

<b>Consent to Care/Treatment Policy</b>	
<b>Author (s)</b>	<p>Kulvant Sandhu Acting Named Nurse for Mental Capacity Act &amp; Dementia (Leeds Community Healthcare NHS Trust)</p> <p>Tracy Taylor Named Nurse for Safeguarding Children (Leeds Community Healthcare NHS Trust)</p> <p>Simon Boycott Head of Development and Governance</p>
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## **Executive summary**

The Leeds GP Confederation (Confederation) is committed to ensuring its employees are acting lawfully when providing care and treatment to people. This principle reflects the rights of our patients to determine what happens to their own bodies, and is a fundamental part of good practice (Department of Health, 2009, *Guide to consent for examination or treatment*, 2<sup>nd</sup> edition). The Mental Capacity Act (2005) outlines the actions that must be taken when providing care and treatment to a person who lacks the capacity to give valid consent.

All Confederation staff must ensure they have obtained valid consent when providing care and treatment to their patients, and ensure they evidence the consent process being followed which supports their clinical practice.

This policy describes and sets out the process of seeking consent and what constitutes to valid consent. It covers how to obtain consent, its duration, and how to act for those who lack capacity under the Mental Capacity Act (2005). This policy also sets out the principles and process for obtaining consent for children and young people, including the use of Parental Responsibility as defined in the Children Act (1984).

Refusal of consent as well as Advance Decisions to Refuse Treatment (ADRT) are also covered within this policy, along with expectations of Confederation staff to comply with the relevant legislations as cited within this document, in relation to providing care and treatment interventions to their patients.

This policy makes specific references to legislations pertaining to consent, these are;

- The Mental Capacity Act 2005
- The Children Act 1989/ 2004
- Mental Health Act 1985
- Police and Criminal Evidence Act 1984
- Section 7a of the Road Traffic Act 1988
- NHS Accessible Information Standard and the Equality Act 2010

## Consent to Care/Treatment Policy

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## 1 Introduction

### Law on consent

It is a general legal and ethical principle that valid consent must be obtained before starting care/treatment, physical investigations, or providing personal care, for a person. This also includes making referrals to other services. This principle reflects the rights of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A healthcare professional who does not respect this principle may be liable to legal or regulatory enforcement action by the patient or their professional body. The employer may also be liable for the actions of their staff.

## 2 Aims and Objectives

For healthcare practitioners to understand the requirements for obtaining valid consent, the process to follow and how to provide care/ treatment lawfully to the people they are in contact with, under the relevant legislations associated with consent.

## 3 Definitions

### What is Consent?

**Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination.**

This must be done on the basis of an explanation by a clinician.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

These terms are explained below:

- **voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family
- **informed** – the person must be given all of the information that can reasonably be given in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment doesn't go ahead
- **capacity** – means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks **capacity** if their mind is impaired or disturbed in some way, which means they're unable to make a

If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected. (NHS-Consent to treatment, 2019)

### Valid consent

For consent to be valid the following three elements must be met:

- The person has to be given sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, the likelihood of its success and any alternatives to it.
- The consent given must be given voluntarily with the person not being under any unfair or undue pressure.
- The person must have the mental capacity to give consent.

Valid consent has three elements; if anyone is not met then the consent is not valid. If the person lacks capacity then an assessment of their capacity must be undertaken and documented to evidence any care/treatment provided is in the person's best interests. If it is believed that the person is under duress to give consent, then concerns must be discussed with a medical lead or the safeguarding team.

When obtaining consent from children and young people, practitioners should ensure they follow the principles of Gillick/Fraser competency (see section 13).

## **4 Responsibilities**

**All staff** employed by, or working with The Leeds GP Confederation must work in concordance with the Leeds Safeguarding Multi-agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and the public with whom they are in contact.

**Chief Executive** is responsible for ensuring that mechanisms are in place for overall implementation, monitoring and revision of this policy.

**Director of Nursing** is responsible for ensuring that clinicians understand how the Consent Policy applies to them and that this is implemented locally via the clinical leads/service managers/etc.

