The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Consent for Examination or Treatment  
(with reference to the Mental Capacity Act 2005)

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1 Introduction

1.1 Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Consent is a patient's agreement for a health professional to provide care. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Consent must be obtained before any examination, treatment or care for competent adult patients. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), verbally, or in writing.

1.2 Consent is a continuous process rather than a one-off decision. It is important that the patient is given continuing opportunities to ask further questions and to review the decision. Patients can change their minds and withdraw consent at any time, as long as they have the capacity to do so.

1.3 Particular criteria must be met if with-holding consent is likely to impact on life sustaining treatment and this policy should be read in conjunction with the policy “Advance Decision to Refuse Treatment”¹, (available on the Trust Intranet Site) and the Mental Capacity Act’s Code of Conduct (Department of Health, 2005)².

1.4 The Department of Health has issued a number of guidance documents on consent. These should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies. Reference guide to Consent for Examination or Treatment ³ 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. Copies may also be accessed on the Internet at www.doh.gov.uk/consent. A copy of the Department of Health’s 12 key points on consent: the law in England is attached as Appendix 1

1.5 In recognition of the significance of consent the Care Quality Commission (CQC) include consent as part of their ongoing monitoring process of “essential” standards. From April 2015 the CQC will move from monitoring “essential” to
“fundamental” standards. “Need for Consent” will continue to be a standard in its own right and will relate to all of the fundamental standards. Breaches of “Need for Consent” or its components will constitute a prosecutable offence. This means that where care and treatment is given without valid consent, and/or against the specific wishes of the service user or without lawful authority, CQC can move directly to prosecution without first serving a warning notice.

2 **Scope**

2.1 This policy aims to ensure that all Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) staff who are involved in undertaking the consent procedure comply with the following policy.

2.2 It is a health professional’s own responsibility:
- to work within their own competence and not to agree to perform tasks which exceed that competence.
- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so.

2.3 Line Managers have a responsibility to ensure all current and new staff are aware of their responsibilities in terms of obtaining consent to provide care and treatment.

2.4 Responsibility for ensuring the application of this policy lies with the Clinical Director of each Directorate, supported by the Directorate Manager.

2.5 Where application of this policy can not be achieved an Incident/Accident/Near Miss reporting form should be completed with a full explanation and methods of remedial action.

3 **Aims**

The guidance offered in this document applies to all staff with responsibilities for obtaining either formal or informal consent and all staff who support the process.

4 **Duties**

4.1 **Trust Board**

The Trust Board is responsible for implementing a robust system of risk management within the organisation. This includes having a system of incident reporting and investigation.

4.2 **Chief Executive**

The Chief Executive is responsible for the statutory duty of quality and clinical governance and takes overall responsibility for this policy.
4.3 **Director of Quality and Effectiveness**  
- has the lead responsibility for consent policy within the Trust  
- monitors incident and audit data for themes and trends, ensures appropriate actions are undertaken if deviation from Trust policy is identified  
- is responsible for taking action in response to any matter arising out of incidents reported and the annual consent audit.

4.4 **Clinical Governance and Quality Committee**  
The role of this Committee is to provide assurance to the Board of overall compliance with all statutory and regulatory obligations. This includes compliance with the Trust’s consent standards. Where specific risks are identified the Committee will refer to the Clinical Risk Group.

4.5 **Clinical Risk Group**  
The group is responsible for;  
- reviewing results of annual consent audit and reported incidents and ensuring appropriate actions are undertaken where necessary.

4.6 **Clinical Directors**  
The Clinical Director is responsible for;  
- deciding whether it is appropriate for consent to be delegated in their department  
- Where applicable;  
- ensuring a formal process of assessing staff’s ability to obtain delegated consent is established  
- ensuring a record of all the staff who are competent to undertake delegated consent, for which procedures and treatments is held centrally and the Clinical Governance and Risk Department is provided with an update of staff registered to obtain delegated consent on a quarterly basis  
- responding to any action highlighted by the annual consent audit.

4.7 **Directorate Managers**  
The Directorate Manager is responsible for ensuring;  
- all members of staff involved in taking consent are fully conversant with the contents of the policy  
- all relevant staff fulfil the standards expected by the Trust and use the appropriate consent forms and patient information leaflets  
- any deviation from the policy is fully investigated and appropriate actions undertaken.

4.8 **Ward Managers/ Head of Department**  
Managers are responsible for ensuring;  
- policy implementation and compliance in their area(s). This includes ensuring that all staff are aware of this policy as part of their Induction to the Trust  
- non compliance with the policy is investigated and addressed appropriately.
4.9 All staff involved in obtaining consent or who support the consent process must:

- Complying with the consent standards in this policy
- Attending Essential Learning Training as per Trust Training Matrix
- Using Trust consent forms
- Only using leaflets that have been approved for use within the Trust
- Being aware of what information is available to patients
- Actively sharing information with patients about services, treatment and care
- Documenting in the patients' health records the discussion and provision of information to patients
- Reporting any incidents involving consent via Trust reporting systems.

