

## Policy for Consent to Treatment and Examination

### Preface

On 22 November 2001 the Department of Health released HSC 2001/023 "Good Practice in Consent" and an Implementation Guide.

Introduced as part of the NHS Plan, the aim of the guidance is to demonstrate commitment to patient-centred practice and provide consistency across the NHS in the way consent is taken. The circular set out requirements for NHS Trusts to implement standard Consent forms for *taking written consent* by 1<sup>st</sup> April 2002 and a model Consent Policy by 31<sup>st</sup> October 2002.

Attached is the model Consent Policy for use and application by East Hampshire PCT directly managed Services. The PCT must use the model consent policy as a core minimum, which should not be amended or removed however local information has been added and is shown in **bold** throughout the policy.

The development of the new consent forms *does not change the current position on when written, as opposed to oral, consent to treatment is necessary. Trusts/PCTs can determine whether oral or written consent is appropriate for individual procedures within the broad guidelines set out in the model Policy.*

**Appendix B** sets out the method of consent in use in the PCTs directly managed Services for key treatments.

### Implementation by Independent Practitioners

Where written consent is already taken it is recommended and considered best practice, that independent practitioners use the standard consent forms for relevant treatment.

Queries to:	Julie Jones, Risk & Governance Manager,
Date approved by Operational Management Group	November 2002
Date approved by Executive Committee	December 2003
Date of first review	December 2003

### Contents

Quick Guide to Consent	
Section 1. Introduction	
Section 2. Documentation	
Section 3. When should consent be sought?	
Section 4. Provision of information	
Section 5. Who is responsible for seeking consent?	
Section 6. Refusal of treatment	
Section 7. Tissue	
Section 8. Clinical photography and conventional or digital video recordings	
Appendix A	12 key points on consent: the law in England
Appendix B	Current forms in use in East Hampshire Primary Care Trust and patient leaflets and information
Appendix C	Useful PCT Contacts
Appendix D	Seeking consent: remembering the patient's perspective
Appendix E	Sample Model Consent to Treatment Forms



## Quick Guide to Consent

<b>A PATIENT REQUIRES TREATMENT</b>
---

*Type of treatment:*

<ol style="list-style-type: none"> <li>1. Non-invasive procedures</li> <li>2. Therapeutic intervention</li> <li>3. Child Immunisation</li> </ol>	<ol style="list-style-type: none"> <li>1. The treatment is invasive or presents significant risks</li> <li>2. Treatment under anaesthetic – local, general, regional, sedation</li> <li>3. Treatment under the Mental Health Act</li> <li>4. Treatment is part of an approved research programme</li> </ol>
<b>Verbal consent or locally produced forms</b>	<b>DOH Model Consent Forms</b>

**In all cases:**

- The treatment should be fully explained by the person carrying out the procedure or capable of carrying out the procedure
- Risks and benefits of the treatment should be fully explained
- Alternatives – if applicable - should be explained
- Verbal information/explanations should be supported with written information for the patient to take away e.g. patient leaflets
- The patient should be asked if they understand what has been explained to them and given the opportunity to ask any questions
- Patients can decline the treatment if they wish

Verbal Consent or locally produced forms	Adult or Competent Child	Children Under 16 (Parental Consent)	Patients who will be alert during procedure	Patients who lack capacity to give consent
	<b>DOH Form 1</b>	<b>DOH Form 2</b>	<b>DOH Form 3</b>	<b>DOH Form 4</b>

**In all cases:**

- Information on the form should be explained to the patient and they should be given the time to read it and ask any questions
- The patient / parent should form all relevant spaces on the form
- Obtaining a signature does not imply consent unless the patient / parent fully understands all of the above**
- The patient should be given a copy of the signed consent form and a copy retained in their notes
- The patient can change their mind about proceeding with the treatment even after signing the consent form

## 1. INTRODUCTION

### Why consent is crucial

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

### This policy

- 1.2. The Department of Health has issued a range of guidance documents on consent (see overleaf), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in this PCT which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

### What consent is – and isn't

- 1.3. "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:
- be competent to take the particular decision;
  - have received sufficient information to take it; and
  - not be acting under duress.
- 1.4. The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.
- 1.5. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, *no one else can give consent on their behalf*. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives see the Department of Health's *Reference guide to consent for examination or treatment* (chapter 1, paragraph 19).

