Kent and Medway
NHS and Social Care Partnership Trust

Consent to Treatment Policy

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DOCUMENT TRACKING SHEET

Consent to Treatment

Version	Status	Date	Issued to/approved by	Comments
1.0	Draft	Jan 2014		Circulated for comments
2.0	Draft	Dec 2014		Minor amendments added to section 16
3.0	Draft	Jan 2017	Mental Health Act Training & Policy Manager	Reviewed and circulated to Trust-wide Patient Safety Group & Mental Health Act Good Practice Group for comments.
4.0	Approved	March 2017	Mental Health Act Training & Policy Manager	Comments incorporated. Final draft following virtual ratification on 13.03.2017
4.1	Approved	February 2018	Policy Manager	Separated the Equality Impact Assessment from the document. Amended 'service line' to 'care group' throughout document.
4.2	Draft	16 September 2020	Mental Health Legislation Operational Group (MHLOG)	Discussed and agreed at MHLOG prior to submission to MHAC.
5.0	Final	12 October 2020	Mental Health Act Committee (MHAC)	Ratified

REFERENCES

Mental Capacity Act 2005
Mental Health Act 1983 (as amended 2007)
Department of Health Reference Guide to Consent or Examination or Treatment (Second Edition)
Department of Health Good Practice in Consent Implementation Guide

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

All Trust and health economy documents which relate in any way to this document	***Current reference code of document***
Mental Capacity Act Policy and Guidelines	KMPT.CliG.052
ECT Policy	KMPT. CliG.070
Interpretation & Translation Policy	KMPT.CliG.053
Physical Health & Examination Policy	KMPT.CliG.026
Medicines Management Policy	KMPT.CliG.008
Intimate Care Policy	KMPT.CliG.015
Locked Door Policy Inpatient Wards	KMPT.CliG.107
Search Policy	KMPT.CliG.138
Observation (Therapeutic) Policy	KMPT.CliG.016
Venepuncture Policy	KMPT.CliG.079
Informal Patients' Policy	KMPT.CliG.022

SUMMARY OF CHANGES

Date	Author	Version	Changes (brief summary)
2017	MHA Training & Policy Manager		• Updated to reflect revised Mental Health Act Code of Practice • Part 3 of policy revised to include more detailed guidance on treatment for patients on a Community Treatment Order (CTO) • Consent to Treatment Flowcharts included • Procedure for facilitating SOAD visits included as Flowchart • Statutory Forms T2/T4/CTO12 amended to include space for patient signature
September 2020	MHA Training & Policy Manager	Version 5	• Updated Covid-19 arrangements in respect to Consent to Treatment – addition of appendix M

CONTENTS

1 INTRODUCTION

1.1 Individuals have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment must be sought in all forms of healthcare, from providing personal care to undertaking major surgery.

1.2 All staff must follow this policy to ensure that clinical practice is ethical and adheres to legal frameworks.

1.3 The Mental Capacity Act 2005 and Mental Health Act 1983 (as amended 2007) set out clear legal frameworks relating to capacity and consent and KMPT expects all staff to act within these set criteria.

2 PURPOSE

2.1 This policy sets out the standards and procedures in this Trust to ensure that health professionals are able to comply with legislative frameworks and best practice guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient.

2.2 Part 3 of this policy deals directly with the consent to treatment rules which apply to patients who are detained under the Mental Health Act 1983 (as amended 2007).

3 DUTIES

3.1 This policy is for the guidance and information for all Kent & Medway NHS and Social Care Partnership Trust staff engaged in the care and treatment of service users.

3.2 The Chief Executive has overall responsibility for ensuring that there are suitable and sufficient arrangements in place which allow for consent to treatment to be sought in accordance with legislation and best practice guidance.

3.3 Each registered healthcare professional is accountable for his/her own practice and should be aware of their legal and professional responsibilities relating to their competence and work within the Code of Practice of their professional body.

3.4 All staff working with patients where consent or capacity to consent to examination and treatment is an issue should be familiar with the procedures detailed in this document and other related policies.

3.5 Team Managers/Service Managers/Ward Managers/Modern Matrons should ensure that all staff are familiar with this policy and related policies. Clinical team managers must ensure via supervision and clinical audit that staff practice within the guidance of this policy and other related policies.

4 PART 1 GENERAL RULES AND GUIDANCE ON SEEKING CONSENT

4.1 The Department of Health has issued a number of guidance documents on consent to treatment and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health care professionals must also be aware of any guidance on consent issued by their own regulatory bodies. The Reference Guide to Consent for Examination or Treatment (second edition) provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent.

4.2 The Reference Guide to Consent for Examination or Treatment (second edition) can be accessed using the following link and should be referred to for further guidance on the general rules on consent:

https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

5 DEFINITION OF CONSENT

5.1 Consent is the voluntary and continuing permission of a patient to be given a particular treatment based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and alternatives to it. Permission given under unfair or undue pressure is not consent. 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.

5.2 A person who lacks mental capacity does not consent to treatment even if they cooperate with treatment or actively seek it.

5.3 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.

5.4 In many cases, 'seeking consent' is better described as 'joint decision-making' whereby the patient and the health professional come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

6 DOCUMENTATION

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

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

6.2.1 The treatment or procedure is complex, or involves significant risks;

6.2.2 The procedure involves general/regional anaesthesia or sedation;

6.2.3 Providing clinical care is not the primary purpose of the procedure;

6.2.4 There may be significant consequences for the patient's employment, social or personal life;

6.2.5 The treatment is part of a project or programme of research approved by KMPT.

6.3 Completed 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 initialled and dated by both patient and health professional.

6.4 It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you

have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past) it would be helpful to do so.

7 PROVISION OF INFORMATION

7.1 Before patients can make a decision to consent to or refuse a particular 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).

7.2 The Trust has published a range of leaflets for patients and service users. These can be obtained from the Trust's Communication Officer at kmpt.communications@nhs.net.

7.3 For queries regarding medication, patients are invited to ring the Trust's Pharmacy Service:

Canterbury: 01227 812193
Dartford: 01322 622070
Maidstone: 01622 723219
Medway: 01634 830000 ext 6650

7.4 It should be identified and recorded where a patient has communication difficulties including hearing, sight or learning impairment/difficulties and specialist in support or interpreting services may be required. Please visit the Trust Intranet site for more information about interpreting services.

8 RESPONSIBILITY OF HEALTH PROFESSIONALS

8.1 The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

8.2 It is a health professional's own responsibility to ensure that:

8.2.1 When they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and

8.2.2 They work within their own competence and do not to agree to perform tasks which exceed that competence.

9 REFUSAL OF TREATMENT AND WITHDRAWAL OF CONSENT

9.1 Patients should be told their consent to treatment can be withdrawn at any time. If an adult with capacity makes a voluntary and appropriately informed decision to refuse or withdraw consent to treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983.

9.2 If the patient withdraws consent, they must be given a clear explanation of the likely consequences of not having treatment and, where relevant, an explanation of the circumstances in which treatment may be given without their consent under the Mental Health Act 1983. A record of this discussion must be documented in the patient's notes

9.3 If an informal patient refuses treatment such as medication, this wish must be respected if they are capable of making this decision. The only authority for treating a voluntary patient is either their valid consent or in their best interests under the Mental Capacity Act 2005 where an informal patient lacks the capacity to consent to or refuse treatment.

10 PART 2 THE MENTAL CAPACITY ACT (MCA) 2005

10.1 Mental capacity is the ability to make a decision. This includes the ability to make a decision, which may affect daily life and also refers to a person's ability to make a decision that may have legal consequences.

10.2 The Mental Capacity Act 2005 (MCA) sets out the law relating to capacity and the Trust-wide Mental Capacity Act Policy and Guidelines should be referred to for further guidance including guidance on Advance Decisions to refuse treatment.