5 Definitions

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

5.2. For consent to be valid, the person giving consent must:

a) be competent to take the particular decision (see sections 8 for information on MCA & section 9 regarding children)

b) have received sufficient information to allow a decision to be made; including benefits & risks of proposed treatment (including risk of mortality) and alternative treatments

c) not be acting under duress.

The person obtaining consent must be:

a) competent to perform the procedure discussed

OR

b) be suitably trained and qualified to obtain delegated consent for the procedure discussed and have been assessed as competent to undertake delegate consent.

6 Consent

6.1 Format of Consent

6.1.1 The validity of consent does not depend on the form in which it is given. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid. Consent must be given without pressure or undue influence being exerted on the person either to accept or refuse treatment. A signature on a consent form
does not itself prove the consent is valid – the point of the form is to record the patient’s decision, and the discussions that have taken place.

6.1.2 Although completion of a consent form is in most cases not a legal requirement (exceptions include certain requirements of the Mental Health Act 1983⁶ and of the Human Fertilisation and Embryology Act 1990⁷ as amended by the Human Fertilisation and Embryology Act 2008) the use of such forms is good practice to take written consent in any of the following circumstances:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the service user’s Employment, social or personal life
- treatment is part of a project or programme of research approved by the Trust.

6.2 Provision of patient information

6.2.1 The provision of information is central to the consent process. To validate the consent the person needs to understand the nature and purpose of the procedure. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on. Patients need sufficient information (written or verbal) clearly communicated to them by the healthcare professional before they can decide whether to give their consent including information about the benefits and risks of the proposed treatment, and alternative treatments, including the option to have no treatment.

6.2.2 Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Traditionally in considering what information to provide on risks the person obtaining
consent should communicate those risks which a responsible body of practitioners in that speciality would communicate ‘Bolam Test’). This is no longer sufficient the Montgomery ruling in March 2015 judged that it was for patients to decide whether the risks of treatment and alternative options have been adequately communicated. The Montgomery ruling means that doctors will have to take “reasonable care to ensure that patients are aware of any material risks involved in any recommended treatment and of any reasonable alternative or variants in treatment.” This means that in considering what information to share with patients the person obtaining consent must now consider what a “reasonable person in the patient’s position would do”. Information given to a patient to support their decision making must be documented on the consent form.

Where the patient makes clear (verbally or non-verbally) that they do not wish to be given information about the treatment proposed, this also should be documented on the consent form. If a hazard that should have been mentioned is not mentioned, the law will impose an obligation to compensate if that hazard occurs. Recent court judgments (Chester vs Afshar) have reinforced the importance of identifying serious risk to the patient, even if that risk is relatively rare. This applies especially if the patient may choose an alternative treatment or no treatment at all if made aware of the risk. It is therefore advisable to inform the person of any ‘material’ or ‘significant’ risks or unavoidable risks, even if small, in the proposed treatment; any alternatives to it; and the risks incurred by doing nothing. A Court of Appeal judgment has stated that it will normally be the responsibility of the doctor to inform a patient of ‘a significant risk which would affect the judgment of a reasonable patient’. For a list of significant cases relating to consent see appendix 2.

The General Medical Council advises that medical discussions should focus on the ‘patient’s individual situation and priorities when providing information about treatment options. Clear, accurate (written or verbal) information should be given to the patient about the risks (including risk of mortality), benefits and alternatives of any proposed investigation or treatment, presented in a balanced way the patient can understand to help them make informed decisions. This form of consent facilitates shared decision making taking the informed consent one step further by allowing the clinician and the patient to discuss the options available. What is important to the patient and the effects of any of the proposed options on the values of the patient. Further information regarding shared decision making is available via the Clinical Governance and Risk Department intranet page. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
6.2.3 Information given to a patient to support their decision making, in particular details of risks and benefits, including mortality risk, where applicable and details of alternative treatments must be documented on the patient’s consent form. Details of any supplementary information provided to the patient such as information leaflets must also be documented on the consent form. Patient information should be the latest version, the version given should be clearly documented. Trust produced information leaflets must be endorsed and archived as outlined in the Patient Information Policy. Where information leaflets are used from external sources the practitioner must ensure that the leaflets reflect best practice and the information leaflet version is clearly documented.

6.2.4 If consent is given over a two stage process (for example: in an outpatient department and/or within primary care or via post for an elective procedure and the patient is admitted at a later date) the healthcare team should confirm that the patient would like to proceed with their decision, if they have any further concerns or would like to reconsider their decision. A health professional involved in the patient’s care when re-admitted should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. If the patient has any queries or concerns he or she must be given time to consider any additional information. Any misrepresentation of the decision will invalidate consent.

6.2.5 Where an anaesthetist is involved in a patient’s care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient’s notes and on the consent form whenever possible. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

6.2.6 In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.
6.2.7 If a student or trainee is carrying out the procedure to further their own education (for example: physical examination) verbal consent is required for this to take place.

