

# CONSENT TO ASSESSMENT, EXAMINATION AND TREATMENT POLICY AND PROCEDURE (N-052)

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*Policies should be accessed via the Trust intranet to ensure the current version is used*

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## **1. INTRODUCTION**

All patients have a fundamental right to make decisions about their lives and determine what happens to their body. Consent is absolutely central to care and treatments in health and social care, from the decision to have an assessment, along with the provision of personal care to undertaking more complex interventions or having major surgery. Seeking consent is also a matter of common courtesy between all care providers and patients. Seeking consent is an integral part of all professional codes of practice (HCPC, SWE, GMC and NMC), the personalisation agenda and within the Making Safeguarding Personal Guidance.

Valid consent must be obtained before beginning any assessment, treatment, investigations or providing personal care to a person. Care and treatment can only be provided to someone with capacity that is able to consent or with a specific legal authority; which may be provided through the Mental Health Act or in the person's best interests within the framework of the Mental Capacity Act.

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult or young person who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

Consent needs to be sought for every action or decision and Capacity assumed, however this must be tested if doubted.

## **2. SCOPE**

This policy is applicable to all permanent and temporary healthcare or social care staff working within all clinical services and locations where consent to assessment, examination or treatment is required.

## **3. POLICY STATEMENT**

This policy provides a framework to enable staff working within Humber Teaching NHS Foundation Trust to be compliant with the legal requirements for consent.

All staff must ensure that all decisions and actions to be taken are discussed with all patients at all times. It is the responsibility for staff to seek and obtain valid consent to assessment, physical examination or treatment prior to the commencement. This may include working in a person's best interests in line with the Mental Capacity Act for those people without capacity in relation to the specific action or decision to be made.

The Consensus statement on suicide (2014) states that practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care generally, and when looking at information sharing and risk in particular. In order to assist practitioners to respect people's wishes, wherever possible, the person's view on who they would wish to be involved – and potentially, who they would wish not to be involved – if there is serious concern over suicide risk, should have been discussed and recorded.

The policy describes the specific requirements for those aged less than 16 years, the requirements for patients aged 16 and over and those who are deemed to lack mental capacity for the specific decision/treatment.

## 4. DUTIES AND RESPONSIBILITIES

### Trust Board

It is a requirement to have a policy on consent to assessment, investigation and treatment. It is the responsibility of the board to ensure systems and processes are in place for the approval and implementation of this policy.

### Chief Executive and Executive Directors

Responsible for ensuring systems are in place to gain assurance on behalf of the organisation, in relation to consent through recognised processes described within this policy

### Divisional Managers and Clinical Leads

Responsible for ensuring the implementation of this policy within their areas and provide assurance of policy into practice.

### Modern Matrons and Service Managers

Responsible for ensuring all staff within their sphere of responsibility are aware of the consent policy and implement on a day to day basis for every action and or decision.

The matron and service manager will:

- support staff to apply the policy into every day practice to ensure safe decisions and actions are taken with the persons consent and or in their best interests
- provide assurance to the care group on their adherence to the policy

### All health and social care staff

It is the responsibility of all health and social care professionals who provide care and treatment to patient to have awareness of the content of this policy and seek consent to any assessment, investigation or treatment to be provided. This must include providing relevant information to the patient to enable the patient to make an informed decision to consent or that the health and social care staff make a decision to provide care and treatment in the person's best interests in line with the statutory framework of the Mental Capacity Act 2005. The health/social care professional must also be aware of other guidance relevant to their role which may, include:

- The Mental Health Act (1983)
- The Children Act (1989)
- The Human Rights Act (1998, amended 2005)
- Equality Act 2010
- Disability Discrimination Act (1995)
- Care Act (2014)
- Consensus statement on suicide (2014)

All staff must understand:

- the circumstances in which consent must be gained and how this would be documented
- Consent must be gained for every action and or decision with the patient and or decisions made in their best interests in line with the Mental Capacity Act
- How to receive information received from families/carers or friends as detailed within the Consensus statement on suicide

## 5. PROCEDURE

### 5.1 Seek Consent

It is essential that consent be sought prior to the commencement of any assessment, treatment or intervention being undertaken. A person can only give consent if they have capacity at the time the decision needs to be made.

## 5.2 Assume Capacity or test if doubted

In line with the first key principle of the Mental Capacity Act (MCA), Capacity should always be assumed but if this is doubted, this must be formally tested using the two-stage test for capacity. Under English law, no one is able to give consent for another adult who lacks capacity unless they have been authorised to do so under a Lasting Power of Attorney or as a Court Appointed Deputy.

The MCA 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 disturbance is permanent or temporary. If capacity is doubted for the decision or action in question, this must be tested

The two stage test for capacity, also known as the functional test is as below:

- Is there 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, and
- The impairment or disturbance means that they are unable to make specific decision at the time it needs to be made

A person is unable to make a decision if they cannot do one or more of the following:

- Understand the information given to them that is relevant to the decision
- Retain the information long enough to make the decision
- Use or weigh up the information as part of the decision making process
- Communicate their decision (Chapter 4 Mental Capacity Act (2005) Code of Practice).

See Appendices 5 and 6 for the Consent and Best Interest Pathways for further guidance and section 14 for the assessment of capacity and best interest documentation

## 5.3 Ensure that Consent is Valid

Consent is only valid **when a patient has the capacity to make a decision**. For consent to be valid it must be given voluntarily by the person. Valid consent can be given by:

- any adult with capacity
- a 16 or 17 year old with capacity
- any young person under the age of 16 who is 'Gillick competent'
- someone with parental responsibility for a patient under the age of 18 (provided that this decision is within the 'zone of parental responsibility')
- someone acting as a Lasting Power of Attorney (LPA) for health and welfare when a person lacks capacity to consent
- someone who has legal authority to make treatment decisions such as a court appointed deputy or through a court direction

Patients can make an advance decision whilst they have capacity for when they may lack the capacity with regards to future care and treatments within an advanced decision to refuse treatment (ADRT) or part of advanced care planning (ACP).

If a person is found to lack capacity to consent to a particular decision or action, care can still be provided in the patients best interests using the framework of the Mental Capacity Act. This must only occur following an assessment of capacity and a decision made that care is in the best interests of the person, this cannot occur following the procedure.

**Any assessment of capacity and decision made should be formally recorded on approved documentation.**

#### **5.4 Ensure that Consent is given Voluntarily**

To be valid consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person to either accept or refuse treatment. People must not be coerced into consenting, as this would invalidate consent.

#### **5.5 Ensure that the Person receives Sufficient Information**

It is important that the patient is fully informed about the proposed treatment or intervention to be provided in a way that is understandable to the person. In line with the five key principles, all practicable steps should be taken to ensure understanding; this could include providing information to the person using simple language or using pictures or photographs and sign language or the use of an interpreter. This information should include both the risks and benefits of the treatment and the proposed outcome to be achieved if undertaken or the risks of doing nothing.

A person is not to be treated as unable to make a decision unless all practicable steps to help have been undertaken without success.

The Trust is committed to ensuring that patients whose first language is not English or those with sensory or other requirements receive the information they need in alternative formats as required e.g. easy read, audio tape, pictures and interpreters, including British Sign Language.

#### **5.6 Involving Family and Friends in Decisions**

In line with consensus statement on suicide, practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care generally, and when looking at information sharing and risk in particular. In order to assist practitioners to respect people's wishes, wherever possible, the person's view on who they would wish to be involved – and potentially, who they would wish not to be involved – if there is serious concern over suicide risk, should have been discussed and recorded.

