Policy for
Consent to Examination or Treatment

V7.1

21 May 13
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Consent Flow Chart

NB: If you will not be carrying out the procedure and have not been trained to obtain consent for this procedure then you must not obtain consent.

Start

Will consent be obtained verbally?

Yes

Confirm that the patient has received sufficient information to make an informed decision. If not, provide required information to patient.

No

Does patient lack capacity?

Yes

Record lack of capacity in patient’s notes (Form 4)

No

Confirm that the patient has received sufficient information to make an informed decision. If not, provide required information to patient.

Record written consent in patient’s notes and the provision of any patient information

End

Will consent be obtained verbally?

Yes

Record verbal consent in patient’s notes and the provision of any patient information

No

Does patient lack capacity?

Yes

If there is an Advance Decision or person with Lasting Power of Attorney refer to paragraph 6.12

No

Is patient satisfied with information provided?

Yes

Record written consent in patient’s notes and the provision of any patient information

No
Introduction

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

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. To ensure that health professionals are able to comply with guidance issued by the Department of Health and the professional bodies that oversee clinical practice. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

3. Scope

3.1. This policy is based on guidance issued by the Department of Health and applies to all Trust staff involved in the physical examination of patients, or in providing any aspect of treatment and care, including for research purposes.

- The policy does not include consent issues relating to:
  - Participation in observational studies
  - The use of personal information
  - The deceased - including post mortems and foetal material

3.2. These are dealt with under separate processes.

3.3. The policy describes the circumstances in which consent should be sought. It does not prescribe whether written, verbal or non-verbal consent should be sought for particular procedures.

4. Definitions / Glossary

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

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

PALS - Patient Advice and Liaison Service ()
PBA - Procedure Based Assessment ()

5. Ownership and Responsibilities

5.1. Medical Director

5.2. The Medical Director has executive responsibility, as the trust lead on consent, for this policy.
5.3. Divisional Quality Learning Group (DQLG)
5.4. The Divisional Quality Learning Group is the trust committee through which corporate decisions relating to consent will be exercised. This includes receiving internal or external reports relating to Trust-wide consent practices and authorising actions arising from such reports.

5.5. Director of Medical Education
5.6. The Director of Medical Education is responsible for ensuring that doctors in training roles understand their limitations in seeking consent in accordance with Deanery guidelines.

5.7. Quality and Safety Team
5.8. The Quality and Safety Team is responsible for co-ordinating policy updates in response to new guidance and for monitoring and reporting trust wide practice in consent.

5.9. Divisional Governance Leads
5.10. It is the responsibility of Divisional Management Teams to ensure that all staff in their divisions who are involved in the process of seeking consent are familiar with the procedures and documentation for seeking consent, and have received the appropriate training. They will ensure their division participates in monitoring this policy.

5.11. Divisional Governance Leads are responsible for assisting the Divisional Management Teams in the process above and for ensuring that departmental registers detailing all those people who are authorised to obtain consent are maintained.

5.12. Clinical Specialties
5.13. Clinical specialties that delegate responsibility for obtaining consent are responsible for providing procedure-specific consent training to the relevant staff.

5.14. Ward and Departmental Managers
5.15. Ward and departmental managers must ensure that all staff have an understanding of consent relevant to their level of involvement in providing care or treatment, and have received the appropriate training.

5.16. Departmental managers are responsible for ensuring that health professionals ‘confirming’ the patient’s consent understand they must seek the advice of an appropriate colleague where they are personally not able to answer any remaining questions, and to ensure that an appropriate colleague is available.

5.17. It is the line manager’s responsibility to ensure the individual is aware of the requirement to seek appropriate advice, and to ensure that an appropriate colleague is available.

5.18. Clinical areas and departments are expected to hold written information on the main investigations and treatments offered to patients in their areas.
5.19. **Role of Individual Staff**

5.20. All health care professionals are responsible for seeking consent for any care or treatment they carry out themselves. Where responsibility for any aspect of the process is delegated to another person, overall responsibility remains with the person who actually carries out the procedure.

5.21. It is a health professional’s own responsibility:

- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so.
- To work within their own competence and not to agree to perform tasks which exceed that competence.

6. **Standards and Practice**

6.1. **Who can obtain consent?**

6.2. All consent for procedures is to be taken either by:

1. The person carrying out the procedure or;
2. A person capable of carrying out the procedure independently or;
3. A trainee capable of performing the procedure under supervision who has been authorised to take consent or;
4. A person who has been trained in taking consent for that procedure.

6.3. **Senior medical staff**

Senior medical staff and senior trainees who have completed their final professional membership exams are assumed competent to take consent for all procedures in their specialty. To assist with audit their names will be included in the departmental register.

