compliance with Risk Management Standards
	4. Failure to comply with the Mental Capacity Act (2005)
	5. Failure to comply with patient’s legal and ethical rights
	6. Patients suffer as a result
		+ - 1. Risk to individual practitioners

 Litigation

**2.4 Equality Impact Assessment**

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer. Please see appendix C for equality impact assessments.

**3. Dissemination and Implementation arrangements (including training)**

**3.1 Dissemination**

This policy is available in read only format via the document store and web page on the Trust intranet and internet.

This policy is shared via weekly communication The Headlinesand the organisation intranet site. Staff are informed of any changes to the policy via the Headlines and the intranet, training and any other form of media where identified.

**3.2 Implementation**

Further advice to assist with the implementation of this policy can be obtained from the author of the policy,professional leads, matrons, practice/quality governance coaches.

**3.3 Training**

The organisation provides a range of training on obtaining consent

E learning course –The Mental Capacity Act and Deprivation of Liberty Safeguards (Trust wide) (Mandatory)

Focused Mental Capacity Act 2005 training (Trust wide) (essential to job role)

E-leaning course - Mental Health Act 1983 (Mandatory)

Consent to treatment (essential to job role)

Safeguarding adults training (Mandatory)

Safeguarding children training(Mandatory)

Ad hoc specialist sessions

For further information about training please see the Learning and Development Prospectus, available on the Trust Intranet.

Training around the area of capacity and consent can be specifically provided for teams and specialist services.

Training needs analysis should reflect the need for ongoing training for all staff who are providing direct care to patients.

Consult with service managers, specialist advisors and staff who have special knowledge and skills in the area of capacity and consent.

All staff who have access to professional standards and advice through their registrant bodies may wish to seek direct advice from them.

1. **Process for monitoring compliance and effectiveness**

This policy provides advice and guidance throughout as to the process for obtaining and recording consent. The responsibilities for monitoring and compliance of this policy is outlined below at 4.1.

Archiving of information and recordings relating to consent are subject to the rules and policies relating to Information Governance and these polices should be consulted regarding the periods for storage and retention.

The Trust has a number of clinical groups and patient safety group who are reporting and monitoring activity relating to the safe management of patient care and treatment in its many forms. This information is reported to identified Committees within the Trust.

The monitoring of this policies effectiveness is also monitored through the incident reporting systems (DATIX), The monitoring of legal services activity, CQC reporting, Customer Services feedback, Incident management reports all contribute to identifying areas of good practice and also to identify areas of concern.

* 1. **Roles and Responsibilities**

**Role of the Chief Executive**

The Chief Executive is ultimately responsible for the safe implementation of the Consent Policy across the Trust.

The policy is integral to the Trust Governance Structure at all levels and should be embedded at all levels within the organisation.

**The Trust Board and Executive Management Team**

Receive data relating to training

Receive associated complaints, incidents and claims

Approval of changes to the policy and procedure (can be delegated to Clinical Governance and Clinical Safety Committee)

**The Medical Director and the Director of Nursing and Quality.**

Ensure that all operational services are aware of this policy via management and professional communication systems.

Be aware of monitoring of compliance and take action as appropriate

Challenge inappropriate clinical practice

Act as an integral member of the Clinical Governance and Clinical Safety Committee

Assess impact of new information and make recommendations for change.

**Business Delivery Unit Managers and Directors**

Support the implementation of this Policy

Support staff to fulfil, their responsibilities to implement this policy

Support staff training

Comply with procedure

Ensure training records are accurate

Ensure this policy is implemented through monitoring of records and professional supervision

**All Medical Staff**

Ensure that all medical staff follow guidance in the policy.

Adhere to the Policy

**Lead Nurses/Matrons, Practice/Quality Governance leads and Allied Health Professionals**

Ensure the environment is appropriate for the intended intervention

Monitor compliance through supervision and record keeping practice

Challenge poor practice

Ensure delegation is appropriate

Ensure that all identified staff attend appropriate training to enable compliance with this policy

**Environment**

The environment should be such that it preserves the dignity and privacy of the patient.

The relationship between the patient and professional should be enhanced and not compromised by the environment in relation to obtaining consent.

An appropriate and therapeutic environment should be identified when obtaining consent.

Support should be provided for the patient e.g, family, IMHA, IMCA, information provided in an accessable format, to enable them to engage in the process

**5. Why we need this policy and its purpose**

* 1. The Department of Health has issued a range of guidance documents on consent. These should be consulted for details of the law and good practice requirements relating to consent. This policy sets out standards and procedures within this Trust to assist professionals whilst treating patients. While this document is primarily concerned with health care, social care colleagues should be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.
	2. As part of gaining consent, this Trust is committed to ensuring that all people experience a service which upholds their dignity.
	3. It is crucial to ensure that a patient has sufficient capacity to make a particular decision at the time the decision is needed and reference should be made to the Mental Capacity Act 2005, NICE Guideline Decision-making and Mental Capacity (NG108), and NICE Quality Standards Decision-making and Mental Capacity (QS194) where necessary.
	4. This policy has been developed in accordance with the Trust’s policy on the Development and Management of Policies and Procedures.
	5. This policy sets out the standards and procedures for performing patient interventions. The aim of the policy is to ensure that health care professionals comply with the guidance for consent to examination and treatment.
	6. This policy outlines the importance of all services directly provided by the Trust and all clinical staff should familiarise themselves with this policy.
	7. The Trust recommends that contractors and agency staff apply the principles of this policy as minimum standards within their practices to ensure that their professional and contractual responsibilities are discharged.
	8. The Department of Health has issued a range of guidance on consent, these should be consulted for details of the law and good practice. It is important that all staff keep well informed about changes to practice and legal cases that may have an impact on practice.

* 1. The Trust will expect services to apply the principles of the Policy as minimum standards within their services, which should be adapted to specific interventions and service needs
		+ - 1.
				2. **6. DEFINITIONS**

**6.1 Consent (see also Section 7 below)**

Definition of “consent” for the purpose of this document is the voluntary and continuing permission of the patient agreement for a health professional to provide care. Patients’ may indicate consent non-verbally through the use of gestures, pictures or the use of digital technology. Consent may also be provided verbally or in writing. Compliance from a patient who lacks capacity is not consent

* + 1. Valid Consent is defined as:
		2. Patients have the capacity to make the particular decision at the time it needs to be made
		3. Have received the pertinent information in an accessible format for the person to make the decision
		4. Not to be acting under any duress

**6.2 Context of Consent**

The context of obtaining valid consent is important to consider and may take many forms, from an active verbal request by a patient for a particular treatment (which may or may not be appropriate or available) to passive acceptance of health professional’s advice (e.g. participating in routine screening programmes). In the majority of cases “seeking consent” may be described as “joint decision making” with patient and health care professionals coming to an agreement on the best way forward, based on the patient’s values, wishes and preferences and the health professional’s clinical knowledge.

**6.3 Consent to Share information**

This is different to consent to treatment and is found in the Trust Information Governance policy <http://nww.swyt.nhs.uk/docs/Documents/804a.aspx>.

**6.4 Registered staff**

Defined as professionals registered with an Accredited Body.

**6.5 Definition of Mental Capacity**

This is found in the body of the Policy but refers to s.2 and s.3 of the Mental Capacity Act 2005.

**6.6 Lack of Mental Capacity**

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves. From the 1st October 2007, a person appointed as an attorney under a registered Lasting Power of Attorney for health and welfare or appointed by the Court of Protection as a Court Deputy will be able to consent or refuse to consent to treatment where authorised to do so in a persons best interests.

Treatment may be given if it is in a patients best interest, providing that treatment has not been refused in a valid and applicable advance decision or declined by an Attorney under an LPower of Attorney (health & welfare) or Court Appointed Deputy with the authority to do so.

##### 7. Consent to Treatment

##### 7.1 Why consent is crucial

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. A health care professional (or other health care staff) who does not respect this principle may be liable both to legal action by the patient and to action by their professional body

**THIS POLICY DOES NOT APPLY TO MEDICATION AND SOME FORMS OF TREATMENT PRESCRIBED FOR MENTAL DISORDER UNDER THE MENTAL HEALTH ACT 1983. FOR GUIDANCE ON CONSENT TO TREATMENT UNDER THE MENTAL HEALTH ACT PLEASE REFER TO THE MENTAL HEALTH ACT 1983, THE REFERENCE GUIDE TO THE MENTAL HEALTH ACT, MHA CODE OF PRACTICE, MHA PART 4 AND PART 4A OR YOUR LOCAL MENTAL HEALTH ACT ADMINISTRATOR.**

**Staff should also consult the Trust “Cardiopulmonary Resuscitation” policy where applicable and the Section 16 Resuscitation Decision Making Policy (including do not attempt resuscitation and advanced decisions).**

Since the original publication of this document the Mental Capacity Act received Royal Assent in April 2005. Section 1-5 came into effect on the 2nd April 2007. Information around Capacity and Consent and Best interest and the appointments of Independent Mental Capacity Advocates can be found on the SCIE web site http://www.scie.org.uk/publications/imca/find as linked in the Trust MCA intranet pages

All staff involved in determining capacity to consent and best interest decisions must give regard to the Mental Capacity Act 2005 and its Code of Practice.