#### **5.7 Who should seek Consent?**

It is the responsibility of the health or social care professional seeking to undertake the assessment, investigation or treatment that should seek the consent. It is their responsibility to check that the person has given valid consent before the treatment or procedure begins. It is vitally important that they have sufficient knowledge about the proposed treatment or procedure and understand the risks and benefits involved in order to be able to provide all appropriate information to the patient to gain valid consent.

Seeking consent should not usually be delegated to another person; however there may be occasions where this needs to occur. It is the responsibility of the healthcare professional to ensure that when they require/request a colleague to seek consent on their behalf they are confident that the colleague has the appropriate competence to do this. Where an anaesthetist is involved in a patient's care e.g.; in administering Electro Convulsive Treatment (ECT) it is their responsibility to seek consent for anaesthesia, discussing the benefits and risks.

#### **5.8 When should Consent be sought?**

The seeking and giving of consent is part of a process rather than a one off event. It is good practice for complex interventions and major treatments, where possible, to seek the person's consent well in advance, allowing plenty of time for questions and the provision of adequate information. Consideration should always be given as to the time of day when the person's understanding is better or to consider if the decision could be postponed to allow the person to make the decision.

All staff should always check that the person still consents prior to the intervention or treatment being initiated.

#### **5.9 Types of Consent (Verbal/Non-Verbal, Written Consent)**

Consent can be verbal, non-verbal or written and the validity of consent does not depend upon the form in which it is given.

Many care and treatments can be undertaken without the need for a consent form and written consent from the person, however there are certain treatments or investigations (exceptions include certain requirements of the Mental Health Act 1983). The use of consent forms must be undertaken when surgery is to be undertaken.

Written consent provides evidence of consent and this must provide evidence that consent was given voluntarily, with appropriate information provided in order for consent valid. Where there is any doubt about a person's capacity, capacity must be established before they are asked to sign a consent form. Details of the assessment of capacity and conclusions reached **must** be recorded in the person's notes on Lorenzo / System One. If the person has capacity but is unable to read or write they may be able to make their mark on the Consent Form to indicate consent and the fact the person has chosen to make their mark in this way should be recorded in the case notes/health records. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent.

### 5.10 Consent Forms

The Department of Health's four model consent forms:

- **Form 1** – patient agreement to investigation or treatment
- **Form 2** – parental agreement to investigation or treatment of a child or young person
- **Form 3** – for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care.
- **Form 4** – for adults who lack capacity to consent to investigation or treatment
- The Mental Health Act (1983) Consent Forms
- Mental Capacity Act Assessment Form
- Key safe consent form – see section 5.3.5

### 5.11 Recording of Consent

The DHSC holds the view that valid consent is not dependent on the form in which it is given. Written consent will however evidence the process that has been followed, with consideration of mental capacity and that relevant information has been shared with the person to seek informed consent. Where a signature is obtained on a form and these procedures have not been satisfied, the signed form will not make the consent valid. Generally for patients over the age of 16, where capacity is assumed an entry in the clinical notes should be made in relation to any discussion for proposed assessment, care and treatment, and resulting consent or refusal. Where it exists, staff should also complete the relevant section relating to capacity and consent on any Trust forms or documentation templates used

Although completion of a consent form is usually not a legal requirement there are some exceptions including some requirements of the Mental Health Act (1983), and requirements of the Human Fertilisation and Embryology Act (1990).

It is good practice to obtain written consent for any significant procedure, such as when the person participates in a research project or a video recording. Where any surgical operation is required, the Royal College of Surgeons state consent relating to surgical procedures should be written and recorded. It is also good practice for the Health or social care professional to make contemporaneous records of any discussions or interactions in relation to proposed care and treatment. Those unable to write can make a mark to indicate their consent; it is good practice to have this mark witnessed by a person other than the health professional seeking consent.

Similarly, if the person has capacity and wishes to give consent, but is physically unable to mark or sign a form, this decision should be recorded in the notes. They could also direct someone to sign the form on their behalf, but there is no legal requirement for this. If consent is given validly, the lack of a completed form does not prevent treatment being given, but a form can be important evidence of consent.

### **5.12 Duration for 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, or the person no longer has the mental capacity to make the specific decision. If new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the times 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.

The clinician should consider whether the new information should be drawn to the attention of the patient and the process of seeking consent repeated on the basis of this information.

If the patient's condition has changed significantly in the intervening time it may be necessary to seek consent again, on the basis that the likely benefits and/or risks of the intervention may also have changed.

If consent has been obtained a significant time before undertaking the intervention, it is good practice for the clinician to confirm that the person who has given consent (assuming that they retain capacity) still wishes the intervention to proceed, even if no new information needs to be provided or further questions answered. It is possible that individuals' wishes may change over time, and it is important to provide opportunities for them to express this. The seeking and giving of consent is usually a process, rather than a one-off event, and time must be dedicated to ensuring the person has had the opportunity to receive an adequate level of information.

If a person is not asked to signify their consent until just before the procedure is due to start, without time to discuss relevant information, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity.

### **5.13 Children and Young People**

In the DOH guide 'Children' refers to people below the age of 16 and 'young people' refers to people aged 16-17. The legal position concerning consent and refusal of treatment by those under the age of 16 is different from that of adults.

Children under the age of 16 can consent to or refuse their own treatment if they are judged to have the competence and understanding to fully appreciate what is involved in their treatment.

### **5.14 Young People**

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. The procedures for establishing mental capacity to consent to specific decision/action, and where appropriate best interest procedures, should be followed.

For children under 16 years the MCA does not apply. Instead a child needs to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'. The term 'Fraser guidelines' are also sometimes used. Although often used interchangeably, they are two different concepts: Fraser guidelines refer to specific guidance that must be followed by the healthcare professional to provide contraceptive advice to a child; and Gillick competence refers to the ability of the child to give consent and is used more broadly.

Those with 'Parental responsibility' cannot override a competent child's refusal to accept treatment. Where a competent child under 16 refuses a specific treatment which is in their best interests, but the parents support the recommendation for treatment, there should be evidence of that providers have attempted to understand both the child's and parents' position. There should also be evidence that alternative treatments have been considered or a compromise is possible. However, ultimately the decision rests with the competent child (Brief guide BG004 Dec 2017).



Parents/those with Parental Responsibility are not able to give consent to care arrangements on behalf of a 16/17 year old that would amount to a deprivation of liberty as highlighted in Re D Judgement [2019] UKSC 42. On appeal from: [2017] EWCA Civ 1695. This significant ruling – ([In the matter of D \(A Child\) \(supremecourt.uk\)](#)) - by the Court of Appeal concerns the extent to which parents are able to consent to the confinement of their incapacitated children in light of *Cheshire West*.

The MHA Code of Practice (2015) at para 19.41 assists in determining the scope of parental responsibility by reference to, in summary, the following matters:

1. Is this a decision that a parent should reasonably be expected to make? Consider factors such as:
  - The type and invasiveness of proposed intervention.
  - The age, maturity and understanding of child or young person: parental role should diminish as the child develops greater independence.
  - Does it accord with the child or young person's current wishes or will they resist?
  - Have they expressed any previous views?
2. Are there any factors undermining the validity of parental consent?
  - Does the parent lack capacity to consent?
  - Is the parent not able to focus on what is in their child or young person's best interests (eg due to an acrimonious divorce)?
  - Is there significant distress/conflict between parents which means they are unable to decide what is best?
  - Is there conflict between decisions of those with parental responsibility?