## Guidance on consent

- 1.6 The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.
- *Reference guide to consent for examination or treatment* provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available from **the Risk & Governance Manager at PCT Management Offices (see Appendix C Useful PCT Contacts)** and on the internet at [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent).
  - *12 key points on consent: the law in England* has been distributed widely to health professionals working in England. This one-page document summarises those aspects of the law on consent which arise on a daily basis and is attached at **Appendix A**. Further copies are available from [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent).
  - Specific guidance, incorporating both the law and good practice advice, is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available [insert local details] and on the internet at [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent).

## 2. DOCUMENTATION

- 2.1. For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions that led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

### Written consent

- 2.2. Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent giving, not a binding contract.
- 2.3. It is rarely a legal requirement to seek written consent,<sup>1</sup> 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 (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
  - the procedure involves general/regional anaesthesia or sedation
  - providing clinical care is not the primary purpose of the procedure
  - there may be significant consequences for the patient's employment, social or personal life

- the treatment is part of a project or programme of research approved by this PCT

**Appendix B lists the method of Consent used by directly managed Services for specified procedures.**

- 2.4. Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.
- 2.5. 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), it would be helpful to do so.
1. The Mental Health Act 1983 requires written consent in certain circumstances.

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

- 2.6. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment). An 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 should also be documented. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.
- 2.7. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.
- 2.8. 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. **To discuss what is needed to obtain a court declaration, contact the PCTs Complaints & Litigation Manager (see Appendix C Useful Contacts).**

**Availability of forms**

- 2.9. Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in **Appendix E**. There are four versions of the standard consent form: **form 1** for adults or competent children, **form 2** for parental consent for a child or young person and **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. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary. **Form 4** is for patients who lack the capacity to give consent.
- 2.10. Arrangements for obtaining copies of forms are provided in **Appendix F**.

### 3. WHEN SHOULD CONSENT BE SOUGHT?

- 3.1 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.

#### Single stage process

- 3.2. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.
- 3.3. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

#### Two or more stage process

- 3.4. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.
- 3.5 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?"
- 3.6. 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.

### Seeking consent for anaesthesia

- 3.7. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) 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.
- 3.8. 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.

### Emergencies

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

### Treatment of young children

- 3.10. When babies or young children are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.
- 3.11. Only people with 'parental responsibility' are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (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.

## 4. PROVISION OF INFORMATION

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



- 4.2. 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 makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.
- 4.3. Patient information and leaflets available in this PCT are listed in **Appendix B**.
- 4.4. This PCT 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.

**Translation and interpreting services can be accessed by contacting the Head of Quality at the PCT Headquarters Office (see Appendix C Useful PCT Contacts).**

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

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

**A PALS Co-ordinator has been appointed, see Appendix C Useful PCT Contacts. Models for a joint Patient Advise & Liaison Service (PALS) for the 3 PCTs are being considered.**

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

- 4.6. 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).

#### **Open access clinics**

- 4.7. 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. This can be by provision of relevant patient information leaflets, referring to the PALS Co-ordinator for further information or other sources, such as primary care colleagues.

### **5. WHO IS RESPONSIBLE FOR SEEKING CONSENT?**

- 5.1. The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.
- 5.2. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, 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.

## Completing consent forms

- 5.3. 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, have been assessed, are aware of their own knowledge limitations and are subject to audit.
- 5.4. 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.

## Responsibility of health professionals

- 5.5. 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
  - to work within their own competence and not to agree to perform tasks which exceed that competence.

If you feel that you are being pressurised to seek consent when you do not feel competent to do so, **contact the Risk & Governance Manager at the PCT Headquarters Office. See Appendix C Useful PCT Contacts.**

## 6. REFUSAL OF TREATMENT

- 6.1. 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, except in circumstances governed by the *Mental Health Act 1983*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.
- 6.2. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.
- 6.3. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.
- 6.4. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient's stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient's care to that health professional.

## 7. TISSUE

- 7.1. The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues and is currently under review. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and hence improvements in healthcare for all. At present, this PCT requires that patients 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. Patients must also be able to record any objections to particular uses or use of particular tissues.
- 7.2. Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply.
- 7.3. Pending the outcome of the review of the law governing the use of human organs and tissue, the Department of Health believes that tissue samples may be used for quality assurance purposes without requiring specific patient consent *provided* there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised.

