

Patient Consent Policy

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Introduction

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

The Department of Health has issued a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Healthcare professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

Specific guidance, incorporating both the law and good practice advice, is available for healthcare professionals working with children, with people with learning disabilities and with older people.

Principles of Consent, Competence and Capacity

Before examining, treating or caring for competent adult patients their consent must be obtained.

Adults are always assumed to be competent unless demonstrated otherwise. If there are any doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?”. This is to assess their capacity.

Unexpected decisions do not prove the patient is incompetent or lacks capacity, but may indicate a need for further information or explanation.

Patients may be competent to make some health care decisions, even if they are not competent to make others.

Giving and obtaining consent is usually a process, not a one-off event. Patients can change their mind and withdraw consent at any time. If there is any doubt, the clinician should always check that the patient still consents to being cared for or treated.

What consent is – and isn't

“Consent” is a patient’s agreement for a healthcare professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), verbally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision
- have received sufficient information for it to be informed
- not be acting under duress

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The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a healthcare professional's advice. In some cases, the healthcare 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 healthcare 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 healthcare professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the healthcare professional's clinical knowledge.

Who should seek consent

It is always best for the person actually treating the patient to seek the patient's consent.

The Department of Health has issued a range of guidance documents on consent which should be consulted for details of the law and good practice.

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

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

Any clinician carrying out a procedure must be conversant with the technique and capable of providing information on informed consent. Only a clinician conversant with a procedure will be able to achieve consent.

Provision for patients whose first language is not English

BrisDoc is committed to ensuring patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. Children or a family member of the patient should not be relied upon to interpret unless the clinician feels this is appropriate to the situation.

If felt not then the appropriate interpretation service should be accessed. In addition, the support of a Health Link Worker, where this service is available in a practice, may be used.

Children and consent

Before examining, treating or caring for a child, consent must be sought just as for an adult.

Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be

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reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent.

Legally, a parent can consent if a competent child refuses treatment, but it is likely that taking such a serious step will be rare.

Treatment of young children

When babies or young children are being cared for, it will not always be practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests. However, it should be remembered that, in law, such consent is required.

Where a child is seen, necessary routine procedures should be discussed with parents and their consent gained in advance for these interventions. If parents specify that they wish to be asked before particular procedures are initiated this must be respected unless the delay involved in contacting them would put the child's health at risk.

Only people with 'parental responsibility' are entitled to give consent on behalf of their children. Healthcare professionals must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If there is any doubt about whether the person with the child has parental responsibility for that child, then the healthcare professional must check.

The concept of Gillick competence

In the case of *Gillick*, the court held that children who have 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. This is sometimes described as being 'Gillick competent'.

The Gillick competencies are assessed using the Fraser guidelines - a child of under 16 years may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent.

The concept of Gillick competence is said to reflect a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus, a child under 16 years may have the capacity to consent to some interventions but not to others. The child's capacity to consent should be assessed carefully in relation to each decision that needs to be made.

In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly Gillick competent at the time that they need to take a relevant decision.

If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared.

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Where advice or treatment relates to contraception, or the child's sexual or reproductive health, the healthcare professional should try to persuade the child to inform his or her parent(s), or allow the medical professional to do so. If, however, the child cannot be persuaded, advice and/or treatment should still be given if the healthcare professional considers that the child is very likely to begin or continue to have sexual intercourse with or without advice or treatment, and that unless they receive the advice or treatment then the child's physical or mental health is likely to suffer.

If the child seeks advice or treatment in relation to e.g. termination and cannot be persuaded to inform her parent(s), every effort should be made to help the child find another adult (such as another family member or a specialist youth worker) to provide support to the child.

When an adult lacks capacity

No-one can give consent on behalf of an adult without capacity. However, the patient may still undergo treatment if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to provide information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

When determining what is in the person's best interests a healthcare professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the healthcare professional must not be motivated by a desire to bring about the person's death.

The Mental Health Act 1983 also requires that, as far as possible healthcare professionals must consult other people if it is appropriate to do so, and take into account their views about what would be in the best interest of the person lacking capacity, as someone to be consulted and who is engaged in caring for patient and their family and friends.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. 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.

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 is potentially serious, a court declaration may be sought.

Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act introduced a duty for the NHS to instruct an Independent Mental Capacity Advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one, other than paid staff, who can speak for them. IMCAs are not decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the Act.

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Lasting Power of Attorney and Court-Appointed Deputy

A person over the age of 18 can appoint an attorney to look after their health and welfare decisions, if they were to lack the capacity to make such decisions in the future. Under a Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests.

The Court of Protection can appoint a deputy to make decisions on behalf of a person who lacks capacity.

Refusal of treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's options. A competent adult patient is entitled to refuse any treatment, except in circumstances governed by the *Mental Health Act 1983 (amended 2007 and 2017)*. The situation for children is more complex: see the Department of Health's *Seeking consent: working with children* available by searching on the nationalarchives.gov.uk website.

Competent adult patients are entitled to refuse treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983.

A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

If after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already given consent, but then changes their mind, the healthcare professional should document this in the patient notes.

Where a patient has refused a particular intervention, any other appropriate care to which they have consented must be provided. The patient must be informed that 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.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, the possible consequences of their partial refusal must be explained. If it is genuinely believed that a procedure cannot be safely carried out under the patient's stipulated conditions, the healthcare professional is not obliged to perform it. Any other appropriate care must continue to be provided.

Documentation

For significant procedures, it is essential for healthcare 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 (written or electronic) that they have given oral consent.

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Written consent

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.

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

Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in the patient's notes. In addition, an assessment of the patient's capacity should be made. The assessment should record why the healthcare professional believes any proposed treatment to be in the patient's best interests, and the involvement of people close to the patient, or Independent Mental Capacity Advocate (IMCA) where appropriate.

Single stage process

In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient.

For example, during a consultation an examination of the abdomen may be required. If the patient is willing to consent for the examination consent will be given verbally.

As long as it is clear that the patient understands and consents, the healthcare professional may then proceed.

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Change Register

Date	Version	Author	Change Details
July 2016	1.1	CL Nicholls	Inclusion of new values picture
November 2018	1.2	CL Nicholls	Inclusion of Big Word interpretation services used by Practice Services. Mapped into new template.
January 2022	1.3	CL Nicholls	Inclusion of Mental Health Act for 2017 version
4 th March 2025	1.4	R Hancock	Removal of related policies section. Policy re-ordering and minor adjustment to consent with children section to be service specific.
08/12/2025	1.5	R Hancock	Full review and not aware of any legislative changes or other updates required.