10.3 Assessments of capacity must be undertaken following the two stage test outlined in the MCA which states that to lack capacity a person must have:

- An impairment or disturbance that affects the way their mind or brain works, and
- The impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

10.4 An assessment of capacity is based on the person's ability to make a specific decision at the time it needs to be made; it is not their ability to make decisions in general. A person may have the capacity to make one decision but not another.

10.5 A person is unable to make a decision, if they meet one of the following criteria:

- They do not understand the information relevant to the decision
- They are unable to retain the information relevant to the decision
- They are not able to use, or weigh up the information relevant to the decision or
- They are not able to communicate their decision

10.6 It is important to remember that the assumption of capacity is the first key principle of the MCA. Therefore, the possibility that a person may have impaired decision making or lack capacity should only be considered if their responses or behaviour is suggestive of this. A person's appearance or a particular diagnosis is not in its self-indicative of a lack of capacity. It is important to record the reasons for considering that the person does not have capacity in relation to a specific decision.

10.7 Following the patient's admission to hospital, the RC should discuss any proposed treatment plan with the patient. The purpose of this discussion is twofold; it provides an opportunity to provide the patient with relevant information about their treatment plan and it also allows the RC to determine whether or not the patient has the capacity to consent to treatment.

10.8 When discussing the proposed treatment plan with the patient, the RC should cover the following points:

- The patient's needs, wishes and feelings about treatment;
- The patient's level of knowledge about, and understanding of, their condition and the treatment options;
- The nature of the patient's condition;
- The likely effects of the treatment;
- The complexity of the treatment;
- The nature and level of risk associated with the investigation or treatment.

10.9 It is from the discussion which the RC has with the patient regarding the patient's treatment that the RC should be able to determine whether the patient has the capacity to consent to the proposed treatment plan.

10.10 Health care professionals should record whether they are satisfied that a patient has the capacity to consent to a particular treatment in the RiO progress notes. If a health care professional doubts that a patient has capacity, a full capacity assessment must be carried out and be recorded in the appropriate MCA section on RiO.

10.11 The capacity of a person with a mental disorder may fluctuate and as such the assessment of a person's capacity to consent to treatment should be an ongoing process throughout the time a patient is in hospital as should discussions regarding the patient's treatment.

10.12 Where an adult patient has been assessed as lacking the capacity to give or withhold consent to a significant intervention, this fact should be documented on Rio and an assessment of the patient's capacity must be completed, including details why the health professional believes the treatment to be in the patient's best interests. The views of relatives, carers or people close to the patient should also be sought. Any capacity assessments completed should be recorded on the MCA Capacity Assessment section on Rio.

10.13 Where a patient is assessed as lacking capacity and a best interests decision is made, details of the best interests decision must also be recorded on the relevant section on Rio.

11 PART 3 PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983

11.1 On 1 April 2015, the current Code of Practice to the Mental Health came into effect. It is essential that all those undertaking functions under the Act understand the five overarching Guiding Principles. The Guiding Principles must always be considered when making any decisions in relation to care, support or treatment provided under the Act.

11.2 Although all Guiding Principles are of equal importance, the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

11.3 The sections below deal with the consent to treatment rules for patients who are detained under the Mental Health Act 1983 (MHA). Such patients are still subject to the rules of consent. However, their position may be modified in some respects. This section sets out the extent of those modifications and the rules which apply.

11.4 Parts 4 and 4A of the MHA sets out circumstances in which persons liable to be detained under the Act may be treated without consent for symptoms or manifestations of their mental disorder. The MHA has no application to treatment for physical disorders unrelated to mental disorder. Treatment for such physical disorders is subject to the Mental Capacity Act 2005, even where the person concerned in detained under the MHA.

11.5 Under the MHA, treatment can also refer to nursing and psychological interventions, specialist mental health habilitation, rehabilitation and care.

11.6 It should not be assumed that patients who are detained under the MHA or that people who have a mental disorder lack the capacity to make a decision in relation to consenting to treatment for their mental disorder.

12 CONSENT TO TREATMENT UNDER PART 4 MHA

12.1 Part 4 of the MHA applies to patients who are subject to the following sections of the MHA:

- Section 2

- Section 3
- Section 37
- Section 37/41
- Section 38
- Section 36
- Section 17A patients who have been recalled
- Section 45A
- Section 47
- Section 48
- Section 47/49
- Section 48/49

12.2 Part 4 of the MHA also applies to patients who have been granted Section 17 Leave.

12.3 Part 4 of the MHA does not apply to:

- Patients detained on short term holding powers (Section 4, 5(2), 5(4), 35, 37(4), 135, 136)
- Patients on Guardianship (Section 7)
- Patients who have been conditionally discharged from a hospital order but are still subject to a restriction order (Sections 41 or 49)
- Informal patients (these patients may only be treated either with their consent or in their best interests in accordance with the Mental Capacity Act. Please refer to the Trust-wide Informal Patients' Policy for more information).

13 THREE MONTH RULE

13.1 If a patient is detained under a section included in the list provided in 12.1, then for the first three months they may be given medication for mental disorder under the authority of their Responsible Clinician without the need for consent or the authorisation of a Second Opinion Appointed Doctor (SOAD). However the MHA Code of Practice states that the patient's consent should still be sought before any medication is administered, wherever practicable. The RC should discuss the proposed treatment plan with the patient in accordance with the guidance provided under paragraphs 10.7 and 10.8 above.

13.2 If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider whether to proceed in the absence of consent, to give alternative treatment or stop treatment.

13.3 The Three Month Rule does not apply to ECT.

14 EXPIRATION OF THE THREE MONTH RULE

14.1 The Mental Health Act Administration office will notify the Responsible Clinician and ward staff one month before the expiration of the three month period. This notification will include details of the requirement to comply with the provisions of Section 58 of the MHA if treatment is to continue. Ward staff should document the expiry date of the Three Month Rule for each patient in the ward diary and alert the Responsible Clinician to review the treatment during ward round prior to the ending of the three month period.

14.2 For patients whose detention has changed from Section 2 to Section 3, without a break, the 3 month period is calculated from the start date of Section 2.

14.3 Prior to the three-month period ending, the Responsible Clinician should again discuss the patient's treatment plan with the patient and consider the patient's capacity to consent to treatment. A full capacity to consent to treatment assessment should be completed if it is felt that the patient lacks capacity to consent. A record of any capacity to consent to treatment assessment should be made on the appropriate section on RiO.

15 TREATMENT FOLLOWING THE THREE MONTH RULE

15.1 After the initial three month period, treatment for mental disorder may be administered to a patient either with his/her capable consent, or if he/she withholds such consent or is incapable of giving it, with authorisation from a Second Opinion Appointed Doctor (SOAD).

16 TREATMENT FOR CONSENTING PATIENTS

16.1 If a patient has capacity and does give their informed consent to continue with proposed treatment, the Responsible Clinician must complete a T2 Form.

16.2 The Trust has modified the statutory T2 Form to include a space for the consenting patient to sign and a checklist on the back of the T2 Form is to be completed by the RC. T2 Forms are available from either the Mental Health Act offices or the ward clerks. Form T2 can be found at **Appendix C** of this policy.

16.3 Guidance for completion of Form T2:

- All drugs proposed (including PRN medication) either by name or by ensuring that the number of drugs authorised in each class is indicated using eBNF categories. If drugs are specified by class, the certificate must clearly state the number of drugs authorised in each class, and whether any drugs within the class are excluded.
- The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed.
- Only the drugs listed on the T2 Form may be administered to the patient unless the criteria for urgent treatment (section 62) are met.

