CLINICAL POLICY
Consent to Examination or Treatment

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Policy Number	CLP213
Version:	V10
Purpose:	This policy sets out the standards and procedures in the Trust which aim to ensure that health professionals are able to comply with the legal requirements relating to consent to treatment.
Consultation:	Clinical Policy Group Consultation Distribution List
Approved by:	Clinical Policy Group
Date approved:	15/05/2025
Author / Reviewer:	Reviewed by: [redacted] Joint Mental Capacity Act Leads
Date issued:	10/06/2025
Review date:	01/06/2028
Audience:	All Clinical staff within the Trust in Gloucestershire
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V1	Dec 2009	Transferred into GHC Trust format and reviewed
V3	May 2011	Policy Reviewed
V4	March 12	Policy Review
V5	March 2017	Policy review
V6.1	July 2019	Policy transferred to revised Trust format
V7	Jan 2020	Policy review and amendment to next review date
V8	03/09/2020	Reviewed
V8.1	04/08/2021	Extension to review date whilst this Policy is reviewed by the

		Head of Safeguarding
V8.2	17/11/2021	Extension to review date
V9	20/05/2022	Streamlined by the Head of Safeguarding and Dr Katie Kelly
V10	10/06/2025	Removal of the term Young People to avoid adultification of children under the age of 18, some amendments in relation to Gillick competence and insertion of reference to the principles of the MCA 2005 where relevant.

SUMMARY
In line with Department of Health guidance and the Mental Capacity Act 2005 the Trust has developed this policy to outline its position in relation to obtaining consent for examination or treatment.

TABLE OF CONTENTS

	Section	Page
1	**Introduction**	**3**
2	**Purpose**	**3**
3	**Scope**	**3**
4	**Duties**	**3**
5	**Mental Capacity Act Compliance**	**3-4**
6	**Policy Detail**	**4-16**
7	**Process for Monitoring Compliance**	**16**
8	**Incident, Near Miss Reporting and Duty of Candour**	**16**
9	**Training**	**17**
10	**References**	**17**
Appendix 1	**Children and Young People**	**18-22**
Appendix 2	**Consent Form 1**	**23-26**
Appendix 3	**Consent Form 2**	**27-31**
Appendix 4	**Consent Form 3**	**32-33**
Appendix 5	**Consent Form 4**	**34-37**

ABBREVIATIONS

Abbreviation	*Full Description*
ANH	Artificial Nutrition and Hydration
BMA	British Medical Association
CTO	Community Treatment Orders
ECT	Electro-Convulsive Therapy
EPR	Electronic Patient Record

GHC	Gloucestershire Health and Care NHS Foundation Trust
GMC	General Medical Council
LPA	Lasting Power of Attorney

1. INTRODUCTION

The Department of Health has issued a range of guidance documents on consent and these offer details of the law and good practice requirements on consent.

2. PURPOSE

This policy sets out the standards and procedures in the Trust which aim to ensure that health professionals are able to comply with the legal requirements relating to consent to treatment. While this document is primarily concerned with healthcare, social care colleagues should also 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.

3. SCOPE

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy.

4. DUTIES

General Roles, Responsibilities and Accountability
Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. POLICY DETAIL

Consent and Capacity:
The issues of consent and capacity are closely linked. Consent enables interventions to lawfully take place on the basis patients are adequately informed, have the capacity to consent, and are free from coercion.

For consent to be valid it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Acquiescence where the person does not know what the intervention entails is not '*consent*'. Where any doubt about the patient's capacity to consent exists the health professional should assess the capacity of the patient to take the decision in question using the 2-stage capacity assessment as set out in the Mental Capacity Act (2005). All mental capacity assessments and best interest decisions must be recorded on the appropriate clinical system using the Trust's mental capacity assessment and best interest forms

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients

must be given sufficient information, in a way they can understand, about the purpose of the examination or treatment.

No-one is able to give consent to the examination or treatment of an adult unable to give consent for themselves, apart from an attorney or deputy under a relevant LPA or court order. Therefore, patients, relatives or members of the healthcare team cannot consent on behalf of such an adult although they have a legal right to be consulted during any Best Interest decision making process, where the person lacks capacity to make the decision for themselves. The best interest process requires the use of a statutory checklist of what to consider when making Best Interest decisions, unless this is deemed to be inappropriate when the reason for exclusion of relatives/carers must be documented.

The Mental Capacity Act 2005 allows for a person to make a Lasting Power of Attorney if they have capacity to do so. This allows them to designate another person or persons; to act as an attorney to make decisions on their behalf and in their best interest, should they lose capacity to make decisions in the future. There are two types of Lasting Power of attorney, one for health and welfare and one for property and finance. Only an attorney for health and welfare can make decisions about care and treatment for a person who lacks capacity to make those decisions for themselves.

The mental Capacity Act 2005 also allows for the Court of Protection to appoint someone as a deputy to make decisions on behalf of a person who has already lost capacity and is unable to create a Lasting Power of Attorney for themselves. The court will specify what kind of decisions a deputy can make on behalf of the person.

Where there is a valid and appropriate attorney or deputy in place, they can consent to care and treatment on behalf of a person who lacks capacity to do so themselves, but they must act in the person's best interest when making decisions.

The key principle concerning treatment where a person is unable to give consent due to a lack of capacity relating to the treatment decision will be what is in their 'Best Interests' recognising that these are not confined to '*medical Best Interests*', but include consideration of emotional, psychological and social aspects of the proposed treatment(s).

The following are some key documents relating to consent:
DoH *'Reference Guide to Consent for Examination or Treatment'* was updated in 2009 to reflect legal developments since the guide was issued including the MCA 2005. Chapter 2 of the DoH guide deals with Adults without Capacity and Chapter 4 deals with '*Withdrawing and Withholding Life-prolonging Treatment*' including for adults and children lacking capacity.