The more coercive the confinement needs to be, the more likely it is that the decision will fall outside the scope of parental responsibility. For example, a *compulsory* admission to a psychiatric ward of an objecting incapacitated 16/17-year-old should not be attempted on the basis of parental consent. That would, it is suggested, be outside the scope and the young person would likely need Article 5 safeguards (of the MHA).

Children under 16 who are not Gillick competent cannot either give or withhold consent to treatment. People with parental responsibility need to make the decision on their behalf (Brief guide BG004 Dec 2017).

### **5.15 Who has Parental Responsibility?**

A person with parental responsibility for a child could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child under certain care orders only
- In extreme circumstances, a local authority or person with an Emergency Protection Order (EPO) for the child. The EPO has limited parental responsibility on the applicant to safeguard or promote the welfare, but it does not replace parental responsibility of anyone else who may have it.

### **Who automatically has parental responsibility?**

The following people automatically have parental responsibility:

- All birth mothers
- Fathers married to the mother at the time the child was born

- Fathers who are not married to the mother, but are registered on the child's birth certificate. The registration or re-registration must have taken place on or after 1 December 2003
- Civil partners and partners of mothers registered as the child's legal parent on the birth certificate.

If a parent refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.

One factor that might undermine the validity of parental consent is where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility, it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court. If there is doubt as to whether or not parental consent can be relied upon to authorise the particular intervention, professionals should take legal advice so that account may be taken of the most recent case law.

In an emergency situation, when a person with parental responsibility is not available to consent the child's best interests must be considered and treatment limited to what is reasonably required to deal with the particular emergency (Brief guide BG004 Dec 2017).

Where the treatment proposed is in relation to mental disorder, regard must be made as to the use of The Mental Health Act. The Act does not apply to treatment for physical disorders unrelated to the mental disorder. A best interest process would need to be followed for decisions relating to physical health needs not related or ancillary to the mental disorder for which the person has been detained.

Humber safeguarding team, the legal team and respective local authority safeguarding teams may advise on complex situations

### **5.16 Life-Sustaining Treatment**

It is not a legal requirement to continue a child's life-sustaining treatment in all circumstances. Where a child is suffering an illness where the likelihood of survival is extremely poor, and treatment will pose a significant burden to the child, it may not be in the best interests of the child to continue treatment. A parent with parental responsibility for a child or young person can give or withhold consent to treatment. They cannot demand particular treatments to be continued if the burden of treatment outweighs the benefits for the child. 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 consider medical, emotional and other factors.

Where there is disagreement between those with parental responsibility for the child and the health care professionals, a ruling should be sought from the court as early as possible.

### **5.17 Refusal/Withdrawal of Consent**

Any one over the age of 16 who is deemed to have mental capacity in relation to the specific decision or action to be taken, who declines to consent to proposed care and treatment must have their decision respected (with the exception of any area of care and treatment that may be dealt with under the Mental Health Act). 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.

If a young person refuses treatment, and by doing so this may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection.

## 5.18 Self-harm

### Please also see section 5.13 – Children and Young people

If a patient aged 16 or over has harmed themselves, an urgent assessment of mental capacity should be made. If it is found the patient lacks mental capacity, it is accepted that in an emergency medical situation, and without prior knowledge of any advanced decisions to refuse treatment (ADRT), advanced care planning (ACP) or the presence of someone with authority to consent on the person's behalf, they may be treated in an emergency situation in the person's best interests. Patients who have attempted suicide and are unconscious should be given emergency and/ or life sustaining treatment where any doubt exists as to their intentions or capacity when they made a suicide attempt.

In non-emergency situations, once any immediate needs of a person lacking capacity have been addressed, staff must communicate with relevant others to make further decisions for care and treatment within a best interest process. Where indicated, a Mental Health Act (1983) assessment should also be initiated. If a capacitated patient refuses treatment and use of the Mental Health Act is not appropriate, then their refusal should be respected, however in certain circumstances courts can overrule. A prompt psychosocial assessment of their needs should also be offered.

Patients with mental capacity **do** have the right to refuse life-sustaining treatment (other than where they meet criteria for detention and treatment for mental disorder under the Mental Health Act 1983 and the treatment required is due to a manifestation of the mental disorder) – both at the time it is offered and in the future.

Where 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. Consideration should be given to following the Vulnerable Adults Risk Management Meeting (VARM) protocol in the East Riding and Kingston upon Hull social services area, or the Multi Agency Self-Neglect Meeting (MASM) in the North Yorkshire area.

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.

## 5.19 Patients at Risk of Suicide

The Consensus Statement on suicide suggests that people should be routinely asked whether and how they wish their family and friends to be involved in their care and this should include if there is a serious concern over a suicide risk. In cases where these discussions have not happened in advance, a practitioner may need to assess whether the person, at least at that time, lacks the capacity to consent to information about their suicide risk being shared. The Mental Capacity Act makes it clear that a person must be assumed to have capacity; if a person's capacity is doubted a mental capacity assessment should be completed before determining whether they have or lack capacity. The Act also states that a person is not to be treated as unable to make a decision merely because they make an unwise decision. **However, if a person is at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time.**

In these circumstances, a professional judgement will need to be made, based on an understanding of the person and what would be in their best interest. This should take into account the person's previously expressed wishes and views in relation to sharing information with families, and, where practical, include consultation with colleagues. The judgement may be that it is right to share critical information. **If the purpose of the disclosure is to prevent a person who lacks**

**capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is considered to be in the person's best interest to do so.**

Disclosure may also be in the public interest because of the far-reaching impact that a suicide can have on others. For example the method of suicide could cause potential serious harm to others. The practitioner will need to make a judgement about whether the benefits to an individual or society in disclosing information without consent outweigh both the individual's and the public interest in keeping it confidential. Determining where to draw the line is a matter for professional judgement in each individual case.

The urgency of the need for disclosure will also be relevant to the judgement. The immediacy of the suicide risk will be affected by the degree of planning a person has done, the type of suicide method planned or already attempted, and circumstances such as being left alone, refusing treatment, drinking heavily or drug use.

It is also clear that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer insight into the individual's state of mind which can aid care and treatment. Good practice will also include providing families with non-person specific information in their own right, such as how to access services in a crisis, and support services for carers.

Sharing information within and between agencies can also help to manage suicide risk. It is therefore important for practitioners to consider discussing cases with colleagues or seeking advice from legal teams, a professional association or regulatory body if they are unsure

The Trust strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. The Trust recognises however that some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk.

It is important to emphasise that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk, **they should use their professional judgement to determine what is in the person's best interest. This must be always be about preserving life**

It is important that the practitioner records their decision about sharing information on each occasion they do so and also the justification for this decision.

Even where a person wishes particular information not to be shared, this does not prevent practitioners from listening to the views of family members, or prevent them from providing general information such as how to access services in a crisis.

## **5.20 Patients Aged 16 and over who Lack Mental Capacity**

The Mental Capacity Act (2005) is the statutory framework for making decisions and taking actions on behalf of incapacitated people in all aspects of life.

Everyone working with, or caring for, adults aged over 16, who lack capacity, must comply with this act when making decisions or acting for that person, and follow the 5 statutory principles which are the values that underpin the act and are set out under Section 7 of this policy and the two stage test for capacity in section 5.1.2.

