Consent for Treatment for All Patients Policy

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Accountable Director		**Managing Director**	
Policy Author/Originator - **Any comments on this document should, in the first instance be addressed to whc.policyqueries@nhs.net**		**Director of Governance and Company Secretary**	
If developed in partnership with another agency, ratification details of the relevant agency			

Equality Impact and Parity of Esteem

Wiltshire Health and Care staff strive to ensure equality of opportunity and parity of esteem for all service users, local people and the workforce. As an employer and a provider of health care, we aim to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

References: ***NHS England 'Everyone Counts: planning for patients 2014-15 / 2018-19' and The Mental Health Crisis Care Concordat (DH 2014).***

Safeguarding

Wiltshire Health and Care have a strong commitment to care that is safe, of a high quality and that upholds our patients' rights. All our patients have the right to live lives free from abuse or neglect and, where they are able, to make or be supported to make informed decisions and choices about their treatment, care and support. Where patients are not able to make their own decisions, Wiltshire Health and Care staff are committed to ensuring that treatment, care and support is undertaken in accordance with the person's best interests. In order to fulfil these commitments, Wiltshire Health and Care follow the Safeguarding principles and responsibilities laid out in sections 42-46 of the Care Act (2014) and are informed by, and apply, the guiding principles and provisions of the Mental Capacity Act (2005) (refer to Wiltshire Health and Care Safeguarding Adults Policy and Procedure, and Mental Capacity Act Policy and Procedure).

Regarding children, WHC is responsible for providing services in accordance with Section 11 of the Children's Act (1989) and works under the principles of Working Together to Safeguard Children (2018).

Special Cases

There are no special cases.

Contents

1 Document Details

1.1 Introduction and Purpose of the Document

In 2009 the Department of Health (DH) (as was) updated its Good Practice in Consent Implementation Guide: consent to examination or treatment, and renamed it 'A Reference Guide to Consent for Examination or Treatment' (Ref 1). Although there is no longer an explicit requirement to adopt the DH policy and model consent forms, Wiltshire Health and Care (WHC) are responsible for ensuring that their Consent Policy and associated consent forms reflect the latest legal and regulatory requirements. WHC has adopted the DH model policy, which allows WHC to make amendments to the provision of patient consent as the legal regulatory framework changes, which includes obtaining consent to hospital post mortems and any subsequent retention of tissue and organs to be used throughout the National Health Service (NHS). For this purpose WHC uses its interpretation of the consent forms. The wards have a process involving local funeral directors who will transport bodies to the mortuary at GWH if there needs to be involvement from coroner/post mortem.

The purpose of this document is to set out the policy of WHC with respect to patient /parent/guardian consent for care and treatment, including post-mortem examination. The policy applies to all employees of WHC (this includes agency workers).

This policy does not include guidance on how to obtain consent for matters other than for clinical treatments and procedures. Please refer to WHC's policies applicable to the disclosure of personal information in relation to the sharing of personal, confidential information.

Young people aged **16** or **17** are presumed in law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CNST	Clinical Negligence Scheme for Trusts
Competent child	Person under 16 who meets the Gillick competence guidance (section 2.15.3) for competence to consent to treatment
COREC	Central Office of Research Ethics Committees
CQC	Care Quality Commission
DH	Department of Health (now the Department of Health and Social Care)
DoLS	Deprivation of Liberty Safeguards
GMC	General Medical Council
HIV	Human immunodeficiency virus
HTA	Human Tissue Authority
Human Tissue	Defined by the HTA as 'relevant material', meaning material other than gametes, which consists of or includes human cells.
IMCA	Independent Mental Capacity Advocate
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
N/A	Not applicable
NHS	National Health Service
NMC	Nursing and Midwifery Council
HCPC	Healthcare Professional Council
Parent	The term parent in this document is used broadly and includes all those deemed to have parental responsibility in the eyes of the law.
Placement Information Plan	A local authority document which provides clarity for the child and the child's carer and has been agreed by all parties.
WHC	Wiltshire Health and Care

2 Main Policy Content Details

2.1 Why is Consent Crucial?

Patients have a fundamental legal and widely-accepted 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 care professionals and patients. Failure to obtain consent for treatment may result in prosecution for assault or battery.

In August 2009, the DH issued the 2nd edition of its *Reference Guide to consent for examination and treatment* (Ref 1), and this must be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in WHC which aim to ensure that clinicians are able to comply with the guidance.

2.2 What is Consent?

'Consent' in a clinical context is a patient's agreement for a clinician to provide care or treatment.

For the consent to be **valid**, the patient must:

- Be competent to take the particular decision;
- Have received sufficient information in a clear and unambiguous manner to enable them to make the decision (i.e. you have explained to the patient what care/treatment you would like to provide, including explaining the benefits and risks of the care/treatment that you are proposing – and whether there are any alternatives); and
- Not be acting under duress (i.e. not being pressured to proceed with the care or treatment by someone else).
- **Section 2.8 outlines the process for patients who lack capacity to provide consent.**

Identifying the correct patient

Prior to seeking consent, clinicians must always check that they have identified the patient correctly (Ref 24).

2.3 The Context of Consent

The context of consent can take many different forms, in some cases, the clinician/health professional will suggest a particular form of treatment or investigation and, after discussion, the patient may agree to accept it. In other contexts, there may be a number of ways of treating a condition, and the clinician 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' which means that the patient and the clinician come to an agreement on the best way forward, based on the patient's values and preferences and the clinician's clinical knowledge.