'Treatment and care towards the end of life: good practice in decision making' was published in June 2010 and came into effect on 01 July 2010. Para 15-16 deal with adults who lack capacity and parts 50 – 80 with Advance Care Planning. Para 129-131 deals with when to consider a Do Not Attempt CPR (DNACPR).

'*Treatment and care towards the end of life: good practice in decision making'* expands on the GMC guidance of June 2008 *'Consent: patients and doctors making decisions together'* and sets out the principles of good decision making for all stages of care.

The Trust adheres to the following chapters from the 'Reference Guide to consent for examination

or treatment' (2009) written by the Department of Health. The following excerpts from the guide provide guidance in relation to practice. The full guide can be found on the DoH website.

Part 1: Seeking Consent
Part 2: Advance Decisions to Refuse Treatment
Part 3: Adults without Capacity
Part 4: Withdrawing and Withholding life Sustaining Treatment
Part 5: Other Exceptions to the Principles

Part 1: Seeking Consent

Valid Consent
For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (this will be the patient or someone with parental responsibility for a patient under the age of 18, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy). Acquiescence where the person does not know what the intervention entails is not 'consent'.

Does the Person have Capacity?
The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary. A person lacks capacity if:

- They have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and
- that impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is unable to make a decision if they cannot do one or more of the following things:

- understand the information given to them that is relevant to the decision
- retain that information long enough to be able to make the decision
- use or weigh up the information as part of the decision-making process
- communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

People may have capacity to consent to some interventions but not to others or may have capacity at some times but not others. Section 1 of the Mental Capacity Act sets out the key principles, one of which is that a person must be assumed to have capacity unless it is established that they lack capacity. If there is any doubt, then the healthcare professional should assess the capacity of the patient to make the decision in question. This assessment and the conclusions drawn from it should be recorded in the patient's notes. Guidance on assessing capacity is given in chapter 4 of the Mental Capacity Act (2005) Code of Practice.

Guidance on how people should be helped to make their own decisions is given in chapter 3 of the Mental Capacity Act (2005) Code of Practice.
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

A person's capacity to consent may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication. However, the existence of such factors should not lead to an automatic assumption that the person does not have the capacity to consent.

Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the person's decision. Under principle 3 of the Mental Capacity Act, a person is not to be treated as unable to make a decision merely because they make an unwise decision. A person is entitled to make a decision which may be perceived by others to be unwise or irrational, as long as they have the capacity to do so.

However, if the decision that appears irrational is based on a misperception of reality, as opposed to a different value system to that of the health practitioner – for example a patient who, despite the obvious evidence, denies that his foot is gangrenous, or a patient with anorexia nervosa who is unable to comprehend their failing physical condition – then the patient may not be able to comprehend, weigh or make use of the relevant information and hence may lack the capacity to make the decision in question.

Principle 2 of The Mental Capacity Act (2005) also requires that all practical and appropriate steps are taken to enable a person to make the decision themselves. These steps include the following:

- Providing relevant information. For example, if there is a choice, has information been given on the alternatives?
- Communicating in an appropriate way. For example, could the information be explained or presented in a way that is easier for the person to understand?
- Making the person feel at ease. For example, are there particular times of the day when a person's understanding is better?
- Supporting the person. For example, can anyone else help or support the person to understand information and to make a choice?

Is the Consent given Voluntarily?
To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Such pressure can come from partners or family members, as well as health or care practitioners. Practitioners should be alert to this possibility and where appropriate should arrange to see the person on their own in order to establish that the decision is truly their own.

When people 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 offers 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 treatment for the person's health. However, threats such as 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.

Although informing people of the nature and purpose of procedures enables valid consent to be given as far as any claim of battery is concerned, this is not sufficient to fulfil the legal duty of care to the person. Failure to provide other relevant information, such as risks and benefits of the procedure, may render the practitioner liable to an action for negligence if a person subsequently

suffers harm as a result of the treatment received.

In the very rare event that the healthcare professional believes that to provide the information about the procedure and associated risks in a balanced way will cause the patient serious harm, the GMC guidance states that this view, and the reasons for it, should be recorded in the patient's notes/ electronic records.

When such concerns arise, it is advisable to discuss the issue within the team caring for the patient. In individual cases the courts may accept such a justification but would examine it with great care. The mere fact that the patient might become upset by hearing the information, or might refuse treatment, is not sufficient to act as a justification.

Some people may wish to know very little about the treatment that is being proposed. If information is offered and declined, it is good practice to record this fact in the notes. However, it is possible that individuals' wishes may change over time, and it is important to provide opportunities for them to express this. GMC and BMA guidance encourages doctors to explain to patients the importance of knowing the options open to them while respecting a person's wish not to know, and states that basic information should always be provided about what the treatment aims to achieve and what it will involve.

Where a person has been given difficult news about a diagnosis or situation, then it may be appropriate to give them time to process this information, before discussing possible treatment or care options.

Ref; Consent; patients and doctors making decisions together:
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

Consent to Visual and Audio Recordings
Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must be clearly explained to the person before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised. GMC guidance gives more detailed advice, including situations when permission is not required and about obtaining consent to use recordings as part of the assessment or treatment of patients and for training or research.

Who Should Seek Consent?
The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person's care will remain ultimately responsible for the quality of medical care provided.
The GMC guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified.

Form of Consent
Although completion of a consent form is in most cases not a legal requirement (exceptions include certain requirements of the Mental Health Act 1983 and of the Human Fertilisation and Embryology Act 1990 as amended by the Human Fertilisation and Embryology Act 2008) the use of such forms is good practice where an intervention such as surgery is to be undertaken. Where

there is any doubt about the person's capacity, it is important, before the person is asked to sign the form, to establish both that they have the capacity to consent to the intervention and that they have received enough information to enable valid consent to be given. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

If the person has capacity, but is unable to read or write, they may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes.

Consent may be expressed verbally or non-verbally: an example of non-verbal consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken. However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid. It is good practice to obtain written consent for any significant procedure, such as a surgical operation or when the person participates in a research project or a video recording (even if only minor procedures are involved).

Reviewing consent
Where a person has been deemed to have capacity to consent to treatment and has given their consent, this consent should be reviewed at regular intervals, if the treatment is ongoing. Practitioners should consider if there has been a change in a person's ability to give their consent, especially if there is evidence they may have lost capacity to consent.

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. GMC guidance advises that patients 'should be told how the proposed treatment differs from the usual methods, why it is being offered, and if there are any additional risks or uncertainties. Clinical trials are covered by the Medicines for Human Use (Clinical Trial Regulations) 2004.[26]

26 Medicines for Human Use (Clinical Trials) Regulations 2004, SI 1031. www.legislation.gov.uk/ si/si2004/20041031.htm

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

When Consent is Refused
If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision **must** be respected, except in certain circumstances as defined by the Mental Health Act 1983 This is the case even where this may result in the death of the person.

Withdrawal of Consent
A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for

the practitioner, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure. At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the practitioner to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may be entitled to continue until that risk no longer applies.

Assessing capacity during a procedure may be difficult and as noted above, factors such as pain, panic and shock may diminish capacity to consent.

Part 2: Advance Decisions to Refuse Treatment
NB: Refer also to the Trust Advance Care Planning Policy and Procedures

A person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of Common Law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable. Further details are available in chapter 9 of the Mental Capacity Act (2005) Code of Practice, but in summary these are:

- The person must be 18 or over
- the person must have the capacity to make such a decision
- the person must make clear which treatments they are refusing
- if the advance decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in healthcare notes), it must be signed and witnessed and it must state clearly that the decision applies even if life is at risk
- a person with capacity can withdraw their advance decision at any time.

Patients should always be offered measures that are essential to keeping them comfortable. This is sometimes referred to as 'basic' or 'essential' care, and includes warmth, shelter, actions to keep a person clean and free from distress and the offer of food and water by mouth.

Consent and the Mental Health Act
Although the Mental Health Act 2007 permits some medical treatment for mental disorder to be given without consent, the patients consent should be sought before treatment is given, wherever practicable. The patients consent or where the patient is incapable of consenting due to a lack of capacity should be recorded in their electronic patient records, as should the treating clinician's assessment of the patient's capacity to consent to the treatment being proposed.

In respect of mental health, the Mental Health Act provides a legal framework by which a detained patient's treatment may be made compulsory in the absence of their consent or their inability to consent due to a lack of capacity. However, the patient's consent should always be sought and their mental capacity to consent or inability to consent should be recorded in full. When patients are detained under the Mental Health Act, they may be given treatment with medication for their mental disorder for the first three months of their treatment, even if they have capacity and refuse to consent, or are incapable of giving consent to that treatment due to a lack of capacity. After this time (except in emergencies), the treatment can be given only under certain conditions and the authority for that treatment must be formally certified. Where the patient has capacity and

consents to the treatment, either the Approved Clinician in charge of it or a second opinion appointed doctor (SOAD) will certify that consent on form T2; where the patient lacks capacity to consent, or has capacity and refuses to consent, the treatment may only be given following a SOAD certification, on form T3, that is appropriate for it to be given. A patient's capacity and consent status should be under continuous review, especially when they have been certified as consenting to treatment by the clinician in charge of treatment.

Self-Harm
Cases of self-harm present a particular difficulty for healthcare professionals. Where the person is able to communicate, an assessment of their mental capacity should be made as a matter of urgency. If the person is judged not to have capacity, then they may be treated on this basis. Similarly, patients who have attempted suicide and are unconscious should be given emergency treatment if any doubt exists as to either their intentions or their capacity when they took the decision to attempt suicide.

However, as noted above, patients with capacity **do** have the right to refuse life-sustaining treatment (other than treatment for mental disorder under the Mental Health Act 2007) – both at the time it is offered and in the future. Making a decision which, if followed, may result in death does not necessarily mean that a person is or feels suicidal. Nor does it necessarily mean that the person lacks the capacity to make the decision now or in advance. If the person is clearly suicidal, this may raise questions about their capacity to make the decision. If a patient with capacity has harmed themselves, a prompt psychosocial assessment of their needs should be offered. However, if the person refuses treatment and use of the Mental Health Act 2007 is not appropriate, then their refusal must be respected.

National Collaborating Centre for Mental Health, commissioned by the National Institute for Clinical Excellence (2004) National Clinical Practice Guideline 16: Self-harm. www.nice.org.uk/nicemedia/pdf/CG16FullGuideline.pdf

Similarly, if practitioners have good reason to believe that a patient genuinely intended to end their life and had capacity when they took that decision, and are satisfied that the Mental Health Act is not applicable, then treatment should not be forced upon the person, although clearly attempts should of course be made to encourage them to accept help.

Part 3: Adults without Capacity

General Principles
The Mental Capacity Act 2005 came fully into force in October 2007 and applies in England and Wales to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves. It is largely based on previous common law and creates a single, coherent framework for decision-making, including decisions about treatment. This chapter summarises the main provisions of the Mental Capacity Act. Detailed guidance is provided in the Code of Practice, which has statutory force.

Under English law, no one is able to give consent to the examination or treatment of an adult who lacks the capacity to give consent for themselves, unless they have been authorised to do so under a Lasting Power of Attorney or they have the authority to make treatment decisions as a court appointed deputy. Therefore, in most cases, parents, relatives or members of the healthcare team cannot consent on behalf of such an adult. However, the Mental Capacity Act sets out the circumstances in which it will be lawful to carry out such examinations or treatment.