**Operational Managers / Team Leaders** are responsible for ensuring:

- dissemination of the policy within their area of responsibility
- implementation of this policy within their area of responsibility
- identification and allocation of resources to enable compliance

### Consent to Care/Treatment Policy

- training and monitoring systems are in place
- all relevant new and existing staff have access to and are informed of the policy
- staff are able to access consent training as required

**Healthcare Professionals (registered and non-registered)** are responsible for following this policy to seek appropriate valid consent for any care/treatment/interventions (including referrals to other services), and to evidence they are following the consent process. Healthcare professionals must also:

- be aware of other relevant legislations related to consent, that they may need to use when providing care/treatment/interventions when they are unable to obtain consent from the person
- take responsibility for their own learning and identify any unmet training needs, ensuring they are up to date with their statutory and mandatory training

## 5 Who can give consent

A person aged 18 years old, and over can give consent for their own care/treatment; those aged 16 and 17 years old can also consent for themselves, if they are deemed competent to do so. Those aged under 16 years old can consent for themselves if they are Gillick competent / in accordance with Fraser guidelines (see children and young people section). There may be times when healthcare professionals are not able to obtain consent from the person (regardless of age). When this is the case in order to provide care / treatment lawfully to the person, another legal framework would need to be used such as:

- When someone lacks capacity, if the care/treatment is in their best interests under the Mental Capacity Act (2005) for those aged 16 years and over.
- Under a Lasting Power of Attorney (LPA) for health and welfare or someone who has the authority to make treatment decisions as a court appointed deputy, also in accordance with the Mental Capacity Act (2005).
- With Parental Responsibility (PR) for a person under the age of 18 years old, in accordance with The Children Act (1989 and 2004), this also includes any relevant court orders made under this Act.
- Within specialist settings (such as custody suites, CAMHS inpatient units) the use of other legal frameworks such as the Mental Health Act (1985), Police and Criminal Evidence Act (1984) (PACE), and Section 7a of the Road Traffic Act (1988), dependent on the circumstances of when these legislations can be used to provide interventions to those who are not able/willing to give consent.

## 6 How to obtain consent

The validity of consent does not depend on the form in which it is given, consent can be given by the person verbally or non-verbally. The emphasis is that the consent process is being followed by which the three elements that make up valid consent are met. Therefore a 'tick box' or signature on a form does not solely evidence the consent process being followed. If there is no evidence of the three elements of voluntariness, appropriate information given and mental capacity not being satisfied, a signature on a form alone will not make the consent valid if the process above has not been followed.

An example of non-verbal consent from a person (after they have received appropriate information) holds out their arm for their blood pressure to be taken. The person must have understood what the examination is intended for, without there being any concerns about their mental capacity. It is good practice to obtain written consent for any significant procedures such as surgical operations or when the person participates in a research project or video recording.

## 7 Providing Information

At the start of the process, healthcare professionals must clearly determine what information they need to present to the person for them to make a decision about consenting to the care/treatment. This will depend on the nature and complexity of the decision itself. The information provided must be tailored and accessible to the person in line with the NHS Accessible Information Standard and the Equality Act (2010).

Information may be provided verbally, in written format, picture format or any other means that can make that information accessible to the person (e.g. with sign language interpreters). A record must be made of what information was given to the person when consent was sought to evidence this part of the process has taken place.

Although there is no set rule of how much information must be given (or evidence as given in the person's records), both NHSE/I guidance and National Institute for Health and Clinical Excellence (NICE) guidelines state *"inform the person of any 'material' or 'significant' risks as well as unavoidable risks, even if small"*. Generally the greater the risk of a treatment/intervention, the more information is expected to be given to the person so that they are fully informed prior to giving you valid consent.



## **8 Consent given voluntarily**

For consent to be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Such pressure can come from partners, family members, as well as healthcare practitioners. Practitioners must be alert to this possibility and where appropriate must arrange to see the person on their own if there are any concerns about the person giving their consent freely, in order to establish that the decision is truly their own. If there are concerns about this aspect, advice must be sought from the safeguarding team.