6.3 Emergencies

Consent needs to be sought for emergency treatment from competent patients. During an emergency situation the two stage process where discussion of options and confirmation that the patient wishes to go ahead with the procedure will follow straight on from each other. Documentation of the discussion and patient’s consent should be clearly recorded on the consent form. Additional information may also be documented in the medical record. The urgency of the patient’s situation may limit the quantity of information that they can be given but should not affect the quality. If emergency treatment is required and the patient does not have capacity to give consent due to being physically or mentally incapacitated, treatment may be carried out. The two stage MC assessment should be undertaken. If the emergency is so great that there is no time to complete the assessment this information must be documented retrospectively. Once recovered the reasons why treatment was necessary should be fully explained to the patient. However there may be clear evidence of a valid advance refusal of a particular treatment. Provided such advanced decision is valid and applicable that treatment should not be given and the decision to refuse treatment should be respected. (See Trust policy on Advance Decisions)

6.4 Additional procedures

During an operation it may become evident that the person could benefit from an additional procedure that was not within the scope of the original consent. If it would be unreasonable to delay the procedure until the person regains consciousness (for example because there is a threat to the person’s life) it may be justified to perform the procedure on the grounds that it is in the person’s best interests. However, the procedure should not be performed merely because it is convenient. For example, a hysterectomy should never be performed during an operation without explicit consent, unless it is necessary to do so to save life.

If a person has refused certain additional procedures before the anaesthetic (for example, specifying that a mastectomy should not be carried out after a frozen section biopsy result), then this must be respected if the refusal is applicable to the circumstances. The GMC guidance states that it is good practice to seek the views of the patient on possible additional procedures when seeking consent for the original intervention.

6.5 Withdrawal of Consent

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

6.6 Consent Documentation

6.6.1 For 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 they have given verbal consent. Further information can be accessed through the intranet at: Clinical Recording and Patients

6.6.2 Standard consent forms and forms for adults who are unable to consent for themselves are available through the normal supply service and should be available wherever a relevant procedure will be undertaken. There are four versions of the standard consent form:

- **form 1** for adults or competent children
- **form 2** for parental consent for a child or young person and
- **form 3** for cases where it is envisaged that the patient will remain alert throughout the procedure and does not involve any impairment in consciousness
- **form 4** should be used when considering consent issues for patients who lack mental capacity.

6.6.3 Directorates are encouraged to use the above mentioned standard consent forms. However, special dispensation may be granted by the Clinical Records Advisory Group to allow the development of procedure-specific consent forms.

6.6.4 All new consent forms must be formally approved by the Clinical Records Advisory Committee (CRAC) (see appendix 3 - Process for introducing consent forms flowchart). To obtain formal approval for new consent forms a proposal for new consent form (appendix 4) must be completed and returned to CRAC. If the proposal for the new consent form is accepted by the Committee a copy of the new consent form and Risk Assessment (appendix 5) must then be submitted to the Committee. New consent forms must be produced using the template for new consent forms. Please see the CGARD template (appendix 8). The content of new consent forms must be given the approval of two senior clinicians who regularly undertake the procedures prior to submission of the proposed consent forms submission to CRAC.
6.6.5 All consent forms (excluding consent forms 1-4 which must be ordered via supplies & the “consent form for non-proceeding living kidney donation for intended recipient” which can be printed directly from this policy - see appendix 6) must be produced in conjunction with Q-pulse document control system.

6.6.6 Completed consent forms should be kept with the patient’s notes. Any changes/modifications to the consent form after it has been signed by the patient should be signed and dated by both the patient and healthcare professional involved in the procedure. If the patient’s records are electronic, the consent document must be signed and then scanned in to the record. A copy of the signed consent form should be offered to the service user.

6.7 Exceptions to Consent process

There are a number of exceptions whereby a capable person can be treated without first obtaining their consent. In these cases, the healthcare professionals can go ahead and give treatment if they believe that it is in the person’s best interests. These exceptions are listed below.

- Under the terms of the Public Health (Control of Disease) Act 9, a magistrate can order that a person be detained in hospital if they have an infectious disease that presents a risk to public health. Diseases that are covered by the Act include rabies, cholera, and anthrax.

- Under the terms of the National Assistance Act 10, a person who is severely ill, or infirm, and living in unsanitary conditions, can be taken to a place of care without their consent.

- Under the terms of the Mental Health Act 6, people with certain mental health conditions, such as schizophrenia, bi-polar disorder, or dementia, can be compulsorily detained at a hospital, or psychiatric clinic, without their consent.

6.8 Refusal of Treatment

An adult with capacity is entitled to refuse any treatment (whether at the time or in advance). This decision must be respected, except in circumstances governed by the Mental Health Act 1983 6 (part 4 sets out circumstances in which persons liable to be detained under the Act may be treated without consent for their mental disorder).

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 signed a consent form but then changes their mind, the health professional, and where possible the patient, should note this on the form.
If a Personal Welfare Lasting Power of Attorney (LPA) or a court Appointed Deputy has been appointed and they have the authority to do so – they can make decisions and consent to or refuse treatment as validly as those made by the person themselves.

If there is no LPA and the adult does not have capacity then the Court of Protection can make an order making a decision on their behalf or appoint a deputy to make a decision on behalf of the person who lacks capacity.