6.4. **Trainee on a specialist training programme**

6.5. Trainees on a specialist training programme who have not yet completed their final professional membership exam must have a record of authorisation to take consent in the departmental training register. However they already have several years of training in their speciality. They have received training on consent and their conduct in relation to consent is under supervision of their Royal College. For these trainees departments may at their discretion assume competence to take consent for some procedures but specify procedures for which they may NOT take consent. For example, specific complex procedures or those with a significant risk to life, limb or quality of life might be specified. Less experienced registrars may be treated as a junior trainee (see below)

6.6. **Junior trainees not yet on a recognised training programme.**

6.7. For these trainees such as core trainees there must be a record of authorisation to take consent for a procedure. There must also be a record that training has been given in taking consent for that procedure. Grouping similar procedures can make training more practicable however and cover many of the procedures that might be undertaken in a particular specialty: In vascular surgery for example juniors might complete a module in taking consent for lower limb bypass procedures. In Obstetrics and Gynaecology a lecture may be given at induction on consent for emergency
procedures. Provided it is adequate and recorded, departments may deliver training in whatever way they think best.

6.8. **Non-training grades.**
6.9. The department must decide whether it is more appropriate for a particular member of staff to be treated in the same way as senior medical staff, specialist trainees or junior trainees. They should then apply the guidelines as above.

### 6.10. Underlying principles
- All staff must take responsibility for the decision as to whether or not they can reasonably take consent.
- Consent should ideally be taken by the clinician performing the procedure but it is acceptable to delegate.
- Senior medical staff delegating consent must be satisfied that the person taking consent is competent to do so.
- Where possible the categories detailed in para 6.2 items 3 and 4 above should use a procedure specific consent form on which the risks and benefits are clearly outlined.
- Each department is expected to compile a simple register of authorisation to take consent. It is the responsibility of each member of staff to ensure that their authorisation to take consent for a procedure or group of procedures is recorded in the register.

### 6.11. Training to obtain consent
6.12. Any record that there has been a discussion of issues surrounding consent can be interpreted as training. This would include:

- Formal training in a classroom setting or completion of a training module such as that provided to endoscopy nurses
- A talk at induction on issues surrounding consent for key procedures such as that provided for trainees in cardiology and obstetrics and gynaecology
- The completion of a Procedure Based Assessment (PBA) where there is a record that consent has formed part of the assessment.
- Informal bedside teaching on consent for a procedure is perfectly acceptable provided there is a record that this has taken place.

6.13. How much training is required will depend on the level of experience of the consent taker. A registrar in the 4th year of training may simply require a discussion of 2 or 3 key points as part of a PBA. A year 1 CT may require completion of a formal training module. It may also be necessary to repeat training such as occurs now for endoscopy nurses.

6.14. In determining whether training is adequate, senior staff should consider whether they could defend its adequacy in a court of law.

### 6.15. Maintaining the departmental consent register
6.16. It will normally be the responsibility of the governance lead to ensure that the register of authorisation to take consent is kept up to date. Junior staff will be expected to inform them of changes as their experience and training increases.

6.17. The consent registers cover those procedures in which written consent is normally taken. Staff performing low risk procedures, normally carried out after verbal
consent, do not require an entry in the consent authorisation register. Examples of such procedures include phlebotomy or cannulation, physiotherapy exercises, application of a splint or plaster or suctioning of airways. If in doubt, seek advice.

6.18. Documentation of consent

6.19. 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 oral consent.

6.20. Written consent

6.21. 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 informed 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.

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

- 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 patient’s employment, social or personal life.
- The treatment is part of a project or programme of research approved by this Trust.

Completed forms should be kept with the patient’s notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

6.23. It will not usually be necessary to document a patient’s consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

6.24. Availability of forms

6.25. Trust standard consent forms and forms for adults who are unable to consent for themselves are available to order via EROS and are also available via the Trust’s Intranet (search for ‘consent forms’). There are three versions of the standard consent form and one for adults who lack capacity:

- Form 1 for adults or competent children
- Form 2 for parental consent for a child or young person
- Form 3 for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care.
- Form 4 for adults who lack the capacity to consent to investigation or treatment.

6.26. The use of Form 3 is optional but may be thought more appropriate than Form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.

6.27. A relevant approved consent Form 1 - 4 must be used wherever written consent is indicated. Forms developed for specific procedures may be used but must be formally approved by the Trust’s Forms Review Group. Guidance on developing and obtaining authorisation for procedure specific forms is provided in detail in Appendix C and on the consent pages of the intranet. These forms must only be printed from the intranet to ensure version control and to acknowledge their fundamental link with this policy. Departments may pre-print forms for higher volume procedures.