**7.2 What consent is – and isn’t**

“Consent” is a patient’s informed agreement for a health professional to provide care and/or treatment. Patients need to communicate their decision, this may be verbally or non-verbally, this means; orally, sign language or in writing or through the use of communication aids. For the consent to be valid, the patient must:

* Have capacity to take the particular decision at the relevant time;
* Have retained the information long enough to make the decision
* Have weighed the information in the balance to make the decision
* Be able to communicate the decision

**7.2.1** 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 capacitious acceptance of a health professional’s advice. It should be noted though that acquiescence where the patient does *not* know or understand what the intervention is or entails does not constitute consent. 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’ may be 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, wishes and preferences and the health professional’s clinical/evidence based knowledge. It should be noted that the refusal of a treatment does not in itself constitute a non-capacitious decision. People have the right to refuse treatment even if the decision is judged by the health professional to be an unwise decision.

**7.2.2** Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves**, only a person who has due authority as a Donee under a Lasting Power of Attorney for personal welfare, or a Court appointed Deputy with the appropriate authority, can give consent on the patient’s behalf. A decision made by the Court of Protection can also provide consent for a treatment, examination or intervention.** However, treatment may be given if it is in the patient’s best interests, as long as it has not been refused in advance in a valid and applicable advance decision.

**7.2.3** When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offered to be perceived coercively, whether or not this is the case. Coercion invalidates consent, and care must be taken to ensure that the person makes decisions freely. Coercion should be distinguished from providing the person with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatments for the person’s health. However threats such as the withdrawal of any privileges, loss of remission of sentence for refusing consent or using such matters to induce consent may well invalidate the consent given and are not acceptable.

**8. Section 4 Mental Capacity Act 2005 states:**

In determining for the purpose of this Act what is in the persons best interests, the person making the determination must not make it merely on the basis of –

* + 1. the persons age or appearance, or
		2. a condition of his or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

**8.1** The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

He must consider -

Whether it is likely that the person will at some time have capacity in relation to the matter in question, and

If it appears likely that he will, when that is likely to be.

**8.2** He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

**8.3** Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

8.4He must consider, so far as is reasonably ascertainable-

The person’s past and present wishes and feelings (and in particular, any relevant statement made by him when he had capacity),

The beliefs and values that would be likely to influence his decision if he had capacity, and

The other factors that he would be likely to consider if he were able to do so.

* 1. He must take into account, if it is practicable and appropriate to consult them, the views of-

Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

Anyone engaged in caring for the person or interested in his welfare,

Any donee of lasting power of attorney granted by the person, and

Any deputy appointed for the person by the court,

as to what would be in the persons’ best interests and, in particular, as to the matters mentioned in subsection (6).

* 1. The duties imposed by subsection (1) to (7) also apply in relation to the exercise of any powers which-
	2. are exercisable under a lasting power of attorney,

or

8.8 Are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

8.9 In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections 1-7 he reasonably believes that what he does or decides is in the best interests of the person concerned.

8.10 “Life sustaining treatment” means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

8.11 “Relevant circumstances” are those-

8.12 of which the person making the determination is aware, and

8.13 Which it would be reasonable to regard as relevant.

##### 9. 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 and NICE Guideline Decision-making and Mental Capacity (NG108), and NICE Quality Standards Decision-making and Mental Capacity (QS194).

*Reference guide to consent for examination or treatment* *2nd edition* provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available both on the Trust’s Intranet site and in the four localities, and may also be accessed on the internet at:

<https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

Reference to the Mental Capacity Act 2005 and the Code of Practice can be found at :- <https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>http://

**10. Documentation**

**10.1** For significant procedures, it is essential for health professionals to document clearly both a patient’s agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient’s notes), or through documenting in the patient’s notes that they have given oral consent (reference local Clinical Record Keeping Policies). In the event of the person lacking capacity the assessment, reasons for concluding that the person lacks capacity and the actions that have been taken in the persons best interests must be recorded.

##### 11. Written consent

 **11.1** 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.

**11.2** It is rarely a legal requirement to seek written consent, but it is good practice to obtain and record the patient’s consent to the treatment or investigation including if:

* 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 primary purpose of the procedure
* There may be significant consequences for the patients employment, social or personal life.
* The treatment is part of a project or programme (research) that is covered by the consent procedures outlined in the Research and Development passport procedure
* The patient is to undergo vaccination. When seeking consent for the vaccination, the consent will be signed by the patient/parent where appropriate.

**11.3** Completed forms should be kept with the patient’s clinical record. 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. Any consent form should be saved to systmone under letters and documents, 6. MCA and saved under the namining convention of consent form xx followed by the date consent was taken (e.g Consent form 4 21.04.21)

**11.4** It is also best practice to document in the clinical record a patient’s consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. Such routine interventions should be incorporated into the patients consent to treatment and intervention care plan with regular review dates.

**12. Procedures to follow when patients lack capacity to give or withhold consent**

**12.1** 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 full record of the assessment of the patient’s capacity, (Section 1-3 Mental Capacity Act 2004) and why the health professional believes the treatment to be in the patient’s best interests (Section 4 Mental Capacity Act 2005). The assessment of capacity lies with the decision maker. Where a patient is deemed to lack capacity to consent and does not have an appropriate person who can be consulted in regard to serious medical treatment or provision of accommodation by an NHS body, an Independent Mental Capacity Advocate (IMCA) must be instructed to represent and support the person to whom acts or decisions proposed under Sections 37, 38, and 39 apply. Guidance on these sections can be found in the Mental Capacity Act Code of Practice

 The standard consent forms should never be used for adult patients unable to consent for themselves. For both significant and minor interventions, this information should be entered in the patient’s notes.

**12.2** 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,psychologists 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.The refusal of a treatment or intervention however unwise the professional judges this decision to be, is not in itself evidence of the patient lacking capacity to consent. As such it cannot automatically be set aside for the treatment or intervention to be authorised through a best interests decision.

**12.3** 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 are potentially serious, a court declaration may be required. (Please see section 10)

###### 13. Availability of forms

**13.1** The Department of Health has produced standard consent forms and forms for adults who are unable to consent for themselves these are reproduced in Appendix A and are available on the Trust’s Intranet site. There are four versions of the standard consent form:

* **form 1** for adults or competent children,
* **form 2** for parental consent for a child or young person
* **form 3** for patient/parental agreement to investigation or treatment and
* **form 4** for cases where the patient is unable to consent to examination and treatment.

There is also a specific consent Form for **ECT.**

**14. 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.

If consent has been obtained a significant time before the intervention is to occur, it is good practice to confirm that the patient who has given consent (assuming that he retains capacity) still consents to the intervention, even if no new information needs to be provided or further questions answered. It is important to remind the patient that they can withdraw their consent should they wish to. The position of those who lack capacity is covered above at 11.1 – 11.3.

###### 14.1 Single stage process

**14.1.1** 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. An example within Mental Health woud be where a patient is consenting to the conditions of S17 leave.

**14.1.2** 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. It is important that the records show any discussion held with the patient and others involved relating to their understanding of the proposed treatment and the options available to them. An example within Mental Health would be the consent process we have been thourgh with individual service users relating to the COVID vaccination process.

###### 14.2.1Two or more stage process

**14.2.2** 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. It is important that the records show any discussion held with the patient and others involved relating to their understanding of the proposed treatment and the options available to them.

**14.2.3** 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?”

**14.2.4** 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.

###### 15. Seeking consent for anaesthesia

**15.1** Where an anaesthetist is involved in a patient’s care, it is their responsibility (not that of a surgeon or doctor) 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 (eg 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 form of anaesthesia.

**15.2** 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.

###### 16. 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.

###### 17. Treatment of young children

**17.1** When babies or young children are being cared for in hospital, it will not usually 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. Where a child is admitted, you should therefore discuss with their parent(s) 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.

**17.2** 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. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

 **https://www.nhs.uk/conditions/consent-to-treatment/children/** http://

**17.3** In order to consent on behalf of a child, the person with parental responsibility must themselves have capacity

**Procedure to obtain consent on behalf of children**

Young people aged 16 and 17 are presumed to have the capacity to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (though 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. Any differences of opinion between the child and their parent(s), or between parents, should clearly be documented in the patients notes. The consent of any one person with parental responsibility is sufficient for treatment lawfully to be given, even if another person with parental authority does not agree.

