

## Consent Policy and Guidance

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# 1 Introduction

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## 1.1 Policy statement

The purpose of this guidance document is to advise all staff at Parkbury House Surgery of the principle of consent and that this is an important part of medical ethics based on the concept of the person and the fundamental dignity and equality of human beings.

The intention of this policy is to ensure that, in accordance with the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014: Regulation 11](#), all people using the services of this organisation, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Staff will obtain the consent lawfully and ensure that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.

This policy should be read in conjunction with the following:

- [DOH – Reference Guide to Consent for Examination or Treatment \(2nd Ed.\)](#)
- [The Green Book – Consent](#)
- [NHS England Consent to Treatment](#)
- [Royal College of Surgeons – Consent](#)
- [CQC GP Mythbuster 8: Gillick competency and Fraser guidelines](#)
- [CQC GP Mythbuster 49: Consent for Minor Surgery in GP surgeries](#)
- [Mental capacity act policy](#)

## 1.2 Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](#). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

# 2 Definition of terms

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## 2.1 Voluntary consent

The decision regarding whether or not to consent must be made by the individual and must not be influenced by healthcare staff, friends or family members.

## 2.2 Informed consent

The patient must be given all the information regarding what the procedure or treatment involves. This includes the associated benefits and risks, information about alternative treatments and the consequences if the procedure or treatment is declined.

## 2.3 Capacity

The person must be capable of giving consent which means they fully understand the information given to them and can use it to make an informed decision.

For further reading, refer to the [Mental Capacity Act Policy](#).

## 2.4 Age of consent

In law, the [Children Act 1989](#) defines that it is a person's 18th birthday that draws the line between childhood and adulthood.

In healthcare matters, an 18-year-old enjoys as much autonomy as any other adult. To a more limited extent, 16 and 17-year-olds can also make medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence. Therefore a child's age alone is an unreliable predictor of any competence when making or considering a decision.

Further reading can be sought at the NHS webpage titled [Children and young people](#).

## 2.5 Gillick competence

Medical professionals need to consider Gillick competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge.

Further reading can be sought from [NSPCC Learning](#) and [CQC GP Mythbuster 8: Gillick competence and Fraser guidelines](#).

## 2.6 Fraser guidelines

The Fraser guidelines apply specifically to advice and treatment about contraception, sexual health and termination of pregnancy. They may be used by healthcare professionals working with under 16-year-olds.

Further reading can be sought from [NSPCC Learning](#) and [CQC GP Mythbuster 8: Gillick competence and Fraser guidelines](#).

# 3 Policy

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## 3.1 General overview

Consent must be voluntary and informed if it is to be deemed valid, while the person consenting must have the capacity to do so. The Medical Protection Society (MPS) webpage titled [Consent](#) details the requirement for consent to be valid, including actions needed when a patient lacks capacity.

Clinicians must respect the decision of a patient who has the capacity to make a voluntary and informed decision, regardless of the consequences. If, however, a patient does not have capacity, clinicians can administer treatment if it is in their best interest. In such instances, clinicians should seek guidance from the patient's carer, relatives or friends.

### 3.2 Key principles for consent

Clinicians must be mindful that a patient's capacity to give consent may be temporarily affected by factors such as pain, fatigue, illness or the side effects of medication. In such cases, clinicians must not assume the patient does not have the capacity to consent.

The British Medical Association summarised a landmark case, [Montgomery Vs Lanarkshire Health Board](#), in 2015 which stated that doctors (read clinicians) must not:

- Make assumptions about what a patient needed to know
- Must take reasonable care to ensure that the patient is aware of any material risks involved in any treatment and of any reasonable alternative or variant treatments

The British Medical Association [Consent toolkit for doctors](#) further details this case.

The Royal College of Surgeons has described [key principles for consent and supported decision making](#) as detailed in [CQC GP Mythbuster 49](#) and advises that any discussion about consent should:

- Aim to give the patient information they need to make a decision about what treatment or procedure (if any) they want
- Be tailored to the individual patient – this needs time to get to know the patient well enough to understand their views and values
- Explain all reasonable treatment options along with their implications
- Include all material risks for each option (refer to the GP Mythbuster for guidance on the 'test of materiality').

Further to this, the General Medical Council (GMC) also provides [guidance](#) on this subject.

This GMC guidance also reiterates the importance of providing information that the patient can understand and that, before beginning any treatment, the doctor or a member of the healthcare team should confirm that the patient still wants to proceed.

### 3.3 Giving consent

A patient may give their consent in the following ways:

Type	Action
Verbally	Consenting to an examination or procedure such as an injection by word of mouth
Written	Signing a consent form for minor surgery or other procedures
Implied or non-verbal	A patient may also give non-verbal consent as long as they understand the treatment or examination about to take place. An example would be to hold out an arm for a blood test.  Implied consent is still valid within a clinical setting.

Patients can withdraw consent at any time and, if this occurs, clinicians must stop the procedure safely, listen to the concerns of the patient and explain the consequences of not finishing the procedure.

### 3.4 Is a consent form enough?

As detailed in the [MPS guidance](#), sufficient information must be given for the patient to make their choice. Simply having a signed consent form only provides evidence that consent was obtained at that time, it does not constitute proof that the consent was valid and may simply be used as a checklist.

[CQC GP Mythbuster 49: Consent for minor surgery in GP surgeries](#) refers. The form at [Annex A](#) can be used to confirm that the patient has been fully briefed about the procedure.

### 3.5 Recording consent in a patient's clinical record

In addition to completing a form, the clinician is to detail that consent had been discussed within the clinical records.

Legally, the presence of this information within the medical record will ensure that evidence of how the patient reached their considered decision was made. Should there ever be any dispute as to whether valid consent was obtained, the key issue will not be whether the patient did or did not sign a form, but whether they were given all the information needed to make a considered decision.

Should the form at [Annex A](#) not be used, then the patient record should be comprehensive and include the following:

- Brief summary of the discussion with the patient
- Details of any decision(s) that were made
- Any requests made by the patient
- Any information given to the patient including hard copies or internet links, a patient information leaflet and any other visual or audio information

If it has been some time since the initial or last consent agreement was made, or should the patient's condition have changed, or if new information has become

available since a patient gave consent, the clinician must again go through the process of obtaining new or further patient consent.

The entry is to be made using an appropriate [SNOMED CT](#) consent code.

The generic 'Consent' code is SCTID: 61861000000100 although it should be noted that there are many other codes that can be used which are more specific to the type of consent given.

### **3.6 When consent is not needed**

There are a few exceptions when treatment may be able to proceed without the person's consent, even if they are capable of giving their permission.

[NHS England Consent to Treatment](#) details the reasons why it may not be necessary to obtain consent.

### **3.7 Obtaining consent**

It is the responsibility of the clinician carrying out the procedure or examination to obtain consent from the patient. The amount of information the clinician needs to provide varies on a case-by-case basis, but the clinician will in all scenarios:

- Try to ascertain the patient's individual needs and wishes
- Ensure the patient has the capacity to consent
- Explain the requirement for and purpose of the procedure, examination or treatment
- Discuss the options available to the patient including the option not to proceed
- Give an explanation of the benefits and associated risks or side effects
- Discuss the possibility of any issues which may arise during the process
- Answer any questions the patient may ask prior to consenting
- Explain that the clinician conducting the examination, procedure or treatment will obtain the patient's consent
- Remind the patient that they can withdraw consent at any time
- Reassure the patient that the examination, treatment or procedure is for their benefit but that the overall choice to proceed rests with them
- Offer the patient the option of a second opinion
- Provide advice regarding the post-examination, treatment or procedure recovery process
- When applicable, a consent form will be completed and signed by the patient

The form at [Annex A](#) should be amended in accordance with UK Government [guidance](#) as appropriate to accommodate:

- Parental agreement to the investigation of or treatment for a child
- Combined patient/parental agreement to investigation or treatment
- Adults who are unable to consent to an investigation or treatment.

This list is not exhaustive and clinicians must ensure that the patient has been given all the necessary information available in order for them to make a voluntary, informed decision.

### **3.8 Delegation of responsibility for obtaining consent**

The clinician undertaking the procedure or treatment may delegate the responsibility for seeking patient consent to someone else provided that they are satisfied that the person to whom this delegation is given:

- Has sufficient knowledge and understands the risks involved in the proposed investigation or treatment
- Is suitably trained and qualified and acts in accordance with the guidance contained in the [BMA patient consent toolkit](#)

### **3.9 Consent for children and young people**

Young people aged 16 to 17 are presumed to be capable of consenting to medical examinations, treatments or procedures. As per adults, consent will only be deemed valid if it is given voluntarily by an appropriately informed young person.

The General Data Protection Regulation (GDPR) does not alter the principle of Gillick competence. The DHSC document titled [Reference guide to consent for examination or treatment](#) details that a child under the age of 16 may be Gillick competent to give consent to medical examinations, treatments or procedures. Gillick competence shows that a child under the age of 16 who has sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention.

The [MPS](#) advises that if the child is not Gillick competent, the parents can consent on behalf of the child, even if the child is refusing the treatment. However, clinicians should consider carefully whether overriding the consent of a distressed child, given the clinical circumstances at the time, is necessary. Often, if sufficient time is given, the parents will be able to encourage the child that the intervention will be beneficial.

There is a duty to keep the child's best interests at the heart of any decision and the child or young person should be involved in the decision-making process as far as possible. However, it is deemed good practice to involve the family or carers of the child in the decision-making process providing the child is content for this information to be shared.

A competent child is legally entitled to withhold consent to treatment. However, if the treating clinician believes that the withholding of consent may be detrimental to the patient's wellbeing, legal advice may be required. It may be necessary for a court to

determine whether treatment can be given against the wishes of the competent young person.

It should be noted that while there is no lower age limit for Gillick competence or Fraser guidelines to be applied, it would rarely be appropriate or safe for a child who is under 13 years of age to consent to treatment without a parent's involvement.

Further detailed information on obtaining permission for children and young people can be sought from [CQC GP Mythbuster 8: Gillick competence and Fraser guidelines](#) and [NSPCC](#).

### **3.10 Safeguarding concerns for under 16-year-olds**

If a young person under the age of 16 presents to a member of the healthcare team then discloses a history raising safeguarding concerns:

- If they are not deemed to be Gillick competent, healthcare staff are obliged to raise the issue as a safeguarding concern and escalate their concerns through the safeguarding process
- If they are deemed to be Gillick competent and disclosure is considered essential to protect them from harm or to be in the public interest, the staff member should escalate concerns through the safeguarding processes
- In both cases, the healthcare staff member should inform the young person of this action unless doing so could pose significant additional risk for their safe care

It is reasonable for the local authority or police to decide whether it is appropriate to inform the parents of the concerns raised. In some circumstances, this may not be in the best interest of the young person.

When it comes to sexual health, those under 13 are not legally able to consent to any sexual activity and therefore any information that such a person was sexually active would need to be acted on regardless of the results of the Gillick test.

### **3.11 Contact details for young people**

At this organisation, requests from young persons who may wish for their personal contact details to be used to contact them as opposed to their parents or those who have parental control will be considered. In these instances, the organisation always consider the patient's capacity and whether this is in their best interest.

### **3.12 Parental consent**

The MPS document titled [Consent](#) provides detailed information on the subject of parental consent and the actions that are needed should parents withhold consent to the treatment of their child, likewise parental actions for a non-compliant child. In all instances, working with the child and family to overcome the issues would be appropriate.



Parental responsibility includes the right to consent to medical treatment on behalf of the child and the disclosure of information held by the organisation about the child. Those with parental responsibility also have a statutory right to apply for access to their children's health records unless the child is capable of consenting.

In the case of immunisation, the consent of one adult is usually acceptable as detailed at [Children Act 1989 s2.7](#) but, if one adult consents and the other disagrees, the immunisation should not be carried out unless both adults with parental responsibility agree to the immunisation or there is court approval for the immunisation to be administered as it is in the best interests of the child.