If it is determined that someone aged 16 or over lacks mental capacity to consent (or decline) to a specific decision or action, then the process for Best interest decision making must be followed. See Appendices 1, 5 and 6 for further details or refer to the Mental Capacity Act (MCA) Code of Practice.

For patients aged 16 and 17 who do not have capacity to consent (or decline) to a specific decision or action, treatment can also proceed with the consent of someone with parental responsibility as long as the treatment falls within the scope of parental responsibility (refer to section 5.5) and is in the best interests of the young person.

Where the patient does not have anyone to consult with, an Independent Mental Capacity Advocate (IMCA) should be consulted with if consent is required where it involves longer term care, and/or a serious medical treatment.

Please refer to the Trust's Mental Capacity Act Policy and the Deprivation of Liberty Policy for further information

### **5.21 Adults – Withdrawing and Withholding Life-Sustaining Treatment**

Except in circumstances governed by the Mental Health Act 1983, if an adult with the capacity to make the decision refuses life-sustaining treatment, or requests it is 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.

There is no legal distinction between withdrawing and withholding life-sustaining treatment. A person with mental 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.

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.

### **5.22 Person without Capacity – Withdrawing and Withholding Life-Sustaining Treatment**

This is considered a serious medical treatment and would require a formal best interest meeting to be held. This may have an independent chair, but must include the decision maker, family and friends, and all relevant others. For decisions about serious medical treatment for a person who lacks capacity, an Independent Mental Capacity Advocate (IMCA) must be appointed. Please refer to the DNA/ReSPECT policy and the Mental Capacity Act and Best Interest Decision Making Policy for further details or please consult the MCA code of practice. Any best interest decision made for serious medical treatment must follow the identified checklist for review

- Identify the views of all the relevant people in the person's life
- Not make assumptions about a person's best interests based upon their person's age, appearance, condition or any aspect of their behaviour
- Consider all the relevant circumstances relating to the decision in question
- Involve the person as fully as possible
- the decision maker must not be motivated by a desire to bring about the person's death

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.

### **5.23 Refusing Treatment**

A person may have made an advance decision (ADRT) (Living will) to refuse particular treatment in anticipation of future incapacity. A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment.

In relation to receiving palliative care, towards the end of life an individual previously assessed as having mental capacity may lose capacity. The courts have stated that if the individual has, while they have capacity, expressed the desire to refuse food until death supervenes, the person cannot be force fed or fed artificially when they lack capacity. Any deviation from any decisions made, or

agreements within a care plan must follow the Mental Capacity Act process/ seek a view from the LPA – Health and Welfare

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.

Where a person is refusing food/fluid as a result of mental disorder, then detention and treatment without consent may be a possibility under the Mental Health Act 1983

#### **5.24 Other Exceptions to the Underpinning Principles of the Policy**

In an emergency situation, where there is doubt as to the appropriateness of treatment, priority should be given to life-sustaining treatment. When more time is available and the patient is an adult or child without capacity, all those concerned with the care of the patient – relatives, partners, friends, carers and the multidisciplinary team – can potentially make a contribution to the ongoing assessment and additional decisions can be made following a best interest process

- The Mental Health Act (1983) does not apply to treatment for physical disorders unrelated to the mental disorder. Even where the person concerned is detained under the Act a best interest process would need to be followed for decisions relating to physical health needs not related or ancillary to the mental disorder for which the person has been detained.
- The Public Health (Control of Disease) Act 1984 provided 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.
- ECT as a treatment – please refer to ECT policy
- Patients subject to CTO – please see policies relating to Mental Health Act for more information
- Neurosurgery for mental disorder or implantation of hormones

#### **5.25 Students and other Trainees**

Although not a legal requirement, it is good practice to make patients aware of a situation when it is intended as part of their development a student or trainee will carry out a procedure.

Clinical staff delegating or overseeing the procedure as part of a patient’s clinical care, must be satisfied that the student is appropriately trained. They should also ensure they are compliant with any regulatory Code requirements around delegation.

Where a student/trainee proposes to conduct a physical examination that is not part of the person’s care then it is essential to explain that the purpose of the examination is to further the student’s training, and to seek consent for that to take place.

#### **5.26 Video and/or Audio Recording**

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 ongoing care being compromised and that when required or appropriate it can be anonymised.

Staff should be aware of, and follow requirements within the organisation’s Photographing video and audio recording policy.

#### **5.27 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.

If the treatment being offered is of an experimental nature, but not part of a research trial, this fact must be clearly explained to a person with capacity before their consent is sought, along with information about standard alternatives. It is good practice to give person information about the evidence to date of the effectiveness of the new treatment, both at national/international levels and in the practitioner's own experience, including information about known possible side-effects.

Where children lack capacity 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. Decisions about any experimental treatments must be made in the child's best interests. It may also be compatible with the welfare principle for a person with parental responsibility to give consent to a research intervention that is not strictly in the best interests of the child, but is not against the interests of the child either. Such an intervention must involve only minimal burden to the child.

### **5.28 Key Safe Consent Form**

Key safes are a secure method of externally storing Keys to a property. Both informal and professional care givers often find these in situ at a patient's home as a way of gaining access and supporting patients continued independent living.

**By having access to a key safe code we are effectively being given the keys to someone's home and holding, sharing and using this information should therefore be done with prior agreement as to the circumstances for its use and the consent would cease to be valid at the end of the current episode of care or patients discharge. For any further episodes of care the key safe protocol would need to be repeated and revised consent completed.**

Once identified the patient has a key safe at their property, the key safe protocol must be followed. See Appendix 8.

## **6. EQUALITY AND DIVERSITY**

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

## **7. MENTAL CAPACITY**

All staff must have an understanding of the give key principles of the Mental Capacity Act (MCA).

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

## **8. BRIBERY ACT**

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The Bribery Act applies to this policy. Valid informed consent must be gained for those lacking mental capacity and recognised procedures followed for decision making and consenting on their behalf, this also applies to the potential financial or other abuse that may occur if valid consent procedures are not followed for other vulnerable people.

## **9. TRAINING**

All staff will receive a basic awareness of the Mental Capacity Act at point of induction via leaflet.

All clinical staff must attend training on MCA/DoLS on commencement of employment and thereafter every three years via face to face or e-learning.

## **10. IMPLEMENTATION**

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.

The revised policy will be disseminated across the organisation via the weekly global email and will additionally be stored and available under Policies and Procedures section on the Intranet home page

Staff unfamiliar with the Mental Capacity Act should attend available training in relation to MCA and in particular be confident in undertaking an assessment of mental capacity in relation to a specific action or decision, and following the best interest decision making process.

This policy does not require additional financial resource.

## **11. MONITORING AND AUDIT**

The monitoring of this policy will be undertaken via patient complaints, adverse incidents and uptake of mental capacity act training. The policy will be audited via record keeping audits and quality and safety reviews.