Younger children must also be as involved as possible in decisions about their healthcare. Further advice is given in the department’s guidance seeking consent: working with children. This can be found at:

[http://webarchive.nationalarchives.gov.uk/20120106063807/http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/documents/digitalasset/dh\_4067204.pdf](http://webarchive.nationalarchives.gov.uk/20120106063807/http%3A//www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/%40dh/%40en/documents/digitalasset/dh_4067204.pdf)

This specifically emphasises the point that legally, it makes no difference whether written consent is obtained as a signed consent form is only a record, not proof that genuine consent has or not been given. It advises that it would be good practice to seek written consent if treatment is complex or involves significant risks or side effects.

Under certain circumstances, sometimes around contraceptive issues, guidance laid down by Lord Fraser is used. This is deemed as assessing a child as “Fraser Competent’. The professional needs to be satisfied that:

* The young Person will understand the professionals advice
* The young Person cannot be persuaded to inform their parents
* The young Person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment
* Unless the young Person received contraceptive treatment, their physical or mental health or both, are likely to suffer.

## **18. Provision of information**

**18.1** 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, alternatives 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.

Comprehensive information must be given about all significant possible adverse outcomes. These warnings must be recorded in clinical/treatment records. Patients should be offered the opportunity to sign the entry confirming they understand and accept the risks. It is equally important to record any refusal of treatment and reason given.

**18.2** Patients and those close to them will vary in how much information they want. 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.

**18.3** Information given to patients to support their decision making will be recorded on the consent forms and/or in clinical records. This recording will form a historical record of information given on previous occasions for future reference. Archived copies of relevant information leaflets are available, as described in the Policy on Information for People who use the Trust services.

**19. Provision for patients whose first language is not English**

**19.1** 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 family or carers to interpret for family members who do not speak English except in extreme emergency situation. If this is the case then the use of family/carer members must be recorded in the patients record.

The Department of Constitutional Affairs has produced an information booklet “Making decisions about your health, welfare and finances”. The booklet is available in the following languages:

* English
* Welsh
* Arabic
* Bengali
* Gujarati
* Hindi
* Punjabi
* Chinese
* Somali
* Urdu
* Vietnamese

<https://www.gov.uk/government/publications/making-decisions-who-decides-when-you-cant>

The Clinical team must arrange for an appropriate translator/interpreter where a patient has difficulty understanding the information being conveyed to them or unable to respond due to communication difficulty. Local arrangements will apply.

Where it appears information leaflets are only available in English enquiries should be made with the relevant department as to the availability of the leaflet being available in a different language or format.

###### Access to more detailed or specialist information

**19.2** Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. This Trust has made the following arrangements to assist patients to obtain such information:

* To speak with their clinical team.

Assistance in accessing:

* Customer Services
* Advocacy Services (IMHA, IMCA, Care Act Advocate, General Advocacy)
* Specialist Mental health Solicitors

###### Access to health professionals between formal appointments

**19.3** 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 make 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).

All patients using Mental Health service will be offered community care as defined in the principles of the Care Programme Approach. The Trust Care Programme Approach policy can be found in the document store at <http://nww.swyt.nhs.uk> patients should be offered a person centred care plan and a named Care Co-ordinator. The patient will be provided with contact details should they require information or assistance between visits.

###### Open access clinics

**19.4** 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.

Provision of information to third parties

Under the Mental Capacity Act 2005, an attorney under Lasting Power of Attorney or Court Appointed Deputy may be authorised to consent to, or refuse medical treatment where a patient is unable to make a decision for themselves. They will require necessary information to make the decision.

If the health care professional is making a decision in the best interest of the patient, then they have a duty to consult person(s) engaged in the care or interested in the welfare of the patient before making a decision in best interests. This will require the sharing of information.

Chapter 16 of the Code of Practice to the Mental Capacity Act provides guidance to professionals on the sharing of information. <http://nww.swyt.nhs.uk/docs/Documents/804a.aspx>

**20. Who is responsible for seeking consent?**

**20.1** 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.

**20.2** 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, team work 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.

**20.3** The Trust approach to providing care is through person centred care. It is in line with the principles of the Mental Capacity Act 2005 that the care to be provided is discussed with the service user and that an agreed care plan is formulated.

###### 21. Completing consent forms

**21.1** The standard consent form provides space for a health professional to record the information they have provided 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.

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

**21.3** Consent for Electroconvulsive Therapy for a voluntary patient must be obtained by the referring consultant. This is consistent with the guidance laid down by the ECT accreditation service.

**21.4** Practitioners should be able to provide information to the patient in regard to the treatment and the right to withhold consent if they do not wish to have the treatment.

**21.5** Staff within the ECT department should make available information in the form of the booklet “Electroconvulsive Therapy ( ECT ) - Information for service users ”. (See the Trust ECT policy)

Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix A and are available on the Trust’s intranet

**Form 1:**  for adults and competent children

**Form 2:** for parental consent for a child and young person

**Form 3:** for patient/parental agreement to investigation or treatment and

**Form 4:** for adults who are not able to consent for themselves

There is also available a specific consent form for **ECT**

22. Responsibility of health professionals

 It is the responsibility of the health care professional:

• To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and

• To work within their own competence and not to agree to perform tasks which exceed that competence.

If you feel that you are being pressurised to seek consent when you do not feel competent to do so please contact your immediate line manager in the first instance.

Under the Mental Capacity Act 2005 it is the responsibility of the person providing the treatment to be assured of the persons capacity to consent to the treatment proposed and in the event that the patient is unable to consent that the treatment is in the patients “best interest”.

It is the responsibility of the treating clinician to obtain written consent where required.

**23. Refusal of treatment**

**23.1** If the process of seeking consent is to be a meaningful one, refusal must be one of the patient’s options. An adult with capacity is entitled to refuse any treatment. Where a person is subject to the MHA 1983, it is possible for the patients capacitous refusal to be over riden and treatment provided under the Mental Health Act 1983. Please see paragraph 27 below. The situation for children is more complex: see the Department of Health’sguidance.

http://webarchive.nationalarchives.gov.uk/20120106063807/http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/documents/digitalasset/dh\_4067204.pdf

for more detail. The following paragraphs apply primarily to adults.

**23.2** 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.

**23.3** 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. These discussions should be clearly documented in the patient’s records

**23.4** 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. 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. These discussions should be clearly recorded in the patient’s records

**23.5** Where a valid and applicable advance decision is available and the patient lacks capacity to consent to part or all of the the proposed treatment, then the advance decision will have the same effect as a contemporaneous refusal of the proposed treatment. The advance decision must be respected and should not be overridden even in cases where the health care professional considers giving the treatment to be in the patient’s best interest. In instances where there is doubt over the validity or applicability of the advance decision then the care team may provide life sustaining treatment whilst a decision from the Court of Protection is being sought. The treating team must abide by the decision of the Court of Protection.

**23.6** Where the patient has a Lasting Power of Attorney for Personal Welfare, and the decision is within the scope of the donee(s) then it is the donee(s) who consent or refuse the treatment as if they were the patient. A refusal of treatment by the donee(s) should be treated in the same maner as a refusal by the patient himself. Where it is considered that the donee(s) are not acting in the patient’s best interests then it is possible to challenge the decision through the Court of Protection. In such cases the Trust Legal Services must be contacted.

**24. Withdrawing and withholding life-sustaining treatment**

**24.1** A healthcare professional’s legal duty is to care for a patient and to take reasonable steps to prolong their life. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment may become futile or stops providing a benefit to the patient and is not clinically indicated, or is not in the patient’s best interests. Any decision to withdraw or withhold life-sustaining treatment must not be motivated by the clinicians desire to bring about the patients death.

**24.2** The legal principles relating to decisions to withhold or withdraw treatment including; artificial nutrition and hydration (ANH), medication or ventilation, are the same as for any other medical treatment decisions. Decisions regarding Do Not Attempt Resuscitation (DNAR) should be taken in line with the Trust’s DNAR policy

**24.3** Decisions about the withholding of ANH to a patient in a permanent vegetative state should be referred to the Court of Protection.

**24.4** There is no legal distinction between withdrawing and withholding life-sustaining treatment. A person with capacity may decide either contemporaneously or by a valid and applicable advance decision compatible with the requirements of s25(5) MCA 2005, or through instructions to the donee(s) to an Lasting power of Attorney for Personal Welfare that they no longer wish to receive treatment. If a patient lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes (if these are known)

**25. HUMAN Tissue**

**25.1** The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and hence improvements in healthcare for all. At present, this Trust requires that patients should be given the opportunity to refuse permission for human tissue (including blood samples and other bodily fluids) taken from them during surgery or other procedure to be used for education or research purposes.

**25.2** The use of human tissue (including blood samples and other bodily fluids) is not an area that the Trust directly delivers. The testing is carried out under service level agreements with other organisations. However staff need to be aware that the Human Tissue Act 2004 must be adhered to in the event that human tissue (including blood samples and other bodily fluids) is intended to be used for research/education. Contact must be made with the Research and Development department for advice and the legal services department within the Trust

**25.3** The obtaining of blood and bodily fluid samples for testing and how it should be handled is specified in “Trust infection prevention and control policies and procedures”. Contact should be made with the Senior Infection Prevention and control Team for further advice.