The Department of Health and Social Security (DHSS) also states that immunisation is an 'important decision' and immunisations should not be administered if two adults with parental responsibility cannot reach an agreement. In such cases, it is advised that the decision be referred to the courts.

Should there be any dispute, any Partner, plus the Practice Manager, are to be consulted as to the most appropriate way to resolve the dispute. The advice of the medical protection body should, where necessary, be obtained. Further reading can be found at the NHS webpage titled [Children and young people](#).

### **3.13 Immunisations**

The general principles of consent apply to the administering of immunisations by a clinician. The process of obtaining consent should be the same whether the consent obtained is written, verbal or implied (e.g., holding out an arm to be vaccinated).

In accordance with [The Green Book – Consent](#) 'There is no requirement for consent to immunisation to be in writing, but it is good clinical practice to record that a discussion has taken place and consent has been obtained. The completion of a consent form is not a substitute for the provision'.

For a patient requiring a course of vaccinations, consent must be obtained each time they attend to have a vaccination.

### **3.14 Lack of mental capacity**

Patients who do not have the capacity to make an informed, voluntary decision are protected under the [Mental Health Act \(MHA\) 2005](#). The MHA only applies to those patients living in England and Wales.

A person is defined as lacking capacity if 'they are unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain'.

Patients lacking capacity have the following rights:

- All decisions will be made in the best interest of the patient
- The liberty of a patient will only be taken in very specific situations. This is referred to as a deprivation of liberty and will only be used if it is the least restrictive way of keeping a patient safe or ensuring the correct medical treatment is provided

- To have support from an advocate. This is someone who acts on the patient's behalf but does not have legal authority to make personal or financial decisions on behalf of the patient
- To have a deputy appointed by the court to make personal or financial decisions for the patient
- To receive guidance from the Court of Protection
- With a severe mental health condition where a patient lacks the capacity to consent to the treatment of their mental health under the MHA, in these cases treatment for unrelated physical conditions will still require consent which the patient may be able to provide despite their mental health condition

Further reading can be sought from the NHS webpage titled [Consent to treatment](#)

The MHA 2005 requires that appropriate steps are taken to enable the patient to make the decision for themselves. These include:

- Providing relevant information, including choice regarding alternative treatment/procedures
- Communicating in an appropriate way, i.e., presenting information in a different manner so it is easier for the patient to understand
- Putting the patient at ease, discussing the matter when the patient feels confident to do so, such as in the morning or afternoon
- Seeking additional support so that the patient has a friend or relative who is able to help them to understand and make a choice

For further information, refer to the [Mental capacity act policy](#) and [www.mind.org.uk](http://www.mind.org.uk).

## Annex A – Consent form

<b>CONSENT FORM</b>			
<b>PATIENT AGREEMENT TO INVESTIGATION OR TREATMENT</b>			
This form is to be used for treatment, immunisation, examination or minor operation			
<b>PATIENT DETAILS</b>			
<b>Surname</b>		<b>Forename</b>	
<b>Title</b>		<b>Sex</b>	
<b>NHS No.</b>		<b>Date of birth</b>	
<b>PROCEDURE DETAILS</b>			
The clinician has discussed with the patient the following:			
<ul style="list-style-type: none"> <li>• The nature of the procedure, techniques used and aftercare</li> <li>• The associated benefits and risks</li> <li>• Any follow-up procedures, examinations or other pertinent information</li> <li>• The rights of the patient</li> </ul>			
<b>Name of clinician</b>		<b>Role</b>	
<b>Date of procedure</b>		<b>Location</b>	
<b>Type of procedure</b>			
<b>Clinician's signature, print name and date</b>			
<b>PATIENT CONSENT</b>			
I understand the need for and consent to the procedure detailed above. I confirm that I have been given all the required information about the procedure, including techniques, aftercare, benefits, risks and the required follow-up process.			
I also have been advised of my rights as a patient.			
<b>Signature of patient</b>			
<b>Date of signature</b>			