## **12. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS**

Mental Health Act Code 2015

Mental Capacity Act Code of Practice (2005)

Department of Health Reference Guide to Consent for examination or treatment (2009) second edition

NHS Choices '*Consent to treatment, children and Young people*' via website

DOH 12 steps for Consent – The Law in England

GMC (2008) *Consent: Patients and Doctors making decisions together*

Royal College of Surgeons (2016) – Consent: Supporting decision making – a guide to good practice

Consensus statement on suicide (2014)

Brief guide BG004: Brief guide: capacity and competence in under 18s, December 2017

## **13. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES**

- Mental Health Act (1983) policies
- Mental Capacity Act including the Deprivation of Liberty Safeguards (DoLS)
- ECT Policy and Clinical Guidelines



- Photography, Audio and Video Recording
- Key Safe Protocol

## **14. LINKS TO FORMS**

Assessment of Capacity Form and Best Interests Form – (in key downloads)

<https://intranet.humber.nhs.uk/resources/mental-capacity-act-2005.htm>

Consent Forms (Department of Health) – <https://www.health-ni.gov.uk/publications/consent-forms-examination-treatment-and-care>

## **15. APPENDICES**

**APPENDIX 1** - Admission for 16-17 Year Olds

**APPENDIX 2** - Treatment for 16-17 Year Olds

**APPENDIX 3** – Admission and Treatment of Under 16s

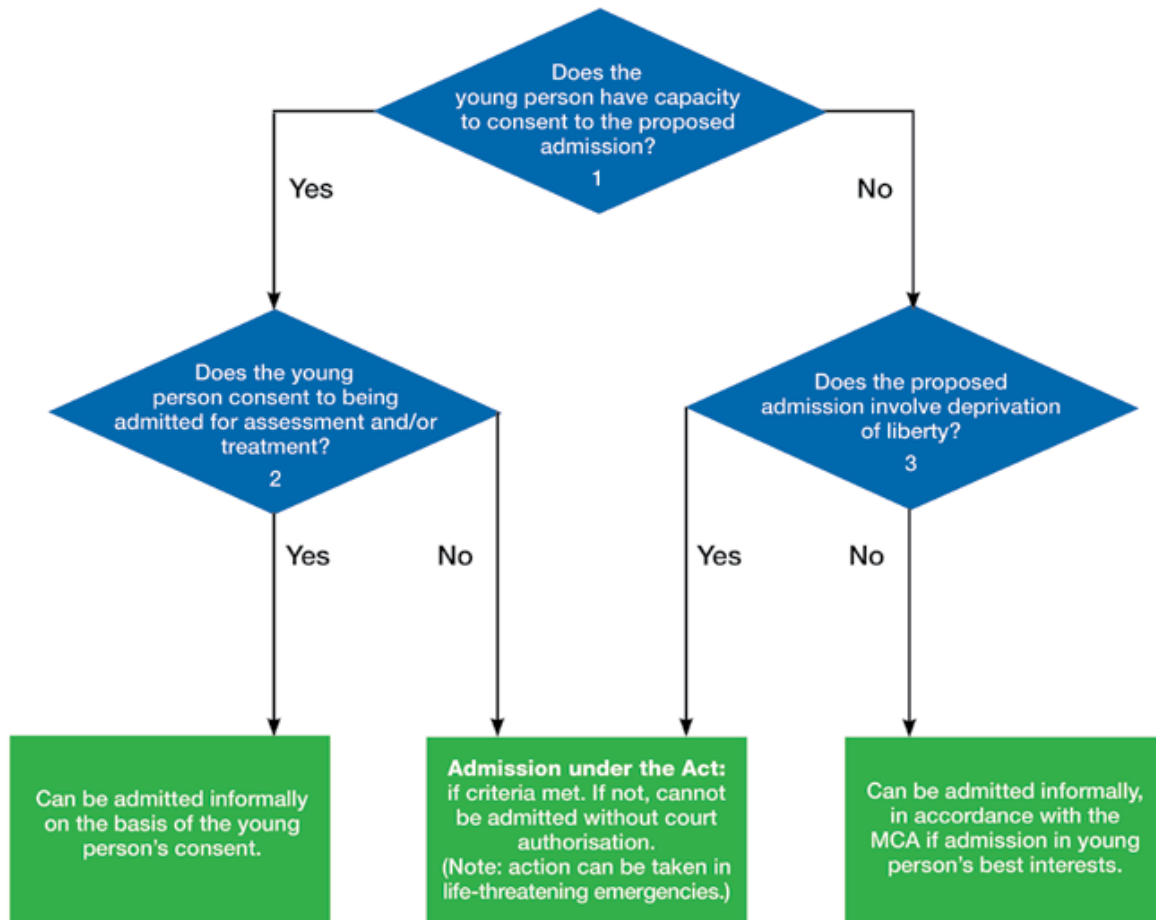
**APPENDIX 4** - Consent Process for the Immunisation of School-Aged Children

