Avon and Wiltshire Mental Health Partnership NHS Trust

Consent to Examination or Treatment Policy

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Contents

1. Introduction

This policy sets out the Trust's approach to obtaining consent to clinical examination or treatment.

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore central in all forms of healthcare, from providing personal care to undertaking major interventions. Seeking consent is also a matter of common courtesy between health professionals and patients.

2. Purpose of Policy

The purpose of this policy is to set out the standards and procedures in this Trust, which aim to ensure that clinical staff are able to comply with statutory requirements as well as best practice guidance on consent. This policy should be read in conjunction with the Human Rights Act 1998, the Mental Capacity Act 2005, Mental Health Act 1983 (as amended by the Mental Health Act 2007), Care Act 2014, and associated Codes of Practice (Mental Capacity Code of Practice 2007 and Mental Health Act Code of Practice 2015) which provides detailed information relevant to consent.

3. Scope

The Policy relates to all aspects of clinical care and treatment. Implementation is to be addressed by all relevant Delivery Units. All healthcare professionals need to be familiar with Trust policy and obtain consent in line with trust policy.

4. Policy Statement

4.1 Consent

Consent is a patient's agreement for a health professional to provide care. Consent may be indicated by non-verbal communication such as presenting an arm to allow a pulse to be taken, verbally or in writing.

For consent to be valid, the patient must:

- Have the capacity (as defined in the Mental Capacity Act 2005) to take the particular decision;
- Consent should be:
  - freely given (not under duress)
  - Specific to each particular examination or treatment
  - Informed (having received sufficient information to make the relevant decision)
  - Communicated by an unambiguous indication of the patient's consent

Use of the Mental Health Act (MHA) 1983 as amended by the MHA 2007 may take precedence over the consent process for some service users in relation to treatment for their mental disorder or physical health problems only to the extent that such treatment is part of, or ancillary to, their treatment for mental disorder. In these circumstances there are safeguards within the Act to protect the individual's interests. (In such situations consideration should also be given to any valid advance directives or advance decisions to refuse treatment, or advance statements as regulated by the Mental Capacity Act 2005) However, neither the existence of mental disorder nor detention under the 1983 Act should give rise to an assumption of incapacity in consenting to a particular examination or treatment. The patient's capacity must be assessed in every case in relation to the particular decision being made. The capacity of a person with mental disorder may fluctuate.

4.2 National Guidance on Consent

The Department of Health (DoH) updated its guidance in 2009 after the Mental Capacity Act and Code of Practice came into effect in its Reference Guide to Consent for Examination or Treatment (2nd Edition). See: https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

Health and social care professionals must be aware of any statutory requirements relating to consent as well as guidance on consent issued by their own regulatory bodies, such as the General Medical Council consent guidance "Consent: patients and doctors making decisions together".

The Human Tissue Authority Code of Practice 1, Consent (July 2014) gives practical guidance and establishes standards on how consent should be sought and what information should be given in relation to the retention, storage and use of human tissue for various specified purposes, and concerning the removal of tissue from the deceased.

5. Documentation

5.1 Overview

For significant procedures, such as ECT, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done through the use of a consent form with further detail in the patient's health and social care record if necessary. In relation to some medications consent may be recorded by the giving of a leaflet setting out the risks and benefits, testing the patient's understanding, then documenting in the patient's record that they have given oral consent. It must also be clear, from the documentation that consideration has been given as to the capacity of the person to give that consent. Where there is a lack of capacity, the relevant provisions of the Mental Capacity Act 2005 are to be complied with.

5.2 Written Consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form may not amount to valid consent if a patient is rushed into signing a form on the basis of too little information. Similarly, if a patient has given valid oral consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may if they wish withdraw consent after they have signed a form; the signature is evidence of the process of consent giving, not a binding contract, and therefore can be withdrawn at any time.

It is rarely a legal requirement to seek written consent[1], but it is good practice to do so if any of the following circumstances apply:

- The treatment or procedure is complex, or involves significant risks. Written consent would be appropriate for Electroconvulsive Therapy, and may also be appropriate for some types of Psychological therapy, DBT, EMDR, Behavioural programmes, Detoxification programmes and occasionally for medication (including Patient Group Directions);
- The procedure involves general/regional anaesthesia or sedation;
- Providing clinical care is not the primary purpose of the procedure (for example, audio / video taping of consultations or direct observation for the purposes of supervision and/or audit or for the purposes of education;
- The treatment is part of a project or programme of research approved by this Trust.