## 8. CLINICAL PHOTOGRAPHY AND CONVENTIONAL OR DIGITAL VIDEO RECORDINGS

- 8.1. Photographic and video recordings made for clinical purposes form part of a patient's record. Although consent to certain recordings, such as X-rays, is implicit in the patient's consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.
- 8.2. Photographic and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient's care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.
- 8.3. Photographic and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient, as long as this policy is well publicised. However, express consent must be sought for any form of publication.
- 8.4. If you wish to make a photographic or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

- 8.5 The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.
- 8.6 If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of some one close to the patient. You must not make any use of the recording that 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.

## Appendix A

### 12 key points on consent: the law in England

#### When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

#### Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some one with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

#### Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

#### What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

#### Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

## Refusal of treatment

10. Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

## Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.
12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

**This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available from the NHS Response Line 08701 555 455 and at [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent).**

## Appendix B

## Consent arrangements in place in East Hampshire PCT

Service & Description of Treatment	Oral or Non-Verbal	Locally produced forms	DOH Consent Forms				Patient Leaflets & Information
			Form 1 (Adult/Competent Child)	Form 2 (Parental Consent)	Form 3 (Pts who will be alert during procedure)	Form 4 (Pts who lack capacity to give consent)	
<b>Child &amp; Family Therapy</b> <ul style="list-style-type: none"> <li>▪ Treatment Plans</li> <li>▪ Therapeutic Contracts</li> <li>▪ Family Therapy Partnership Agreements</li> <li>▪ Case Programme Approaches</li> </ul>		3 3 3 3					<ul style="list-style-type: none"> <li>▪ Child &amp; Family Therapy Service Information Leaflet</li> <li>▪ Data Protection Leaflet</li> <li>▪ Family Therapy Leaflet</li> <li>▪ ADHD Information Sheet</li> <li>▪ Mental Health Information Sheet " Young Minds"</li> <li>▪ Information On Ritalin</li> <li>▪ Parent/Child Game</li> <li>▪ Video Interactive Guidance</li> <li>▪ Drama Therapy</li> <li>▪ Play Therapy</li> </ul>
<b>Community Hospitals</b> <ul style="list-style-type: none"> <li>▪ Self Medication – Trialled at Havant War Memorial and Emsworth Hospital</li> <li>▪ All other procedures and treatments in the 3 community hospitals</li> </ul>	3	3					<ul style="list-style-type: none"> <li>▪ Out-Patients in Community Hospitals (Colo-rectal information sent with PHT appointment letter.)</li> <li>▪ Out Patients in Community Hospitals (Ultra-sound information sheet sent with PHT appointment letter).</li> </ul>
<b>Dentistry</b> <ul style="list-style-type: none"> <li>▪ All clinical dental treatment</li> <li>▪ School screenings</li> </ul>		3 3					<ul style="list-style-type: none"> <li>▪ Instructions following the extraction of teeth</li> <li>▪ Taking of prescribed antibiotics</li> <li>▪ Instructions to patients receiving dental treatment under relative analgesia</li> <li>▪ Information for patients receiving treatment under general anaesthetic at the Poswillo Centre</li> </ul>
<b>District Nursing</b> <ul style="list-style-type: none"> <li>▪ All District Nursing Intervention</li> </ul>	3						<ul style="list-style-type: none"> <li>▪ District Nursing Information leaflet that provides details of the service patients can expect &amp; contact telephone numbers. There is also a section for patients to send in their comments.</li> </ul>
<b>Elderly Medicine</b> <ul style="list-style-type: none"> <li>▪ Syncope</li> <li>▪ All treatment involving anaesthetic</li> </ul> <p>Other significant treatment carried out by PHT whose staff who take consent</p>			3 3			3	<ul style="list-style-type: none"> <li>▪ Syncope Patient Leaflet</li> </ul>
<b>Elderly Mental Health</b> <ul style="list-style-type: none"> <li>▪ ECT</li> </ul>							<ul style="list-style-type: none"> <li>▪ Royal College of Psychiatrists Fact Sheet on ECT</li> </ul>