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 (note that the Mental Capacity Act 2005 and Mental Capacity Policy (Ref 5) introduced legal requirements in respect of 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 DH *Reference guide to consent for examination or treatment*, chapter 1, paragraph 19 (Ref 1).

2.4 Remembering the Patient's Perspective

In March 2015 there was a landmark legal case of Montgomery v Lanarkshire Health Board (Ref 3) which changed the requirement of consent law. The clinician responsible for taking consent is now legally required to take reasonable care to ensure that the patient is aware of any "material risks" (explained below), involved in any recommended treatment and any reasonable alternative or variant treatments.

In March 2017 Thefaut v Johnston (Ref 23) confirmed that doing nothing is an alternative which should be discussed with the patient. The clinician should also consider what the patient may class as an important factor to them, and therefore personalise the consent to the individual.

Material risks

The term 'risk' is used to refer to any adverse outcome, including those which some clinicians would describe as 'side-effects' or 'complications'.

The key passages from the Montgomery judgment describe what a patient would consider a material risk:

The clinician is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

This means that the clinician should consider whether they believe it is likely that a patient's decision to agree to the care/ treatment would be influenced by knowledge of the risk.

Some key points from the judgment were:

- Whether or not a risk is material doesn't only depend on how frequently it occurs.
- Your advisory role involves talking to the patient to make sure they understand the risks and benefits of their treatment, so they can make an informed decision.
- Simply providing the information or getting a signature on a consent form may not be enough to evidence proper consent, but can be helpful as part of the consent process.

Therapeutic exception

In a situation, where being given information about risks would be seriously detrimental to the patient's health, the Supreme Court ruled that it can be withheld.

However, this is a limited exception and it is likely that it will only be applicable in very rare circumstances.

The importance of taking into account what is important to the patient

In Rogers v Whitaker (an Australian case) (Ref 20) a surgeon who was due to perform a procedure disclosed all risks that had a 1% or higher chance of occurring. However, there was a one in 14,000 chance of blindness in one eye.

Although the risk was remote, the claimant was already blind in the other eye, making the risk of great significance to the claimant. The court found the doctor's failure to disclose this risk to be negligent.

Some points to consider relate to what the patient may be thinking when consent is being taken are below:

• "What do they think is wrong"
• "What treatment might help?"
• "How would it help me?"
• "What would it involve?"
• "Will it hurt?"
• "What about the risks?"
• "Are there any alternatives?"
• "What are the risks and benefits of the alternatives?"
• "Will I have to stay in hospital? If so, for how long?"
• "Can I drive/ work/ look after my family?"
• "Maybe I'd like to talk it over with…"

2.5 Guidance on Consent

The *Reference guide to consent for examination and treatment* (Ref 1) issued by the, as was, DH, provides good advice, but clinicians must also be aware of any guidance on consent issued by their own regulatory bodies.

Other guidance available:

- Nursing and Midwifery Council *(*NMC*) Code: Standards of conduct*, *performance and ethics for nurses and midwives, NMC, 2008* (Ref. 7A);
- Health Care Professionals Council (HCPC), *Standards of conduct, performance, and ethics* (Ref. 7B);
- *Consent: patients and doctors working together,* General Medical Council (GMC) (Ref 8).

2.6 Documentation

For 'significant procedures' for example a procedure involving anaesthetic or a procedure which involves touching the patient, it is essential for clinicians/ health care professionals to document, clearly, both the patient's and family's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's health records if necessary), or through documenting in the patient's health records that they have given consent.

Whilst administrative arrangements will vary, it must 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.

2.7 Written Consent

(section 2.8 covers Powers of Attorney)
Consent is often incorrectly equated with the provision of 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, see section 3.2.

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.

Although it is not a legal requirement to seek written consent, 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 clinicians 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 WHC;
- Post mortem activities such as the post mortem itself (unless requested by the Coroner) and the removal of organs or tissue for transplantation.

Completed forms must be kept with the patient's health records. Any changes to a form, made after the form has been signed by the patient, must be initialled and dated by both patient and clinician.

Consent forms should be completed in handwriting (or pre-populated forms should be signed by hand). Where a SOP for the use of electronic signatures in the consent taking process is ratified, the consent form may be signed electronically. Please check the Policy Master Tracker.

If an information leaflet, where risks and benefits of the procedure are explained, is provided to the patient as part of the consent process, the consenting clinician must still record the risks and benefits on the consent form. The leaflet name and reference number must be recorded on the consent form.

It will not usually be necessary to use a consent form to document a patient's consent to routine and low-risk procedures (for example taking blood). However, verbal consent should be sought, and this should be recorded in the patient's medical record.

All completed/signed consent forms must be kept with the patient's record, and also be scanned into SystmOne.

2.8 Procedures to Follow when a Patient Lacks the Capacity to Provide Consent

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact must be documented on the relevant consent form.

This section of the policy details the process for adults who are unable to consent to investigation or treatment. This includes:

- Assessing the patient's capacity
- Assessing why the clinician believes the treatment to be in the patient's best interests
- The involvement of those close to the patient.