Completed forms should usually be uploaded to the patient's electronic health & social care record unless specifically instructed otherwise e.g. research consent forms. Any changes to a

[1] The Mental Health Act 1983 as amended by the MHA 2007 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

form made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care, or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about similar care in the past) you should do so.

5.3 Research and Development

Consent for participation in Trust-approved research and development projects must be obtained within the ethical and governance frameworks. The format, recording and storage of consent should be according to the NHS research ethics committee favourable ethical opinion and Trust R&D approval. Inclusion of participants who lack capacity to consent into research must only be with NHS research ethics favourable opinion and Trust R&D Office approval and within the provisions of the Mental Capacity Act (2005) and The Medicines for Human Use (Clinical Trials) Regulations (2004).

5.4 Advance Decisions

Treatment cannot usually be given for patients who have made a valid advance refusal (otherwise known as Advance Directive), and healthcare professionals should take appropriate steps to establish if an advance directive has been made. The clinician must be satisfied that the advance refusal is valid and applicable. Where an advance decision concerns treatment that is necessary to sustain life, the clinician must be satisfied that it complies with the additional formalities. Reference should be made to the Mental Capacity Act policy (as amended by the Deprivation of Liberty Safeguards) for further guidance around the authority of a Lasting Power of Attorney (health and welfare) or a Deputy appointed by the Court of Protection in relation to Advance Decisions.

5.5 Procedures to follow when patients lack capacity to give or withhold Consent

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who are not able to make their own decisions. A key principle of the law is that all adults have the right to make their own decisions, and are assumed to have capacity to do so unless it is proved otherwise. Most of the Act also applies to 16 and 17 year olds, with some specific exceptions. Further details are set out in the guidelines on consent in children and young people. Where an adult service user lacks the mental capacity (either temporarily or permanently (as defined by the Mental Capacity Act 2005) to give or withhold consent for themselves, the only person who can give consent on their behalf is a person appointed as having Lasting Powers of Attorney (health and welfare) or Deputy appointed by the Court of Protection as set out in the Mental Capacity Act 2005.

Full guidance on mental capacity issues can be found in the Trust's Policy for the Mental Capacity Act 2005, as amended by the Deprivation of Liberty Safeguards. Checklists for capacity and best interests are also available. Staff should refer to this policy for further guidance.

If the care team feel that the patient may lack capacity to give consent, the Mental Capacity Act policy (as amended by DOLS) must then be followed. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented using the appropriate "form for adults who are unable to consent to investigation or treatment", along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient and anyone appointed as having Lasting power of attorney (health and Welfare) /Deputy of the Court of Protection under the Mental Capacity Act 2005. The usual consent form should not be used for adult patients unable to consent for themselves. For more minor interventions, the relevant information should be entered in the patient's record.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties. You may need to involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. A person should have access to an interpreter of their first language or, where appropriate, someone who signs as a first language. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways, use of speech and language therapists and interpreters. All of the above should be done with reference to the Mental Capacity Act 2005.

Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having or not having the treatment are potentially serious, a court declaration may be sought from the Court of Protection. Refer to the Trust's Mental Capacity Act 2005 Policy (as amended by DOLS), and Chapters 8 and 15 of the Mental Capacity Act 2005 Code of Practice 2007, for more detail. Certain treatment can only be provided with Court of Protection approval, as set out in the Mental Capacity Act 2005.

5.6 Availability of Forms

Standard consent forms and forms for adults who are unable to consent for themselves are listed in Appendix 1 (a current list will be maintained on the intranet) and are available from the Intranet and from your ward/team manager. There are various classes of forms:

- For Adults or competent children;
- For adults who lack capacity;
- For parental consent for a child or young person.

6. The Consent Process

6.1 Overview

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

6.2 Single Stage Process

In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a psychologist may suggest cognitive therapy; a psychiatrist may suggest medication or a physiotherapist may suggest a particular manipulative technique. Each of these health professionals may explain how it might help the service user's condition and whether there are any significant risks. If the service user is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, oral consent will be given. If a proposed procedure carries significant risks, (e.g. as with ECT), it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient opportunity to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

6.3 Two or More Stage Process

In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one

occasion (either within primary care or in a hospital outpatient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in outpatients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment however, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

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

7. Seeking Consent for Anaesthesia

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

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

8. Emergencies

In emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality. Reference should be made to the Mental Capacity Act 2005 as appropriate.