16.4 The original T2 form should then be submitted to the Mental Health Act Office which will provide the ward with two copies, one for the patient's notes and the other to be attached to the in-patient Drug Chart.

17 PATIENTS WHO REFUSE TO GIVE CONSENT/LACK CAPACITY TO CONSENT

17.1 Consent must be voluntary and based on sufficient understanding of the treatment. If a patient refuses consent or is unable to give valid consent because they lack capacity, then the Responsible Clinician must request a SOAD visit to authorise and continue treatment.

17.2 Where a patient is assessed as not having capacity to consent, the full capacity assessment including details of the reasons why a patient lacks the capacity to consent must be recorded on the MCA section on RiO.

17.3 The Responsible Clinician must complete a request for a SOAD using the online form on the CQC website. A copy of this form should be sent to the Mental Health Act Office. SOADs can be requested at any time prior to the expiry of the initial three month period and to avoid delay, this should be completed as soon as it is identified that a SOAD will be needed.

18 PROCESS FOLLOWING A REQUEST FOR A SOAD

18.1 Responsible Clinicians should ensure that SOADs are informed if the hospital is aware that the patient has an attorney or deputy who is authorised under the Mental Capacity Act to make decisions on the patient's behalf about medical treatment. Details of any relevant advance decisions, or advance statements of views, wishes or feelings should be provided to the SOAD.

18.2 To enable a SOAD to carry out their duty to complete a second opinion, it is important for staff to effectively manage, organise and facilitate SOAD ward visits. Individual care groups are responsible for ensuring that SOAD visits are co-ordinated and managed effectively and a flowchart outlining the process for facilitating SOAD visits for each care group can be found at **Appendix L.**

18.3 The treatment proposal for the patient, together with notes of any relevant multi-disciplinary discussion on which it was based, must be given to a SOAD before or at the time of the visit. SOADs have a right of access to records, without the patient's consent if necessary and the member of staff allocated with responsibility for facilitating the SOAD visit will be responsible for ensuring that the SOAD has prompt access to the patient's record.

18.4 When a SOAD visits they must interview the patient (in private if possible), discuss the treatment plan with the Responsible Clinician in charge of treatment, and consult with two other persons who have been professionally concerned with the patient's medical treatment. The member of staff on the ward who is responsible for facilitating the SOAD visit are also responsible for ensuring that the Responsible Clinician and two statutory consultees are available in person at the time the SOAD visits.

18.5 One of these 'statutory consultees' must be a nurse, and the other must be neither a nurse nor a doctor (the second consultee may be, for example, a psychologist, a social worker, or an occupational therapist who has been professionally concerned with the patient's care and treatment). The consultees must ensure that they make a record of their consultation with the SOAD within the patient's case notes.

18.6 If the SOAD visits and agrees that the treatment is appropriate and completes a Form T3 then this should be submitted to the Mental Health Act Administration office which will provide the ward with two copies, one for the patient's notes and the other to be attached to the in-patient Drug Chart.

18.7 The SOAD must also provide a written explanation of the reasons for their decision. The SOAD will complete a form documenting the nature of and reasons for their decision and the Mental Health Act Administration Office will send a copy of this to the ward to be placed in the patient's notes. The Responsible Clinician should ensure that the patient is informed of the SOAD's decision and make a note of this discussion in the patient's notes.

18.8 The Responsible Clinician should ensure that the Record of SOAD's Decision form at **Appendix I** is completed and indicate that the patient has been informed of the outcome of the SOAD visit or provide an explanation as to why this has not been done. The statutory consultees should ensure that the form at **Appendix J** is completed to confirm that they had a discussion with the SOAD. One copy of each of these forms should be placed in the patient's notes on the ward and the other copy to be sent to the MHA Administration Office.

19 ADMINISTRATION OF MEDICATION

19.1 Where a health care professional administers prescribed medication to a patient who is detained under the MHA and subject to the provisions of Part 4, he/she should ensure that he/she is legally entitled to do so and that all legal requirements are satisfied. After the end

of the three month period, Form T2 or Form T3 will represent the legal authority to continue administering medication to detained patients who are subject to Section 58. A copy of any current Form T2 or T3 should be kept with the Drug Chart and nurses should refer to it when they administer to the patient any medicine for mental disorder.

19.2 In the case of a patient who has been detained and receiving medicine for at least three months, it will be unlawful to administer medicine for mental disorder to him/her unless it is covered by a Form T2 or a Form T3. The only exception to this rule is in the case of urgent treatment where Section 62 may apply (please see paragraph 21).

19.3 Where a Form T2 or Form T3 has not been completed, the administration of a medicine for mental disorder to a patient without their consent will constitute an assault and therefore a civil wrong and/or a criminal offence.

19.4 Before administering medication for mental disorder, the health care professional should:

- Check the Drug Chart for the date of entry of a prescription for the medicine, for its dose, and for the route of administration.
- Ensure that the three month rule has not been exceeded.
- Where a patient has consented to medication beyond the three month period, ensure that a Form T2 is in place, correctly completed and that the patient still consents.
- Where a second opinion from a SOAD has been obtained, ensure that Form T3 is in place, correctly completed, and, if the patient has been assessed as lacking capacity to give consent, that the patient remains incapacitated.
- Ensure that the administration of medication is consistent with the guidance contained in the following documents: "Code of Professional Conduct" (NMC, 2002); “Guidelines for Mental Health and Learning Disabilities Nursing” (UKCC, 1998); "Guidelines for the Administration of Medicines" (NMC, 2002).

20 REVIEWS OF TREATMENT

20.1 Authority for treatment should be reviewed regularly and in the following situations:

- If the Responsible Clinician wishes to change the medication on Form T2 they must discuss this with the patient and then either complete a new Form T2 if the patient still consents to the treatment or request a SOAD visit if the patient does not consent or is incapable of consenting to the new treatment proposed
- Each time a section is renewed it is good practice to review the treatment being provided on Form T2. If a Form T3 is in place, the Responsible Clinician must complete a Section 61 Review of Treatment Form which will be sent to them by the Mental Health Act Administration Office if a patient’s section is renewed
- A Section 61 Review of Treatment Form is required when a section is restored under Section 21B (following a period of a patient being Absent Without Leave over 28 days)
- A Section 61 Review of Treatment Form may be specifically requested by a SOAD e.g. they may have time limited the authority for treatment or specified the requirement for periodic reports on the Form T3
- Whenever there is a permanent change of Responsible Clinician, a new Form T2 should be completed
- If the patient is transferred under Section 19 of the Act
- If the patient’s capacity to consent to treatment status changes i.e. if a T3 has been issued due to lack of capacity but then the patient regains capacity, the patient

should be asked whether they consent to the treatment. If the patient declines to consent, a new SOAD request needs to be submitted to continue treatment. In the interim Section 62 may be considered if the treatment meets the criteria.

20.2 When consent to treatment is reviewed, the RC should consider whether a full capacity to consent to treatment assessment needs to be carried out.

21 URGENT TREATMENT

21.1 Section 62 provides that treatment can be given in response to an urgent situation in the absence of the forms required by Section 58 above (i.e. a T2 or T3 certificate). If it is proposed to continue with the treatment after the urgent situation has passed, the usual procedures set out above apply, that is to say that the legal authority for giving patients treatment will be represented by a duly completed T2 or T3.

21.2 To be lawful any medication given using section 62 must be 'immediately necessary' to:

a) Save the patient's life OR

b) Prevent a serious deterioration in the patient's condition OR

c) Alleviate serious suffering OR

d) Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others

21.3 With the exception of treatment covered in the first bullet point the treatment must also not have any unfavourable physical or psychological consequences which are irreversible.