2.8.1 **The Mental Capacity Act 2005 (MCA 2005)**

The Mental Capacity Act 2005 (Ref 5) provides a statutory framework to protect those who are not able to make their own decisions and codifies many common law principles already widely in use.

Clinicians must ensure that a **two stage assessment of capacity** is completed.

- **Stage 1-** The first part of the assessment should clearly record the presence of an impairment of the mind or brain (assuming applicable).
- **Stage 2** - The second part of the assessment addresses functionality; i.e. whether the individual's impairment is sufficient to disrupt individual decision making. This is achieved by assessing the individual's understanding, retention, weighing of information, and ability to communicate the decision.

The assessment must be recorded and placed in the patient's medical record clearly denoting that a mental capacity assessment has been conducted.

Without clear evidence of the presence of this level of assessment, practitioners and WHC will not be protected from liability under section 5 of the Mental Capacity Act.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The clinician must 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 must be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

Where treatment continues over a long period, the patient's ability to give consent and whether treatment continues to be in their best interests must be reviewed at regular intervals (how often will be a patient-specific decision).

The key principles of the Mental Capacity Act 2005 are as follows:

- There is a presumption of all those aged over 16 having full mental capacity;
- 'All practical steps' must have been taken to assist a person to gain capacity before decisions are made on their behalf;
- Unwise decisions do not imply that a person does not have capacity;
- Any act done with regards to an incapacitated person must be done in their best interests;
- Consideration must be given to any less restrictive forms of treatment able to achieve the same purpose.

Under the Mental Capacity Act 2005, a person will be said to lack capacity if, on a balance of probabilities, they are unable to:

- Understand information relevant to the decision;
- Retain that information;
- Use or weigh that information as part of the process of making the decision;
- Communicate their decision.
- Where patients are unable to consent for themselves (i.e. do not have the capacity), there are three options.

    - Where an adult has no one to make a decision on his or her behalf, treatment can be provided where it is both necessary and in the patient's best interests – a 'best interests' decision
    - Where the incapacitated adult has previously nominated someone to make the decision – a welfare attorney, this is a best interest decision and not a consent process

- Where the Court of Protection has appointed a deputy to make the decision this is a best interest decision and not a consent process

2.8.2 **Best Interests**

Importantly the Act also provides for a (statutory) best interests test. All healthcare professionals are legally required to take the following steps when assessing what is in a patient's best interests for all treatment and for the Treatment Escalation Plan (Ref 6):

- Encourage the patient to participate in decision making;
- Identify all relevant circumstances (what things would the person who lacks capacity have taken into account when making their decision);
- Find out the patient's views (past and present wishes and feelings, expressed verbally, in writing or by conduct; beliefs and values; and other relevant factors);
- Avoid discrimination;
- Assess whether the person might regain capacity and if so, when;
- If the decision concerns life-sustaining treatment, not to be motivated in any way by a desire to bring about the person's death;
- Consult others (anyone previously named by the patient as someone to be consulted with, anyone engaged in caring for the patient, close relatives and friends who take an interest in the patient's welfare, attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney; deputy appointed by the Court of Protection to make decisions for the person);
- Avoid restricting a patient's rights – are there other options that may be less restrictive of a patient's rights;
- Take all of the above into account; weigh up all of the factors in order to make a decision about what would be in a patient's best interests.

2.8.3 **Independent Mental Capacity Advocates (IMCA)**

IMCAs must be instructed where decisions in the following key areas need to be made and there is no one to consult:

- Serious medical treatment, but excluding treatment under the Mental Health Act 1983 (amended by the Mental Health Act 2007) (Ref 10) for mental disorders which do not require consent;
- NHS-arranged accommodation or change in accommodation in hospital for 28 days or more or in care home for eight weeks or more;
- Local Authority accommodation for eight weeks or more, except in an emergency.

An IMCA's role is to represent a person's best interests; as such they must also follow the statutory best interests test outlined in the MCA 2005. Any information or reports provided by an IMCA to clinicians must be taken into account in reaching a decision about whether a treatment is in a patient's best interests. If an IMCA disagrees with the decision made by clinical employees, they are entitled to challenge the decision, ultimately to the Court of Protection. Where disagreements arise between the clinicians and an IMCA, legal advice must be sought at the earliest opportunity.

IMCAs are entitled to meet the patient in private and to view confidential medical records.

Employees wishing to instruct an IMCA or seek advice about the IMCA service must contact the Wiltshire Independent Advocacy Service on 0300 456 0111.

For more information see the Mental Capacity Act 2005 Policy and Procedures (Ref 11).

2.8.4 **Occasions where there is No Agreement on Best Interests**

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/life threatening, a court declaration may be sought. In the first instance advice must be sought from the Safeguarding Lead.

2.9 Availability of Consent Forms

Consent forms are available on SystmOne and local databases for use in wards. Any new forms, or amendments to existing forms, **must be approved by the Clinical Policies Approval Group.** Please contact the Director of Governance if you have any questions about this.

If a team wishes to use such a consent form that is not a WHC approved consent form, they must seek approval from the **Clinical Policies Approval Group**.

2.10 Process for Obtaining Consent

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.

2.11 Single-stage Process (i.e. consenting for a procedure which will take place there and then)

In many cases, it will be appropriate for a clinician 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 material 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 verbally, and then documented on the clinical record system.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and the clinician 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 clinician may then proceed.