The legal requirements in the Mental Capacity Act are underpinned by five statutory principles.

Principle 4 of the Act states that any act done for, or any decision made on behalf of, a person who lacks capacity must be done, or made, in that person's best interests. This principle applies to health professionals as it does to anyone working with and caring for a person who lacks capacity. The Act also creates a new offence of ill treatment or wilful neglect of someone who lacks capacity by someone with responsibility for their care or with decision-making powers.

The Mental Capacity Act provides healthcare professionals with protection from civil and criminal legal liability for acts or decisions made in the best interests of the person who lacks capacity. A healthcare professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.

The Act requires that a healthcare professional **must** consider all the relevant circumstances relating to the decision in question.

In considering the relevant circumstances, the Act rules that the healthcare professionals **must** take the following steps:

- Consider whether the person is likely to regain capacity and if so whether the decision can wait.
- Involve the person as fully as possible in the decision that is being made on their behalf.

As far as possible, consider:

- The person's 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, and the other factors that the person would be likely to consider if they were able to do so
- As far as possible, consult other people if it is appropriate to do so and take 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
- anyone engaging in caring for or interested in the person's welfare
- any attorney appointed under a Lasting Power of Attorney
- any deputy appointed by the Court of Protection to make decisions for the person.

For decisions about serious medical treatment, where there is no one appropriate to advocate for the person healthcare professionals have to instruct an Independent Mental Capacity Advocate (IMCA).

If the decision concerns the provision or withdrawal of life-sustaining treatment, the person making the best interests decision must not be motivated by a desire to bring about the person's death.

In cases of serious doubt or dispute about an individual's mental capacity or best interests, an application can be made to the Court of Protection for a ruling. The duty officer of the Official Solicitor can advise on the appropriate procedure if necessary.
Further details about the Official Solicitor can be found at www.officialsolicitor.gov.uk/os/offsol.htm (contact would usually be made through the legal department of the NHS body involved)

Statements of Preferences and Wishes
A healthcare professional must take all statements of a person's preferences and wishes into consideration as part of a best interest's assessment. Written statements which request specific

treatments made by a person before losing capacity should be given the same consideration as those made by people who currently have capacity to make treatment decisions. However, a healthcare professional would not have to follow a written request if they thought that the specific treatment would be clinically unnecessary or not appropriate for the person's condition, and therefore not in the person's best interests. If the decision is different to a written statement, a healthcare professional should keep a record of this and be prepared to justify the decision if challenged.

There is an important legal distinction between a written statement expressing treatment preferences, which a healthcare professional must take into account when making a best interests decision, and a valid and applicable advance decision to refuse treatment.

Lasting Power of Attorney
The Mental Capacity Act enables a person aged 18 or over to appoint an attorney to look after their health and welfare decisions if they should lack the capacity to make such decisions in the future. Under a personal welfare LPA, the attorney – if they have the authority to do so – can make decisions that are as valid as those made by the person themselves.

Mental Capacity Act 2005 (Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian) Regulations 2007, SI 2007, 2161 and www.publicguardian.gov.uk/forms/Making-an-LPA.htm

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 will have the authority to make decisions and consent to or refuse treatment as set out in the LPA. Healthcare practitioners should read the LPA if it is available, in order to understand the extent of the attorney's power.

The attorney must follow the statutory principles under the Mental Capacity Act and make decisions in the best interests of the person lacking capacity. If there is a dispute that cannot be resolved, e.g. between the attorney and a doctor, it may have to be referred to the Court of Protection. More information about LPAs is given in chapter 7 of the MCA Code of Practice.

Court Appointed Deputies
If a person lacks capacity to make a decision relating to their personal welfare, then the Court of Protection can make an order making a decision on their behalf. Alternatively, the Court of Protection can appoint a deputy to make decisions on behalf of the person who lacks capacity. The court must ensure that any deputy appointed has the necessary skills and abilities and is prepared to take on the duty and responsibility of the role.

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 court's authority or where there is no other way of settling the matter in the best interests 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 than the healthcare professional who makes the treatment decision. A deputy cannot go against a decision of an attorney under an LPA made before the person lacks capacity. A deputy cannot refuse consent to the provision of life-sustaining treatment. More information about the powers of the Court of Protection and the role of deputies is given in chapter 8 of the Code of Practice.

Independent Mental Capacity Advocates
NHS bodies have a duty to instruct an IMCA in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. In matters that meet the definition of serious medical treatment, IMCAs are only able to represent and support people whose treatment is arranged by the NHS. They have the right to information about an individual and can see relevant healthcare records.

The duties of an IMCA are to:

- support the person who lacks capacity and represent their views and interests to the decision-maker
- obtain and evaluate information, both through interviewing the person and through examining relevant records and documents
- obtain the views of professionals providing treatment for the person who lacks capacity
- identify alternative courses of action
- obtain a further medical opinion, if required, and
- prepare a report (that the decision-maker must consider).

IMCAs are not decision-makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision-making for people who lack capacity is done appropriately and in accordance with the Mental Capacity Act.

Consent Forms
Where treatment is provided to a person who lacks capacity following a best interest's decision, any consent form should not be signed by someone else unless they have a personal welfare LPA that authorises them to make the decision in question, or they are a court appointed deputy with similar authority.

Referral to Court
The Mental Capacity Act established the Court of Protection to deal with decision-making for adults (and children in a few cases) who may lack the capacity to make specific decisions for themselves. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court.

The courts have identified certain circumstances when referral should be made to them for a ruling on lawfulness before a procedure is undertaken. These are:

- Decisions about the proposed withholding or withdrawal of ANH from patients in a permanent vegetative state
- cases involving organ, bone marrow or peripheral blood stem cell donation by an adult who lacks the capacity to consent (see chapter 3 for information on children)
- cases involving the proposed non-therapeutic sterilisation of a person who lacks the capacity to consent to this (e.g. for contraceptive purposes), and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.