9. Consent for Children

National and professional guidance on consent for children must be followed.

The Department of Health (DoH) updated its guidance in 2009 after the Mental Capacity Act and Code of Practice came into effect in its Reference Guide to Consent for Examination or Treatment (2nd Edition). See: https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

The Mental Health Act Code of Practice 1983 (2015) is available here: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

The GMC's guidance, 'Involving Children and Young People in Making Decisions', is available here: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_involving_children_and_young_people.asp

9.1 Young People Aged 16 and 17

Once children reach the age of 16, competence to consent for surgical, medical or dental treatment, and any associated procedures, such as investigations, anaesthesia or nursing care is presumed. Patients aged 16-17 can withhold consent to treatment, but this can be overruled in exceptional circumstances if it is considered to be in their best interests, either by someone with parental responsibility or by the courts.

For those young people who do not have mental capacity, most of the Mental Capacity 2005 Act will apply (see the Mental Capacity Act Code of Practice 2007).

9.2 Children Under 16

Children under 16 can consent to medical treatment provided they understand what is proposed and are deemed to be "Gillick competent". Children under 16 who are not "Gillick competent" and very young children cannot either give or withhold consent. Those with parental responsibility need to make the decision on their behalf.

You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

10. The Provision of Information

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

10.1 Key Recent Legal Judgements on Material Risks

The legal duty on health professionals with regard to informed consent has been expressed in the case of Montgomery v Lanarkshire Health Board [2015] which was heard by the Supreme Court. This judgement requires a health professional to ensure that a patient is made aware of all material risks:

'The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is

or should reasonably be aware that the particular patient would be likely to attach significance to it.'

Therefore, providing information by reference to the standards of a reasonable medical practitioner is no longer adequate. The relevant standard is whether the patient would attach significance to the risk. It is a standard that explicitly recognises the patient as an individual and not a homogenous entity.

The doctor is however entitled to withhold from the patient information as to a risk if it is reasonably considered that its disclosure would be seriously detrimental to the patient's health – the therapeutic exception.

The Montgomery case makes three further points:

- The assessment of whether a risk is material cannot be reduced to percentages. It is fact sensitive and sensitive also to the characteristics of the individual patient.
- The clinician's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of the condition, the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, including doing nothing, so that the patient is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The duty is not therefore fulfilled by bombarding the patient with technical information which the patient cannot reasonably be expected to grasp, let alone by routinely demanding a signature on a consent form.
- It is important that the therapeutic exception should not be abused. It is a limited exception to the general rule that the patient should make the decision.

The issue of what constitutes 'materiality' has been considered in subsequent court cases;

Jones v Royal Devon and Exeter NHS Foundation Trust (2015) found that a Trust breached its duty of care to a patient by only informing her at a late stage that her operation would be performed by a different consultant surgeon, not the more experienced surgeon she had understood would be performing it. This was despite the consent form explicitly stating that there was no guarantee as to the identity of the surgeon. Mrs Jones succeeded in her claim for damages for negligence arising from the way the operation was performed and from the failure to provide her with sufficient information to enable her to consider consent, which the judge found was an infringement of her right to make an informed choice.

It will therefore be necessary to re-emphasise early in the consent process if the Trust cannot guarantee that a specific clinician will carry out the procedure.

In Spencer v Hillingdon Hospital NHS Trust (2015) the judge considered that the Trust failed in its duty of care to give advice post operatively regarding the signs and symptoms of deep vein thrombosis and pulmonary embolism to a patient who had undergone a general anaesthetic. The basic principle within Montgomery is now likely to be applied to all aspects of the patient's journey through the healthcare system, not just consenting procedures.

10.2 How Much Information to Provide

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

10.3 Sources of Patient Information

The following sources are available in the Trust:

- Patient information library
- Ward and team managers/senior clinicians
- AWP Patient Advice and Liaison Service (PALS)

In terms of accessibility, all wards/teams should carry a full selection of information leaflets as shown on the Trust Intranet. Ward/team managers should ensure copies of all leaflets are available for patients.

In terms of readability, the Trust requires all patient information leaflets to be developed in accordance with Trust guidance and the agreed procedure.