21.4 When any of these criteria apply, the Responsible Clinician must complete a Section 62 Urgent Treatment – Medication (S58) Form (**see Appendix E**) indicating the medicine to be given, dosage, length of treatment and eBNF category. A copy of the Section 62 Urgent Treatment – Medication (S58) Form should be sent to the Mental Health Act Administration Office. A copy should also be placed in the patient's file on the ward.

21.5 In circumstances when the RC is awaiting a SOAD visit to complete Form T3, the treatment can continue under Section 62 provided that the conditions above still apply. If the patient's condition means it is no longer immediately necessary, the normal requirements for consent to treatment certificates apply. If Section 62 is being used as authority to treat whilst awaiting a SOAD visit, it is good practice for the Responsible Clinician to only authorise medication given under Section 62 for up to 7 days at a time and specify on the Section 62 Urgent Treatment – Medication (S58) Form the date on which the medication authorised under Section 62 will be reviewed. Following such a review, the Responsible Clinician should complete a new Section 62 Urgent Treatment – Medication (S58) Form if required for a further 7 day period.

22 SECTION 58A ELECTROCONVULSIVE THERAPY (ECT)

22.1 This section deals directly with ECT and medication administered as part of ECT. Staff should be aware that:

- Patients who have the capacity to consent may not be given ECT unless they consent to it
- ECT is not covered by the Three Month Rule
- Before any course of ECT the patient must give valid consent and have a Form T4 completed by RC (where the patient has capacity) OR have a Form T6 completed by a SOAD (where the patient lacks capacity)
- A SOAD can only authorise ECT if the patient lacks capacity and not if the patient has capacity but are refusing
- ECT may not be given where there is an applicable advance decision, a Lasting Power of Attorney or deputy who objects to the ECT or a decision by the Court of Protection conflicting with the giving of ECT

23 ECT FOR PATIENTS WHO HAVE CAPACITY TO CONSENT

23.1 As with other treatments, the patient's capacity to consent to ECT must be established before any treatment is planned and any capacity assessment carried out must be recorded on RiO.

23.2 If the patient is assessed as having capacity, ECT cannot be given unless the patient consents. To give valid consent the patient must be able to understand the processes involved and communicate their decision clearly. There must be a clear and detailed record of this process and Form T4 should be completed by the Responsible Clinician.

23.3 The Trust has modified the statutory T4 Form to include a space for the consenting patient to sign and a checklist on the back of the T4 Form is to be completed by the RC. T4 Forms are available from either the Mental Health Act offices or the ward clerks. Form T2 can be found at **Appendix D** of this policy.

23.4 Consent can be withdrawn by the patient at any stage of the process.

24 ECT FOR PATIENTS LACKING CAPACITY TO CONSENT

24.1 Where the patient is assessed as not having capacity, a second opinion must be sought from a SOAD. The RC should request for a SOAD visit via the CQC website. If the SOAD agrees that the treatment plan is appropriate, he or she will complete Form T6 and treatment can commence once this is completed.

25 URGENT ECT TREATMENT

25.1 By virtue of Section 62, there are some circumstances where the Responsible Clinician can authorise ECT to go ahead prior to a SOAD completing Form T6. To satisfy the legal criteria for urgent ECT under Section 62, the treatment must be:

- Immediately necessary to save the person's life OR
- (Not being irreversible) prevent a serious deterioration in the patient's condition

25.2 If either of the above criteria apply, the Responsible Clinician must complete Form Section 62 – Urgent Treatment – ECT (S58) (**please see Appendix F**) before ECT is given under Section 62. A copy of the Section 62 Urgent Treatment – ECT (S58) Form should be sent

to the Mental Health Act Administration office. A copy should also be placed in the patient's file on the ward and on the Drug Chart.

26 PART 4A MHA NON-RECALLED PATIENTS ON A CTO

26.1 Part 4A of the MHA applies to patients on a Community Treatment Order (CTO) who have not been recalled to hospital by their Responsible Clinician. The rules differ depending on whether or not the patient has the capacity to consent or refuse the treatment in question. CTO patients can only be given treatment if they consent to it or, if they lack the capacity to consent, do not actively object.

27 NON-RECALLED CTO PATIENTS WHO HAVE CAPACITY TO CONSENT

27.1 After one month of the patient being discharged on to a CTO, treatment can only continue if authorised by a part 4A certificate. Where a patient is considered to have capacity and to be consenting to their proposed treatment plan then the Responsible Clinician can complete a CTO12 form within one month of the patient being discharged on to a CTO. If the three month rule under section 58 is still in operation, then the RC would complete the CTO12 at the end of the period.

27.2 The Trust has modified the statutory CTO12 Form to include a space for the consenting patient to sign and a checklist on the back of the CTO12 Form is to be completed by the RC. CTO12 Forms are available from the Mental Health Act offices or can be found at **Appendix G** of this policy.

27.3 Patients who have been assessed as having the capacity to consent to treatment may only be given treatment if they consent to it.

28 NON-RECALLED CTO PATIENTS WHO LACK THE CAPACITY TO CONSENT

28.1 If a patient lacks capacity to consent to treatment then within the first month of being discharged onto a CTO the Responsible Clinician will be required to complete a SOAD request so that the certificate requirements are in place one month from the patient being discharged onto a CTO unless of course s58 is still applicable (i.e. the three month rule still applies). The SOAD will need to certify that treatment is appropriate on form CTO11. The Responsible Clinician should discuss this with the patient prior to the patient leaving the hospital or within the first month of the patient being discharged onto a CTO and also discuss any a suitable places where the patient can be seen by the SOAD.

28.2 Treatment cannot be given to CTO patients in the community lacking capacity to consent if:

- The treatment (for a patient 18 or over) is contrary to a valid and applicable advance decision by the patient.
- The treatment (for a patient 16 or over) is contrary to someone authorised under the MCA to refuse the treatment (i.e. attorney, deputy, or court of protection).
- Force is needed to administer the medication and the patient was objecting to the treatment (this applies to patients of any age).

29 EMERGENCY TREATMENT FOR NON-RECALLED CTO PATIENTS

29.1 In an emergency, treatment can also be given to part 4A patients who lack capacity to consent to or refuse a treatment (and who have not been recalled to hospital) under section 64G MHA.

29.2 It is an emergency only if the treatment is immediately necessary to:

- Save the patient's life OR

- Prevent a serious deterioration in the patient's condition OR
- Alleviate serious suffering OR
- Prevent the patient behaving violently or being a danger to themselves or others and the treatment represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others

29.3 With the exception of treatment covered in the first bullet point the treatment must also not have any unfavourable physical or psychological consequences which are irreversible.

29.4 If the treatment is ECT (or medication administered as part of ECT), only the first two categories above apply.

29.5 In addition, force may be used (whether or not the patient objects), provided that:

- The treatment is necessary to prevent harm to the patient, and
- The force used is proportionate to the likelihood of the patient suffering harm and to the seriousness of that harm.

29.6 These are the only circumstances in which force may be used to treat patients on CTOs who object, without recalling them to hospital. This exception is for situations where the patient's interests would be better served by being given urgently needed treatment by force outside hospital rather than being recalled to hospital. This might, for example, be where the situation is so urgent that recall is not realistic, or where taking patients to hospital would exacerbate their condition, damage their recovery or cause them unnecessary anxiety or suffering. Situations like this should be exceptional.

29.7 If Section 64G is used in the community, Form Section 64 Urgent Treatment – Part 4A Form (**see Appendix H**) must be completed by the Responsible Clinician. A copy of this form should be sent to the Mental Health Act Administration Office and two additional copies should be kept within the patient's notes and on the Drug Chart.