If a young person aged 16 -17 or child under 16 and deemed Gillick competent refuses treatment, it is possible in certain circumstance that the decision is overridden by either a person with parental responsibility or a court (for example: if treatment is refused and the outcome will probably lead to death or severe permanent injury to the child/young person or where there is a serious and imminent risk that the child/young person will suffer grave and irreversible mental or physical harm). Power to over-rule may be given to any one parent or person who has ‘parental responsibility’ or the court if need be. In cases where the child’s best interest is disputed a court decision may be required.

6.9 **Assessing capacity**

6.9.1 The Mental Capacity Act (MCA 2005) applies in England and Wales to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves. The MCA 2005 states ‘A person must be assumed to have capacity unless it is established that he lacks capacity.’

The MCA 2005 defines a lack of capacity as follows:

‘For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’ MCA Code of Practice.

6.9.2 A person is entitled to make a decision which may be perceived by others to be unwise or irrational as long as they have the capacity to do so.

6.9.3 All people aged 16 and over are presumed, in law, to have the capacity to consent to treatment unless there is evidence to the contrary. A patient who is suffering from a mental disorder or impairment does not necessarily lack the competence to consent to treatment. Competent adult patients are entitled to refuse treatment, even where 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.
6.9.4 Where there is doubt about a person’s capacity they must be assessed using the MCA two stage test of capacity. If following the two stage test of capacity it is deemed that the person lacks capacity to give consent then any decision taken must follow the ‘Best Interests’ principle. The Trust MCA Policy should be followed. Forms MCA 1, (Record of a Mental Capacity Assessment) and MCA 2, (Record of actions taken to make a best interest decision) are available on the Trust Intranet (Safeguarding Adults web pages).

6.9.5 The decision of whether or not the patient has capacity is ‘decision and time specific’ and therefore must relate to the procedure being proposed. An optimal time for the patient during the day must be chosen when the assessment of capacity takes place. An appropriate location and respect and dignity for the patient should be maintained at all times and support from other people or professionals should be offered as required. If the person has capacity, but is unable to read or write, they may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes. If the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes. Alternatively, the person can direct someone to sign the form on their behalf, but there is no legal requirement for them to do so. If consent has been given validly, the lack of a completed form is no bar to treatment, but a form can be important evidence of such consent.

6.10 Lack of capacity

6.10.1 In most cases, parents, relatives or members of the healthcare team cannot consent on behalf of such an adult. The MCA 2005 sets out the circumstances in which it will be lawful to carry out such examinations or treatment. Consent may be given by someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy.

6.10.2 A patient who lacks capacity can, following a capacity assessment consultation may be given treatment if it is in their best interests in accordance with the MCA as long as this has not been refused by a valid and applicable Advance Decision, LPA or Court Appointed Deputy. Legally an advance decision is a refusal of treatment made, in advance, at a time when the adult has capacity to make it and made in accordance with the provisions of the MCA 2005. Unlike Advanced Decisions, Advance Statements are not legally binding but are indicative of the service users’ preferences and wishes and should not be ignored. For
further details on advance directives see the Department of Health’s Reference /Guide to Consent for Examination or Treatment. Information on making care decision in advance is available in the Deciding Right document.

6.11 Independent Mental Capacity Advocate (IMCA)

6.11.1 The MCA imposes a statutory duty on the NHS body to instruct an Independent Mental Capacity Advocate (IMCA) in certain circumstances.

An IMCA **MUST** be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever;

- An NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than eight weeks.

An IMCA **MAY** be instructed to support someone who lacks capacity to make decisions concerning:
- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved.

6.11.2 The IMCA’s role is to support and represent the person who lacks capacity. Because of this, the IMCAs have the right to see relevant healthcare and social care records. For more information regarding IMCA referrals see MCA code of practice / MCA Policy.

6.11.3 Any decisions regarding treatment limitation on the basis of quality of life and burden of treatment must abide by current UK legislation including the MCA 2005 and the Human Rights Act 1998. If you require further guidance about on the involvement of IMCA please refer to the checklist in the Best Practice Guidance “The Involvement of IMCA in Serious Medical Treatment Decisions”

6.12 Children/Young People

6.12.1 Parental Responsibility

Only people who have ‘parental responsibility’ are entitled to give consent on behalf of their children. Not all parents have parental responsibility for their children (for example: unmarried fathers do not automatically have such responsibility although they can acquire it).
6.12.2 When babies or young children are being cared for, it will not usually seem practicable to seek their parents’ consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child’s health at risk.

6.12.3 Children under 16 – the concept of Gillick competence
The concept of 'Gillick' competent is when a child is deemed to have the understanding and intelligence to enable them to understand fully what is involved in a proposed intervention and have the capacity to consent to that proposed intervention. Additional consent by a person with parental responsibility is not required. However, it is good practice to involve the child’s family in the decision-making process.

In some cases a child’s mental state may fluctuate significantly. Hence careful consideration should be taken in the decision whether the child is truly Gillick competent and has the capacity to consent at the time they need to make a relevant decision.

6.12.4 Young people aged 16-17
By virtue of the Family Law Reform Act 1969 young people who are aged 16-17 are presumed to be capable of consenting to their own medical treatment. Consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention.

In order to establish whether a young person aged 16-17 has the requisite capacity to consent to the proposed intervention, the same criteria as for an adult should be used (see section 7).