2.12 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, discussions of options and initial decision, and the second being confirmation that the patient still wants to go ahead. The consent form must 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 must 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. There is a section on the original consent form to document this. 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 an open question: for example 'Can you tell me what you're expecting to happen', rather than 'is everything OK?'

2.13 Seeking Consent for Anaesthesia

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 type of anaesthesia.

2.14 Emergency Surgery or Treatment

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 medical records to document any discussion and the patient's consent, rather than using a form. The urgency of the situation may limit the quantity of information that they can be given, and must not affect its quality.

2.15 Treatment of Young Children

When babies or young children under 16 years of age are being cared for by Wiltshire Health and Care, clincians must remember that consent is required.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. Clinicians/health care professionals must be aware that not all parents have parental responsibility for their children. If clinicians are in any doubt about whether the person with the child has parental responsibility for that child, they must check with the parents by asking, for example, "*is your name on X's birth certificate*"? Bear in mind that not all people with parental responsibility will be named on a birth certificate, but may have an adoption certificate or a parental order.

2.15.1 **Parental Responsibility**

The following classes of person automatically have parental responsibility:

- The biological mother of the child (unless parental responsibility has been removed by a court order);
- Married biological parents of a child;
- Parents of a jointly adopted child.

For children born before 1 December 2003, unmarried biological fathers can obtain parental responsibility by:

- Marrying the mother or obtaining a parental responsibility order from the court;
- Registering a parental responsibility agreement with the court or by an application to court

For children born after 1 December 2003, unmarried biological fathers can obtain parental responsibility by:

- Registering the child's birth jointly with the mother (i.e. the father appears on the birth certificate);
- By being married to the mother at the time of the birth;
- Obtaining a parental responsibility order from the court;
- Registering a parental responsibility agreement with the court or by an application to court.

Children over the age of 16 are assumed to be competent to make decisions about their own treatment and care. However those with parental responsibility are still able to consent on behalf of a child up until the age of 18. If there is conflict between parent and a child over the age of 16, the child's wishes must take precedence.

2.15.2 **Absent Responsible Parent**

When a child requires non-urgent clinical treatment and the 'Responsible Parent' is not present, for example the child is in foster care, consent is still required, and the following paragraphs apply:

Where the child has routine clinical matters it is the health care professionals' responsibility to check whether the Placement Information Plan delegates the consent rights to the foster parents. The health care professional can check by asking the foster parents or the appropriate Local Authority. Consideration must also be given as to whether there is a Child Arrangements Order (given by a court) in place which may permit other people to give consent on behalf of the child.

If either of these provisions is not in place, employees must obtain consent from the 'Responsible Parent'. If the responsible parent is not able to be present for discussions, a telephone conversation discussing the procedure, risks, benefits and alternatives must be undertaken, with full documentation of this in the patient's health records. Verbal consent is enough to proceed with surgery.

As with all children, consideration must be given to Gillick competence (Ref 1, page 33). Where Gillick Competence can be established, it may not be necessary to obtain consent from the responsible parent.

In non-routine situations where a child requires urgent surgery/treatment and no one with parental responsibility is available to give consent, the procedure can be undertaken in the child's best interests. This decision must be recorded in the patient's medical record. This must be followed up with further attempts to contact those with parental responsibility as soon as possible. Attempts to contact the responsible parent (or authority) must be documented within the patient's medical notes.

2.15.3 **Gillick Competence**

Children below the age of 16 are assumed not to have capacity to consent to treatment, unless they are able to demonstrate otherwise.

If a child below the age of 16 is deemed to have '*sufficient understanding and intelligence to enable him or her to understand fully what is proposed*' then she can be described as being Gillick competent.

This concept originated from the case of Gillick v West Norfolk & Wisbech HA [1986] (Ref 1, page 33) where it was deemed that it would not be unlawful to offer children advice and contraceptive treatment without consulting their parents, provided they could demonstrate understanding of the nature and implications of the treatment.

If a Gillick competent child and those with parental responsibility for that child disagree about a proposed treatment option, the wishes of the competent child must again override those of the parents.

N.B. Gillick Competence does not extend to the withdrawal of life-sustaining treatment. In this case, those with parental responsibility can override a child who wishes to withdraw life-sustaining treatment, provided the treatment is in the best interests of the child.

NB Gillick Competence covers all medical treatment, however if the required treatment is for contraception and sexual health, Fraser Guidelines should be used.

2.15.4 **Disagreement between Parents and Clinicians**

If there is disagreement between clinicians and parents about what is in the best interests of a non-competent child, particularly in respect of life-sustaining treatment, then legal advice must be sought as soon as possible. In the first instance advice must be sought from WHC's Children's Safeguarding lead, who will refer onwards to WHC's Director of Governance/external solicitors acting for WHC if appropriate. If advice is needed out-of-hours the on-call manager should be contacted.

Where children are below 16 and are not considered Gillick competent, it is good practice to gain assent from the child, using language and information that is easily understandable to the child concerned.

2.16 Consent for Blood Transfusion

Where possible, informed verbal consent from the patient must be obtained prior to blood transfusion.