**26 Clinical photography and conventional or digital video recordings**

Please read this in conjunction with the TRUST Policy for Photography, Video and Audio Recording of Service Users and Carers. <http://www.southwestyorkshire.nhs.uk/documents/337.doc>

**26.1** 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.

**26.2** 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 24.3 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.

**26.3** 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. Staff should follow the “Research and Development Procedures” in these cases.

**26.4** 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.

**26.5** 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.

**26.6** 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 some-one 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.

**27 Mental Health Act 1983**

**27.1** Neither the existence of mental disorder nor the fact of detention under the Mental Health Act 1983 (MHA) should give rise to an assumption of incapacity. The person’s capacity must be assessed in every case in relation to the particular decision being made. The capacity of a person with a mental disorder may fluctuate.

**27.2** Part 4 of the MHA sets out the circumstances in which persons liable to be detained under the MHA may be treated without their consent. Treatments for physical disorders that are unrelated to the mental disorder are subject to the legal principles set out above. Further guidance can be found in chapters 23, 24 and 25 of the MHA Code of Practice 2015.

**27.3** It is not permissible to administer ECT to a person who has capacity and is refusing, whether that refusal is through a contemporaneous decision or through a valid and applicable advance decision. The only exception to this being in emergency situations where S62 provides authority to treat. (See Trust ECT policy)

**27.4**  Part 4A of the MHA sets out the circumstances in which persons subject to a Community Treatment Order (CTO) may be treated whilst in the community. On recall to hospital the person becomes subject to Part 4 in respect of treatment decisions

**27.5** No-one, (whether or not he is detained under the MHA1983) may be given neurosurgery for mental disorder (‘psychosurgery’) or have hormones surgically implanted in order to reduce male sex drive, unless they consent to the procedure and it has been independently approved in accordance with s57 of the MHA 1983.

**28. Research and Innovative Treatment**

 The same legal principles apply when seeking consent from a person for research purposes as when seeking consent for investigations or treatment. Research involving patients lacking capacity is a complex matter. The Trust Research and Development Unit should be contacted for advice and guidance in these matters.

**29. Public Health**

The Public Health (Control of Disease) Act 1984 section 36 and 37 provides that, on an order made by a magistrate, persons suffering from certain notifiable infectious diseases could be medically examined, removed to and detained in a hospital without their consent. A magistrate when ordering the detention of a person in a hospital could not order that a person undergo medical treatment. The treatment of such persons must be based on the principles previously described. The Act is now amended by the Health and Social Care Act 2008. Under Part 2A there is express provision prohibiting regulations under new sections 45B or 45C from legislating for the administering of medical treatment by force. Nor will there be power for a magistrate to order compulsory treatment under the new section 45G, which gives powers to magistrates to make orders in relation to persons who pose a threat to the health of others.

**30. Useful Contact Details**

Further advice or guidance on any of the issues covered in this Policy should firstly be discussed with your line manager and or professional lead, for further help and advice contact:

* Legal Services, Fieldhead
* Tel: 01924 316000

**30.1 How to seek a court declaration**

In the event that a member of staff should wish to seek legal advice with regard to matters covered in the Policy they should contact the Legal Services at Fieldhead on 01924 316000

**Out of hours staff should contact the on call manager for advice.**

**31. Review and Revision of this policy**

* 1. **Process for reviewing this policy**

The review date for this policy will be **April 2024 and every three years thereafter** unless otherwise indicated by an identified need for change. The policy will be reviewed by the Assistant Director Legal services in consultation and communication with a range of stakeholders.

**Please see Appendix C D and E**

* 1. **Version control**

This policy has been revised from its previous format and is version 4 Please **See appendix E**

**32. References and Further Reading**

Marsden Manual

Nursing policies and Procedures for clinical Intervention

Policies and Procedures relating to clinical intervention

Patient Safety procedures and policies

Incident management policies

Safeguarding policies

NICE Guidance Decision-making and mental Cacpity (NG108)

This is not an exhaustive list – it is advised that staff are aware and up to date with their own professional codes of practice and procedures as well as up to date guidance relating to your specific areas of practice. Please do not hesitate to contact your professional leads for information.

**33. Associated documents**

**Mental Capacity Act 2005**

**Mental Health Act 1983**

**Children Act**

**Consent Forms 1 to 4 and the attached DOH guidance**

**Appendix A**

## **South West Yorkshire Partnership NHS Foundation Trust**

## (Consent form 1)

**Patient agreement to investigation**

**or treatment**

**Patient details (or pre-printed label)**

Patient’s surname/family name..……………………………….

Patient’s first names .…………………………….…………….

Date of birth ………………………………………..………….

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

ÿ Male ÿ Female

Special requirements …………………………………….……

(eg other language/other communication method)

Name of any Donee of a LPA for Personal Welfare……..……

……………………………………………………………..…..

Is there an advance decision to refuse treatment? Yes / No

If Yes please attach a copy of the advance decision.

Responsible health professional.………………………………

Job title …………………………………………….………….

To be retained in patient’s notes

### Patient identifier/label

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

……………..…………………………………………………………………………..………………………………………………………………………………………………….……………

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

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

The intended benefits ………………………………………………………..……….……………………………..……

…………………………………………………………………………………………………….

Significant, unavoidable or frequently occurring risks……………………………………… …………………………………………...………………………………………………..………

...…………………………………………………………………………………………….…….

Any extra procedures which may become necessary during the procedure

ÿ blood transfusion…………………………………..…….……………………………………

ÿ other procedure (please specify) ……………………………….....…………….…..…….

…………………………………………………………………………...………………….…..

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

ÿ The following leaflet\* or audio\*/visual\* recording has been provided (\* delete as appropriate) ……………….………………………..…………………………………………..

This procedure will involve:

ÿ general and/or regional anaesthesia ÿ local anaesthesia ÿ sedation

Signed: …….…………………………………… Date: ……………………………

Name (PRINT) ………………………………... Job title: …..………………….…

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

**Statement of interpreter** (where appropriate)

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

Signed ………………………….……………………. Date ………………..…………….

Name (PRINT) …………………..…………………………………………………………..

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

### Statement of patient Patient identifier/label

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

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

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

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

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health and does not conflict with any advance decision listed below.

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

### ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Patient’s signature …………………………………… Date…………………………..

Name(PRINT)………………………………………...

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

Signature …………………………………………… Date…………………..….………

Name(PRINT)……………………………………...

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

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

Signed:…….…………………………………… Date …………………….……….

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

Important notes: (tick if applicable)

* See also attached advance decision
* Patient has a LPA for personal welfare
* Patient has withdrawn consent Patient signature ……………...……………….

 Patient name (print)……………………………

 Date…………………………………………….

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

What a consent form is for

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

# **The law on consent**

See the Department of Health’s *Reference guide to consent for examination or treatment* (second edition) for a comprehensive summary of the law on consent (also available at https://www.gov.uk/government/uploads/system/uploads/.../dh\_103653\_\_1\_.pdf

### Who can give consent

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

### When NOT to use this form

If the patient is 18 or over and lacks capacity to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not have capacity to give consent if:

* S/he is unable to understand information relevant to the decision and/or
* S/he is unable to retain that information and/or
* S/he is unable to use or weigh that information as part of the process of making the decision and/or
* S/he is unable to communicate the decision by any means

.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign this form on behalf of an adult who lacks capacity to consent for him/herself unless they have been given the authority to do so under a lasting power of attorney or as a court appointed deputy.

### Information

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

## **South West Yorkshire Partnership NHS Foundation Trust**

##  (Consent form 2)

**Parental agreement to investigation or**

**treatment for a child or young person**

**Patient details (or pre-printed label)**

Patient’s surname/family name..……………………………….

Patient’s first names .…………………………………………..

Date of birth ……………………………………………………

Age ……………………………………………………………..

NHS number (or other identifier)………………………………

ÿ Male ÿ Female

Special requirements …………………………………………..

(eg other language/other communication method)

Responsible health professional.……………………………….

Job title …………………………………………………………

To be retained in patient’s notes

### Patient identifier/label

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

…………………………………………………………………………………………………………………………………………………………………………

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

I have explained the procedure to the child and his or her parent(s) or person who has parental responsibility. In particular, I have explained:

The intended benefits …..……………………………………………..……….………

…………………………………………………………..…………………………..…………….………………………………………………………………………………………………………………………………………………………………………………….

Significant, unavoidable or frequently occurring risks to the procedure ..………….

...………………………………………………………………………………….……….

………………………….………………………………………………..………………..

……………………………………………………………………………………………..

Any extra procedures which may become necessary during the procedure

ÿ blood transfusion ………………………………..…….……………………..……………………………………………………………………………………………………………………………..