If the 16-17 year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility. However it is good practice to involve the young persons’ family in the decision-making.

6.12.5 Refusal of treatment
Where a young person of 16 or 17 who could consent to treatment in accordance with section 8 of the Family Law Reform Act 1969, or a child under 16 but Gillick competent, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury.
The courts have, in the past, also found that parents can consent to their competent child being treated even where the child/young person is refusing treatment. However, there is no post-Human Rights Act 1998 authority for this proposition, and it would therefore be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

(Reference guide to consent for examination or treatment Second edition)

6.12.6 Children lacking capacity
Where a child under the age of 16 lacks capacity to consent (i.e. is not Gillick competent), consent can be given on their behalf by any one person with parental responsibility (if the matter is within the ‘zone of parental control’).

6.13 Provision of consent by anyone other than a competent patient
Consent may be given by someone with parental responsibility (see section 9), someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy.

6.14 Delegated consent
The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person’s care will remain ultimately responsible for the quality of medical care provided.

The GMC guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified and are competent to do so, to work within their own competence and not to agree to perform tasks which exceed that competence. They must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved, in order to be able to provide any information the patient may require.

Competence records must be held by each Directorate in which consent is delegated. It is the Directorate’s responsibility to establish a formal process of assessing staffs ability to obtain delegated consent and to keep a record of all the staff who are competent to undertake delegated consent and for which procedures and treatments. The Directorate is responsible on a quarterly basis for providing the Nurse Specialist – Patient Safety with an update of any procedures for which consent is delegated.
If a clinician takes consent for a procedure they are not competent to perform and have not been formally assessed as being competent to take delegated consent an incident form must be completed and the incident investigated by the Directorate.

6.15 Removed tissue

The Human Tissue Act 2004 makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or the deceased for specified health-related purposes and public display. It also covers the removal of such material from the deceased. This Trust requires that patients should be given the opportunity to refuse permission for tissue to be taken from them during surgery or other procedures to be used for education or research purposes (Appendix 7). The Human Tissue Act 2004 which is in force now does not require consent for use of tissue from the living individuals for the purpose of public health surveillance but the Act requires that explicit consent is taken from families of the deceased individuals for such use of the tissue.

Further information can be accessed through the Clinical Governance website at: Organ Tissue Donation

6.16 Clinical Photography and audio recordings

Consent should be obtained for any visual or audio recording, including photographs or other visual images. The purpose and possible future use of the recording must be clearly explained to the person before their consent is sought for the recording to be made. If it is to be used for teaching, audit or research, people must be aware that they can refuse without their care being compromised and that when required or appropriate it can be anonymised. Further information can be accessed through the Clinical Governance website at: Medical photography service guidance within working hours

6.17 Requirements concerning gametes

It is a legal requirement under the Human Fertilisation and Embryology Act 2008 that consent must be obtained in writing before a person’s gametes can be used for the treatment of others, or to create an embryo in vitro. Consent in writing is also required for the storage of gametes. Information and an opportunity to receive counselling must be provided before the consent is given. Where these requirements are not satisfied, it is unlawful to store or use the person’s gametes for these purposes. Clinicians should ensure that written consent to storage exists before retrieving gametes.

6.18 Post Mortem consent

The process of obtaining consent to post mortem is outlined in the Care after Death Policy/Procedural Guidelines for the Acute Setting.
7 Training

7.1 Generic consent training

It is recommended as best practice that staff with responsibility for obtaining written consent undertake the Trust solicitors’ training a minimum of every 5 years. This consists of an online training module and a face to face training session with the Trust solicitors.

It is recommended as best practice that staff with responsibility for supporting the consent process undertake the one off online Consent for Examination and Treatment training.

It is recommended as best practice that new medical staff receive training on how to obtain consent as part of the medical staff induction programme.

A training needs analysis should be undertaken by the Directorate Management Teams to identify the training needs of all staff in relation to consent. Consideration must be given to ensure competencies set meet individual staff needs.

7.2 Delegated Consent Training

The GMC guidance states that the task of seeking consent may be delegated to a professional who is not able to perform the specified procedure, as long as they are suitably trained and qualified and are competent to do so. They must have sufficient knowledge of the proposed investigation or treatment and understand the risks involved in order to be able to provide any information the patient may require.

Training programmes and competency assessment for health professionals involved in the consent process, who do not themselves carry out the specific procedure (delegated consent), should be developed within the relevant Clinical Directorates. This training and assessment should be provided by a person competent to undertake the procedure. Training should relate to a specific procedure or groups of procedures and cover the knowledge and skills required to enable the practitioner to advise the patient and respond to specific queries in relation to all issues.

To allow the Trust to identify clinical staff who are not capable of performing a procedure but who are authorised to obtain consent for that procedure a copy of the training records for delegated consent and for which procedures should be kept at departmental level (Appendix 6) and a copy sent to the Nurse Specialist, Patient Safety. If an individual has obtained consent for a procedure without the authorisation to do so this must be recorded on a Datix incident form and investigated by the
Directorate team. If appropriate the Trust will inform the GMC of an individual who has obtained consent without authorisation.

7.3 Post Mortem consent training

Details of training requirements for obtaining consent to post mortem is outlined in the Care after Death Policy/Procedural Guidelines for the Acute Setting.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring and Review

<table>
<thead>
<tr>
<th>Standard/process/issue</th>
<th>Monitoring and audit</th>
<th>Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring of consent related issues</td>
<td>Consent incident report</td>
<td>Nurse Specialist Patient Safety</td>
<td>Clinical Risk Group</td>
<td>6 monthly</td>
<td></td>
</tr>
<tr>
<td>Record Keeping Audit – inclusive of consent</td>
<td>Audit of Record Keeping</td>
<td>Clinical Effectiveness Manager</td>
<td>Clinical Records Advisory Committee</td>
<td>6 monthly</td>
<td></td>
</tr>
<tr>
<td>Mortality Review for in patient deaths pertaining to patients with learning disabilities – inclusive of consent</td>
<td>Mortality Review</td>
<td>Learning Disability Liaison Nurse</td>
<td>Clinical Risk Group</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Learning Disability Pathway Audit (including consent)</td>
<td>Audit</td>
<td>Learning Disability Liaison Nurse</td>
<td>Clinical Risk Group</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Information given to patients and documented during consent process</td>
<td>Audit of consent information</td>
<td>Nurse Specialist Patient Safety</td>
<td>Clinical Governance and Quality Committee &amp; Clinical Risk Group</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Completion of consent forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10 Consultation and review

The processes in this policy have been reviewed and agreed by the Clinical Risk Group.
11 Implementation

Revised policy with significant changes communicated to all staff via Policy Newsletter.

12 References

5. NUTH (2011) Patient Information Policy & Procedure
9. Public Health (Control of Disease) Act
10. National Assistance Act
12. Deciding Right
   www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1969/cukpga_19690046_en_2#ptH1g8
15. The Human Tissue Act 2004
16. NUTH (2011) Organ, Corneal and Tissue Donation for Transplantation Policy

13 Associated Documents

See list of references

Author: Nurse Specialist Patient Safety
12 key points on consent: the law in England

When do health professionals need consent from service users?

1. Before you examine, treat or care for competent adult service users you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this service user understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the service user is incompetent, but may indicate a need for further information or explanation.

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

4. Giving and obtaining consent is usually a process, not a one-off event. Service users can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the service user still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. 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 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, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the service user to seek the service user’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Service users need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the service user is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the service user gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the service user’s decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.
Refusal of treatment

10. Competent adult service users 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 service user 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.

Adults who are not competent to give consent

11. No-one can give consent on behalf of an incompetent adult. However, you may still treat such a service user 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 service user when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the service user may be able to give you information on some of these factors. Where the service user has never been competent, relatives, carers and friends may be best placed to advise on the service user’s needs and preferences.

12. If an incompetent service user has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an ‘advance refusal’), and those circumstances arise, you must abide by that refusal.
Montgomery v Lanarkshire Health Board [2015] UKSC 11 is a significant case which changes 30 years of practice. Until now, in the United Kingdom, the Bolam test specified that the conduct of the person obtaining consent would be considered acceptable if it would be supported by a responsible body of medical opinion. The Montgomery ruling found that it was for patients to decide whether risks of treatment and alternative options had been adequately communicated.

Nadine Montgomery, who has diabetes, was not told of the risks of shoulder dystocia to her baby boy, who subsequently developed cerebral palsy. Her obstetrician justified holding back this information on the grounds that it might have discouraged her from having a vaginal delivery.

The UK Supreme Court ruling judged that it was for patients to decide whether risks of treatment and alternative options had been adequately communicated. The Montgomery ruling means that doctors will have to take “reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments.”

What counts as a material risk? Here the Supreme Court has landed a clear and crucial blow to medical paternalism. Instead of a responsible body of medical opinion, the judgment now rests with “a reasonable person in the patient’s position.”

The court is uncompromising: the law now obliges “even those doctors who have less skill or inclination for communication, or who are more hurried, to pause and engage in the discussion.”

Ms B v An NHS Hospital Trust [2002] 2 All ER 449
Following an illness, Ms B became tetraplegic and reliant on an artificial ventilator. She asked that the ventilator that was keeping her alive be switched off, and claimed that the continued provision of artificial ventilation against her wishes was an unlawful trespass. The court was asked to decide whether Ms B had the capacity to make the decision about whether the ventilator should be removed. The Court held that Ms B did have capacity to refuse treatment and had therefore been treated unlawfully. Where a patient has the capacity to make decisions about treatment, they have the right to refuse treatment – even when the consequences of such decisions could lead to their death. If a doctor feels unable to carry out the wishes of the patient, their duty is to find another doctor who will do so.

Glass v United Kingdom- 61827-00 [2004] ECHR 103
The European Court of Human Rights held that a decision of health professionals to override the wishes of the mother of a seriously ill child gave rise to a breach of Article 8 of the European Convention on Human Rights. The court was critical of the fact that the courts were not involved at an earlier stage, and held that, in the event of a continued
disagreement between parents and doctors about a child’s treatment, the courts should be consulted, and particularly before the matter reaches an emergency situation.