30 TREATMENT OF RECALLED CTO PATIENTS

30.1 If the patient is recalled they are subject to s.58 and 58A treatment rules under the MHA in the same way as other detained patients, i.e. they will be subject to Part 4 of the MHA. However there are 3 exceptions to this and a T2/T3 certificate will not be required if:

- Less than one month has passed since the patient was discharged from hospital and became a CTO patient.
- The treatment is explicitly authorised for administration on recall on the patients Part 4A certificate. This will be documented on form CTO11.
- Treatment that was already being given in the community on the basis of a Part 4A certificate may be continued even if not authorised specifically for administration on recall if the Responsible Clinician considers discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with s.58 or 58A. In other words, it applies only for the time it takes to obtain the certificate that would normally be required, or for a SOAD to decide that it is not appropriate to issue such a certificate. The Responsible Clinician must however in the meantime complete form 62A where the criteria for s62A are met.

30.2 During the recall period if the patient has capacity and is consenting to the proposed treatment, treatment can be authorised by the Responsible Clinician completing a T2 form.

31 INDEPENDENT MENTAL HEALTH ADVOCACY

31.1 Where the patient wishes to use the services of an Independent Mental Health Advocate (IMHA) to support them in making decisions about their care and treatment, every effort must be made to facilitate this and, where possible adequate time must be allowed for the IMHA to consult with the patient and speak on his/her behalf.

32 IMPLEMENTATION INCLUDING TRAINING & COMPLIANCE

32.1 Basic training on consent is given as part of the induction course received by all new staff. However, clinicians can receive additional training by attending a workshop organised by the Trust's Training Department. For further information about training courses available, please contact the Trust's training department at kmpt.training@nhs.net.

32.2 Compliance with Part 4 and Part 4A of the MHA will be monitored in the Mental Health Act offices by regular audits and scrutiny checks.

33 EQUALITY IMPACT ASSESSMENT

33.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

34 HUMAN RIGHTS

34.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

35 EXCEPTIONS

35.1 Part 4 of the MHA only applies to those patients detained under the MHA on sections listed in paragraph 16.1 of this policy. Part 4A of the MHA only applies to CTO patients.

APPENDIX A EQUALITY IMPACT ASSESSMENT

The Equality Impact Assessment for this policy is published as a separate document.

APPENDIX B ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983 (as amended 2007)
SOAD	Second Opinion Appointed Doctor
RC	Responsible Clinician
ECT	Electroconvulsive Therapy

APPENDIX C FORM T2 & RC CHECKLIST

Form T2 (Regulation 27(2)) Mental Health Act 1983

Section 58(3)(a) – certificate of consent to treatment

I (*PRINT* full name and address)

The approved clinician in charge of the treatment described below / a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD) *(delete the phrase which does not apply)* certify that

(*PRINT* full name and address of patient)

(a) is capable of understanding the nature, purpose and likely effects of: *(Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.)*

(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)

AND

(a) has consented to that treatment.

Signed: Date:

I confirm that I have discussed the above treatment plan with the approved clinician in charge of my treatment / a SOAD and have consented to it.

Patient Signature: Date:

RC CHECKLIST & RECORD OF DISCUSSION WITH PATIENT

NAME OF PATIENT:	
WARD:	

PLEASE COMPLETE CHECKLIST BELOW	YES/NO
Have you discussed any medication side effects with the patient?	YES/NO
Have you discussed the benefits/likely of the treatment with the patient?	YES/NO
Have you given details of any risks/alternative treatments to the patient?	YES/NO
Is the patient capable of understanding information relating to the nature, purpose and likely effects of treatment?	YES/NO
Is he/she able to retain that information?	YES/NO
Is he/she capable of weighing up that information to enable him/her to make a decision?	YES/NO
Is he/she able to communicate that decision?	YES/NO
Have you documented the discussion that has taken place between you and the patient and note that you have done so in the patient's RiO record? RiO: MCA/MHA & information sharing and consent > MCA/MHA assessments	YES/NO
Have you documented in the RiO progress notes the drug(s) prescribed, their route, frequency, maximum daily dose as set out in the eBNF and planned date to review? RiO: Progress notes	YES/NO

RC (or AC) Comments:	
Conclusion (please tick one option):	
The patient has capacity and consents to treatment	
The patient has capacity but is refusing to consent to treatment and I have requested a SOAD	
The patient lacks capacity to consent to treatment and I have requested a SOAD	

RC Signature: **Date:**

APPENDIX D FORM T4 & RC CHECKLIST

Form T4 *(Regulation 27(3)(b))* Mental Health Act 1983

Section 58A(3) – Certificate of consent to treatment (patients at least 18 years old)

THIS FORM IS NOT TO BE USED FOR PATIENTS UNDER 18 YEARS OF AGE

I (*PRINT* full name and address)

The approved clinician in charge of the treatment described below / a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD) *(delete as appropriate)* certify that

(*PRINT* full name and address of patient)

who has attained the age of 18 years,

(a) is capable of understanding the nature, purpose and likely effects of: *(Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.)*

(If you need to continue on a separate sheet please indicate here ( ) and attach that sheet to this form)

AND

(b) has consented to that treatment.

Signed: Date:

I confirm that I have discussed the above treatment plan with the approved clinician in charge of my treatment / a SOAD and have consented to it.

Patient Signature: Date:

RC CHECKLIST & RECORD OF DISCUSSION WITH PATIENT

NAME OF PATIENT:	
WARD:	

PLEASE COMPLETE CHECKLIST BELOW	YES/NO
Have you discussed any treatment side effects with the patient?	YES/NO
Have you discussed the benefits/likely of the treatment with the patient?	YES/NO
Have you given details of any risks/alternative treatments to the patient?	YES/NO
Is the patient capable of understanding information relating to the nature, purpose and likely effects of treatment?	YES/NO
Is he/she able to retain that information?	YES/NO
Is he/she capable of weighing up that information to enable him/her to make a decision?	YES/NO
Is he/she able to communicate that decision?	YES/NO
Have you documented the discussion that has taken place between you and the patient and note that you have done so in the patient's RiO record? RiO: MCA/MHA & information sharing and consent > MCA/MHA assessments	YES/NO
Have you documented in the RiO progress notes the drug(s) prescribed, their route, frequency, maximum daily dose as set out in the eBNF and planned date to review? RiO: Progress notes	YES/NO

RC (or AC) Comments:	
Conclusion (please tick one option):	
The patient has capacity and consents to treatment *(if the patient has capacity and refuses to consent to ECT, ECT, cannot be administered)*	
The patient lacks capacity to consent to treatment and I have requested a SOAD	

RC Signature: **Date:**

APPENDIX E SECTION 62 URGENT TREATMENT MEDICATION (S58)

Section 62 allows the RC, or the doctor nominated to act as RC, or the Duty Consultant, to authorise urgent treatment for a patient's mental disorder if it is immediately necessary – MHA CoP Paragraph 25.37

Name of Patient		Ward	
Date of Birth		NHS number	
Responsible Clinician			

Intended treatment (including dosage and eBNF category):

Date recorded in medical notes by RC: …… Date……..

In compliance with the Mental Health Act 1983, urgent treatment under Section 62 is *(please tick as appropriate):*

- ❑ Immediately necessary to save the patient's life
- ❑ Immediately necessary to prevent a serious deterioration in the patient's condition
- ❑ Immediately necessary to alleviate serious suffering of the patient
- ❑ Immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself/herself or others

Comments:

Review Date *(treatment under Section 62 should not be given for more than 7 consecutive days):*

Signature		**Designation**	
Name in block capitals			
Date		**Time**	

- ❑ Copy to Patient's MHA File
- ❑ Copy to Patient's prescription chart
- ❑ Copy sent to the Mental Health Act Administrator

APPENDIX F SECTION 62 URGENT TREATMENT ECT (S58)

This form is valid for ONE treatment only for patients detained under the Mental Health Act (1983)

Section 62 allows the RC, or the doctor nominated to act as RC, or the Duty Consultant, to authorise urgent treatment for a patient's mental disorder if it is immediately necessary – MHA CoP Paragraph 25.37

NOT TO BE USED FOR PATIENTS ON COMMUNITY TREATMENT ORDERS

Name of Patient		Ward	
Date of Birth		NHS number	
Responsible Clinician			

Intended treatment (Including dosage and eBNF category):

Date recorded in medical notes by RC: …… (Date)

In compliance with the Mental Health Act 1983 urgent treatment under Section 62 is (please tick as appropriate):

- ❑ Immediately necessary to save the patient's life
- ❑ Immediately necessary to prevent a serious deterioration in the patient's condition and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed

Comments:

Signature		Designation	
Name in block capitals			
Date		Time	

- ❑ Copy to Patient's MHA File
- ❑ Copy to Patient's prescription chart
- ❑ Copy sent to the Mental Health Act Administrator

APPENDIX G FORM CTO12 & RC CHECKLIST

Form CTO12 regulation 28(1A) Mental Health Act 1983

Section 64C(4A) Certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate)

(To be completed on behalf of the responsible hospital)

I (*PRINT* full name and address)

am the approved clinician in charge of the treatment of

(*PRINT* full name and address of patient)

who is subject to a community treatment order.

I certify that this patient has the capacity/is competent to consent *(delete the one that is not appropriate)*

and has consented to the following treatment.

The treatment is:

(Give description of treatment or plan of treatment)

Signed: Date:

I confirm that I have discussed the above treatment plan with the approved clinician in charge of my treatment and have consented to it.

Patient Signature: Date:

RC CHECKLIST & RECORD OF DISCUSSION WITH PATIENT

NAME OF PATIENT:	
COMMUNITY TEAM:	

PLEASE COMPLETE CHECKLIST BELOW	YES/NO
Have you discussed any medication side effects with the patient?	YES/NO
Have you discussed the benefits/likely of the treatment with the patient?	YES/NO
Have you given details of any risks/alternative treatments to the patient?	YES/NO
Is the patient capable of understanding information relating to the nature, purpose and likely effects of treatment?	YES/NO
Is he/she able to retain that information?	YES/NO
Is he/she capable of weighing up that information to enable him/her to make a decision?	YES/NO
Is he/she able to communicate that decision?	YES/NO
Have you documented the discussion that has taken place between you and the patient and note that you have done so in the patient's RiO record? RiO: MCA/MHA & information sharing and consent > MCA/MHA assessments	YES/NO
Have you documented in the RiO progress notes the drug(s) prescribed, their route, frequency, maximum daily dose as set out in the eBNF and planned date to review? RiO: Progress notes	YES/NO

RC (or AC) Comments:	
Conclusion (please tick one option):	
The patient has capacity and consents to treatment	
The patient lacks capacity to consent to treatment and I have requested a SOAD	

RC Signature: **Date:**

APPENDIX H SECTION 64G URGENT TREATMENT
FOR PATIENTS ON COMMUNITY TREATMENT ORDERS WHO LACK CAPACITY TO CONSENT TO OR REFUSE A TREATMENT ONLY

Name of Patient		Address	
Date of Birth		NHS number	
Responsible Clinician			

Intended treatment (Including dosage and eBNF category):

Date recorded in medical notes by RC: …… (Date)……

In compliance with the Mental Health Act 1983 treatment under Section 64G is (please tick as appropriate) :

- ❑ Immediately necessary to save the patient's life
- ❑ Immediately necessary to prevent a serious deterioration in the patient's condition
- ❑ Immediately necessary to alleviate serious suffering of the patient
- ❑ Immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself/herself or others

Patient Comments:

Signature of Patient: ……Date:……...

RC Comments:

Review Date *(treatment under Section 64G should not be given for more than 7 consecutive days):*

Signature		Designation	
Name in block capitals			
Date		Time	

- ❑ Copy to Patient's MHA File
- ❑ Copy to Patient's prescription chart
- ❑ Copy sent to the Mental Health Act Administrator

RECORD OF SOAD'S DECISION

FOR COMPLETION BY RESPONSIBLE CLINICIAN

Patient's Name:……. DOB:……..……

Ward:……..…. Section……..……

Please delete 1 or 2

1. I have conveyed the SOAD's decision to the above named patient today and I have discussed the reasons for the decision with the patient.

Patient's comments:

Patient's signature: Date:

2. I have not conveyed the SOAD's decision to the patient for the following reasons:

Signed:……(RC) Date:……...

Original sent to MHA Administrator ❑ Copy filed in patient notes (MHA section) ❑

APPENDIX J RECORD OF CONSULTEE DISCUSSION WITH SOAD

CONFIRMATION OF APPOINTED CONSULTEE DISCUSSION WITH SOAD

As detailed in the Code of Practice at point 25.56, it is essential that Consultees must comment on the following:

- The proposed treatment and the patient's ability to consent to it;
- Other treatment options;
- The way in which the decision to treat was arrived at;
- The facts of the case, progress, attitude of relatives etc;
- The implications of imposing treatment upon a non-consenting patient and the reasons for the patient's refusal of treatment;
- Any other matters relating to the patient's case upon which the "Consultee" wishes to comment.

FOR COMPLETION BY NURSE:

☐ I confirm that I was consulted by the SOAD on: ……

☐ I can confirm that the consultation included the information above

☐ I have given feedback back to the named patient

☐ I have entered this information into the patients RIO record

NAME: **SIGNATURE:** **DATE:**

FOR COMPLETION BY SECOND STATUTORY CONSULTEE (not a nurse or doctor):

☐ I confirm that I was consulted by the SOAD on: ……

☐ I can confirm that the consultation included the information above

☐ I have given feedback back to the named patient

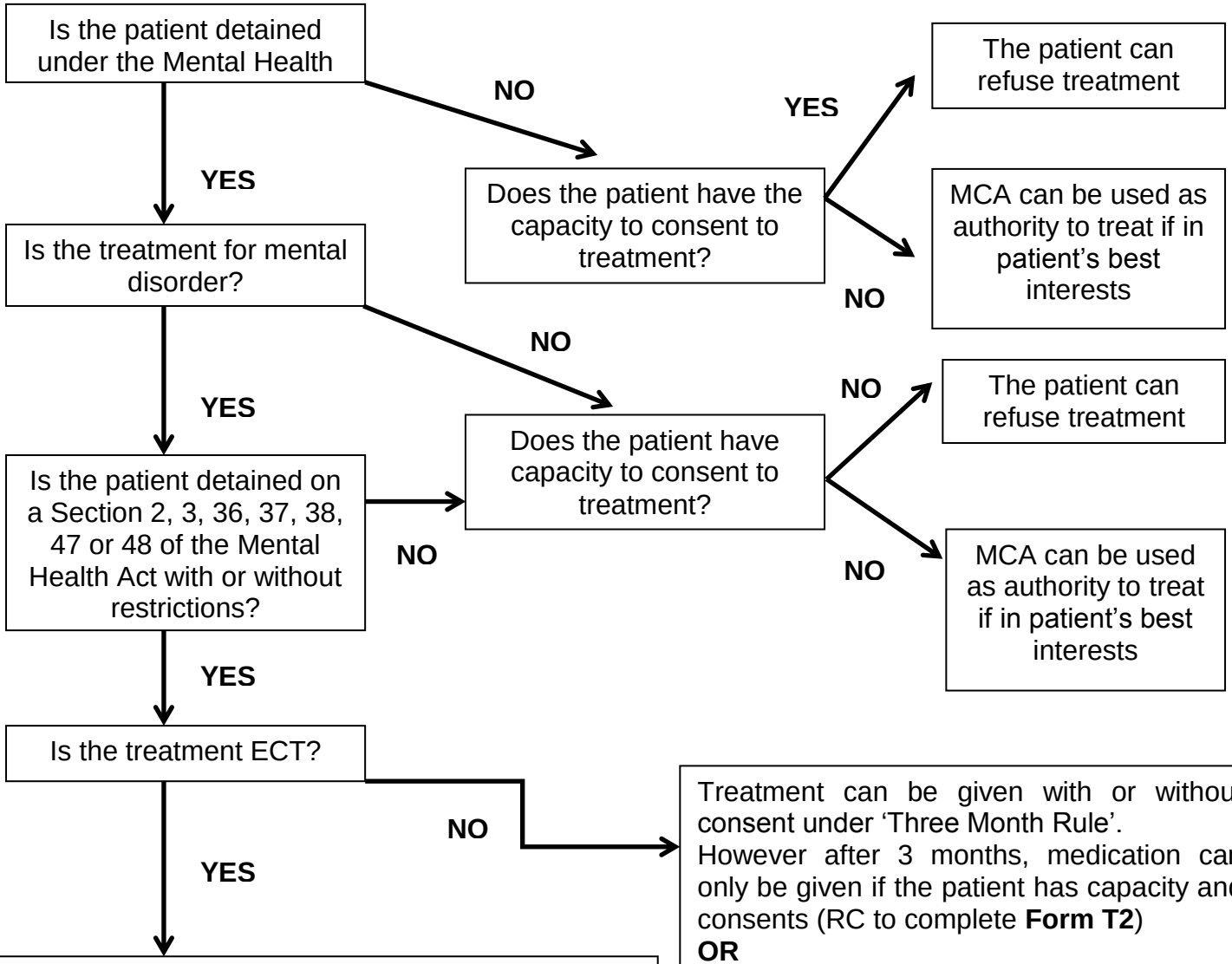
☐ I have entered this information into the patients RIO record

NAME: **SIGNATURE:** **DATE:**

Original sent to MHA Administrator ❑ Copy filed in patient notes (MHA section) ❑

APPENDIX K CONSENT TO TREATMENT FLOWCHARTS

Flowchart of Consent to Treatment – Part 4 MHA



Capacity to consent will need to be established.

Patients with capacity:

Form T4 to be completed by RC. This will authorise treatment. A patient who has capacity and who is refusing ECT cannot be given ECT.

Patients lacking capacity:

A SOAD request must be completed by the RC in order for a **Form T6** to be completed. This will authorise treatment.

In the absence of Form T6, urgent treatment can only be given under section 62 in the absence of a T6 if the treatment is immediately necessary to:

a) Save the patient's life **OR**
b) Prevent a serious deterioration of the patient's condition

Section 62 – Urgent Treatment – ECT (S58) Form must be completed

Treatment can be given with or without consent under 'Three Month Rule'.

However after 3 months, medication can only be given if the patient has capacity and consents (RC to complete **Form T2**)

OR

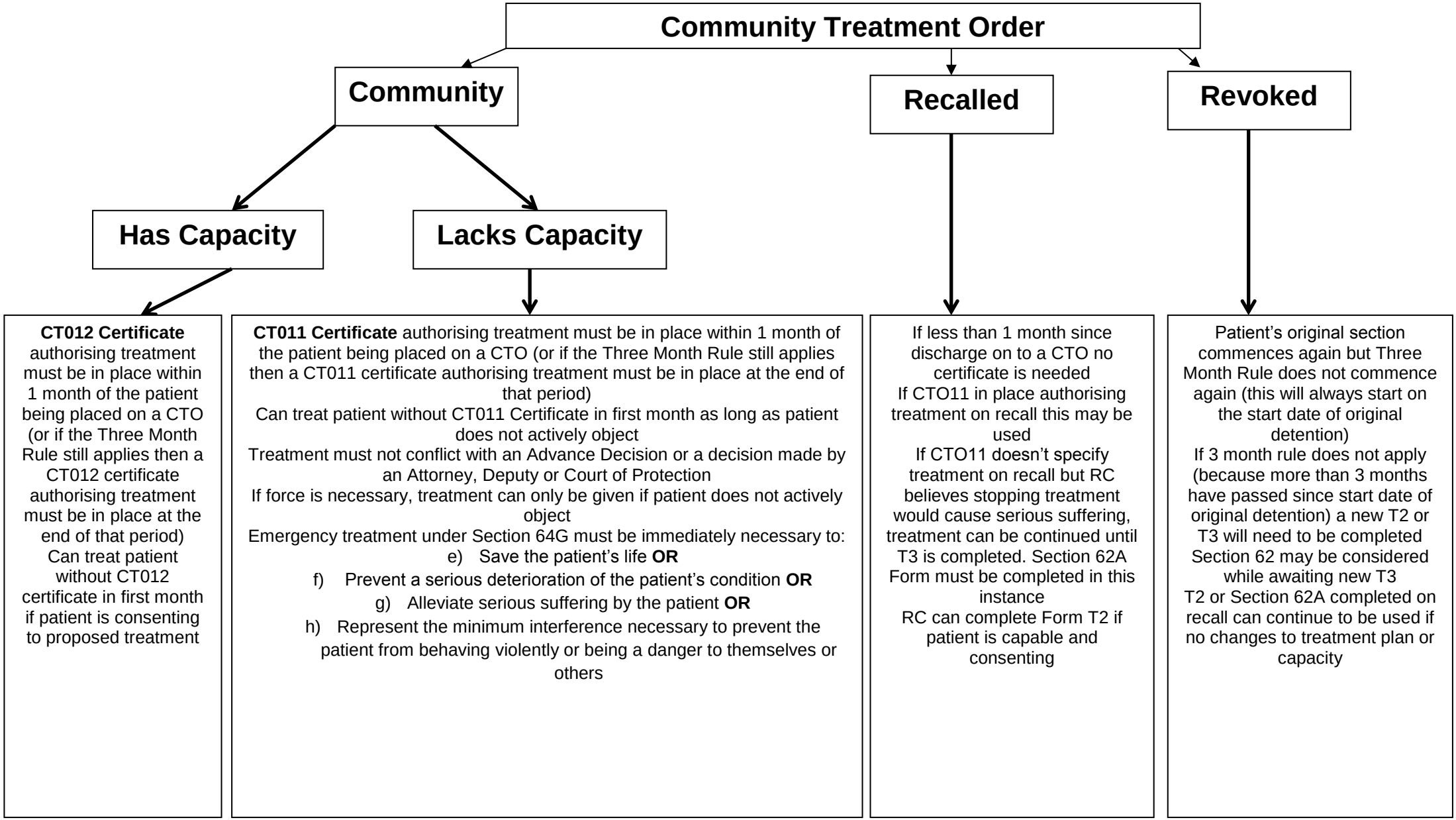
If the patient lacks capacity to consent/is refusing to consent to a particular treatment then treatment can only be given if authorised by a SOAD on **Form T3**

In the absence of Form T2/T3, urgent treatment can only be given under section 62 if it is immediately necessary to:

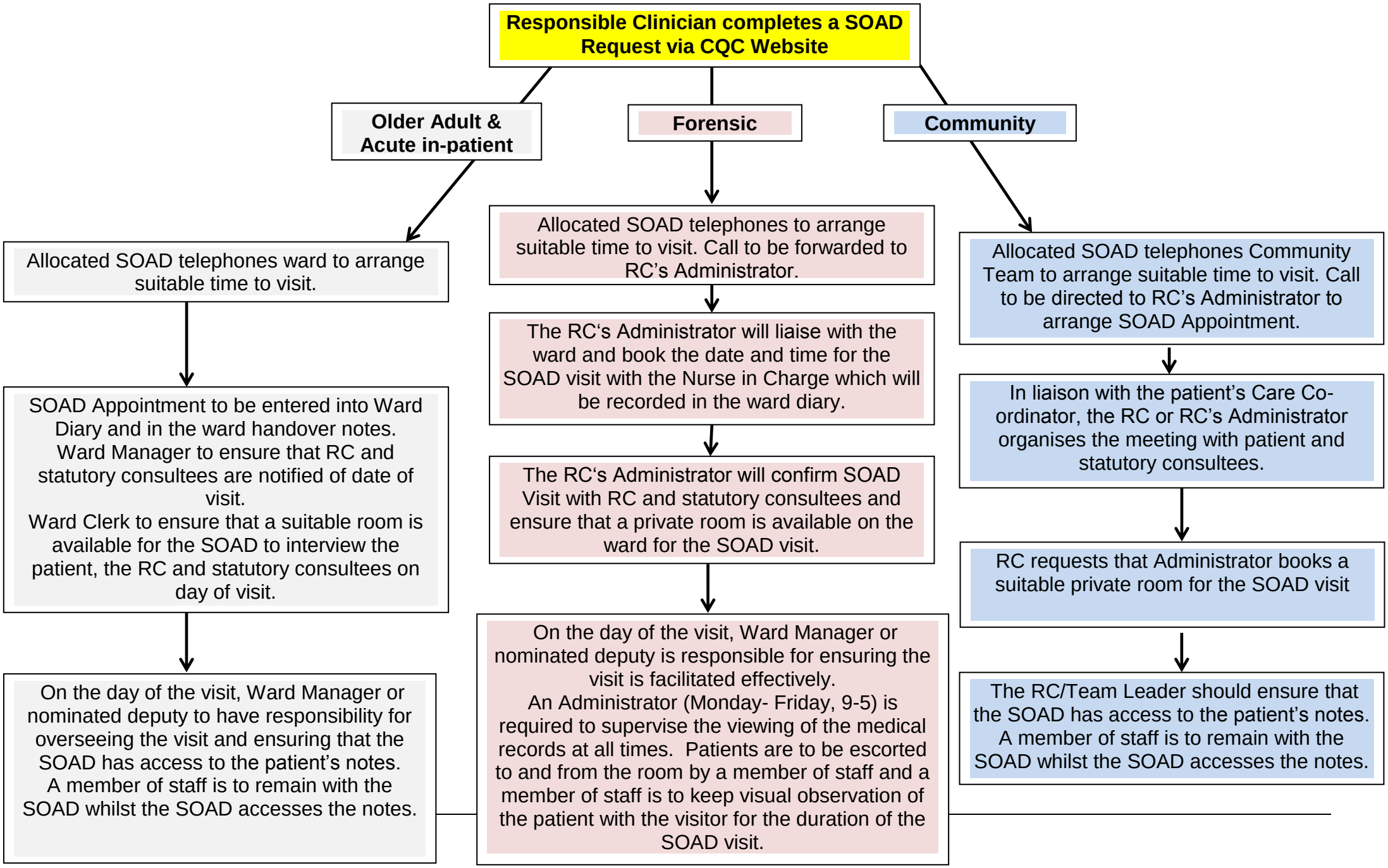
a) Save the patient's life **OR**
b) Prevent a serious deterioration of the patient's condition **OR**
c) Alleviate serious suffering by the patient **OR**
d) Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others.

Section 62 – Urgent Treatment – Medication (S58) Form must be completed

Flowchart of Consent to Treatment – Part 4A MHA



APPENDIX L SOAD VISIT PROCESSES BY CARE GROUP



APPENDIX M CONSENT TO TREATMENT – INTERIM METHODOLOGY FOR SECOND OPINIONS WITHIN COVID-19 PROVISIONS

Due to the Covid-19 pandemic, CQC has reduced the visits to hospital sites to minimise the risk to patients, staff and the public. During the Covid-19 pandemic, procedures for remote working for Mental Health Act SOAD's (Second Opinion Appointed Doctors) are as follows:

1. **Mental Health services to provide a summary of the patient's current issues to the CQC when we submit a second opinion request, which SOAD's will then use instead of visiting the hospital to examine the care records.**

2. **Consultations will now take place with professionals, including the Responsible Clinician by telephone or video conferencing links.**

3. **Following on from the telephone consultations they will ask services that support patients who are agreeing to speak with SOAD's to ensure they have access to telephones or technology to support a video call with the SOAD.**

4. **SOAD's will no longer post original copies of certificates, but instead an electronic copy of the certificate will be emailed across to the local MHA team for the Trust**

To ensure remote working SOAD's are requesting health services to provide a summary of the patient's current issues to the CQC when submitting any SOAD request.
After submission, of a SOAD request, a secure email or an encrypted attachment providing a summary document outlining the current issues should be sent. The CQC are not expecting any new documentation to be created but ask for one of the following to be used to provide such information:

- a tribunal or managers' report
- a recent admission summary; or

The CQC are also looking for a summary or copy of any documents that give key information on any physical health and risk issues showing any significant positives or negatives.
All documents should be emailed securely from an nhs.net account to cqc.soadteam@cqc.cjsm.net
The SOAD doctors will use this data as a proxy for the clinical notes which they would otherwise have accessed on a visit to the hospital.

- Consultations with professionals, including the responsible clinician, will be undertaken by telephone.
- Following such telephone conversations if a patient wishes to consult the SOAD then an arranged telephone or video conferencing call with the SOAD should be facilitated in a timely and appropriate manner. If a patient refuses this as a means of contact, it then be by the discretion of the SOAD as to whether or not to proceed with the second opinion, as is the situation in normal circumstances where the patient may decline to see the SOAD.
- SOAD's will continue to produce and retain the paper copies of the certificate, until such a time it is deemed appropriate to forward these on.

Where the revised procedures cannot be implemented:

There may be circumstances where SOAD's are unable to obtain the information necessary to reach a justifiable legal decision regarding certification of treatment. If this happens then the CQC will review the information available and assess if either a visit may be possible to complete the process or whether the CQC advise services to consider provisions for emergency treatment under Section 62 or 64 of the MHA, or alternatives through emergency legislation.

Urgent cases where certificates are not required (sections 62, 64B, 64C and 64E)

Section 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary (Section 62). Similarly, a part 4A certificate is not required in urgent cases where the treatment is immediately necessary (sections 64B, 64C and 64E).

This applies only if the treatment in question is immediately necessary to:

a) Save the patient's life
b) Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed
c) Alleviate serious suffering by the patient, and the treatment doe not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard, or
d) Prevent patients behaving violently or being a danger to themselves or others, and the treatment represents the minimum inference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

If the treatment is ECT (or medication administered as part of ECT) only the first two categories above apply.

Providers and clinicians will need to consider two options where attendance of a SOAD is either not possible or not desirable and treatment must be continued;

a) If the patient already has T certificate in place, but the certificate does not authorise a new/different treatment then S62(1) may apply. That is what most provider clinicians will be familiar with – completion of a locally-generated s62 form. It will not be necessary to generate a new S62 form for every dose, most especially if © or (d) above apply. The need for a continued s62 should be reviewed, and documented in the notes, on a regular basis e.g. ward round/MDT's or other review meeting.
b) If the patient does not have a T certificate in place but has reached the end of the '3 month rule', then S62(2) may be applicable. This will allow the continuation of an existing plan of treatment until the 'certificate requirements' can be met, when a SOAD can review the treatment or until the patient's condition improves such that they can and do consent and a T2 can completed.

   In the event that S62(2) is deemed applicable, no special form is necessary – it will be sufficient for the AC/RC to record in the notes that the treatment is being continued past the 3 month period under S62(2), together with the justification (either (c) or (d) above) and the reason – unavailability of SOAD due to COVID19.