**APPENDIX 5** - Key Safe Consent

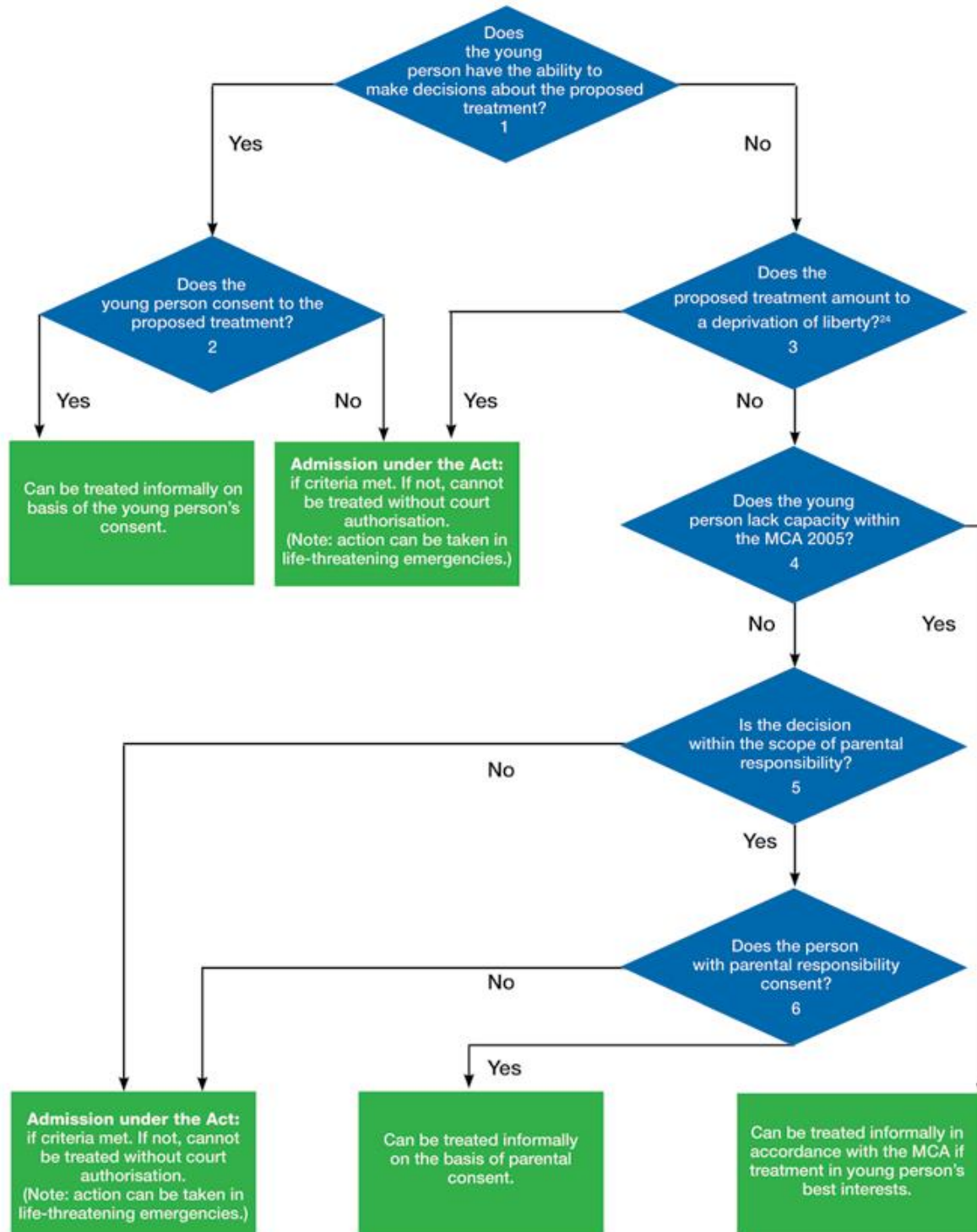
**APPENDIX 6** - Document Control Sheet

**APPENDIX 7** - Equality Impact Assessment (EIA)

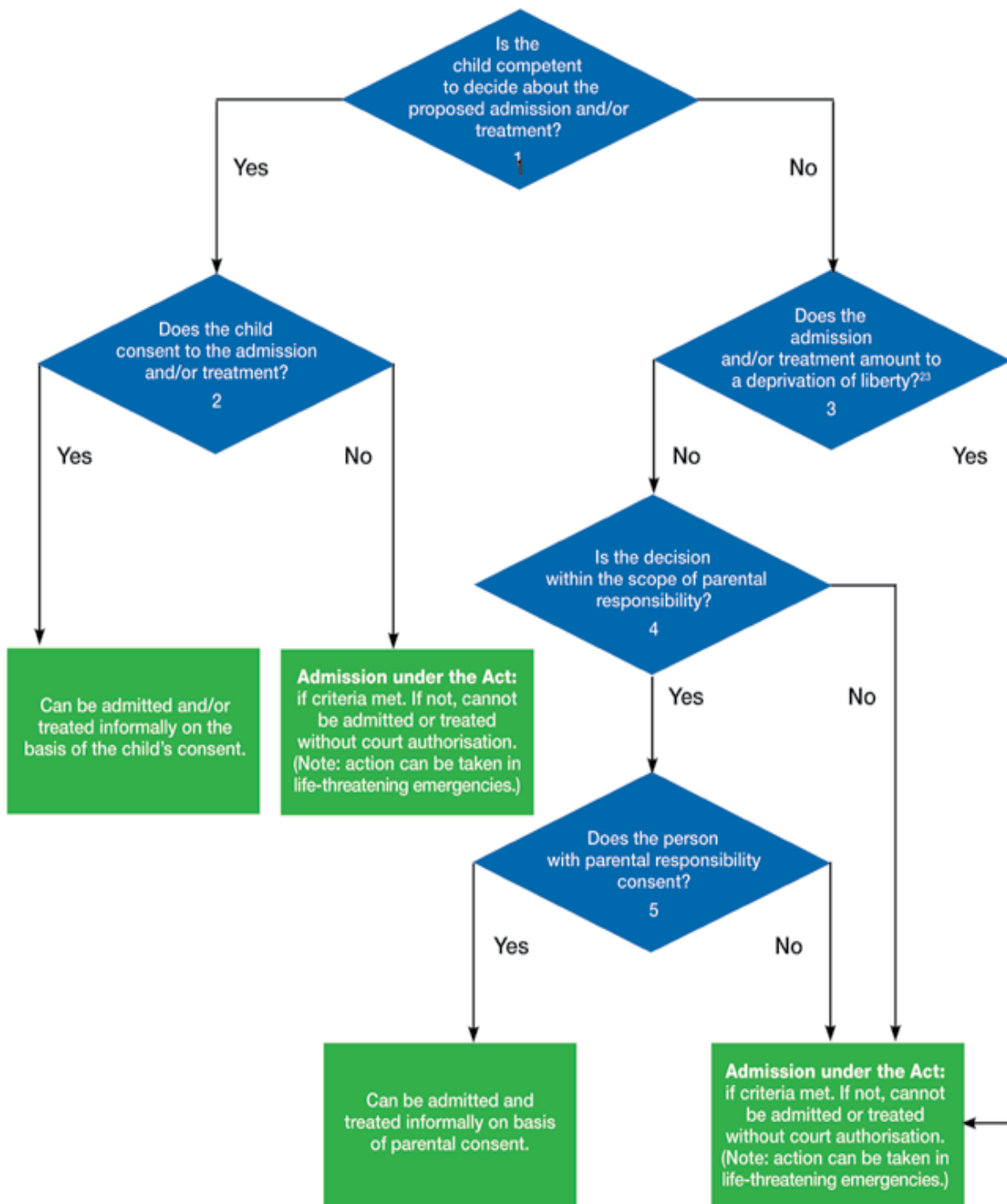
## Appendix 1: Admission for 16-17 Year Olds



## Appendix 2: Treatment for 16-17 Year Olds



**Appendix 3: Admission and Treatment of Under 16s**



## Appendix 4: Consent Process for the Immunisation of School-Aged Children

### Humber Teaching NHS Foundation Trust Consent process for the immunisation of school-aged children

See Standard Operating Procedure: Immunisation Cold Store. See Children's Services Immunisation Schedule for details of: schedule, vaccine details and including type and amount. See Order and cold chain process, for routine and urgent orders and couriers.

Consent issued to schools

Humber Child Health Information System Department (CHIS Dept.) prints an immunisation consent form for each child in the nominated school, as per the current SystemOne electronic record information. This is forwarded to the nominated school together with an immunisation information letter and leaflet to each parent.



The nominated school staff distribute an immunisation consent form, information letter and booklet to each child. If there is no immunisation consent form available for a child, school staff issue a blank immunisation consent form (supplied by the CHIS Dept.) for parents to complete. School staff issue reminders to parents to return consent forms, via text/ email/ school newsletter prior to immunisation session. School staff to return completed consent forms to CHIS Dept. for checking one week prior to the session taking place.

Written parental consent obtained for child in mainstream school

Two CHIS staff attend the session to distribute immunisation consents to the children. CHIS staff record who has consented and who has been issued with a completed consent. These consents are then collected by CHIS staff after immunisation is completed and documented as per Patient Group Directive (PGD).

Written parental consent **NOT** obtained for child in mainstream school



A child requests immunisation with no written consent during the session. CHIS staff ask the child to complete personal details, including parental phone contact on an appropriate immunisation consent form.



The immuniser checks the child's immunisation history on SystmOne via telephone to the CHIS office. Where there is any doubt, the immuniser should also contact the child's GP to ascertain any immunisations provided at the GP surgery.



The immuniser should ascertain if the child is Gillick competent, if so the child can self-consent to receive immunisation. Where there is doubt regarding the child's capacity to self-consent, then the immuniser should contact the parent via the telephone number provided to discuss the immunisation that their child requires, also to provide information on action required in the event of an adverse reaction following immunisation and where to seek further medical advice. Any verbal consent or self-consent is documented on the appropriate consent form.



When an immunisation session is busy, consideration is to be made as to whether the right to self-consent is withdrawn. This is due to self-consents taking longer to complete, than previously sought written parental consent.

The appropriate immunisation is then provided by the Immunisation Team at the next immunisation session held at the school. This would follow the same procedure detailed in the box above- to contact parents on the contact details provided prior to session and obtain verbal consent, which is then documented on the appropriate consent form.

Is written/previously documented verbal consent obtained for Special School or catch-up session?