Once approved, the Communications Team will publish the leaflets on Ourspace and the Trust website. It is the responsibility of the originator of the leaflet to ensure relevant healthcare staff are made aware of the new leaflet and its intended use. Anyone wishing to develop or amend such leaflets should contact the Communications Officer for advice. Department of Health Guidance on readability of such materials is also available and should be used to guide staff when drafting patient leaflets

Specific provision needs to be made for patients who, for reasons of disability or otherwise, would not find printed information particularly accessible (tapes and pictorial materials, etcetera, are currently being developed by the Trust).

10.4 Advocacy

Where a patient has requested help from an independent advocate, staff should give assistance to patients to contact these advocates. Information about access to advocacy services should be available on all wards/teams. Please contact the Patient Advice & Liaison team at Jenner House for further information about advocacy and Independent Mental Capacity Advocates (IMCA). Patients under compulsion are entitled to an Independent Mental Health Advocate (IMHA).

10.5 Provision for Patients Whose First Language is not English

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

10.6 Access to More Detailed or Specialist Information

Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. Patients should discuss their additional requirements with their Consultant/team manager/ward manager. Information from sources such as the National Electronic Library for Health can be accessed for patients.

10.7 Access to Health Professionals Between Formal Appointments

After an appointment with a health professional in primary care or in outpatients, patients will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the patient's choice). Patients should contact their care co-ordinator, consultant's secretary or the ward/team manager if they require access to information between appointments.

10.8 Open Access Clinics

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

11. Responsibility for Seeking Consent

The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, teamwork is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent. It is essential that anyone involved in the consenting process has a thorough understanding of the risks and benefits of the procedure and the assessment of capacity, and members of staff do not undertake tasks above their level of competence.

11.1 Completing Consent Forms

The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so, either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure. Staff should be aware of their own knowledge limitations and be subject to audit. Where health professionals confirming the patient's consent are personally not able to answer any remaining questions, they should contact the team/ward consultant in the first instance.

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

11.2 Responsibility of Health Professionals

It is a health professional's own responsibility to:

- Ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- Work within their own competence and not to agree to perform tasks which exceed that competence.

If you feel that you are being pressurised to seek consent when you do not feel competent to do so you should contact your Clinical Director or Head of Profession.

12. Refusal of Treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment even if the decision is unwise, except in circumstances governed by the Mental Health Act 1983 (amended by the Mental Health Act 2007). The following paragraphs apply primarily to adults.

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

Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that

the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

13. Tissue Retention

The Human Tissue Authority Code of Practice (last updated in July 2014) sets out recommended practice for all those who communicate with relatives of children and adults who may undergo, or have undergone, a post-mortem examination (whether or not ordered by the coroner). This also includes communication after pregnancy loss. A post mortem examination (or autopsy) may take place either because the coroner has ordered it, or because the hospital and the family have agreed upon it.

A coroner's post mortem examination is carried out according to the provisions of the Coroner's and Justice Act 2009 in order to determine the cause of death. The family's consent is not required for this examination. Consent must still be obtained for the retention and use of organs following a coroner's post mortem.

A hospital post mortem examination is carried out at the request of the family or the hospital to gain a fuller understanding of the deceased's illness or the cause of death, and to enhance future medical care. Consent must be obtained for a hospital post mortem. Consent must also be obtained for the retention and use of organs and tissues following a hospital post mortem. The code of practice also defines who can give consent for post mortems and for the retention and use of organs and tissues.

The Trust does not engage in surgical activity. However, there may be occasions when staff need to consider tissue retention. The legal position regarding the use of human tissue retained for education and research requires consent to be given. Care should be taken to consider any religious or cultural issues. The Trust does not have pathology laboratories in any of its units and contracts through Service Level Agreements with Acute Trusts for the provision of any post mortem services. The appropriate consent forms should be completed.

Service users should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes. Obtaining written consent is integral to the Research Ethics Committees' acceptance of most research studies. Please refer to the Research & Development Guidance. Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.

14. Clinical Photography and Audio, Video or Digital Recordings

Photographic and audio/video or digital recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or audio/video or digital recording will result from that procedure.

Photographic and audio/video or digital recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. If you wish to use such a recording for education, publication, or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to

control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

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

The Trust takes the view that it is good practice to obtain written consent for all audio/video or digital recordings. The service user should be informed about who will be seeing or hearing the recording; why the recording is being made and viewed; and the conditions of the recordings storage and destruction.