ÿ other procedure (please specify) …………..………………………...….…..………

…………………………………………………………………………...………………….……………………………………………………………………………………………..

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

ÿ The following leaflet\* or audio\*/visual\* recording has been provided (\* please deleate as appropriate)……………….…………………………………………

This procedure will involve:

ÿ general and/or regional anaesthesia ÿ local anaesthesia ÿ sedation

Signed:…….…………………………………… Date ..…………………...……….

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

**Contact details** (if child/parent or person with parental responsibility wish to discuss options later) ……………….…………………

Patient identifier/label

**Statement of interpreter** (where appropriate)

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

Signed ………………………….……………………. Date ……………..…………….

Name (PRINT) ……………………………………………………………………………

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

### Statement of parent or person with parental responsibility

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

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

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

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

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

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

### ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature …………………………………………. Date…………………………..

Name (PRINT) …………………………Relationship to child…………………………

Patient identifier/label

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

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

Name ……………………………………… Signature ……………………..….………

Date …………………………………………….

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

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

Signed:…….…………………………………… Date .. …………………….……….

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

Important notes: (tick if applicable)

ÿ Parent or person with parental responsibility has withdrawn consent (ask Parent or person with parental responsibility to sign /date here) ………………...…

………………………………………………………………………………………………

………………………………………………………………………………………………

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

**This form**

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

###  Who can give consent

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

Although children acquire rights to give consent for themselves as they grow older, people with ‘parental responsibility’ for a child retain the right to give consent on the child’s behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child’s treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child’s consent before providing treatment unless any delay involved in doing so would put the child’s life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department’s guidance *Seeking consent: working with children.* Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient’s notes.

Where a young person of 16 or 17 or a Gillick competent child under 16, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

**Parental responsibility**

The person(s) with parental responsibility will usually, but not invariably, be the child’s birth parents, or if they’ve jointly adopted a child, both have parental responsibility. They will both keep parental responsibility if they later divorce. People with parental responsibility for a child include: the child’s mother; the child’s father if married to the mother at the child’s conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child’s mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement or in England and Wales by jointly registering the birth of the child with the mother (from 1 December 2003) (although this may change in the future). Where the parents are in a same-sex relationship and are identified as being civil partners, both have parental responsibility if they were civil partners at the time of the treatment, eg donor insemination or fertility treatment. For same sex partners who aren’t civil partners, the 2nd parent can get parental responsibility by either:

• applying for parental responsibility if a parental agreement was made or

•becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth

### Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

**Guidance on the law on consent**

###### See the Department of Health publications *Reference guide to consent for examination or treatment (second edition)* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.doh.gov)

## **South West Yorkshire Partnership NHS Foundation Trust**

##  (Consent form 3)

**Patient / Parental agreement to investigation or**

**treatment**

**(procedures where consciousness not impaired)**

**Patient details (or pre-printed label)**

Patient’s surname/family name..……………………………….

Patient’s first names .…………………………………………..

Date of birth ……………………………………………………

Age ……………………………………………………………..

NHS number (or other identifier)………………………………

ÿ Male ÿ Female

Special requirements …………………………………………..

(eg other language/other communication method)

Responsible health professional.……………………………….

Job title …………………………………………………………

To be retained in patient’s notes

### Patient identifier/label

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

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

I have explained the procedure to the patient and his or her parent(s) or person who has parental responsibility. In particular, I have explained:

The intended benefits......................................................................................... …..………………………………………………………..……….…………………………………………………………………..…………………………..…………….…………………………………………………………………………………………………….

Significant, unavoidable or frequently occurring risks to the procedure……………

……………………………………………………………………………………………..

Any extra procedures which may become necessary during the procedure

ÿ blood transfusion.................................................................................................. ………………………………..…….……………………………………………..……….

ÿ other procedure (please specify)......................................................................... ………………………………...……...…………….…..……….....................................

…………………………………………………………………………...………………….…….........................................................................................................................

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

ÿ The following leaflet\* or audio\*/visual\* recordinghas been provided (\* delete as appropriate)……………………………....................................................... ……………….…………………………………………………………………………..…

Signed:…….…………………………………… Date ....……….……….…….........

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

**Contact details** (if child/parent or person with parental responsibility wish to discuss options later) ……………….…………………...............................................

Patient identifier/label

**Statement of interpreter** (where appropriate)

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

Signed ………………………….……………………. Date ………..…………….

Name (PRINT).........................................................................................................

### Statement of parent or person with parental responsibility

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

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

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

**I understand** that the procedure will/will not involve local anaesthesia.

Signature ……………………………………….. Date…………………………..

Name (PRINT)………………………………Relationship to patient…………………

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent / person with parental responsibility have signed the form in advance)

I have confirmed that the patient and his or her parent(s) or person with parental responsibility has no further questions and wishes the procedure to go ahead.

Signed:…….…………………………………… Date .. …………….……….

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

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

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

**This form**

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

###  Who can give consent

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

Although children acquire rights to give consent for themselves as they grow older, people with ‘parental responsibility’ for a child retain the right to give consent on the child’s behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child’s treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child’s consent before providing treatment unless any delay involved in doing so would put the child’s life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department’s guidance *Seeking consent: working with children.* Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient’s notes.

Where a young person of 16 or 17 or a Gillick competent child under 16, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child or to severe permanent injury. It would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

**Parental responsibility**

 The person(s) with parental responsibility will usually, but not invariably, be the child’s birth parents,. or if they’ve jointly adopted a child, both have parental responsibility. They will both keep parental responsibility if they later divorce. People with parental responsibility for a child include: the child’s mother; the child’s father if married to the mother at the child’s conception, birth or later; a legally appointed guardian; the local authority if the child is on a care order; or a person named in a residence order in respect of the child. Fathers who have never been married to the child’s mother will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement or in England and Wales by jointly registering the birth of the child with the mother (from 1 December 2003) (although this may change in the future). Where the parents are in a same-sex relationship and are identified as being civil partners, both have parental responsibility if they were civil partners at the time of the treatment, eg donor insemination or fertility treatment. For same sex partners who aren’t civil partners, the 2nd parent can get parental responsibility by either:

• applying for parental responsibility if a parental agreement was made or

•becoming a civil partner of the other parent and making a parental responsibility agreement or jointly registering the birth

**Information**

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about ‘significant risks which would affect the judgement of a reasonable patient’. ‘Significant’ has not been legally defined, but the GMC requires doctors to tell patients about ‘serious or frequently occurring’ risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

**Guidance on the law on consent**

###### See the Department of Health publications *Reference guide to consent for examination or treatment (second edition)* and *Seeking consent: working with children* for a comprehensive summary of the law on consent (also available at www.doh.gov)

## **South West Yorkshire Partnership NHS Foundation Trust**

## (Consent form 4)

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

**Patient details (or pre-printed label)**

Patient’s surname/family name..……………………………….

Patient’s first names .…………………………………………..

Date of birth …………………………………………………...

NHS number (or other identifier)………………………………

ÿ Male ÿ Female

Special requirements …………………………………………..

(eg other language/other communication method)

Name of any Donee of a LPA for Personal Welfare…………...

………………………………………………………………….

Is there an advance decision to refuse treatment? Yes / No

If Yes please attach a copy of the advance decision.

Responsible health professional.……………………………….

Job title …………………………………………………………

To be retained in patient’s notes

###  Patient identifier/label

**All sections to be completed by health professional proposing the procedure**

**A. Details of procedure or course of treatment proposed**

…………………………………………………………………………………………………….…………………………………………………………………………………………………….…………………………………………………………………………………………………….………………………………………………………………………………………………

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

## **B. Assessment of patient’s capacity**

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

## ÿ the patient is unable to understand the information relevant to the decision; and/or

##  the patient is unable to retain that information; and/or

## ÿ the patient is unable to weigh that information as part of the process of making the decision; and/or

## ÿ the patient is unable to communicate his decision by any means.

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

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

## **C. Assessment of patient’s best interests**

## To the best of my knowledge, the patient has not refused this procedure in a valid and applicable advance decision. To the best of my knowledge there is no Donee under a LPA for personal welfare or a Court Appointed Deputy with the authority to make this decision or court order addressing this decision. As far as is reasonably possible, I have considered the persons past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. Where possible and appropriate, I have consulted with colleagues and those close to the patient and have where there is no one other than a paid carer to consult with I have instructed an IMCA. As a result of these actions I believe the procedure to be in the patient’s best interests because:

………………………………………………………………………………………..…………………………………………………………………………………………..…………………………………………………………………………………………..………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

Where the lack of capacity is likely to be temporary, (for example if patient unconscious, or where patient has fluctuating capacity or under the influence of a substance), I have consulted as outlined above and am of the opinion that The treatment cannot wait until the patient recovers capacity because:

…………………………………………………………………………………………………….…………………………………………………………………………………………………….……………………………………………………………………………………………………………………

1. **Involvement of the patient’s family and others close to the patient**

The final responsibility for determining whether a procedure is in an incapacitated patient’s best interests lies with the health professional performing the procedure unless there is a valid and applicable advance decision, a Donee of a LPA for personal welfare or a Court Appointed Deputy with the authority to make such a decision, or a Court Ruling. The MCA s.4 requires you to consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. “Best interests” go far wider than “best medical interests”, and include factors such as the patient’s wishes and beliefs when competent, their current wishes, their general well-being, (physical, social and psychological) and their spiritual and religious welfare.