- This should include discussion about the risks, benefits and possible alternatives of transfusion. The patient must be informed that they will no longer be able to donate blood.
- The consent conversation must be documented in the medical records along with the reason for transfusion, pre-transfusion haemoglobin level, target haemoglobin level, the number of units to be given and any special requirements.
- To assist with this discussion, leaflets produced by NHS Blood and Transplant Service are available in all clinical areas. Contact the blood transfusion team at GWH (Savernake units), or RUH (Chippenham and Warminster wards) for leaflets in other languages.
- In some circumstances, where patients are unaware that they have received a transfusion, it is important that they are retrospectively given information. An information leaflet for this can be obtained by contacting the blood transfusion teams at GWH/RUH.

When a patient refuses blood or blood products, this should be documented in the patient's medical record. For more information please see Jehovah's Witnesses and other Patients who Refuse Transfusion of Blood or Blood Components Clinical Guideline (Ref 22).

2.17 Consent for Post Mortem Activities

It is important to establish clearly when consent has been given to ensure the removal, storage and use of any tissue is lawful – this would be the responsibility of a doctor.

The giving of consent must not be seen as a single act – the signing of a consent form. Rather, it must be seen as part of a continuing process, in which individuals and their relatives or close friends can discuss the issue fully, ask questions, and make an informed choice.

It is good practice, where possible, for discussions to take place with the relatives prior to a person's death. Relatives may know the patient's wishes.

In the event of seeking consent for post mortem examination care must be taken regarding the possible disclosure of information, such as genetic information or HIV (Human immunodeficiency virus) status, which the deceased person may not have wished to be disclosed, or which may have significant implications for other family members.

The way in which a post mortem examination is discussed with the deceased patient's relatives or close friends is extremely important. They need to be given:

- Honest, clear, objective information;
- An opportunity to talk to someone they can trust and of whom they feel able to ask questions;
- Reasonable time to reach decisions (about hospital post mortem and about any donation of organs or tissue;
- Privacy for discussion between family members;
- Support if they need and want it including the possibility of further advice or bereavement counselling or psychological support.

For more detailed or specialist information regarding post mortem examination, relatives or close friends will be directed to the GWH **Mortuary Manager** on-call if after hours. These GWH staff members will be able to provide information to the bereaved.

2.18 Provision of Information

The provision of information is central to the consent process.

Before patients can come to a decision about treatment, they need easy-to-understand information about:

- Their condition
- Possible treatments/ investigations
- The risks and benefits of the possible treatments/ investigations (including the risks or 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 they will stay, how long they will be in hospital, how they will feel afterwards and recovery time. Where relevant, information about anaesthesia must be given alongside information about the procedure.

Although not a legal requirement, it is important that the patient is informed if the procedure is to be undertaken by a student or trainee.

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 clinicians 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 and non-verbally) that they do not wish to be given this level of information, this must be documented.

2.19 Patient Information Available in WHC

2.19.1 **Information Available in Wiltshire Health and Care**

Contact whc.policyqueries@nhs.net for guidance on creating new patient information.

Information for relatives and parents in relation to post mortem examination can be found on the Human Tissue Authority's website (Ref 17).

2.19.2 **Information Available in WHC's Community Settings**

Each community service provides information about the service and treatment provided. This is available in clinics, on the wards, from professionals providing patient care, or from the patient's General Practitioner (GP).

N.B. The information a patient has been provided with and any discussions that take place on risks, benefits and alternatives must be documented fully on the consent form.

2.20 Provision for Patients whose First Language is not English

WHC 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 employees. Leaflets are available in the languages prevalent within Wiltshire. In addition, all employees can access translation and interpreting services and should refer to the Standard Operating Procedure: Translation and Interpretation Services (Ref 13) for further information.

WHC employees or family members should not be used as a translator unless it is an emergency situation.

2.21 Services Available for People with Communication or Hearing Difficulties

WHC is committed to ensuring that patients with communication or hearing difficulties receive the information they need and are able to communicate appropriately with healthcare employees.

Refer to WHC's Translation and Interpretation Services (Ref 13) for further information.

2.22 Access to More Detailed or Specialist Information

Patients may also be directed to specialist information, where available, who can offer details of support or self-help groups, along with contact numbers for further supporting literature normally includes website addresses and email/telephone details. It is important to guide the patient to appropriate sites for accurate information.

It is good practice to record details of who the patient was directed to so as to receive additional advice, support, and guidance, in the medical record.

2.23 Access to Health Professionals between Formal Appointments

After an appointment with a clinician in primary care or in outpatients, patients will often think of further questions which they would like answered before they make their decision. Where practicalbe patients will be given the opportunity to contact the clinician's secretary by telephone to pass on any questions or queries 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).

Contact telephone numbers are given to enable the patient to seek further advice during normal office hours. Where a card has not been given directly to the patient, clinicians may be contacted through the relevant switchboard.

2.24 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, except in circumstances governed by the Mental Health Act 1983. The situation for children is more complex, see Reference guide to consent for examination and treatment (2nd edition) (Ref 1) for more detail.

An Advance Decision to Refuse Treatment (ADRT) (Living Will) is a legally binding document, which cannot be over-ridden. The ADRT must list all the treatments to be refused.

The following paragraphs apply primarily to adults:

If, after discussion of possible treatment options, a patient refuses a treatment, this fact must be clearly documented in their health records, using their own words. If the patient has already signed a consent form, but then changes their mind, the clinician (and where possible the patient) must note this on the consent form.

Where a patient has refused a particular intervention, the clinician must ensure that they continue to provide any other appropriate care to which they have consented. The clinician must 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 must be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, the clinician must explain to the patient the possible consequences of their partial refusal. If the clinician genuinely believes that the procedure cannot safely be carried out under the patient's stipulated conditions, they are not obliged to perform it but must record their decision within the patient's medical record. The clinician must, however, continue to provide any other appropriate care. Where another clinician believes that the treatment can be safely carried out under the conditions specified

by the patient, they must on request be prepared to transfer the patient's care to that health professional.

For every patient who refuses equipment or care regarding Tissue Viability, a referral needs to be sent to the Tissue Viability team. Where the patient refuses the treatment offered by the Tissue Viability team, this should be recorded in the patient's medical record.

2.25 Human Tissue

2.25.1 **The Living**

Consent for treatment and examination including the removal of tissue is a common law matter dealt with in the Department of Health's *Reference Guide to Consent for Examination and Treatment* (Ref. 1). Under The Human Tissue Act 2004 (Ref 2) tissue may be taken for a variety of circumstances, for example:

- In the course of diagnostic procedures, e.g. taking a blood or urine sample, tissue biopsy, cervical screening, etc.;
- In the course of treatment procedure, e.g. removing tissue (organs, tumours, etc.) during surgery;
- When removed specifically for the purpose of research.

Consent is needed for the storing and use of tissue for:

- Obtaining scientific or medical information which may be relevant to any other person, now or in the future (i.e. where the purpose is storage or use in relation to another person, rather than where it might, incidentally, be of future relevance to another person);
- Research in connection with disorders or functioning of the human body (see exceptions in specific circumstances below);
- Public display;
- Transplantation.

2.25.2 **Exceptions**

Consent is NOT needed for storage and use of tissue for:

- Clinical audit purposes;
- Education or training relating to human health (including training for research into disorders, or the functioning of the human body);
- Performance assessment;
- Quality assurance.

Tissue from the living may be stored for use and/or used without consent provided that:

- The research is ethically approved;
- However, it is good practice for there to be mechanisms in place to provide assurance that the tissue has been obtained with valid consent. The tissue is anonymised such that the researcher is not in possession of information identifying the person or re-identifies the patient through the use of DNA from whose body the material has come and is not likely to come into possession of it.

2.25.3 **The Deceased**

Consent is needed:

- Where, after a Coroner's post mortem, the continued storage and use of material is no longer required to be kept for the Coroner's purpose;
- For the removal storage and use in the following scheduled purposes:

- Anatomical examination;
- Determining the cause of death;
- Establishing, after a person's death, the efficacy of any drug or other treatment administered to them;
- Obtaining scientific or medical information, which may be relevant to any other person now or in the future;
- Public display;
- Research in connection with disorders or functioning of the human body;
- Performance assessment;
- Public health monitoring;
- Quality assurance.

This applies to all tissue removed at post mortem.

2.25.4 **Exceptions**

Consent is NOT needed for:

- Carrying out an investigation into the cause of death under the authority of the Coroner;
- Keeping material after a post mortem under the authority of the Coroner for as long as the Coroner requires it;
- Keeping material in connection with a criminal investigation or following a criminal conviction.

Any tissue required for research purposes will be part of a separate consent process. This will have been discussed with WHC's Clinical Research Organisation (operating out of Bath University), in advance and the relevant information and consent forms will be available.

2.26 Consent for Research

All research involving human participants requires approval from an appropriate Ethics Committee. Central Office of Research Ethics Committees (COREC) issue detailed guidelines on seeking informed consent from participants involved in research. These guidelines must be followed. Further information is available from the Director of Quality, Professions, and Workforce or the Director of Governance.

2.27 Clinical Photography and Conventional or Digital Recordings

For information on clinical photography and digital recordings refer to WHC's Medical Photography Storage Policy (Ref 14).

2.28 Who is Responsible for Seeking Consent?

The clinician 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 on.

Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the clinician responsible. However, team work 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 usually the responsibility of the treating clinician to seek consent for post mortem examination, knowing the clinical problems and unresolved aspects that merit investigation. There may be different options for who actually discusses the post mortem and obtains consent, but most will involve a team approach. Anyone seeking consent for a hopsital post mortem examination must be sufficiently senior and well informed, with a thorough knowledge of the procedure. They must have been trained in the management of bereavement and in the purposes and procedures of post mortem examinations and they must have witnessed a post mortem examination.

2.29 Completing Consent Forms

The standard consent form provides space for a clinician to provide information to patients and to sign confirming that they have done so.

If the patient signs the form in advance of the procedure (for example in outpatients or at a pre-assessment clinic), a clinician involved in their care on the day must 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 answer **themselves**.

2.29.1 **Who is permitted to take Consent?**

The following groups of employees are permitted to take consent in WHC:

1. Clinicians capable of undertaking the procedure which is being consented to;
2. Clinicians who are not trained to undertake the procedure but have undertaken procedure-specific consent training and have been assessed as competent to take consent for the procedure.

No other employee groups are permitted to take consent.

Process for undertaking procedure-specific consent training:

1. Training programme devised by an employee capable of performing procedure, including assessing competency;
2. Employee attends training delivered by capable employee;
3. Competency reviewed every two years.

2.30 Audit and Monitoring

An audit of the consent process is undertaken at least once a year. This audit will be carried out by the Quality team to ensure compliance with this policy.

During the audit, a sample of health records will be reviewed in order to ensure that they meet the following criteria:

1. Completed patient identifiers i.e. first name, surname, NHS number, date of birth.
2. Name and grade of clinician taking consent.
3. Name of procedure consented to.
4. Procedure performed within remit of consent.
5. Risks and benefits of the procedure documented as having been discussed.
6. Has it been documented that a patient information leaflet has been provided or that no leaflet exists?
7. Signature of clinician taking consent.
8. The clinician has confirmed his/her competence to perform the procedure, or that they have been assessed as competent to consent for the procedure.
9. Signature of patient.
10. If other person consenting on behalf of a child
    a) Name of person consenting;
    b) Relationship to child documented;
    c) Signature of person consenting;
    d) Person in accordance with legal requirement.

11. In exceptional circumstances e.g. unable to contact parent of a child, patient unable to give consent because of mental incapacity or level of consciousness:
    a) Rationale for decision to undertake procedure;
    b) Reason for not taking consent;
    c) Name and grade of clinician(s) making the decision;
    d) Signature of clinician making the decision.
12. All entries dated.

2.31 Following up those who are Unauthorised to Take Consent

Invalid consent maybe identified from audits, as part of a complaint, incident or the legal process. During the audit process, if it is identified that a clinician has obtained consent for a procedure without being authorised to do so, the consent is invalid. The Quality team will report the matter to the relevant operational lead.

Where the Quality team is made aware of repeated and deliberate disregard for this policy (repeated in this context meaning on three separate occasions) or there is a serious lack of understanding of the consent process, this will be reported to the Chief Operating Officer and Director of Quality, Professions, and Workforce.

Depending on the severity of the situation, the above will be dealt with in accordance with the Medical and Dental Revalidation and Appraisal Policy (Ref 18) and in some cases the matter will be referred to the applicable professional regulatory body.

3 Duties and Responsibilities of Individuals and Groups

3.1 Managing Director

The Managing Director is ultimately responsible for the implementation of this document.

3.2 Company Secretary

The Company Secretary has Executive responsibility for ensuring that consent is undertaken in accordance with the legislative and regulatory framework.

The Company Secretary is also responsible for reviewing the consent policy every two years to ensure, so far as is reasonable and practicable, that it complies with all relevant legislation and the regulatory framework.

3.3 All employees

All employees are responsible for ensuring that they act in accordance with this policy when consenting patients for treatment including recognising when they are not permitted to take consent.

3.4 Learning and Development Lead

The Learning and Development Lead is responsible for ensuring that relevant staff receive training in relation to consent.

3.5 Operational Performance and Planning Group

The Operational Performance and Planning Group is the group with delegated responsibility from the WHC Board (via the WHC Executive Committee), for overseeing the consent policy and associated processes.

4 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified?**
Only clinicians capable of undertaking the procedure which is being consented to or those who are not trained to undertake the procedure but have undertaken procedure specific consent training and assessed as competent take consent	Random sample of 20 case notes of patients who had given consent	Head of Legal Services and Corporate Governance	At least annually	Synopsis presented at Quality Assurance Committee	A member of the Quality team will meet with individual clinicians.

5 Review Date, Arrangements and Other Document Details

5.1 Review Date

This document will be fully reviewed every 3 years. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

5.2 Regulatory Position

The author has made every reasonable effort to ensure that this policy complies with the legal and regulatory framework.

References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. no.	**Document Title**	**Document Location**
1	Reference guide to consent for examination and treatment (2nd edition)	www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition
2	The Human Tissue Act 2004	www.legislation.gov.uk/ukpga/2004/30/contents
3	MDU guidance on Montgomery Consent changes	www.themdu.com/guidance-and-advice/guides/montgomery-and-informed-consent

Ref. no.	Document Title	Document Location
4	CQC Standards for Hospitals	www.cqc.org.uk
5	Mental Capacity Act 2005	www.legislation.gov.uk/ukpga/2005/9/contents
6	Treatment Escalation Plan and Resuscitation Decision Policy	T Drive/Wiltshire Health and Care Documents
7A	NMC Code: Standards of Conduct	www.nmc-uk.org/standards/code
7B	Health Care Professionals Council (HCPC), *Standards of conduct, performance, and ethics*	https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
8	Consent: patients and doctors working together	www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent
9	Deprivation of Liberty Safeguards (DoLS and Mental Capacity Act) Policy	T Drive/Wiltshire Health and Care Documents
10	Mental Health Act 1983 (amended by the Mental Health Act 2007)	www.legislation.gov.uk/ukpga/1983/20/contents
11	Mental Capacity Act 2005 Policy and Procedures	T Drive/Wiltshire Health and Care Documents
12	(blank)	T Drive/Wiltshire Health and Care Documents
13	Translation and Interpreting Services	T Drive/Wiltshire Health and Care Documents
14	Medical Photography Storage Policy	T Drive/Wiltshire Health and Care Documents
15	Human Tissue Authority Code of Practice Code A: Guiding principles and the fundamental principle of consent	www.hta.gov.uk/hta-codes-practice-and-standards-0
16	Human Tissue Authority Code of Practice Code F: Donation of solid organs and tissue for transplantation	www.hta.gov.uk/hta-codes-practice-and-standards-0
17	Human Tissue Authority Code of Practice Code F: Post-mortem examination	www.hta.gov.uk/hta-codes-practice-and-standards-0
18	Appraisal Policy	T Drive/Wiltshire Health and Care Documents
19	Mandatory Training Policy	T Drive/Wiltshire Health and Care Documents
20	BMJ Update on UK consent law	www.bmj.com/content/350/bmj.h1481
21	Information Governance Policy and Strategic Management Framework	T Drive/Wiltshire Health and Care Documents
22	Jehovah's Witnesses and other Patients who Refuse Transfusion of Blood or Blood Components Clinical Guideline	T Drive/Wiltshire Health and Care Documents
23	Thefaut v. Johnston (2017) EWHC 497 QB	ukhealthcarelawblog.co.uk/rss-feed/80-thefaut-v-johnston-a-game-changer-for-consent-in-elective-surgery
24	Patient Identification Policy	T Drive/Wiltshire Health and Care Documents