## **9 CONSENT FOR ADULTS**

### **9.1 Adults without capacity**

Under English law, no one is able to give consent for care/treatment on behalf of an adult (over 18 years old) who lacks the capacity to give consent for themselves, unless they have been authorised to do so under a Lasting Power of Attorney (for health and welfare) or they have the authority to make treatment decisions as a court appointed deputy. Therefore, relatives or members of the healthcare team cannot consent on behalf of such adults. The Mental Capacity Act (2005) sets out the statutory principles and guidance when care/treatment can be provided lawfully to those who lack capacity, under a best interests decision.

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

A person lacks capacity if:

- They have an impairment or disturbance that affects the way their mind or brain works (for example a learning disability, condition such as dementia, Multiple sclerosis, brain trauma, or under the effects of alcohol or drugs).

### **AND**

- That impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

If there are concerns about a person's capacity to make a decision and give valid consent, an assessment of the person's capacity must be undertaken (based on their ability to make that specific decision and not their ability to make decisions in

general). The assessment must be undertaken by the 'decision-maker' which is the practitioner who is undertaking the care/treatment.

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

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

If a person is found to lack capacity to consent for their care/treatment, these can be provided if it is deemed to be in the person's best interests. The practitioner who decides this would be the practitioner who will be carrying out the care/treatment. When providing care/treatment or interventions under the Mental Capacity Act (2005), there must be documented evidence of the capacity assessment and the best interests decision made.

## **9.2 Lasting Power of attorney (LPA)**

The Mental Capacity Act (2005) enables a person aged 18 or over to appoint an attorney to look after their health and welfare decisions if they should lack capacity to make such decisions in the future. Under a LPA for health and welfare, the attorney can make decisions that are as valid as those made by the person themselves. The LPA must be made in the form of, and meet the criteria as set out in the Mental Capacity Act (2005), and it must be registered with the Office of the Public Guardian before it can be used. A copy of the LPA must be held in the patient's records if it is for health and welfare decisions.

The Mental Capacity Act (2005) established the Court of Protection to deal with decision-making for adults (and children in some cases) who may lack the capacity to make specific decisions for themselves. The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare. In cases of serious dispute, where there is no other way of finding a solution, or when the authority of the court is needed to make a particular decision or take a particular action, the court can be asked to make a decision.

If practitioners need further advice around checking registered LPAs, disputes on decisions, or need to refer cases to the Court of Protection, they must get in touch with the Named Nurse for MCA & Dementia or the safeguarding team (for adults and children) for further support and advice.

### 9.3 The duration of consent

When a person gives valid consent to care/ treatment, in general that consent remains valid for an indefinite duration, unless there is a change to the person's mental state or treatment, or it is withdrawn by the person. However that does not mean the process of obtaining consent is a one-off exercise, in reality (and in accordance with registered professionals' relevant governing bodies), practitioners are required to obtain consent for every intervention and on every separate occasion.

The initial consent obtained will be a more formal process as practitioners already do this when they meet new patients, undertake initial assessments and ask for valid consent for the proposed treatment/care plan. The subsequent follow-up appointments would involve the practitioner informally checking the valid consent process is still occurring.

*An example:*

A new patient is seen by a district nurse, assessed and care plan created for leg wound dressings 3 times a week. With sufficient information being given and no concerns of the person's capacity, the person gives their valid consent voluntarily to the care plan. On follow-up appointment for the leg wound to be dressed, the nurse informally checks the consent "*hello, I've come to dress your leg wound, is this still ok?*" to which the person says "*yes*" sits down and presents their leg for the dressing- the nurse still has no concerns about the person's capacity and they are freely presenting their leg for the intervention. This is the consent process happening continuously. If new information becomes available regarding the proposed intervention then the practitioner must inform the person and reconfirm their consent. If consent is required for a new different treatment or there is a change in the person's mental state (whereby they may lack capacity), then the valid consent process must start again.