Service & Description of Treatment	Oral or Non-Verbal	Locally produced forms	DOH Consent Forms				Patient Leaflets & Information
			Form 1 (Adult/Competent Child)	Form 2 (Parental Consent)	Form 3 (Pts who will be alert during procedure)	Form 4 (Pts who lack capacity to give consent)	
			3			3	
<b>Health Visiting</b> <ul style="list-style-type: none"> <li>▪ Head Lice Treatment (prescription &amp; combing)</li> <li>▪ Immunisations</li> <li>▪ Treatment of Cradle cap</li> <li>▪ Granuloma at stoma site</li> <li>▪ Constipation Management</li> <li>▪ Phenylketunuria Test</li> <li>▪ Wet Wrapping Treatment of Eczema</li> </ul>	3 3 3 3 3 3 3						<ul style="list-style-type: none"> <li>▪ The Prevention &amp; Treatment of Head Lice</li> <li>▪ A new Guide to childhood immunisations (up to 15 months). A Guide to pre-school immunisations (3-5 years old)</li> <li>▪ About your Baby's Blood Test</li> <li>▪ A Guide to Wet Wraps</li> </ul>
<b>Occupational Therapy</b> <ul style="list-style-type: none"> <li>▪ All Occupational Therapy Intervention</li> </ul>	3						<ul style="list-style-type: none"> <li>▪ Data Protection Information Leaflet</li> </ul>
<b>Palliative Care</b> <ul style="list-style-type: none"> <li>▪ Involvement of Palliative Care Team</li> <li>▪ Psychology</li> <li>▪ Research Projects</li> </ul>	3 3	3					<ul style="list-style-type: none"> <li>▪ Information Leaflet</li> <li>▪ Data Protection Leaflet</li> </ul>
<b>Physiotherapy</b> <ul style="list-style-type: none"> <li>▪ Non-invasive Treatments</li> <li>▪ Invasive Treatments (Acupuncture/Manipulation)</li> </ul>	3	3					
<b>Podiatry</b> <ul style="list-style-type: none"> <li>▪ Nail surgery</li> <li>▪ All other advice and treatment</li> </ul>	3	3					<ul style="list-style-type: none"> <li>▪ Nail Surgery Information Sheet</li> <li>▪ Post-operative Information Sheet</li> </ul>
<b>School Nursing</b> <ul style="list-style-type: none"> <li>▪ Heaf Test and BCG Immunisation</li> <li>▪ Rachel Maddocks Special School : <ul style="list-style-type: none"> <li>- Administration of Medicines and other Treatments</li> </ul> </li> <li>▪ Bedhampton House : <ul style="list-style-type: none"> <li>- Administration of Medicines</li> <li>- Perenteral Feeding</li> </ul> </li> </ul>		(Parental Consent) 3 3 3 3					<ul style="list-style-type: none"> <li>▪ Bedwetting: A guide for Parents</li> </ul>



## Appendix C

**Useful PCT Contacts****Risk & Governance Manager**

Julie Jones  
PCT Management Offices  
Raebarn House  
Hulbert Road  
Waterlooville, PO7 7 GP

**Code A****PALS Co-ordinator****Code A**

Cosham Park House  
Cosham Park Avenue  
Cosham, PO6 3BG

**Code A****Complaints & Litigation Manager**

Elaine Williams  
PCT Management Offices  
Raebarn House  
Hulbert Road  
Waterlooville, PO7 7 GP

**Code A****Head of Quality**

Sue Damarell-Kewell  
PCT Management Offices  
Raebarn House  
Hulbert Road  
Waterlooville, PO7 7 GP