**Chester v Afshar [2004] UKHL 41**
The House of Lords judgment held that a failure to warn a patient of a risk of injury inherent in surgery, however small the probability of the risk occurring, denies the patient the chance to make a fully informed decision. The judgment held that it is advisable that health practitioners give information about all significant possible adverse outcomes and make a record of the information given.

**Burke v the General Medical Council [2005] 3 WLR 1132**
The Court of Appeal held that the General Medical Council (GMC) guidance on withholding and withdrawing life-prolonging treatment was lawful. A patient cannot demand a particular treatment, but health professionals must take account of a patient’s wishes when making treatment decisions. Where a patient with capacity indicates his or her wish to be kept alive by the provision of Artificial Nutrition and Hydration (ANH), the doctor’s duty of care will require the doctors to provide ANH for as long as such treatment continues to prolong life. Where life depends upon the continued provision of ANH, ANH will be clinically indicated. A health professional who deliberately brought that patient’s life to an end by withdrawing ANH would be in breach of their duty of care and guilty of murder. If the patient lacks capacity, all reasonable steps that are in the person’s best interests should be taken to prolong their life. Although there is a strong presumption in favour of providing life-sustaining treatment, there are circumstances when continuing or providing life-sustaining treatment stops providing a benefit to a patient and is not clinically indicated.
Appendix 3

Process for introducing consent forms – flowchart

Complete consent proposal form (appendix 4) and submit to CRAC

- Proposal accepted
- Proposal rejected. Rationale for rejection provided. Recommendations made

- Complete template for consent form
- Complete risk assessment tool for consent form

Submit completed template and risk assessment to CRAC

- New consent form approved
- New consent form rejected

- Agreement to permanently introduce consent form into clinical practice & notify Consent Policy author
- Agree to pilot new consent form

- Contact supplies to arrange printing
- Pilot consent form with formal review submitted to CRAC within 3 months

Final decision regarding document approval

KEY
Applicant Actions
Committee Actions
Appendix 4

New consent proposal form

Procedure details

Procedures for which it is proposed that a specific consent form is designed

Directorate/s in which it is proposed the consent will be used

Average number of procedures undertaken per year

**Rationale for introduction of consent form** (please outline why the standard forms are not appropriate for the proposed procedure and give full details of how the new form will improve practice, patient safety etc)

Contact details of clinician proposing new consent form

Name

Designation

Telephone

Email

Please forward completed form to Raman.diddee@nuth.nhs.uk
Risk Assessment tool for consent form

Please ensure all sections of the following form have been completed prior to it’s submission to the Clinical Records Advisory Committee

**Procedure details**
Procedures for which it is proposed that a specific consent form is designed

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Directorate/s in which it is proposed the consent form will be used

The template consent form must be reviewed by two senior clinicians who regularly undertake the procedure and the contents agreed prior to submission to the committee.

**Contents of the populated consent form template, has been reviewed by;**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact details of clinician proposing new consent form**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Telephone | Email
--- | ---

Please forward completed form & completed consent form template to Raman.diddee@nuth.nhs.uk
Consent form for non-proceeding living kidney donation for intended recipient

<table>
<thead>
<tr>
<th>Donor details</th>
<th>Recipient details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>DOB:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Hospital Number:</td>
<td>Hospital Number:</td>
</tr>
</tbody>
</table>

| NHS Number: | NHS Number: |

My name is: and I am the donor of a kidney which is intended for recipient name: 

I understand that there is a very small risk that it may not be possible for the surgeon to transplant my kidney into the patient named above once surgery has begun (only two cases of this nature have been identified in the last ten years). In this situation, I wish the following to take place:

Please select only one option

1. I wish for my kidney to be transplanted into an alternative recipient
   Please circle: Yes No

2. I wish for my kidney to be re-implanted.
   Please circle: Yes No

3. I wish for my kidney to be used for research
   Please circle: Yes No
4. I wish for my kidney to be disposed of
   Please circle: Yes No

I also confirm that the surgeon has discussed what the risks and benefits associated with each option are; and that I have had the opportunity to ask any questions and have them answered to my satisfaction.

Name of donor (Print): .................................................................................................
Signature: ........................................ Date:..........................................

Medical Practitioner / Living Donor Coordinator (Print):
Name: .........................................................................................................................
Designation: ........................................ Hospital: .........................
Signature: ........................................ Date:.........................................
The Newcastle upon Tyne Hospitals NHS Trust

Supplementary Consent for Gifting of Tissue

You will shortly be undergoing biopsy (tissue sampling) or surgery to remove diseased tissue. The major purposes of this procedure are to confirm your diagnosis and contribute to your treatment.

Once your diagnosis has been made, remaining tissue is very valuable to this Trust for use in education, research and quality assurance. We therefore request your consent to use any remaining tissue for these purposes, by making a gift of the material to this Trust. An information leaflet (reference) is available containing more information about the Trust’s use of such tissues and describing our policy for the safe keeping of tissue gifted in this way.

Your diagnosis and treatment will not be compromised in any way by giving consent. Any research studies in which your tissue is used will have been approved by our local research ethics committee or an equivalent organisation, to ensure that the research is valid and meets current ethical standards. Research will be conducted anonymously; tissue samples will be identified by a code and your personal details will not be accessible by researchers. Your confidentiality will be respected at all times.