## 10 CONSENT FOR CHILDREN AND YOUNG PEOPLE

### 10.1 Children and the law on consent

Under British law all persons under 18 years of age are referred to as minors, those under 16 years of age as children, and those aged 16 and 17 years old as young persons. Childhood is recognised as a developmental period, as children grow and develop in maturity, their views and wishes must be given greater weight. As they develop towards adulthood, these views/wishes must be respected and promoted.

The above principle is reflected in the law on consent when applied to children. As per Kennedy & Grubb (1998), children pass through 3 developmental stages on their journey to becoming an autonomous adult:

1. The child of tender years who relies on a person with parental responsibility to consent to treatment
2. The Gillick competent child under 16
3. Young person's 16 and 17 years old who are able to consent to treatment as if they 'were of full age'

Persons aged 16 and over are entitled to consent to their own care/treatment. Like adults, young people (aged 16 and 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 years can consent to their own care/treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

Otherwise, someone with parental responsibility can consent for them. This 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
- a local authority or person with an emergency protection order for the child

## **10.2 Gillick competency**

In accordance with the case law definition of Gillick competence, children under 16 years of age can give consent themselves if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options.

## **10.3 Fraser Guidelines**

The Fraser guidelines apply specifically to sexual health and contraceptive advice/treatment. Health practitioners can proceed to give sexual health and contraceptive advice/treatment to a person aged under 16 years of age if they are satisfied on the following:

- That the person under the age of 16 years old, will understand the advice;
- That the practitioner cannot persuade the person to inform their parents or to allow them to inform their parents that they are seeking contraceptive advice;
- That the person is very likely to continue having sexual intercourse with or without contraceptive treatment;
- That unless they receive contraceptive advice or treatment, their physical or mental health or both are likely to suffer;
- That in their best interests, requires the practitioner to give them contraceptive advice, treatment or both without the parental consent.

#### **10.4 Balancing children's rights with the responsibility to keep them safe from harm**

When practitioners are trying to decide whether a child is mature enough to make decisions, they often think about whether the child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. Practitioners working with children in any context need to consider how to balance children's rights and wishes with their responsibility to keep children safe from harm. Key issues to bear in mind include:

- The child's safety is paramount. Child safeguarding concerns must always be shared with the relevant agencies, even if this goes against the child's wishes.
- Underage sexual activity is a possible indicator of child sexual exploitation and children who have been groomed may not realise they are being abused.
- Sexual activity with a child under 13 is a criminal offence and must always result in a child safeguarding referral.

#### **10.5 Parental responsibility (PR)**

The person with PR must have the capacity to give consent. If a parent refuses to give consent to care/treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.

If one person with PR gives consent and another doesn't, the healthcare practitioner can choose to accept the consent and perform the treatment in most cases (if they feel the decision is in the best interest of the child or young person). If the practitioner has concerns regarding the decision making, they should seek advice from a medical lead or the safeguarding team. If the people with PR disagree about what's in the child's best interests, the courts can make a decision.

In an emergency, where treatment is vital and waiting to obtain parental consent would place the child at risk, treatment can proceed without consent.

## 10.6 Who has Parental Responsibility (PR)

Biological mother and father

- Mother automatically has parental responsibility from the child's birth.
- Father has parental responsibility if he was married to the child's mother when the child was born.
- If the father is listed on the birth certificate after a certain date they also hold PR (England and Wales - 01/12/2003; Scotland - 04/05/2006; Northern Ireland 15/04/2002.)

Adoptive parents

- Have parental responsibility.

Foster carers

- Do not have parental responsibility.

Special Guardians

- Are awarded a court order which means they share PR with the parents. However, the special guardians would have overriding PR.
- Carers who have a child arrangement/ residency order also have PR.

The Local Authority

- Can obtain a court order which would mean the local authority would share PR with the parents. However, the local authority would have overriding authority to make decisions about treatment in the best interests of the child.

Surrogacy

- The woman who gives birth is treated as the child's mother in UK law (and holds PR) even if they are not genetically related to the child.
- PR can be transferred to the genetic parents by parental order or adoption.