Immunisers arrange to collect immunisation consents on the day of the session, from the CHIS Department. If unavoidable the consents can be collected the day before, the immunisation consents are to be stored in a lockable, secure bag and transported to the immunisation session. Immunisations are completed and documented as per PGD. Consents are returned to the CHIS Department.

Following all immunisation sessions, completed consent forms arrive in the CHIS office via CHIS staff or immunisers



CHIS Dept. staff input immunisation details and place a scanned copy of immunisation consent within two working days onto SystemOne. Immunisation details are forwarded to the child's GP. Consents are audited by the CHIS team leader for quality assurance and disposed of as per the Trust's Waste Management Policy. Any missing immunisation consents are immediately reported by CHIS department to the immunisation coordinator.



The immunisation coordinator is responsible for contacting the immunisers who attended the session, school staff and the child's parents (as required) to ascertain if the immunisation was administered. The immunisation coordinator liaises with CHIS staff to ensure SystemOne records are updated with the appropriate immunisation information.

## Appendix 5: Key Safe Consent

Forename

Surname:

NHS No

### Key Safe Protocol/Consent

Key safes are a secure method of externally storing Keys to a property. Both informal and professional care givers often find these in situ at a patient's home as a way of gaining access and supporting patients continued independent living.

**By having access to a key safe code we are effectively being given the keys to someone's home and holding, sharing and using this information should therefore be done with prior agreement as to the circumstances for its use and the consent would cease to be valid at the end of the current episode of care or patients discharge. For any further episodes of care the key safe protocol would need to be repeated and revised consent completed.**

Consideration must be given to a patient's mental capacity, if a clinician has any concerns in relation to decisions made on behalf of patients lacking mental capacity, their proposed care and treatment and/or the potential for deprivation of liberty they must exercise their Safeguarding duties and discuss with the Safeguarding Team.

In the event the patient or their representative does not consent (through a best interest process) to the use and recording of this code, an agreement should be made as to what actions the person involved in their care should take in the event they have concern for the patient's IMMEDIATE safety and wellbeing when attending the home.

Once it has been identified that a patient has a key safe at their home, the key safe protocol should be followed and consent recorded below.

#### Consent

The clinician involved in my care has discussed access to my home property to deliver care as agreed, where patient lacks capacity this may be decided as part of a best interests discussion

- I consent to my key safe number being recorded on this form and placed in my medical record  
**(The Key Safe Number must not be typed into the patients name or address fields on their electronic record)**
- OR** where patient lacks mental capacity, it has been agreed as part of a best interest discussion to record patient's key safe number and also place on medical record

Key safe number

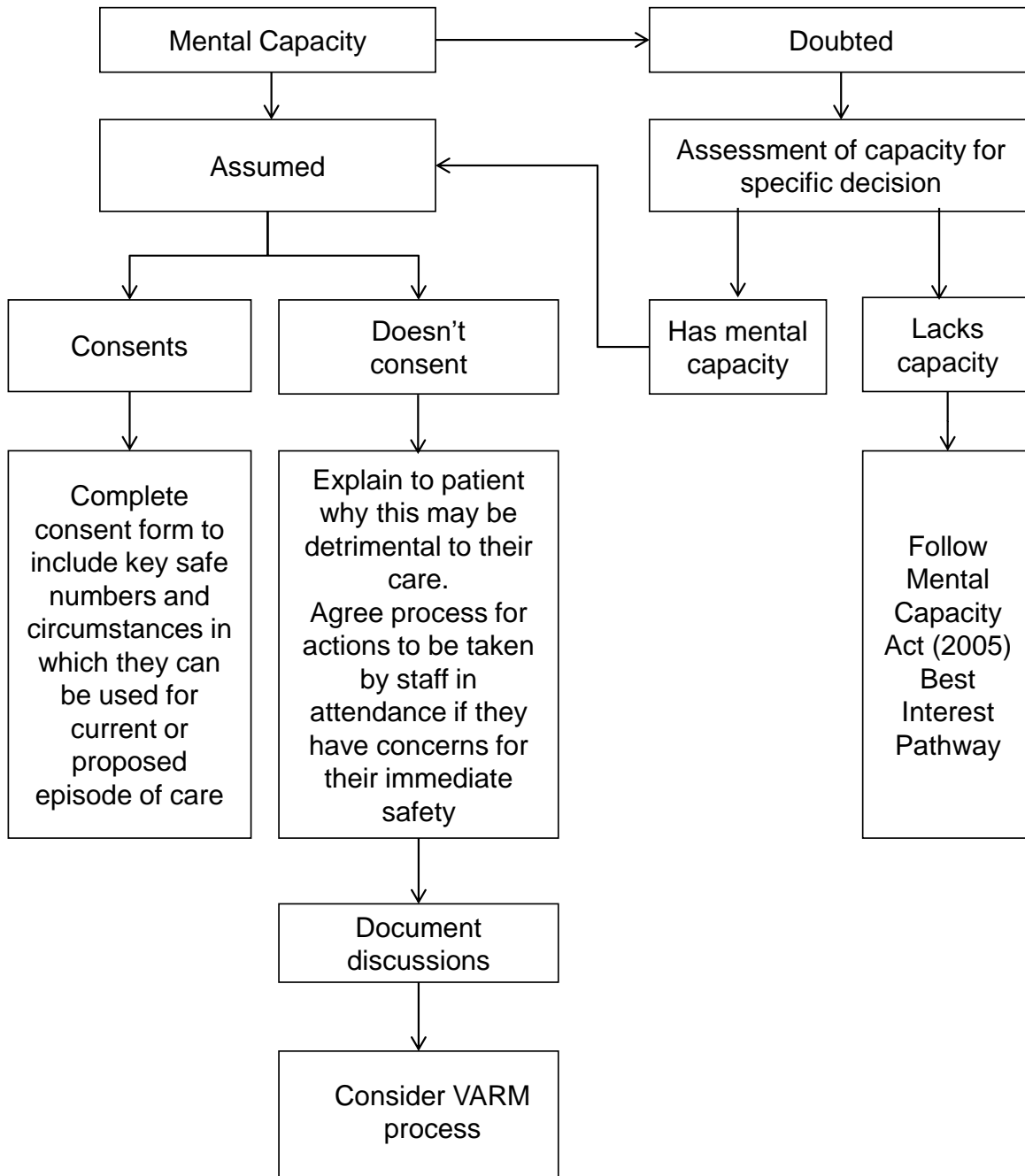
- I DO NOT consent to my key safe number being recorded in my / my relatives\* medical record and would like the person involved in my/their care to take the following actions in the event they have concern for my / my relatives IMMEDIATE safety and wellbeing.