We may use the tissue in association with commercial partners but human tissue is never sold (this is illegal) and our partnerships are organised on a not-for-profit basis, with any resulting benefits being used directly to improve patient care within the Trust. Use of your tissue for education, research or quality control in this way will not influence your treatment directly. Withholding consent will not harm your diagnosis or treatment in any way. If you do not wish to give consent, we guarantee that any tissue surplus to needs for diagnosis is disposed of appropriately, following national guidelines.

Statement to be signed by patient:

I agree to the use of my tissue after diagnosis for education, research and quality assurance

YES NO

I understand that by agreeing to this I am making a gift of the tissue to Newcastle upon Tyne Hospitals NHS Trust and that subsequent use of the material will be entirely at the discretion of the Trust.

Signed: ………………………………………………………………

Name (please print): ………………………………………………………

Witnessed by: ……………………………………………………………… (signature)
…………………………………………………………… (name)
…………………………………………………………… (position)

Date: ………………………………………………………………
This template is designed to meet Department of Health requirements. The highlighted area's only are provided for free text and may be amended where specified.

<table>
<thead>
<tr>
<th>Responsible Health professional</th>
<th>Surname</th>
<th>Patient Id number</th>
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<tr>
<td>Job title………………………</td>
<td>Forename</td>
<td>DOB</td>
</tr>
<tr>
<td>Address</td>
<td>Gender. Male/Female</td>
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</tr>
<tr>
<td>Postcode</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of proposed procedure or treatment…

Statement of health professional( to be completed by professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient. In particular I have explained:

The intended benefits;

Serious or frequently occurring risks;

Any extra procedures which may become necessary during the procedure;

I have also discussed what the procedure is likely to involve, the benefits and risks of any alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided………………………………..

This procedure will involve (delete any which are never applicable)

☐ General and/or local anaesthesia
☐ Local anaesthesia
☐ Sedation
☐ Radiological investigation – potential risk in pregnancy

Signature of person receiving consent
Signed: ...........................................

Name (PRINT) ...........................................

Contact details (if patient wishes to discuss options later)

Statement of interpreter (where appropriate)
Statement of interpreter (where appropriate)………………………………….

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand
Signed: ...........................................

Name (PRINT) ...........................................

Copy accepted by patient parent: yes / no (please circle)

Appendix 8

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Statement of patient person with parental responsibility for patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I understand that information held by the NHS and records maintained by the General Register Office may be used to audit the quality and outcome of clinical treatment.

☐ I agree ☐ disagree to this

I understand that for educational purposes, students may be involved in my examination during anaesthesia.

☐ I agree ☐ disagree to this

Signature…………………………………….

Name (PRINT)…………………………. Relationship to patient…………………….

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here.

Signed: ...........................................

Name (PRINT) .................................. Relationship to patient………………...

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed: ...........................................

Name (PRINT)…………………………... Relationship to patient……………………

Important notes: (tick if applicable)

☐ See also advance directive/living will (eg Jehovah’s Witness form)

☐ Patient has withdrawn consent (ask patient to sign /date below

Patient’s signature: ...........................................

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### Appendix 9: Delegated Consent

**Directorate**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Which grade/s of staff take delegated consent</th>
<th>Clinician responsible for competency assessment</th>
<th>Staff trained to take delegated consent</th>
<th>Where are competency records held</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Specialty Nurse SHO SpR</td>
<td>Mr Peter Smith Consultant</td>
<td>John Smith Specialist Nurse</td>
<td>Mr Peter Smith Line Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mr John Doe Consultant</td>
<td>Anne Jones Specialist Nurse</td>
<td>Mr John Doe Line Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tom Baker Specialist Nurse</td>
<td>Tom Baker Specialist Nurse</td>
<td>Mr John Doe Line Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bob Brown Specialist Nurse</td>
<td>Jim Bell Specialist Nurse</td>
<td>Mr John Doe Line Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dawn Dodd Specialist Nurse</td>
<td>Dawn Dodd SpR</td>
<td>Mr John Doe Line Manager</td>
</tr>
<tr>
<td>Assessed by</td>
<td>Mr Peter Smith</td>
<td>Mr John Doe</td>
<td>Mr John Doe</td>
<td>Mr John Doe</td>
</tr>
</tbody>
</table>

**Clinical Director/ Directorate Manager**

Please return this form to the Nurse Specialist Patient Safety at the end of each Quarter.
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Consent to Examination or Treatment (with reference to the MCA 2005)</th>
<th>Policy Author:</th>
<th>Nurse Specialist Patient Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes/No?</td>
<td>You must provide evidence to support your response:</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(a).</td>
<td>Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4(b).</td>
<td>If so can the impact be avoided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4(c).</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4(d).</td>
<td>Can we reduce the impact by taking different action?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:                                                                                     Action Plan due (or Not Applicable): NA

Name and Designation of Person responsible for completion of this form: Karen Collingwood Nurse Specialist Patient Safety Date: 25/07/2013

Names & Designations of those involved in the impact assessment screening process: Clinical Governance and Quality Committee

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)