Where the patient has no one other than a paid carer to consult with a referral should be made to the relevant local authority for an “Independent Mental Capacity Advocate” as outlined in the Mental Capacity Act.

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

**Consulted Party’s – including IMCA**

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

Any other comments (including any concerns about decision)…………………………………………………………………….……………………………………………………………………………..…………………………………………………………………………………..………………………………………………………………………………..

Name ……………………………………………………………………………….……………………………………………………………………………….

Relationship to patient…………………………………………………….

### Address (if not the same as patient) ………………………………………………………………………………..

………………………………………………………………………………..…………..……………………………………………………………………………………………………………………………………………………

………………………………………………………………………………..…………..……………………………………………………………………………………………………………………………………………………

Signature ………………………………………………………………….

Date…………………………………………………………………………

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone?)

ÿ Yes ÿ No

Details ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for him/herself. Where possible and appropriate I have discussed the patient’s condition with those close to him or her, and taken their knowledge of the patient’s views and beliefs into account in determining his or her best interests. Where there was no one other than a paid carer to consult with, and the decision was not urgent I instructed an IMCA. (see attached report)

I have/have not sought a second opinion.

Signature:…….……………………………… Date …………………….

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

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

Signature:…….…………………………………… Date ..……………..

Name (PRINT) ……………………….………………………………….

Job title…………………………………………………………………….

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

This form should only be used where it would be usual to seek written consent by an adult patient (16 or over) who lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard Consent Form 1 and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part 4 or Part 4A of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in certificate of authorisation forms as directed by the MHA 1983 (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment then you must abide by that refusal. For further information on the law on consent, see the Department of Health’s *Reference guide to consent for examination or treatment second edition*

(<https://www.gov.uk/government/uploads/system/uploads/.../dh_103653__1_.pdf>).

# **When treatment can be given to a patient who lacks capacity to Consent**

 All decisions made on behalf of the patient who lacks capacity must be made in accordance with the MCA 2005. More information about the Act is given in the Code of Practice. Treatment can be given to a patient who is unable to consent, only if the following apply:

### the patient lacks the capacity to give or withhold consent to this procedure

OR

* any Donee of a LPA for personal welfare or a Court Appointed Deputy who has the authority to make the decision provides consent to the procedure

AND

### the procedure must be in the patient’s best interests.

### Capacity

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

* unable to understand the information relevant to the decision; and/or
* unable to retain that information; and/or
* unable to use or weigh that information as part of the process of making the decision; and/or
* unable to communicate the decision by any means

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

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

Best interests

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

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

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

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

**INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)**

The Mental Capacity Act introduced a duty on the NHS to instruct a IMCA in respect of serious medical treatment decisions. When a person who lacks capacity lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCA’s 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 MCA 2005.

**LASTING POWER OF ATTORNEY AND COURT APPOINTED DEPUTY**

A person over the age of 18 who has the capacity may appoint an attorney to look after their health and welfare decisions, should the person lack the capacity to make such decisions in the future. Under a lasting power of attorney (LPA) the attorney can make decisions that are as valid as those made by the person himself. The LPA may specify limits to the attorney’s authority and the LPA must specify whether or not the attorney has the authority to make decisions about life sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person’s best interest.

The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary

Actions cannot be carried out without the courts authority or where there is no other way of settling the matter in the best interest of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity then it is the deputy rather that the health professional who makes the treatment decision and the deputy must make decisions in the patients best interest.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient’s condition prevents this. The court of protection deals with serious decisions affecting personal welfare matters, including health care, which were previously dealt with by the High Court. Cases involving:

* Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
* Cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent
* Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g for contraceptive purposes
* Termination of pregnancy and
* All other cases where there is a doubt or dispute about whether a particular treatment will being a persons best interests (include cases involving ethical dilemmas in untested areas)

Should be referred to the court for approval. The court can be asked to make a decision in cases where there are doubts about he patients capacity and also about the validity or applicability of an advance decision to refuse treatment.

Contact details when seeking a court declaration:

Director of Nursing, governace and patient safety

Or

Legal Services (01924 316000) swy-tr.legalservices@nhs.net

**Appendix B – Equality impact assessment**

**Date of assessment: June 2021**

|  |  |  |
| --- | --- | --- |
|  | **Equality Impact Assessment Questions:** | **Evidence based answers & actions:** |
| **1** | **Name of the document that you are Equality Impact Assessing** | Guidelines for obtaining consent to examination and treatment or clinical intervention – Trust Wide – all services |
| **2** | **Describe the overall aim of your document and context?****Who will benefit from this policy/procedure/strategy?** | The overall aim of the document to is to advise and guide staff in the requirements of consent to treatment in respect of all service users under our care.This document applies to all clinical services within the Trust where there is the offer of treatment.Service users will benefit from the document as it will guide staff through the often complexity of consent service users relating to proposed care and treatment.It will assist staff in understanding the complexity of obtaining consent and also the rights of the service user to refuse treatment if they have capacity to make such a decision.It will assist staff I understating what intervention they need to make and on what basis should the service user lack capacity to make their own decisions.This document applies the same right to an individual regardless of the background in respect of the Equality Act. |
| **3** | **Who is the overall lead for this assessment?** | * **Medical Director**
 |
| **4** | **Who else was involved in conducting this assessment?** | * Equality and engagement
* Mental Health Act staff

Performance and Information  |
| **5** | **Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?****What did you find out and how have you used this information?** | This document is based on the Department of Health Template and the Legal requirements of obtaining consent.As this document is for review only it has been shared with clinical staff, Allied Health Professionals and Medical staff.It has also been reviewed by staff from Legal services.Minor amendments required for the policy1 request to have an example relating to mental health situation as the document is generic to cover all services. |
| **6** | **What equality data have you used to inform this equality impact assessment?** | Population statistics for our localities in respect of race equality, disability, gender, age and sexual orientation, religion and belief, marriage and civil partnership from census data. We also have access to JNA and public health profiles for our localities. **The communities we serve:**In all communities the 2011 census tells us there is on average across all areas there is a 1% difference in the population reported as male and female, with female reporting higher. Across all ages Calderdale has the highest 0-15 population at 19.6% and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%. Christianity and Islam respectively are both the highest reported religion and belief.We know that White British people make up 87% of our region’s local authority population, more than the England average of 81%. The other main minority groups include Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the UK’s population growth (Policy Exchange, 2014). We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in our local areas range from 8% to over 13% in the communities the Trust cover. **Workforce data**As per workforce annual report 2020 The Trust currently employs **4,328** staff delivering a range of services including mental health, learning disability, forensic, some physical health and an extensive range of community services.* The Trust split of 77.9% female to 22.1% male is reflected approximately across most areas, except for Medical Staff (36%/64%). As in previous years, female staff make up over three quarters of Trust staff
* As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59 with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support Services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over
* The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year.
* The Trusts staff profile has a larger White British representation than the local demographic of the people that it serves collectively. Trust wide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%). Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%. However, the Trust’s local demographic has large variation in BAME representation and there is a significant under-representation of South Asian staff in Kirklees/Calderdale (exact figures not available due to mixed teams)
* The number of staff who have not stated their religious belief (Unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3%Islam, 12% other and 17% Atheism.
* There has been a significant increase in the number of staff reporting their religion and sexual orientation. Currently 83% of staff have provided data indicating their sexual orientation, which is a slight improvement on last year’s figures.