The situation may sometimes arise where you wish to make a recording specifically for education, publication, or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. If possible the agreement of someone close to the service user or a person with Lasting Power of Attorney or an Independent Mental Capacity Advocate (Mental Capacity Act 2005) should be sought. The decision to make such a recording should also be discussed with colleagues and/or supervisors. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient or a person with lasting power of attorney or an Independent Mental Capacity Advocate. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

15. Training in Consent

Training is available from the Learning and Development department on the Mental Health Act and Mental Capacity Act, which includes consent issues. Training requirements for ECT staff are set out in the ECT Good Practice Guidelines and include training on consent. Further information may be obtained from the Trust Learning & Development Department. Further guidance and advice can also be sought from the Trust's Mental Health Act and/or Mental Capacity Act Leads.

16. Roles and Responsibilities

16.1 Board and Executive Responsibility

Responsibility for operational implementation sits with the Operations Directorate. The Operations Director oversees the Delivery Units and line manages the Clinical Directors. The Director for Nursing and Quality oversees governance and assurance processes, and Learning & Development, which will encompass training around the consent process, including Mental Health Act and Mental Capacity Act training and training in relation to ECT.

The Board or its relevant governance committee or forums should receive regular reports on compliance including the outcomes of audits and performance management reports. The reports should highlight areas of non-compliance and risk.

16.2 Delivery Units

The Delivery Units hold responsibility for the implementation of the policy within their area of responsibility, and for providing assurance around implementation and auditing compliance.

16.3 Professionals

The professional carrying out the procedure is ultimately responsible for ensuring that the service user is genuinely consenting to what is being done, and has the capacity to do so.

17. Definitions

17.1 Capacity

The ability to carry out the processes involved to make and communicate a specific decision at a specific time (as set out in the Mental Capacity Act 2005).

17.2 Consent

“Consent” is a patient’s agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- Have capacity to take the particular decision;
- Have received sufficient information to take it;
- Not be acting under duress.

17.3 Material Risk

A material risk is one that the patient would attach significant risk to, or to which a reasonable person would attach significance to.

18. Standards

The key standards that this policy relates to are drawn from:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11
- Mental Capacity Act 2005
- Care Act 2014
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Capacity Act 2005 Code of Practice (Department of Constitutional Affairs, 2007)
- Mental Health Act 1983 Code of Practice 2015
- General Data Protection Regulation 2016

19. Monitoring and Audit

This policy and its standards will be monitored periodically via the consent forms, feedback from service users and Audit. Managers should regularly review clinical notes and ensure staff comply with policy.

20. References

- Mental Capacity Act 2005
- Mental Health Act 1983 (as amended by Mental Health Act 2007)

- Care Act 2014
- Mental Health Act 1983 Code of Practice 2015
- Mental Capacity Act 2005 Code of Practice (Department of Constitutional Affairs, 2007)
- AWP Policy for the Mental Capacity Act 2005 as Amended by the Deprivation of Liberty Safeguards.
- Reference guide to consent for examination or treatment Second Edition (Department of Health, 2009),
- Families and post mortems: a code of practice (Department of Health, 2003),
- The Human Tissue Act 2004
- Human Tissue Authority: a code of practice (last updated July 2014)
- Human Rights Act 1998 (HRA) Articles 8 and 14 / Bournewood case
- Coroner's and Justice Act 2009 (including Chief Coroner's Guide to the Coroner's and Justice Act 2009)
- Montgomery v Lanarkshire Health Board [2015]

21. Useful contact details

Consenting for ECT

22. Appendices

Section 58 Mental Health Act 1983 guidelines for staff

Version History

Version	Date	Revision description	Editor	Status
1.0	25 Mar 2009	Approved by Trust Board	Assistant Director, Quality & Effectiveness and Trust Solicitor	Approved
2.0	11 May 2016	Complete review of previous policy and re-written	Medical Director	Approved
3.0	21 April 2017	Reviewed and admin changes made Approved by Director of Nursing	Associate Director for Statutory Delivery	Approved
3.1	18 June 2018	Extended to 31 July 2018	Medical Director	Approved
3.2	06 September 2018	Extended to 30 September and marked as under review	JW	Approved