Research
The Mental Capacity Act sets out a legal framework for involving people who lack the capacity to consent to taking part in research. The Act provides for when such research can be carried out and for safeguards to protect people involved in the research who lack capacity, for example

ensuring that the wishes and feelings of the person who lacks capacity are respected. Anyone setting up or carrying out such research will need to make sure that the research complies with the provisions set out in the Act and will need to follow the guidance given in chapter 11 of the Mental Capacity Act (2005) Code of Practice. The Act does not include clinical trials, which are covered by the Medicines for Human Use (Clinical Trial Regulations) 2004.

The Act requires that a family member or unpaid carer must be consulted about any proposal and agree that the person who lacks capacity can be part of the research. If such a person cannot be identified, then the researcher must nominate a person who is independent of the research project to provide advice on the participation of the person who lacks capacity in the research.

Part 4: Withdrawing and Withholding Life-Sustaining Treatment

General Principles
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 stops providing a benefit to a patient and is not clinically indicated. 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 that they have reached a stage where they no longer wish treatment to continue. If a person lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes (if these are known).

Sometimes decisions will need to be made immediately – for example whether it is appropriate to attempt resuscitation after severe trauma. In an emergency situation, where there is doubt as to the appropriateness of treatment, there should be a presumption in favour of providing life-sustaining treatment.

See Trust 'Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy'

Artificial Nutrition and Hydration
Legally, the use of artificial nutrition and hydration (ANH) constitutes medical treatment. Thus, the legal principles that apply to the use of ANH are the same as those that apply to all other medical treatments, such as medication or ventilation.

There is an important distinction between withdrawing or withholding treatment that is of no clinical benefit to the patient or is not in the patient's best interests and taking a deliberate action to end the patient's life. A deliberate action that is intended to cause death is unlawful. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment stops providing a benefit to a patient and is not clinically indicated. Healthcare professionals should discuss the situation with a patient with capacity and agree if and when the patient no longer wishes treatment to continue. If the patient lacks capacity, this decision must be taken in their best interests and in a way that reflects their wishes, beliefs and values (if these are known). Suitable care should be provided to ensure that both the comfort and dignity of the patient are maintained.

Adults with Capacity
Except in circumstances governed by the Mental Health Act 2007, if an adult with the capacity to make the decision refuses life-sustaining treatment, or requests that it be withdrawn, practitioners **must** comply with the person's decision, even if it may result in the person's death. If a refusal is

ignored, they will be treating the person unlawfully.

Adults without Capacity
If an adult lacks capacity and has not made a valid and applicable advance decision to refuse life-sustaining treatment, the provisions of the Mental Capacity Act will apply and the decision must be based on the best interests of the adult, again involving the person as far as this is possible.

Part 5: Other Exceptions to the Principles

Certain statutes set out specific exceptions to the principles noted in the previous chapters. These are briefly noted below. Those concerned with the operation of such statutes should consult more detailed guidance.

Part 4 of the Mental Health Act 2007 sets out circumstances in which persons liable to be detained under the Act may be treated without consent for their mental disorder. The 2007 Act does not apply to treatment for physical disorders unrelated to the mental disorder. The Mental Health Act Code of Practice (2015) offers guidance on consent and medical treatment in this context.

Neither the existence of mental disorder nor the fact of detention under the 2007 Act 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.

7. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
To ensure compliance of this guidance an audit of consent to examination or treatment will be undertaken every 2 years commissioned by the Director of Nursing, Therapies and Quality. This will involve an examination of detained patient's health and social care record. The audit criteria will include assessing compliance against the following standards: *Recording of consent in the health and social care records.* An audit of Recording of capacity and consent with respect of S63 and S58 of MHA	Every 2 years Every 2 years	The outcomes of these audits (this may be in the form of exception reporting) will be presented in report format to the Mental Health Act Scrutiny Committee that will be responsible for the development and monitoring of any identified actions within the scope of the audit.

8. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

9. TRAINING

Training and information for staff is provided as an e-learning module as part of statutory and mandatory training and also as part of the web-based level 2 MCA training.

10. REFERENCES

DoH Consent for examination or treatment; 2009

DoH Reference Guide to Consent for Examination or Treatment; 2009

DoH Treatment and care towards the end of life: good practice in decision making; 2010

GMC Guidance - Consent: patients and doctors making decisions together; 2008

Human Fertilisation and Embryology Act; 1990, as amended by the Human Fertilisation and Embryology Act; 2008

Mental Capacity Act (MCA); 2005

Mental Health Act; 1983

Medicines for Human Use (Clinical Trial Regulations); 2004

National Institute for Health and Care Excellence (NICE) Guidance Adult Mental Health: CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services; 2011

National Institute for Health and Care Excellence (NICE) Guidance; CG138; Patient experience in adult NHS services: Improving the experience of care for people using adult NHS services; February 2012

National Institute for Health and Care Excellence (NICE) Guidance NG108; Decision-making and mental capacity; 2018

National Institute for Health and Care Excellence (NICE) Guidance NG204; Babies, children and young people's experience of healthcare; August 2021

Appendix 1

CHILDREN

The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults.

Children aged 16–17

By virtue of section 8 of the Family Law Reform Act 1969, [47] people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed child capable of consenting to the particular intervention. However, unlike adults, the refusal of a capacitous person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court (see paragraphs 14–18 below).

47 *www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1969/cukpga_19690046_en_2#ptH1g8*

Section 8 of the Family Law Reform Act 1969 applies only to the child's own treatment. It does not apply to an intervention that is not potentially of direct health benefit to the child, such as blood donation or non-therapeutic research on the causes of a disorder. However, a child may be able to consent to such an intervention if they have the mental capacity to do so as outlined in the Mental Capacity Act 2005,

In order to establish whether a child aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used (see chapter 1, paragraph 2). If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over (see chapter 2). If, however they are unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, then the Act will not apply to them and the legality of any treatment should be assessed under common law principles. It may be unclear whether a child lacks capacity within the meaning of the Act. In those circumstances, it would be prudent to seek a declaration from the Court of Protection. More information on how the Act applies to children aged 16 and 17 is given in chapter 12 of the Mental Capacity Act (2005) Code of Practice.[48]

48 *www.publicguardian.gov.uk/mca/code-of-practice.htm*

If the 16/17-year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the child It is, however, good practice to involve the child's family in the decision-making process – unless the child specifically wishes to exclude them.

Children under 16 – the concept of Gillick competence

In the case of *Gillick*, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention.[49] This is sometimes described as being 'Gillick competent'. A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent.

49 *Gillick v West Norfolk and Wisbech AHA [1986] AC 112*

The concept of Gillick competence is said to reflect a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus, a child under

16 may have the competence to consent to some interventions but not to others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.

In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not.

If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared.

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

Consideration should be given to the Gillick and Fraser guidelines (originates from the same case) in relation to contraception and sexual health. Please refer to the NSPCC website for further information and guidance.
https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines

If a competent child seeks advice or treatment in relation to abortion and cannot be persuaded to inform her parent(s), every effort should be made to help the child find another adult (such as another family member or a specialist youth worker) to provide support to the child.[50]
50 *Axon v Secretary of State for Health [2006] EWHC 37 (Admin)*

It is a criminal offence to have sexual intercourse with a child under 13 and would have to be reported to the local authority children's safeguarding team. Advice can also be sought from the Trust's safeguarding team advice line on: 0300 421 6969

The Requirement of Voluntariness
Although a child may have the capacity or competence to give consent, this is only valid if it is given voluntarily. This requirement must be considered carefully. Children may be subject to undue influence by their parent(s), other carers or a sexual partner (current or potential).

Child with Capacity or Competence Refusing Treatment
Where a child of 16 or 17 who could consent to treatment in accordance with section 8 of the Family Law Reform Act 1969, or a child under 16 but Gillick competent, 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/young person or to severe permanent injury.

In the case of *Re W (a minor) (medical treatment),*[51] the court stated that it has jurisdiction to override a refusal of a child, at least where they seek to refuse treatment in circumstances that will, in all probability, lead to the death of the child or to severe permanent injury; or where there is a serious and imminent risk that the child will suffer grave and irreversible mental or physical

harm.
51 *Re W (a minor) (medical treatment) [1992] 4 All ER 627*

The courts have, in the past, also found that parents can consent to their competent child being treated even where the child is refusing treatment.[52] However, there is no post-Human Rights Act 1998 authority for this proposition, and it would therefore be prudent to obtain a court declaration or decision if faced with a competent child who is refusing to consent to treatment, to determine whether it is lawful to treat the child.
52 *Re R (a minor) (wardship: medical treatment) [1991] 4 All ER 177*

Where the treatment involved is for mental disorder, consideration should be given to using mental health legislation.

The changes made to section 131 of the Mental Health Act 1983 by section 43 of the Mental Health Act 2007, mean that when a child of 16 or 17 has capacity (as defined in the Mental Capacity Act 2005) and does not consent to admission for treatment for mental disorder (either because they are overwhelmed, do not want to consent or refuse to consent), they cannot then be admitted informally on the basis of the consent of a person with parental responsibility (see chapter 36 of the Code of Practice to the Mental Health Act 1983, as amended 2008[53]). Therefore, they can only be forcibly admitted under a section of the Mental Health Act 1983
53 *www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/ DH_084597*

A life-threatening emergency may arise when consultation with either a person with parental responsibility or the court is impossible, or the person with parental responsibility refuses consent despite such emergency treatment appearing to be in the best interests of the child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

Assessing Gillick Competence

Gillick competence should be assessed by the health care professional that is proposing the treatment. The health care professional must have a clear understanding of what Gillick competence means and what is expected of the child in terms of their understanding of the proposed treatment. They should also be aware that, a competent child cannot refuse treatment, where that treatment is needed to sustain life or prevent long term harm to the Child.

Child Lacking Competence
Where a child under the age of 16 lacks competence to consent (i.e. is not Gillick competent), consent can be given on their behalf by any one person with parental responsibility (if the matter is within the 'zone of parental control'[54]) or by the court. As is the case where patients are giving consent for themselves, those giving consent on behalf of child patients must have the capacity to consent to the intervention in question, be acting voluntarily and be appropriately informed. Even where a child lacks competence to consent on their own behalf, it is good practice to involve the child as much as possible in the decision-making process.
54 *The concept of the 'zone of parental control' derives largely from case law from the European Court of Human Rights in Strasbourg. Chapter 36 of the Code of Practice to the Mental Health Act 1983, as amended, gives guidelines about what may fall in the zone, which will depend on the particular facts of each case*

Where necessary, the courts can overrule a refusal by a person with parental responsibility. It is recommended that certain important decisions, such as sterilisation for contraceptive purposes, should be referred to the courts for guidance, even if those with parental responsibility consent to

the operation going ahead.

The European Court of Human Rights judgment in a case where doctors treated a child contrary to his mother's wishes, without a court order (*Glass v United Kingdom*[55]), made clear that the failure to refer such cases to the court is not only a breach of professional guidance but also potentially a breach of the European Convention on Human Rights. In situations where there is continuing disagreement or conflict between those with parental responsibility and doctors, and where the child is not competent to provide consent, the court should be involved to clarify whether a proposed treatment, or withholding of treatment, is in the child's best interests. Parental refusal can only be overridden in an emergency.

55 *Glass v The United Kingdom – 61827-00 [2004] ECHR 103*

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

- the child's mother
- the child's father, if he was married to the mother at the time of birth
- unmarried fathers, who are detailed on the child's birth certificate for any child born after 1st December 2003
- unmarried fathers can acquire parental responsibility with the agreement of the mother or via a court order.
- a local authority or other authorised person who holds an emergency protection order in respect of the child.

Consent given by one person with parental responsibility is valid, even if another person with parental responsibility withholds consent. However, the courts have stated that a 'small group of important decisions' should not be taken by one person with parental responsibility against the wishes of another, citing in particular non-therapeutic male circumcision and immunisation.[58] Where persons with parental responsibility disagree as to whether these procedures are in the child's best interests, it is advisable to refer the decision to the courts.

58 *Female circumcision is always prohibited, under the Prohibition of Female Circumcision Act 1985; Re J [2000] 1 FLR 571 at 577; Re B (a child) sub nom in Re vaccination/MMR litigation: A v B : D v E sub nom in Re C (a child) (immunisation: parental rights) : in Re F (a child) (immunisation: parental rights) (2003)*

Where there is doubt about whether a parent is acting in the interest of the child or young person, then the healthcare practitioner would be unwise to rely on the parent's consent, for example if a child alleges abuse and the parent supports psychiatric treatment for the child.

In order to consent on behalf of a child, the person with parental responsibility must themselves have capacity. Where the person with parental responsibility for a child is themselves under 18, they will only be able to give valid consent for their child's treatment if: aged 16 or 17 they have mental capacity, or if aged under 16 are Gillick competent.

Where a child is a ward of court, no important step may be taken in the life of the child without the prior consent of the court. This is likely to include more significant medical interventions but not treatment for minor injuries or common diseases of childhood.

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

Research

Where children lack capacity or competence to consent for themselves, parents may give consent for their child to be entered into a trial where the evidence is that the trial therapy may be at least as beneficial to the patient as the standard therapy

Adults and Children Lacking Capacity or Competence

If a child lacks capacity or competence, it is still good practice to involve the child as far as is possible and appropriate in the decision. The decision to withdraw or withhold life-sustaining treatment must be made in the best interests of the child. The best interests of a child in the context of the withholding of medical treatment should be interpreted more broadly than medical interests and should include emotional and other factors. There is a strong presumption in favour of preserving life, but not where treatment would be futile, and there is no obligation on healthcare professionals to give treatment that would be futile. If there is disagreement between those with parental responsibility for the child and the clinical team concerning the appropriate course of action, a ruling should be sought from the court as early as possible.

A person with parental responsibility for a child is legally entitled to give or withhold consent to life sustaining treatment if that is in the child's best interests. However, a person with parental responsibility cannot demand a particular treatment to be continued where the burdens of the treatment clearly outweigh the benefits for the child. If agreement cannot be reached between the parent(s) and the healthcare professionals, a court should be asked to make a declaration about whether the provision of life-sustaining treatment would benefit the child.

Appendix 2 – Consent Form 1: Patient Agreement to Investigation or Treatment
Click **here** for an editable / downloadable version of this form

with you, for you

NHS
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GLOUCESTERSHIRE HEALTH AND CARE NHSFT 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 .....

Responsible health professional.....

Job title .....

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

☐ Male ☐ Female

Special requirements .....
(e.g. other language/other communication method)

To be scanned and uploaded to patients' Electronic Patient Record

Consent Form 1 Page 1 of 4

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

.....
.....
.....
.....

Serious or frequently occurring risks

.....
.....
.....
.....

Any extra procedures which may become necessary during the procedure
☐ blood transfusion.....

☐ 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.

☐ The following leaflet/tape has been provided
.....
.....

This procedure will involve:
☐ general and/or regional anaesthesia ☐ local anaesthesia
☐ sedation

Signed:..... Date .....
Name (PRINT) .....Job title .....

Consent Form 1 Page 2 of 4

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)

.....

Copy accepted by patient: yes/no (please ring)

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF PATIENT

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.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which 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 advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask patient to sign /date here)

Consent Form 1 Page 4 of 4

Appendix 3 – Consent Form 2: Parental Agreement to Investigation or Treatment for a Child - Click **here** for an editable / downloadable version of this form

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

GLOUCESTERSHIRE HEALTH AND CARE NHSFT 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 .....

Responsible health professional.....

Job title .....

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

☐ Male ☐ Female

Special requirements .....
(e.g. other language/other communication method)

To be scanned and uploaded to patients' Electronic Patient Record

Consent Form 2 Page 1 of 5

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). In particular, I have explained:

The intended benefits

.....
.....

Serious or frequently occurring risks

.....
.....
.....
.....

Any extra procedures which may become necessary during the procedure

☐ blood transfusion.....

☐ 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.

☐ The following leaflet/tape has been provided

.....
.....

This procedure will involve:

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

Signed:..... Date .....
Name (PRINT) .....Job title .....

Consent Form 2 Page 2 of 5

Contact details (if child/parent wish to discuss options later)

.....

.....

Statement of interpreter (where appropriate)

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

Signed ..... Date .....

Name (PRINT)

.....

Copy accepted by patient: yes/no (please ring)

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF PARENT OF PATIENT WHERE PATIENT LACKS CAPACITY OR COMPETENCE TO CONSENT OR DECLINE THE PROCEDURE.

IDENTIFIER/LABEL

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 which may become necessary during my child's treatment. I have listed below any **procedures which I do not wish to be carried out** without further discussion.

.....
.....

Signature ..... Date.....

Name (PRINT) .....Relationship to child.....

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/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) that they have no further questions and wish the procedure to go ahead.
Signed:……Date ……..

Name (PRINT) ……Job title ……..

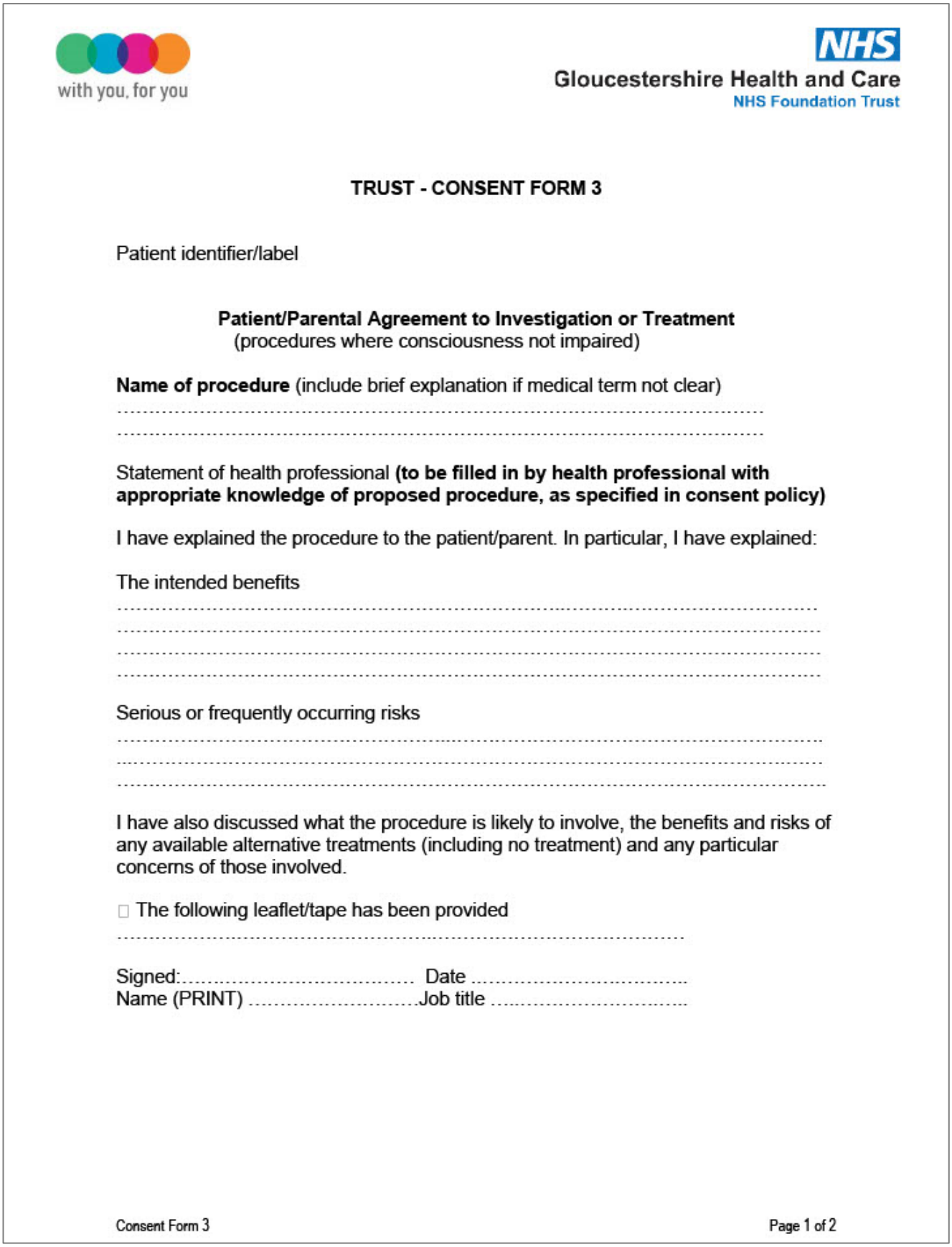
Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask parent to sign /date here)

……
……

Appendix 4 – Consent Form 3: Patient/Parental Agreement to Investigation or Treatment
Click **here** for an editable / downloadable version of this form



with you, for you

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TRUST - CONSENT FORM 3

Patient identifier/label

Patient/Parental Agreement to Investigation or Treatment
(procedures where consciousness not impaired)

Name of procedure (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/parent. In particular, I have explained:

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

Serious or frequently occurring risks
.....
.....
.....

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 those involved.

☐ The following leaflet/tape has been provided
.....

Signed:..... Date .....
Name (PRINT) .....Job title .....

Consent Form 3 Page 1 of 2

Statement of interpreter (where appropriate)

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

Signed ..... Date .....

Name (PRINT) .....

Statement of patient/person with parental responsibility for patient
I agree to the procedure described above.

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 has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

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

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

Copy accepted by patient: yes/no (please ring)

Appendix 5 – Consent Form 4: Form for Adults Who Are Unable to Consent to Investigation or Treatment Click **here** for an editable / downloadable version of this form

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TRUST CONSENT FORM 4

Form for Adults Who Are Unable to Consent to Investigation or Treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names.....

Date of birth .....

Responsible health professional.....

Job title .....

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

☐ Male ☐ Female

Special requirements .....
(e.g. other language/other communication method)

To be scanned and uploaded to patients' Electronic Patient Record

Consent Form 4 Page 1 of 4

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:

☐ **the patient is unable to comprehend and retain information material to the decision; and/or**
☐ **the patient is unable to use and weigh this information in the decision-making process; or**
☐ **the patient is unconscious**

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. Should be recorded on the Trust MCA assessment form on the patients EPR

C Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests as outlined in the Trust best interest form recorded in the EPR

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

D 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. However, it is good practice 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 and their spiritual and religious welfare.

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

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 (e.g. over the telephone?) ☐ Yes ☐ 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 himself or 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.

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 .....