If a healthcare practitioner has any concerns about delivering care/treatment to a child, young person, or the appropriate use of PR, they can seek further guidance by contacting the safeguarding team.

## **11 REFUSAL OF CONSENT**

### **11.1 When consent is refused**

If an adult with capacity makes a voluntary and appropriately informed decision to refuse care/treatment, this decision must be respected, even where this may result in the death of the person. The exception is in certain circumstances as defined by the Mental Health Act (1983) and when interventions are undertaken under Police and Criminal Evidence Act (1984). Refusal of care/treatment by those under the age of 18 years old, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury. This could be overruled by someone appropriately using PR under The Children Act (1989) or by the Court of Protection.

Anyone who gives the practitioner consent on the grounds of parental responsibility may take it back at any time, but the health practitioner only needs consent from one person who holds PR to proceed, so long as they continue to have consent from one person who holds PR they have the legal right to proceed with care/treatment.

Where a health professional accepts the consent of a Gillick competent child it cannot be overruled by the child's parent. However, where the same child refuses consent then they may obtain it from another person with PR who can consent to care/treatment on the child's behalf. Parents can consent to their competent child being treated even when the child/young person is refusing treatment, however it would be wise to obtain a court declaration/ decision if faced with a competent child/young person who is refusing to consent to treatment, to determine whether it is lawful to treat them.

If a young person refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection. The parents of a young person who has refused treatment may consent for them, but it's usually best practice to go through the courts in this situation.

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

## 12 Advance Decisions to Refuse Treatment (ADRT)

A person aged 18 or over can make an advance decision to refuse particular treatments in the future in the event they lose capacity (previously referred to as a 'living will' or 'advance directive'). A valid and applicable ADRT has the same power as a person with capacity who is refusing treatment. This is part of common law and the Mental Capacity Act (2005). The full requirements of a valid and applicable ADRT are set out in chapter 9 of the Mental Capacity Act (2005) Code of Practice, in summary they are:

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

Healthcare professionals must follow an ADRT if it is valid and applicable, even if it may result in the person's death. If they do not, they could face criminal prosecution or civil liability. If there is genuine doubt or disagreement about an ADRT's existence, validity or applicability, the case must be referred to the Court of Protection. However the court does not have the power to overturn a valid and applicable ADRT. While a decision is awaited from the courts, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration of the patient's condition.

ADRT made in accordance with the Mental Capacity Act (2005) cannot refuse 'basic' or 'essential' care, this includes warmth, shelter, actions to keep a person clean and free from pain/distress, and the offer of food and water by mouth. However an ADRT can refuse artificial nutrition and hydration.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process which creates a form with individualised recommendations for a person's clinical care in emergency situations, including cardiorespiratory arrest, when they are not able to decide for themselves or communicate their wishes. Although ReSPECT forms are not legally binding, healthcare professionals must be prepared to justify valid reasons for overriding any recommendations on a ReSPECT form.



### **13 Documentation**

It is essential there is evidence of the process being followed for obtaining valid consent for care/treatment interventions within the person's clinical records. Staff giving care need to ensure appropriate documentation within the person's records reflects the discussions and decisions taken place to evidence that they have obtained valid consent from the person, or using PR, or delivering care/treatment interventions under another appropriate legislation such as Mental Capacity Act (2005), Mental Health Act (1984), and/or Police and Criminal Evidence Act (1984).

Although completion of a consent form by a patient is in most cases not a legal requirement (exceptions include certain requirements under the Mental Health Act (1984)) the use of such forms is good practice where there is an intervention such as surgery to be undertaken. Within the Leeds GP Confederation Community Dermatology service, there is a contractual requirement to evidence written consent for any procedure, such as a biopsy.

Where there is any doubt about the person's capacity, it is important before the person is asked to sign the form, to establish both that they have the capacity to consent to the care/treatment and that they have received enough information to enable valid consent to be given.

If the person has capacity, but is unable to read or write, they can make their mark on a consent form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the healthcare practitioner seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the person's records. Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the consent form, this fact must also be recorded in the records. The person can also direct someone else to sign the form on their behalf, but there is no legal requirement for them to do so. If consent has been given validly, the lack of a completed form is no bar to treatment.