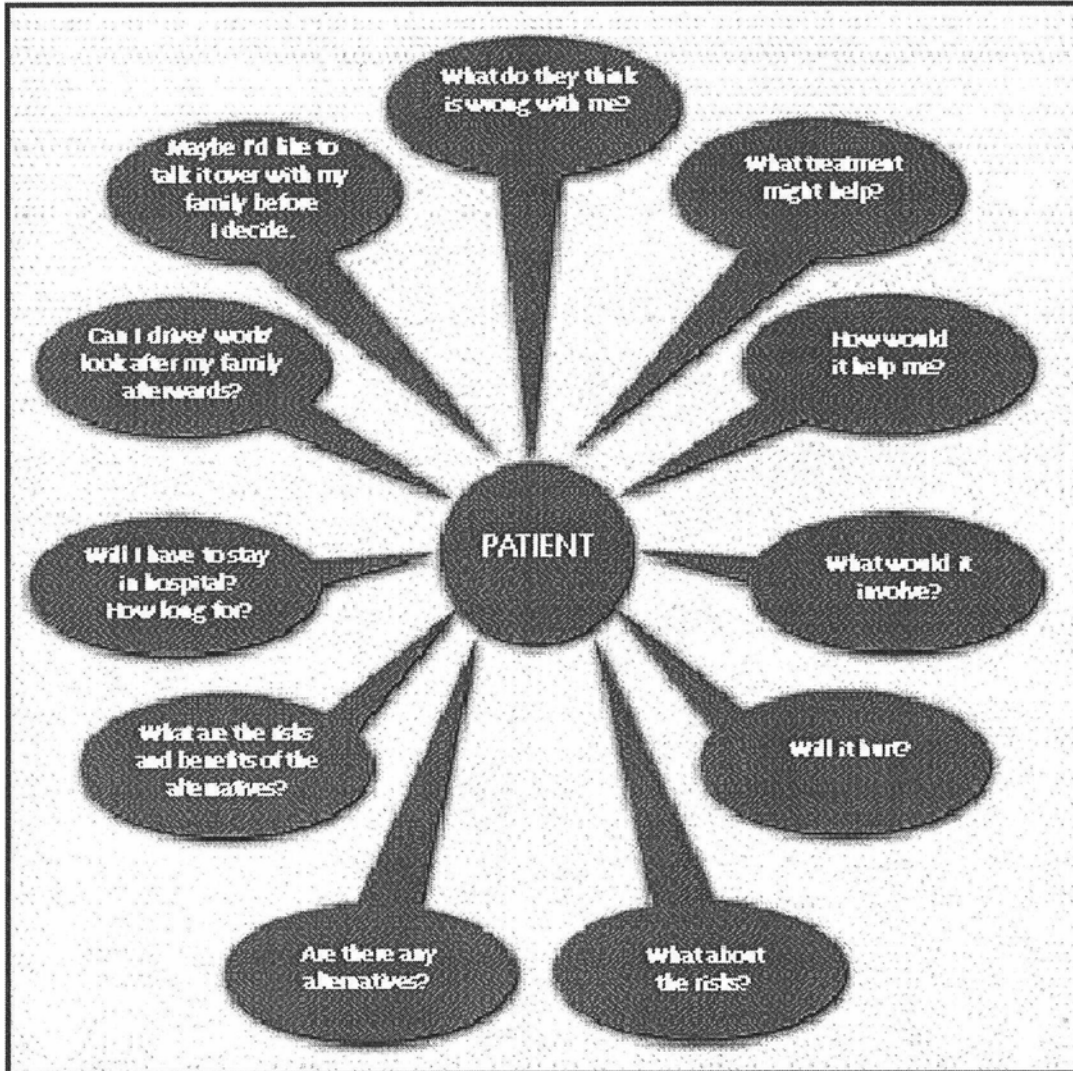
**Code A****Clinical Governance Lead for the PCT**

Dr Ian Reid  
Department of Medicine for Elderly People  
South Block  
Queen Alexandra Hospital  
Southwick Hill Road  
Cosham, PO6 3LY

**Code A**

Appendix D

Seeking consent: remembering the patient's perspective



Appendix E

**Sample Model Consent to Treatment Forms**

**Form 1**

Patient agreement to investigation or treatment

**Form 2**

Parental agreement to investigation or treatment for a child or young person

**Form 3**

Patient/parental agreement to investigation or treatment procedures where consciousness is not impaired

**Form 4**

Form for adults who are unable to consent to investigation or treatment

## Appendix F

**Model Consent to Treatment Forms: Centralised Production Facility**

**1 April 2002** is the date for the introduction of the new consent to treatment forms and accompanying patient information and all PCT services should now be using them.

**Following numerous expressions of interest, and to help reduce unit costs, the DoH has been working with the NHS Purchasing and Supply Agency and Collector Set Printers to provide a central production point for the forms.**

These can be ordered directly from the printers (there is no need to go through Supplies). The print specifications will also be made available on this website to allow for local production.

To order the forms, please contact Collector Set either by fax, post, or e-mail, stating how many of each form you require, and giving the full delivery and invoice address:

Collector Set Printers Ltd  
Unit F Forstal Road  
Nr. Maidstone  
Kent ME20 7BU

Tel: **Code A**  
Fax: **Code A**

Contact names:

Claire Marsh, stock office manager  
Ron Smith, Orders manager - ext: **Code A**  
Paul Ridgewell, sales manager: ext: **Code A**

email: [sales@collectorsetprinters.co.uk](mailto:sales@collectorsetprinters.co.uk) [orders@collectorsetprinters.co.uk](mailto:orders@collectorsetprinters.co.uk)

Web: [www.collectorsetprinters.co.uk](http://www.collectorsetprinters.co.uk)

DoH Contact: **Code A**  
DoH Website: [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent)