GP TOWER HAMLETS CARE GROUP CIC POLICY : CONSENT TO EXAMINATION AND TREATMENT

APPROVAL	Clinical Lead	Date approved:
EFFECTIVE FROM		
AUTHOR/FURTHER INFORMATION		
REVIEW DUE		

APPLICATION
Included in policy: *For the groups listed below, failure to comply with this policy may result in investigation and management action which may include formal action in line with the Care Group's disciplinary or capability procedures for Care Group's employees, and other action in relation to organisations contracted to the Care Group, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.*
All Care Group staff, working in whatever capacity
Other staff, students and contractors working within the Care Group
Managers • Ensure that all clinical staff the undertake training in consent where required under the Care Group's Training Needs Analysis • Ensure the effectiveness of the consent procedures are monitored and changes to practice implemented as required. • Maintain and update the Care Group's Consent Training and Delegation Database. **All staff working with patients** • Protect patient's rights, including the right to refuse treatment. • Ensure that patients are given necessary information and opportunities to ask questions about treatment before giving consent • Identify those patients who may lack the capacity and to ensure that they are assessed under the Mental Capacity Act procedures. • Be aware of any patient being treated under the Mental Health Act and that special consent requirements may apply • Ensure that the process of seeking and obtaining consent to treatment is appropriately documented in each case • Work within own competence and not to agree to perform tasks which exceed their

competence.
- Escalate any concerns about consent to a senior clinician, manager or member of the Legal Team

Staff undertaking procedures for which written consent is required
As above, plus the following:
- Document consent using the appropriate form
- Work to ensure that consent is taken at the appropriate time
- Ensure that consent is not delegated to staff not capable of performing the procedure.

Healthcare Governance staff
- To provide advice as required and to support the monitoring process,

Legal Services Team
- To facilitate access to legal advice as required.
- To monitor the consent process and follow up any cases where this policy has not been followed.

Exempted from policy:
No staff groups are exempt from this policy.

CONSENT TO EXAMINATION AND TREATMENT

1 INTRODUCTION AND AIMS OF POLICY

1.1 This local policy incorporates the Department of Health model policy. It has been updated locally in line with Human Rights, Mental Capacity and Equality and Diversity legislation as well as changing national guidance.

Why consent is crucial

1.2 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 and high risk surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

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.

PROCESS

Documentation

2.1 For significant procedures, it is essential for health professionals to document clearly both the patient'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 record if necessary), or through documenting in the patient's record that they have given verbal 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, (1) but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to the potential for adverse outcomes, including those which some health professionals would describe as 'sideeffects' 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 Trust

2.4 Completed forms include summary details of the information given to the patient and the discussion with the patient about the risks, benefits and any alternative to treatment as well as a record of the patient's consent. Additional details may be included in the patient's continuous healthcare record if required. A record must be kept in the healthcare records if the discussion leads to a refusal or withdrawal of consent. The consent 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 initialed and dated by both patient and health professional.

Consent where no form is used

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, taking a blood sample, routine observations. However, if the health professional or care giver has 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 have become very distressed about receiving similar care in the past), it would be prudent and best practice to do so. A record of this and any discussions with the patient should be made in the health record.

(1) The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances 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 have become very distressed about receiving similar care in the past), it would be prudent and best practice to do so. A record of this and any discussions with the patient should be made in the health record.

Patients lacking capacity who are not capable of consent

2.6 Where an adult patient does not have the capacity to give or withhold consent to a significant or high risk procedure or intervention, this fact should be documented in Consent Form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves.

2.7 For more minor interventions such as routine nursing care, bathing, feeding , skin care , information relating to this decision making and that the patient lacks capacity should be entered in the patient's notes and if appropriate recorded on CRS. In these cases it should be recorded that care is being provided in the patients 'best interests' If the patients care and or relative has been involved in the decision making discussions this should also be recorded along with any decisions or information discussed by the MDT.

Local provision for the use of customised or pre printed consent forms

2.8 Only consent forms approved may be used within the Tower Hamlets Care Group. In cases it may be appropriate for departments to develop standard information relating to specific, frequently conducted procedures, to be preprinted on consent forms which

are in other respects the same as the standard consent forms. Any such development must be approved by the Clinical Lead, on a case by case basis.

When should consent be sought?

2.9 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

2.10 In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, a nurse will seek consent prior to carrying out a wound dressing. 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 most such cases, verbal consent is provided.

2.11 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.

2.12 In most cases where written consent is being sought, treatment options will generally be discussed 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 or preadmission 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.

2.13 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 out-patients, at a pre-admission clinic, or when they arrive for treatment.

2.14 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?"

2.15 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. Therefore it is not best practice and will in most cases be inappropriate to ask a patient to sign the consent form on the morning of surgery or 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

2.16 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 out-patients, 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.

2.17 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. Responsibility for giving this information will rest with the dentist, along with the anaesthetist if an anaesthetist is involved in the treatment.

2.18 During operative procedures it sometimes becomes evident that the patient requires treatment other than the one for which consent has been obtained and which has not been anticipated nor discussed during the consent taking process.

2.19 In such cases, the policy of Tower Hamlets Care Group is that if the revised treatment can be undertaken on an elective, non-emergency basis, the patient must be given the opportunity and time to make the decision about the additional treatment. This may include waking and returning the patient to the ward and re-consenting them for the revised treatment plan, consistent with best practice guidance. If the treatment need is urgent then treatment should be given in the patient's best interests, providing this is not prohibited by any advance decision that the patient may have taken (see Section VII below).

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Emergencies

2.20 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 children

2.21 Consent for minors (under 18) may be given either by the person with parental responsibility for the child or, where the child has capacity to give consent, by the child. Generally, a parent makes the decision for their child. However, where the child has sufficient maturity and understanding of the proposed procedure (often referred to as meeting the Frazer guidelines or being "Gillick competent"), then the child is legally able to consent to treatment (but may not be able to refuse treatment). In the event of a conflict between a parent and a child, healthcare professionals should discuss this with the Legal Team.

2.22 It is the responsibility of the clinician responsible for the treatment to assess and document the child's capacity if the child may be asked to give consent or indicates a wishes to be involved in the consent process. A checklist of issues which must be considered in all cases when assessing and documenting. In any case which involves complex issues, including potential conflict between adult and child choices, treatment of a child without parental knowledge etc, staff are expected to use the form 'Gillick Competency Assessment for under 16s including Fraser Guidelines' to document the process of obtaining consent.

Young People aged 16-17

2.23 Under Section 8 of the Family Law Reform Act 1969, people aged 16 or 17 are entitled to consent to their own medical treatment and any ancillary procedures involved in their treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed patient capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court. In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used.

2.24 If the requirements for valid consent are met, it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to that of the young person. It is however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them.

Babies and young children

2.25 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.

"Parental responsibility"

2.26 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, following amendment of the Children Act 1989 by the Adoption & Children Act 2002, an unmarried father has parental responsibility if his name is registered on the birth certificate of a child born after 1st December 2003, but may not always do so where the birth occurred before that). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check, involving the Legal Services Managers if necessary.

2.27 For further information and local guidance on consenting children and young people, please refer to the also refer to the DoH's guidance Seeking consent: working with children, November 2001

Provision of information

2.28 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.

2.29 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 judgment 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.

2.30 Wherever possible, information should be given both verbally and in writing, eg through a patient information leaflet given during a consultation with a relevant clinician.

2.31 Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets.

Provision for patients whose first language is not English

2.32 Tower Hamlets Care Group has access to bilingual advocates, independent advocacy and other patient support services that might be required during the consent process, such as interpreters or signers. This includes an out of hours advocacy and interpreter service.

Access to health professionals between formal appointments

2.33 After an appointment with a health professional in primary care or in out-patients, 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 may be late for the information genuinely to affect the patient's choice).

2.34 The person seeking written consent should provide contact details of where further sources of information and advice can be accessed should patients wish to discuss their proposed treatment between formal appointments or admission. Contact details must be written in the designate space provided on the consent form.

Open access clinics

2.35 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.

Who is responsible for seeking consent?

2.36 The clinician carrying out the procedure or treatment is ultimately accountable 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.

2.37 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.

2.38 Accountability for obtaining written consent normally rests with the clinician delivering the care or carrying out the procedure. That person may, however, delegate responsibility for taking consent to another clinician who is also competent to carry out the procedure and who is aware of any special factors relating to the patient and the procedure which may need to be included in the discussion leading to consent.

2.39 In certain circumstances, responsibility for taking consent may be delegated to a clinician who is not competent to undertake the procedure. This may only be done as set out at Appendix C.

2.40 The taking of written consent may not be delegated to nursing, medical or midwifery students. However, it may be appropriate for other members of the team to observe or participate under direct supervision, as part of their education and training.

Completing consent forms.

2.41 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. They should also be able to demonstrate that they are aware of their own knowledge limitations and be subject to periodic supervision and audit.

2.42 If the patient signs the form in advance of the procedure (for example in outpatients 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.

Refusal of treatment

2.43 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.

2.44 If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their health record. 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.

2.45 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.

2.46 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.

2.47 If a patient is refusing treatment that is essential for their welfare and you have any concerns about their mental state at the time of this refusal, you should discuss the case with a member of the Legal Team.

Withdrawal of consent

2.48 A patient with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a patient does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the patient's concerns and explain the consequences of not completing the procedure. If stopping the procedure at that point would genuinely put the life of the patient at risk, the practitioner may be entitled to continue until the risk no longer applies.

2.49 Assessing capacity during a procedure may be difficult but the practitioner should try to establish whether at that time the patient has the capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the patient's best interests, although this should not be used as an excuse to ignore distress.

3 PATIENTS WHO LACK CAPACITY TO GIVE OR WITHHOLD CONSENT

3.1 This section is included in the Tower Hamlets Care Group Consent Policy to reflect the implementation of the Mental Capacity Act 2005.

3.2 The Mental Capacity Act provides a statutory framework to empower and protect adults aged 16 or over who lack capacity to make their own decisions.

Assessing capacity

3.3 The Mental Capacity Act 2005 is recent legislation which is intended to empower and protect adults 16 and over who may lack capacity to consent to treatment. A checklist of issues which must be considered when assessing and documenting capacity is included in Appendix D.

3.4 The Act sets out a two stage test and assessment for capacity in an adult patient.
Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?
Stage 2: Does the impairment or disturbance prevent the person from making a particular decision?

3.5 It is a "decision-specific" and time specific test. The Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance or behaviour.

3.6 A person is unable to make a decision if they cannot:

- understand the relevant information
- retain that information
- use the information as part of the decision making process

3.7 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.

Advance decision making

3.9 Prior to the implementation of the Mental Capacity Act, competent adults could indicate their wishes in relation to future treatment through an Advance Directive. An Advance Directives made prior to the implementation of the Mental Capacity Act continues to carry the same weight as previously, provided that it meets particular conditions. These are that there is a reasonable belief that the advance decision was made before 1 October 2007, a reasonable belief that the person has lacked capacity to amend their advance decision since 1 October 2007 and the advance decision is in writing (Article 5 of the Mental Capacity Act (Transitional and Consequential Provisions) Order 2007.

3.10 Since the implementation of the Mental Capacity Act, competent adults (aged 18 and over) can make decisions about what treatment they may not wish to receive in the event that they subsequently become incapable, by means of an Advance Decision to refuse treatment. This decision may be expressed verbally or in writing.

3.11 If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance decision to refuse treatment'), and those circumstances arise, then the health professional(s) must abide by that refusal. However, if the refusal is in relation to treatment essential to preserve life, this advance decision must have been made in writing and included a clear statement that it applied even in the case of treatment essential to preserve life.

3.12 Further information about Advance Decisions, see the Lord Chancellor's Mental Capacity Act 2005 Code of Practice.

Lasting Power of Attorney

3.13 Prior to the implementation of the Mental Health Act, there was provision for a competent adult to appoint another adult "Enduring Power of Attorney", which would allow that attorney to make decisions about the person's affairs should they lose capacity at some point in the future. Where an Enduring Power of Attorney arrangement was in place before the implementation of the Mental Capacity Act, this continues to have effect. However, this power does not include decision making in relation to health matters or consent to treatment.

3.14 The Mental Capacity Act introduces the "Lasting Power of Attorney" (LPA) which allows an adult who has capacity to appoint an attorney to make a wider range of decisions on their behalf, including health and welfare decisions, should they lose capacity at some point in the future. Before a LPA can be used it must be registered with the new Office of Public Guardian. If treatment is to be given to an incapable person who has previously established a LPA, the consent of their Attorney must be obtained for the patient, and the same considerations apply in relation to the Attorney as would apply to a competent adult making decisions on their own behalf. www.publicguardian.gov.uk

Independent Mental Capacity Advocate (IMCA)

3.15 Where the patient has no friends or family to consult, decision makers in Local Authorities and NHS Trusts (for example social workers and doctors) must instruct an Independent Mental Capacity Advocate (IMCA) in situations where:

- The decision is about providing, withholding or stopping ***'serious medical'*** treatment provided by the NHS.
- It is proposed by the NHS body or a Local Authority that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home
- A long-term move (8 weeks or more) to different accommodation is being proposed by an NHS body or Local Authority.

3.16 The only exception to the requirement to consult an IMCA before taking such a decision can be in situations where an urgent decision is needed.

3.17 Serious medical treatment is defined as treatment that involves giving new treatment, stopping treatment that has already started, or withholding treatment that could be offered in circumstances where:

- a single treatment is proposed and there is a fine balance between the likely benefits and the burden to the patient, and the risks involved *or*
- a decision between a choice of treatments/clinical care is finely balanced

or

- what is proposed is likely to have serious consequences for the patient

(Refer to the Code of Practice for some examples of serious medical treatment)

3.18 An IMCA may be instructed in the following circumstances:

- care reviews or
- an adult protection case.
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3.19 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.

3.20 For further information relating to the Mental Capacity Act 2005 please refer to the Mental Capacity Act 2005 Code of Practice.

6 TRAINING AND COMPETENCY ASSESSMENT

Generic teaching and education on Consent

6.1 Tower Hamlets Care Group is committed to ensuring that all staff receive appropriate training, education and supervision to enable them to carry out their duties safely and competently and this applies to the patient consent process and policy.

6.2 Care Group's requirements in relation to consent training are set out in each pre mergered Care Group'ss Training Needs Analysis and monitored as set out in Statutory and Mandatory Training Policy.

6.3 Outside of the routine programme of consent training, additional sessions relating to Consent and Capacity, including consent practice, accountability and the law, can be provided by the Legal Services Managers. The Care Group recognises that training on consent issues may be included in relevant training courses for example record keeping training and immunisation training.

7 BREACHES OF POLICY

7.1 Any breach of the arrangements set out in this policy which is identified during clinical practice must be reported as an incident and followed up in line with the Care Group's incident reporting policy, escalating as a serious incident if the circumstances make this appropriate.

7.2 Any breach of the arrangements set out in this policy which is identified as a result of audit will be noted in the audit report and actions required to avoid further breaches will be included in the resulting action plan.

7.3 In addition to the above, in any case where it appears that consent has been taken by a person who is neither capable of doing the procedure nor authorised, the Legal Team must be notified. The Legal Team will follow up such each case with the clinician concerned and their supervisor and will agree and document any action that is taken in relation to the breach.

8 MONITORING THE EFFECTIVENESS OF THIS POLICY

Monitoring method	Lead	Frequency	Scope	Report
Consent documentation (including evidence of consent process, information given and documentation of discussion), included in Medical Records Audit	Clinical Lead	At least biennially	Sample of records from all specialties	Summary to Board; detailed report to Board Members
Rolling audit of consent documents and compliance with delegation arrangements set out in this policy	Chief Executive	Annually	Sample of records from all surgical specialties	Annual Report to Board
Any breaches of consent delegation arrangements identified through the above will be reported to the GMC in line with GMC/NHSLA recommendations	Chief Executive	Ongoing	Sample of medical records from all specialties	Annual Report to Board
Annual review of Consent Training and Delegation Database, giving numbers of clinicians and procedures included, by Division	Director Of Human Resources	Annually	All records in consent database	Included in above report
Review of breaches of policy (including delegation arrangements) and action taken	Chief Executive	Annually	All relevant Data records and cases identified through audit	Included in above report

END