Overall consent can be given verbally or non-verbally by a person, it is therefore imperative for healthcare practitioners to evidence that they have obtained valid consent within the person's clinical records. Further guidance on documentation can be found within service specific guidelines.

### **14 Mental Capacity Act (MCA 2005 Code of Practice)**

This Act applies to all persons over the age of 16 who are assessed to lack capacity to consent or withhold consent to treatment or care. Under the MCA there are occasions when anyone lacking capacity should, or may require an Independent Mental Capacity Advocate, where treatment or residence

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decisions have a significant impact on an individual's life and rights.

## **15 Deprivation of Liberty (DoLs)**

In the ruling of *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16, known as the 'acid test', it was determined that a person without capacity is deprived of their liberty if they are both subject to continuous supervision and control, and not free to leave.

Any deprivation of liberty of a person who lacks capacity has to be carried out in accordance with law. If a Confederation staff member is aware of anyone they believe is or is likely to be deprived of their liberty, they must act in accordance with the MCA policy and DoL's guidance or they must discuss their concerns with a member of the Adult Safeguarding Team.

For further information on the MCA 2005 or on Deprivation of Liberty see the Confederation Intranet or speak to the Named Nurse MCA/DoLS & Dementia or one of the MCA Champions.

## **16 Safeguarding**

The Safeguarding Children and Adults at Risk policies describe the roles and responsibilities for the Confederation in relation to the safeguarding of children and young people.

Confederation staff and workers are expected to follow the multi-agency procedures, comply with this policy and assist in taking the necessary action to safeguard children experiencing or at risk of abuse.

It is an expectation that all provider organisations, including The Leeds GP Confederation, demonstrate robust safeguarding systems and safe practice within agreed local multi-agency procedures.

The Children Acts of 1989 and 2004 and the statutory guidance *Working Together to Safeguard Children* (2018) set out the safeguarding principles for and promoting the welfare of children and young people.

The Children Act 2004 emphasises that we all share a responsibility to safeguard children and young people.

## **17 Training Needs**

Staff and Workers in the GP Confederation have the responsibility to ensure that they meet the core training requirements set out by the Workforce Committee.

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**18 Monitoring Compliance and Effectiveness**

<b>Minimum requirement to be monitored / audited</b>	<b>Process for monitoring / audit</b>	<b>Lead for the monitoring / audit process</b>	<b>Frequency of monitoring / auditing</b>	<b>Lead for reviewing results</b>	<b>Lead for developing / reviewing action plan</b>	<b>Lead for monitoring action plan</b>
Complaints relating to Consent	Datix® reporting system	Clinical Lead for Compliance and Development through the Contracts and Compliance Manager	Monthly	Governance Meetings	Service Managers and Leads	Quality Committee
Incidents relating to Consent	Datix® reporting system	Clinical Lead for Compliance and Development through the Contracts and Compliance Manager	Monthly	Governance Meetings	Service Managers and Leads	Quality Committee
Learning shared and demonstrated	Professional meetings, line managers	Service Managers and Leads	Monthly	Governance Meetings	Service Managers and Leads	Quality Committee

**19 Approval and Ratification process**

The policy has been approved by the Quality Committee.

**20 Dissemination and Implementation**

Dissemination of this policy will be via the Document Library and Confederation website.

Implementation will require:

- Operational Managers / Team Leaders to ensure staff have access to this policy and understand their responsibilities for implementing it into practice

**21 Review arrangements**

This policy will be reviewed in two years or sooner if there is a local or national requirement.

**22 Associated documents**

This policy links to the following Confederation documents:

- Adults at Risk Policy
- Safeguarding Children Policy
- Records Management Policy
- Incident Management Policy (Including Serious Incidents)

**23 References**

Working Together to Safeguarding Children- A guide to inter-agency working to safeguard and promote the welfare of children (2018) HM Government, Crown Copyright

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Reference Guide to Consent for Examination or Treatment, DH, 2001 (amended 2009), <https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition>

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