5.3 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Deputy Head of Podiatry	1/4/19 (0.2)
Advanced Systems Manager	23/10/19 (0.5)
Data Protection Officer (Salisbury Foundation Trust)	23/1/20 – (0.5) comments made
Head of Adult Safeguarding	23/9/19 – (0.5) comments made

Appendix A – Equality Impact Assessment

Protected Characteristic	For employees	For patients
Age	Employment practices including recruitment, personal development, promotion, entitlements and retention encompass employees with protected characteristics.	• Services are provided, regardless of age, on the basis of clinical need alone. •
Disability -	Reasonable steps will be taken to accommodate the disabled person's requirements, including: • Physical access • Format of information • Time of interview or consultation event • Personal assistance • Interpreter • Induction loop system • Independent living equipment • Content of interview of course etc.	Reasonable steps are taken to accommodate the disabled person's requirements, including: • Physical access • Format of information • Time of consultation /event • Personal assistance • Interpreter • Induction loop system
Gender reassignment -	There is equal access to recruitment, personal development, promotion and retention. Confidentiality about an individual's gender status is maintained.	There is equality of opportunity in relation to health care for individuals irrespective of whether they are male or female. Confidentiality about an individual's gender status is maintained and supported by a specific policy.
Marriage and Civil Partnership	There is equal access to recruitment, personal development, promotion and retention for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil partnership	There is equality of opportunity in relation to health care for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil partnership.
Pregnancy and Maternity -	There is equal access to recruitment, personal development, promotion and retention for female employees who are pregnant or on maternity leave. A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. • There is a Flexible Working Policy.	There is equality of opportunity in relation to health care for women irrespective of whether they are pregnant or on maternity leave. A woman is protected against discrimination on the grounds of pregnancy and maternity.
Race - including Nationality and Ethnicity	There is provision for interpreter services for people whose first language is not English. Documents can be made available in alternative languages/formats Written communications are in plain English and the use of language particularly jargon or colloquialisms are avoided. Religion, belief and culture are respected.	There is provision for interpreter services for people whose first language is not English. Documents can be made available in alternative languages/formats Written communications are in plain English and the use of language particularly jargon or colloquialisms are avoided. Religion, belief and culture are respected.
Religion or Belief	HR policies cover consideration of: • Prayer facilities • Dietary requirements. • Gender of staff when caring for patients of opposite sex. • Respect for requests from staff to	Equality and Diversity guidelines enable consideration of: • Prayer facilities • Dietary requirements. • Gender of staff when caring for patients of opposite sex.

	have time off for religious festivals and strategies. • Respect for dress codes	• Respect for religious festivals • Respect for dress codes
Sex	HR policies cover consideration of: • Equal access to recruitment, personal development, promotion and retention. • Childcare arrangements that do not exclude a candidate from employment and the need for flexible working. • The provision of single sex facilities, toilets	Single sex facilities, including toilets and on wards, are provided.
Sexual orientation	HR policies cover consideration of: • Recognition and respect of individual's sexuality. • Recognition of same sex relationships in respect to consultation for Best Interest determinations. • The maintenance of confidentiality about an individual's sexuality. • Consider the effect on heterosexual, gay, lesbian and bi-sexual people	There is: • Recognition and respect of individual's sexuality. • Recognition of same sex relationships in respect to consultation for Best Interest determinations. • The maintenance of confidentiality about an individual's sexuality. • Consideration of the effect on heterosexual, gay, lesbian and bi-sexual people

Appendix B – Quality Impact Assessment Tool

Purpose To assess the impact of individual policies and procedural documents on the quality of care provided to patients by Wiltshire Health and Care		
Process The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.		
Monitoring the Level of Risk The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. High Risks must be reported to the relevant Executive Lead.		
Impact Assessment Please explain or describe as applicable.		
1.	Consider the impact that your document will have on our ability to deliver high quality care.	*The policy will assist staff to deliver high quality care having obtained the relevant consent before treatment*
2.	The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care).	
3.	Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall.	*This document will not compromise care in any other area*
4.	Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is.	
Impact on Clinical Effectiveness & Patient Safety		
5.	Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm.	*The policy is designed to ensure that patients are aware of their rights to receive (or refuse) health care.*
Impact on Patient & Carer Experience		
6.	Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment.	*The policy allows patients to be fully informed of their rights to consent to treatment (or refuse it).*
Impact on Inequalities, and Parity of Esteem		
7.	Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language).	*There should be no negative impact on any groups of patients.*