Patients / Representative Name (print)	Signed:	Date:
Name (print)	Signed	Date
Designation & Band		Time:

**The consent form should be placed in the integrated medical notes AND scanned into Lorenzo/SystemOne and an alert placed on electronic record.**

**Consent to care and treatment and to share information (including key safe information / access to home property where relevant)**



## Appendix 6: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Policy and Procedure – Consent to assessment, examination and treatment		
Document Purpose	To ensure that valid consent is obtained before beginning any assessment, treatment, investigations or providing personal care to a person. Care and treatment can only be provided to someone with capacity that is able to consent or with a specific legal authority; which may be provided through the Mental Health Act or in the person's best interests within the framework of the Mental Capacity Act.		
Consultation/Peer Review:	Date:	Group/Individual	
<i>List in right hand columns consultation groups and dates</i>	17/05/19	LD Clinical Network Meeting	
	23/05/19	Mental Health Clinical Network Meeting	
	11/06/19	CAMHS Clinical Network Meeting	
	13.07.22	QPAS	
Approving Committee:	QPAS	Date of Approval:	13.07.22
Ratified at:	Minor amends	Date of Ratification:	Minor amends
Training Needs Analysis: <i>(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)</i>	Incorporated into the mandatory MCA training.	Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/> Rationale:
Publication and Dissemination	Intranet <input checked="" type="checkbox"/>	Internet <input type="checkbox"/>	Staff Email <input checked="" type="checkbox"/>
Master version held by:	Author <input type="checkbox"/>	HealthAssure <input checked="" type="checkbox"/>	
Implementation:	<i>Describe implementation plans below – to be delivered by the author:</i>		
	<ul style="list-style-type: none"> <li>Dissemination to staff via global email</li> <li>Individual Units and Teams responsible for ensuring policy read and understood</li> </ul>		
Monitoring and Compliance:	The monitoring of this policy will be undertaken via patient complaints, adverse incidents and uptake of mental capacity act training. The policy will be audited via record keeping audits and quality and safety reviews. In respect of patients detained under the MHA the recording of capacity to consent to treatment is regularly audited via the MHA audit in the Perfect Ward app (soon to transfer to MyAssurance).		

<b>Document Change History: (please copy from the current version of the document and update with the changes from your latest version)</b>			
Version number/name of procedural document this supersedes	Type of change, e.g. review/legislation	Date	Details of change and approving group or executive lead (if done outside of the formal revision process)
3.00	Review	5/9/11	Policy approved at Governance committee and Ratified
3.01	Review	7/11/11	Removal of paragraphs re: forms used 5.6
3.02	Review	5/12/11	New sub-heading 'Non-transferable' under section 3
3.03	Review	4/2/13	Minor changes and revised Pathways Appendix 2
3.04	Review	Dec 16	Reviewed in line with policy management requirements, new Appendices 5 and 6
3.05	Review	Mar 17	Update following discussions within QPaS, link to Mental Capacity Act
3.06	Review	April 17	Update including the consensus statement on suicide

3.07	<i>Review</i>	March 19	Reviewed in preparation for the opening of the CAMHS unit
3.08	<i>Review</i>	July 19	Full review as part of CAMHS (minor amends) Approved QPaS 24-July-2019
3.09	<i>Review</i>	June 2022	Full review. – (minor amends) <i>Version number amended to reflect minor/major changes</i> Page 9 – Added case law regarding whether it is appropriate for those with parental responsibility to consent to care arrangements for 16 – 17 year olds. Deleted Appendix 1, 5 and 6 in relation to MCA and referred staff to MCA Policy instead. <i>Approved QPaS 13-July-22</i>

## Appendix 7: Equality Impact Assessment (EIA)

### For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Consent to Assessment, Examination and Treatment Policy**
2. EIA Reviewer (name, job title, base and contact details): **Michelle Nolan, Mental Health Act Clinical Manager**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

<b>Main Aims of the Document, Process or Service</b>			
<p>This policy outlines: The responsibility for staff to seek and obtain informed and valid consent to assessment, physical examination or treatment. Care and treatment can only be provided to someone with capacity that is able to consent or with a specific legal authority; which may be provided through the Mental Health Act or in the person's best interests within the framework of the Mental Capacity Act. Specific guidance has been outlined for individuals aged less than 16 years, for those over the age of 16 and for individuals who are deemed to lack mental capacity for a specific decision/treatment.</p>			
<p><i>Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma</i></p>			
<p>Equality Target Group</p> <ol style="list-style-type: none"> <li>1. Age</li> <li>2. Disability</li> <li>3. Sex</li> <li>4. Marriage/Civil Partnership</li> <li>5. Pregnancy/Maternity</li> <li>6. Race</li> <li>7. Religion/Belief</li> <li>8. Sexual Orientation</li> <li>9. Gender Reassignment</li> </ol>	<p>Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?</p> <p>Equality Impact Score  <b>Low = Little or No evidence or concern (Green)</b>  <b>Medium = some evidence or concern (Amber)</b>  <b>High = significant evidence or concern (Red)</b></p>	<p>How have you arrived at the equality impact score?</p> <p>Draft EIA assessment circulated to triumvirate leads for discussion and comment prior to final version being agreed</p>	
Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
<b>Age</b>	<p>Including specific ages and age groups:</p> <p>Older people Young people Children Early years</p>	<b>Low</b>	<p>This policy is consistent in its approach regardless of age. The consent policy seeks to guide staff in the management of consent for all age groups linking to the Mental Capacity Act for those people who may lack the capacity to consent and with specific guidance on consent for children and young people.</p>
<b>Disability</b>	<p>Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities:</p> <p>Sensory Physical Learning Mental health</p> <p>(including cancer, HIV, multiple sclerosis)</p>	<b>Low</b>	<p>This policy is consistent in its approach regardless of disability.</p> <p>The consent policy upholds the requirements of the Mental Capacity Act to ensure capacity is considered and where required, assessed, on a decision /action specific basis with an intention to support the individual's ability to make and communicate an informed decision. It makes clear where the individual lacks capacity to make a specific decision or take a specific action, the procedures that must be followed to achieve agreement in the individual's best interest, or where the use of the mental health act may be considered.</p>
<b>Sex</b>	<p>Men/Male Women/Female</p>	<b>Low</b>	<p>The policy applies to all irrespective of gender with consent sought or care and treatment for every action or decision or care is provided in a person's best interests in line with</p>

			MCA is found a person lacks the capacity to consent
<b>Marriage/Civil Partnership</b>		<b>Low</b>	The policy applies to all irrespective of relationship status.
<b>Pregnancy/ Maternity</b>		<b>Low</b>	
<b>Race</b>	Colour Nationality Ethnic/national origins	<b>Low</b>	The policy applies to all irrespective of race. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure. Services must ensure where translator services are provided to ensure 'all practicable steps' are taken to ensure understanding in line with the five key principles of the MCA.
<b>Religion or Belief</b>	All religions  Including lack of religion or belief and where belief includes any religious or philosophical belief	<b>Low</b>	The policy applies to all irrespective of religion or believes, with consent sought or care and treatment for every action or decision or care is provided in a person's best interests in line with MCA is found a person lacks the capacity to consent.
<b>Sexual Orientation</b>	Lesbian Gay men Bisexual	<b>Low</b>	The policy applies to all irrespective of sexual orientation, with consent sought or care and treatment for every action or decision or care is provided in a person's best interests in line with MCA is found a person lacks the capacity to consent
<b>Gender re-assignment</b>	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	<b>Low</b>	This policy is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

## Summary

<i>Please describe the main points/actions arising from your assessment that supports your decision above.</i>	
<p>The principles and procedures set out in this policy provide clear specific guidance to professionals to effectively assess an individual's ability to make an informed decision as set out in the Mental Capacity Act (2005), ensuring at all times that staff seek consent for every action or decision or care is provided in a person's best interests in line with MCA is found a person lacks the capacity to consent.</p> <p>This policy and procedure and pathways and guidance seek to uphold principles of individualised care planning and the ongoing provision of care to people. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.</p>	
EIA Reviewer: <b>Michelle Nolan, Mental Health Act Clinical Manager</b>	
Date completed: <b>24 June 2022</b>	Signature: <b>M Nolan</b>