**Volunteers**The diversity of volunteers recruited by the Trust will be improved following a targeted piece of work to reach communities which highlighted several recommendations. The current position for volunteers is reported below and the service will aim to ensure the volunteer offer is reflective of the communities we serve.

|  |  |
| --- | --- |
| **Ethnicity** | **Number of** |
| **Arab** | **1** |
| **Asian or Asian British Chinese** | **1** |
| **Asian or Asian British Indian** | **3** |
| **Asian or Asian British Pakistani** | **4** |
| **Black British**  | **1** |
| **Black or Black British African** | **2** |
| **Black or Black British Caribbean** | **2** |
| **Black or Black British Other**  | **1** |
| **Caribbean** | **1** |
| **Mixed White & Black Caribbean** | **1** |
| **White British** | **210** |
| **White Irish** | **4** |
| **White Other**  | **3** |
| **Not Stated**  | **2** |
| **Cognitive Delay**  | **4** |
| **Learning Disability**  | **5** |
| **Long Term Condition**  | **5** |
| **Mental Health**  | **102** |
| **No Disability**  | **93** |
| **Other**  | **8** |
| **Physical Impairment**  | **13** |
| **Blank**  | **6** |
| **Bi-Sexual** | **9** |
| **Gay** | **8** |
| **Heterosexual** | **195** |
| **Lesbian** | **6** |
| **Transgender** | **0** |
| **Prefer not to say** | **13** |
| **Blank** | **5** |
| **Agnostic**  | **2** |
| **Buddhist** | **3** |
| **Christian** | **127** |
| **Hindu** | **1** |
| **Jewish** | **1** |
| **Muslim** | **6** |
| **No Religion** | **66** |
| **None stated**  | **3** |
| **Other**  | **16** |
| **Prefer not to say** | **7** |
| **Blank** | **4** |
| **No of Volunteers**  | **236** |

 |
| **7** | **What does this data say?** | The local population we serve and the staff who work in our services represent a diverse population. Our public sector equality places a legal duty to ensure we do not discriminate and ensure fair and equal access to our services making sure they are cultural appropriate and that working conditions for staff offer equality of opportunity in employment and development. From the figures shown in the data there is more work to do to ensure that our services reach and support our diverse population and that workforce and volunteers continue to reflect and represent the population we serve. This work will be reflected in the annual action plan for equality and inclusion, workforce and volunteers.  |
| **8** | **Taking into account the information gathered above, could this document affect any of the following equality group unfavourably:** | **No** | **Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** This document is applicable to all service users who access care and treatment from the Trust.Rights to accept or refuse treatment are the same for all consenting patients this includes young persons and children who are Gillick and Frazer competent.For service users who are unable to consent the document follows the provision of the Mental Capacity act.For service users who are subject to the Mental Health and require treatment for mental disorder, the document provides guidance in line with the provisions of Part 4 and Part 4A of the Mental Health Act 1983.In terms of gaining consent non verbally for people with Learning disability/physical disability/children and young people/dementia or psychosis, consideration is given as to the preferred and most appropriate method of communication is fully considered and this is supported by following the accessible information standards and making use of information both written and verbal in a manner that is easy to follow/pictoral/easy read and also using specialist services such as speech and language services and occupational Therapists.The Trust has a commissioned interpreting/translation service which is available for all service users. During the period of December 2020 – May 2021, the top 3 languages that were requested in highest requests 1st was Polish, Urdu and Punjabi. An area that was notable is people requiring British Sign Language services was consistently requested within the top 5 requests.The information below describes the demographic makeup of the communities we serve, and figures are based on the 2011 census. The Trust will update these figures following the information from the census due in 2021.  |
| **8.1** | **Race** | **No** | The Trust need to consider services which meet the needs of our diverse population. Specific targeted work to ensure the **diverse population of Kirklees** are served well and the emerging growth of an **Asian population in Wakefield** will be considered in all service development and delivery. Support can be provided via the Trust commissioned service to assist people who’s first language is not English. They can provide assistance to the assessor and the person being assessed in respect of obtaining consent and also development of care plans to address consent issues.**Race equality**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | White | Asian | Black | Mixed | Chinese & Other |
| England % av. | 85.5 | 5.1 | 3.4 | 2.2 | 1.7 |
| **Kirklees** |  |  |  |  |  |
| % average | 79.1 | 15.7 | 1.9 | 2.3 | 0.7 |
| **Barnsley** |  |  |  |  |  |
| % average | 97.9 | 0.7 | 0.5 | 0.7 | 0.2 |
| **Calderdale** |  |  |  |  |  |
| % average | 89.6 | 7 | 0.9 | 1.3 | 0.6 |
| **Wakefield** |  |  |  |  |  |
| % average | 95.4 | 2.6 | 0.77 | 0.9 | 0.29 |

*Taken from Census 2011 for each area* |
| **8.2** | **Disability** | **No** | Across all communities the Trust will ensure that **services remain fully accessible due to a higher than national average** proportion of people whose day to day activities are limited ‘a lot’ by their disability. We will use the **service EIA to ensure we fully understand the nature of the disability** so we can adjust and adapt our services according to need, remaining person centred throughout. **Disability groups**

|  |  |
| --- | --- |
|  | **Day to day activities limited by disability** |
|  | Not at all | A little | A lot |
| England % av. | 47.2 | 13.2 | 4.2 |
| **Kirklees** |  |  |  |
| % average | 45.5 | 12.5 | 13.7 |
| **Barnsley** |  |  |  |
| % average | 76.1 | 11.3 | 12.6 |
| **Calderdale** |  |  |  |
| % average | 56.5 | 12.2 | 13.8 |
| **Wakefield** |  |  |  |
| % average | 77.93 | 9.33 | 8.31 |

*Taken from Census 2011 for each area* |
| **8.3** | **Gender** | **No** | Gender equality is reported as part of our workforce approach and services continue to ensure **environments and workplaces remain gender sensitive** and appropriate.

|  |  |  |
| --- | --- | --- |
|  | **Male** | **Female** |
| England % av. | 49.2 | 50.8 |
| **Kirklees** |  |  |
| % average | 49.4 | 50.6 |
| **Barnsley** |  |  |
| % average | 49.1 | 50.9 |
| **Calderdale** |  |  |
| % average | 48.9 | 51.1 |
| **Wakefield** |  |  |
| % average | 49 | 51 |

*Taken from Census 2011 data* |
| **8.4** | **Age** | **No** | The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that **Barnsley represent a higher than average older population** and **Calderdale a higher than average age range of 0-15 age range**. The Trust will ensure that information, communication and environments support people of all ages.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **0-15** | **16-29** | **30-44** | **45-64** | **65+** |
| England % av. | 18.9 | 18.6 | 20.3 | 22.4 | 16.9 |
| **Kirklees** |  |  |  |  |  |
| % average | 15.8 | 18.5 | 20.3 | 22.2 | 15.8 |
| **Barnsley** (2011 data) |  | 16-24 | 25-44 | 45-59 | 60+ |
| % average | 18.5 | 10.8 | 26 | 20.9 | 23.8 |
| **Calderdale** |  |  |  |  |  |
| % average | 19.6 | 16.4 | 20.1 | 24.2 | 16.6 |
| **Wakefield** |  |  |  |  |  |
| % average | 18.4 | 17.2 | 19.6 | 24.2 | 17.6 |

*Taken from Census 2011 data*  |
| **8.5** | **Sexual orientation** | **No** | The Trust will **improve on the recording of sexual orientation in line with the ‘Sexual Orientation Monitoring standard’** so the Trust can ensure that services and workforce adequately represent the population they serve. The 2020/21 census may contain further baseline information which can be used to support the Trust understanding further. A campaign to support better data collection will improve our reporting.  |
| **8.6** | **Religion or belief** | **No** | Faith and spiritual care and support in an important component of **person-centred care** provided. The Trust have a **spirit in mind** service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in driving our offer. The Trust has a Pastoral care and Chaplaincy team, this service provides digital chaplaincy services to both patients and staff. Appointments can be made via the service. The service provides pastoral care and is a person centred approach. It also provides spiritual care which is a holistic approach to recovery and well being.The service provides:Multi faith Sessional ChaplainsBereavement counsellorsBefriendersEcumenical chaplainsMuslim chaplainCanine Befrienders.The information below tell us that **Calderdale and Kirklees require a focus on Muslim faith, with Christian faith** **representing a large proportion of people who use our services in all areas**. Other faiths will be reflected in geographical areas and in line with **service EIAs and person-centred care and planning**.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Christian** | **Buddhist** | **Hindu** | **Jewish** | **Sikh** | **Muslim** | **Other** | **No religion** |
| England % av. | 71.8 | 0.3 | 1 | 0.5 | 0.7 | 10.1 | 0.2 | 15.1 |
| **Kirklees** |  |  |  |  |  |  |  |  |
| % average | 67.2 | 0.2 | 0.3 | 0.1 | 0.7 | 10.1 | 0.2 | 14 |
| **Barnsley**   |  |  |  |  |  |  |  |  |
| % average | 59.4 | 0.5 | 1.5 | 0.5 | 0.8 | 5 | 0.4 | 24.7 |
| **Calderdale** |  |  |  |  |  |  |  |  |
| % average | 60.6 | 0.3 | 0.3 | 0.1 | 0.2 | 7.8 | 0.4 | 30.2 |
| **Wakefield** |  |  |  |  |  |  |  |  |
| % average | 66.4 | 0.16 | 0.25 | 0.04 | 0.12 | 2.0 | 0.3 | 24.4 |

*Taken from 2011 Census data* |
| **8.7** | **Transgender** | **No** | * A **trans equality policy** aimed at workforce and people who use services will be co-designed and the approach endorsed by partner organisations. The policy and agenda for transgender people will remain a key focus and data collection will be reviewed and improved using a campaign to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data. Trans people are treated with dignity and respect when accessing hospital services.
* Records that we hold reflect the correct gender identity..

The Trust has developed a policy that assists staff in providing appropriate care and treatment to people who are undergoing transgender procedures. The aim of the policy is to * Ensure that Trans people are treated with dignity and respect.
* Ensure that Wards and Departments are supported to ensure they are able to comply with the legal requirements contained in the Equality Act 2010 in respect of the Transgender protected characteristic and Gender Recognition Act 2004 as well as duties contained in the Data Protection Act 1998, Human Rights Act 1998.
* Ensure that information governance and health records protocols are in place to facilitate an individual’s choice to change their name or gender at any time.

The Trust also has a carers passport which supports the Trust and carer with entering into joint working, offering the best care possible to the service user. The purpose of the passport is to record the skills and knowledge that has been developed by the carer and to offer the following as a means of support:Carers champions/lead championStaff and carers awareness trainingCarer information sessionsCarers wellbeing workshopsSign posting to support services.  |
| **8.8** | **Maternity & Pregnancy** | **No** | **Workforce policies** and services aimed at maternity and pregnancy will be **co-designed** with people who represent this group. **Peer support worker roles** in areas of work that support people with maternity and pregnancy mental health issues are increasing, this ensures that lived experience is reflected in our service offer.  |
| **8.9** | **Marriage & civil partnerships** | **No** | Marriage and civil partnerships will be recorded in line with **workforce recruitment** and selection procedures and as part of **person-centred care and planning.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Married** | **Single** | **In a [registered] civil partnership** | **Divorced** | **Widowed** | **Separated** |
| England % av. | 46.6 | 34.6 | 0.2 | 9.0 | 6.9 | 2.7 |
| **Kirklees** |  |  |  |  |  |  |
| % average | 48.4 | 32.4 | 0.2 | 9.3 | 6.8 | 2.8 |
| **Barnsley**  |  |  |  |  |  |  |
| % average | 46.6 | 34.6 | 0.2 | 9 | 6.9 | 2.7 |
| **Calderdale** |  |  |  |  |  |  |
| % average | 46.7 | 32.1 | 0.3 | 10.5 | 7.3 | 3.0 |
| **Wakefield** |  |  |  |  |  |  |
| % average | 48.2 | 30.9 | 0.18 | 10.5 | 7.5 | 2.6 |

Source unknown  |
| **8.10** | **Carers (Our Trust requirement)** | **No** | It’s likely that every one of us will have caring responsibilities at some time in our lives with the challenges faced by carers taking many forms. Many carers juggle their caring responsibilities with work, study and other family commitments. Some, younger carers, are not known to be carers and this means that the sort of roles and responsibilities that carers must provide varies widely.Within the local footprint of South West Yorkshire Partnership NHS Foundation Trust, there is an estimated **160,000 unpaid carers.**The Trust will continue to record carers as part of equality monitoring and continue to develop and deliver actions to support carers as part of the strategy action plans. The Trust has developed a “carers passport” for staff in the organisation who have unpaid carers responsibility. The Purpose of the passport is so that staff members and managers can have an open discussion to enable a member of staff to continue working whilst at the same time the organisation is able to facilitate working hours to fit in with those responsibilities. The agreement is a live document and belongs to the member of staff. |
| **9** | **What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy: -** | This document is monitored locally by the clinical services through its day to day implementation.Monitoring relating to changes to legislation is via legal services department and clinical specialists.This document can also be influenced by changes in “case law” following legal proceedings relating to the use of the Mental Health Act and Mental Capacity Act.This policy should also be reviewed in response to any changes brought about by NICE guidelines. |
| **9a** | **Promotes equality of opportunity for people who share the above protected characteristics** | The Trust ensure that all **training is recorded and monitored**, study leave forms are completed and that training outcomes are identified through formal learning needs analyses. From the workforce data in 2020 the Trust sees no adverse barriers to training access for any of its staff regardless of their ethnicity, disability or sexuality **Development of BAME staff** – The Trust supports the BAME network, thedevelopment of both ‘Stepping Up’ and “Ready Now”, the NHS LeadershipAcademy inclusive leadership programmes; and partnering with BradfordDistrict Care Trust on the ‘Moving Forward’ programme.**Supporting staff with a disability** – Continuing to focus on improving staffdisability experience remains a priority, and we have established a StaffDisability network across the Trust and are implementing the WorkforceDisability Equality Standard (WDES). The Trust encourages all staff toaccess Occupational Health and wellbeing services, access health checksand attend Trust wellbeing workshops.**A representative workforce** that is reflective of its localisedneed – The Trust considers workforce diversity issues as part of our annualplanning process and will continue to support the ‘New Horizons’ project,working with schools and engaging with local communities in the areas ofmental health awareness, employability skills and promoting the NHS as anemployer of choice, particularly regarding apprenticeships and HCSWopportunities in the Trust. The Trust is continuing with its participation in theInsight programme which seeks to increase Trust Board BAMErepresentation. |
| **9b** | **Eliminates discrimination, harassment and bullying for people who share the above protected characteristics** | **Harassment & Bullying** – The Trust has introduced a new model forpreventing Harassment and Bullying and has 12 months communicationsplan. A senior leadership forum with a focus on Making SWYT A Great Placeto Work is being rolled out and will include local action plans on creating ateam culture to prevent harassment and bullying. The RACE Forward network has been established to review the approach to harassment and bullying from service users, carers and visitors. |
| **9c** | **Promotes good relations between different equality groups** | The Trust values promote good relations and these form part of recruitment, training and appraisal functions. Other areas are: * Mandatory training
* Staff Networks
* WRES and WDES monitoring information
* Race forward
* Accessible information standard
* Translation and interpreter services

The accessible information standard promotes equality of access for service users by providing information in a manner that allows sometimes complex information to be shared. The policy is developed on the format of the Department of Health. This policy is supported by local information that is used by staff to assist service users and where applicable carers in providing information in an accessible manner. |
| **9d** | **Public Sector Equality Duty – “Due Regard”** | The Equality Delivery System (EDS2) captures our progress against several standards. These standards are reported on each year and a report is shared at the Equality and Inclusion Committee who identify a grading for the Trust. EIAs are routinely completed at a service level and updated every 3 years. These documents are used in the planning and development of services. A The voice of people who use our services is captured using feedback and involvement. All activity is equality monitored and the findings are reported for each protected group to ensure the reach and audience are reflective of the target audience and that any differential impact is recorded and considered.  |
| **10** | **Have you developed an Action Plan arising from this assessment?** | No action plan indicated |
| **11** | **Assessment/ Action Plan approved by** |  |
|  | **(Director Lead)** | **Sign:** |
| **12** |  | ***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Engagement Development Managers:***Aboobaker.bhana@swyt.nhs.ukZahida.mallard@swyt.nhs.uk**Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.** |

##

**Appendix C - Checklist for the Review and Approval of Procedural Document**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Title of document being reviewed:** | **Yes/No/Unsure** | **Comments** |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | YES |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | YES |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | YES |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | YES |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | YES |  |
|  | Are people involved in the development identified? | YES |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | YES |  |
|  | Is there evidence of consultation with stakeholders and users? | YES |  Medical Staff, professional staff. Communications, information Governance, clinical legislation manager, Engagement and equality leads |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | YES |  |
|  | Is the target population clear and unambiguous? | YES |  |
|  | Are the intended outcomes described?  | YES |  |
|  | Are the statements clear and unambiguous? | YES |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | YES |   |
|  | Are key references cited? | N/A |  |
|  | Are the references cited in full? | N/A |  |
|  | Are supporting documents referenced? | YES |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it?  | YES |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | YES | Training on Consent to treatment under MCA and MHA is now mandatory for all staff in the Trust |
|  | Does the plan include the necessary training/support to ensure compliance? | YES |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | YES |  |
|  | Have archiving arrangements for superseded documents been addressed? | YES |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | N/A |  |
|  | Is there a plan to review or audit compliance with the document? | YES |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | YES | Within 3 years or sooner if legislation changes |
|  | Is the frequency of review identified? If so is it acceptable? | YES |  |
| **11.** | **Overall Responsibility for the Document** |  | Medical Director |
|  | Is it clear who will be responsible implementation and review of the document? | YES |  |

**Appendix D - Version Control Sheet**

*This sheet should provide a history of previous versions of the policy and changes made*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| 1 | March 2003 | Director of Risk and Governance | Final | Final version approved by Trust Board |
| 2 | September 2010 | Head of Legal Services | reviewed | No change |
| 3 | November 2012 | Assistant Director Legal Services | reviewed |  Full review – changes based on DOH guidance, and other related changes. Reviewed old SWYPHT and Barnsley consent policy |
| 4 | February 2018 | Assistant Director Legal Services | reviewed | Full review – changes due to developments in case law  |
| 5. | June 2021 | Assistant Director Legal Services | reviewed | Full review – changes due to case lase and changes in organsiational structures |
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