6.28. Procedures to follow when patients lack capacity to give or withhold consent
(See also RCHT Mental Capacity Act policy)

6.29. Trust staff should be aware that the Mental Capacity Act (MCA) details five guiding principles which underpin its fundamental concepts and govern its implementation.

6.30. The five key principles are:

- Assume capacity unless it is proved otherwise
- Give all appropriate help before concluding someone cannot make their own decisions
- Accept the right to make what might be seen as eccentric or unwise decisions
- Always act in the best interests of people without capacity
- Decisions made should be the least restrictive of their basic rights and freedoms.

6.31. All professional staff must have regard and make reference to the Mental Capacity Act Code of Practice. This is a statutory requirement.

6.32. Every effort should be made to find ways of communicating with someone before deciding that they lack the capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone.

6.33. Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in form 4 (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient’s capacity, why the health professional believes the treatment to be in the patient’s best interests, and the involvement of people close to the patient.

6.34. If the incapacitated patient has a valid advance refusal to treatment that relates to an intended intervention then this has the same authority as a patient with capacity making their own decisions.
6.35. On occasion a patient may have a court appointed person with Lasting Power of Attorney (LPA) or the Court of protection may have appointed a deputy to make decisions on behalf of the patient. If the terms of the LPA or the Deputy extend to decisions relating to personal welfare, such a person may have the authority to consent to or withhold medical treatment on behalf of a patient. This does not extend to making decisions about carrying out or continuation of life-sustaining treatment unless this is clearly stated.

6.36. Where a serious medical intervention is proposed for a patient who lacks capacity and there are no persons close to the patient who can be consulted other than paid carers, then there is a duty to instruct an Independent Mental Capacity Advocate (IMCA). This person will help establish the best interests of the patient. In an emergency where there is no time to refer to an IMCA then the healthcare professional can and should act in the patient's best interest. (See ‘Decision making flowchart’ in RCHT Mental Capacity Policy)

6.37. Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult’s best interests. Where the consequences of having, or not having, the treatment are potentially serious, an application to the Court of Protection may be appropriate. To make an application contact the Trust Legal Services Department who will act as the Trust’s link with appropriate solicitors. In urgent situations outside of normal office hours contact the on-call hospital manager via the Royal Cornwall Hospital switchboard.

6.38. When should consent be sought?

6.39. When a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of ‘seeking consent’. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient’s condition.

6.40. Whatever the circumstances, respect for patients' dignity must be given due priority throughout the process, in particular with regard to enabling patients to maintain the maximum possible independence, choice and control, and respecting their right to privacy.

6.41. Single stage process

6.42. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient’s condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

6.43. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.
6.44. **Two or more stage process**

6.45. In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital outpatient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

6.46. Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure. They should have received a copy of the page documenting the decision-making process, and information about the consent form itself. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment a member of the healthcare team must check with the patient whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure.

6.47. While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. **It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment** (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient’s condition.

6.48. **Seeking consent for courses of treatment**

6.49. If you are seeking a patient’s consent to undergo a course of treatment consisting of identical interventions repeated over a defined length of time or according to a fixed regimen, then it is acceptable to document their agreement to the course as a whole on one consent form at the beginning. Where subsequent repeat treatments are given as part of the course, verbal consent should be documented each time confirming that the patient is still happy to proceed and to note any changes or adjustments regarding the course of treatment.

6.50. In all other cases, where examination or treatment is repeated periodically, consent must be sought and documented for each episode.

6.51. **Seeking consent for anaesthesia**

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

6.53. Further guidance can be found in The Association of Anaesthetists of Great Britain and Ireland’s ‘Consent for Anaesthesia’ (revised edition 2006).

6.54. 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.

6.55. **Emergencies**

6.56. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient’s notes to document any discussion and the patient’s consent, rather than using a form. The urgency of the patient’s situation may limit the quantity of information that they can be given, but should not affect its quality.

6.57. **Treatment of children and young people**

6.58. When babies or young children are being cared for in hospital, every effort should be made to discuss planned interventions with their parents. Where risk is involved, written consent must be sought from the parents unless delay would put the child’s health at risk. In law parental consent is required even for routine interventions such as blood tests, urine tests and X-rays. It may be more practical to discuss with parents in advance what routine procedures may be necessary, and ensure their consent. 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.

6.59. Only people with ‘parental responsibility’ are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children. The Adoption and Children Act (2002) grants the unmarried father parental rights, but only if the parents register the birth together. This Act only applies for children born after the 1st December 2003. If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

6.60. For further details on who may have parental responsibility, see ‘Reference guide to examination and treatment’ 2nd edition (Chapter 3, paragraph 22).

6.61. Detailed guidance on working with children and young people is available in:

- Seeking consent: working with children (DH, 2001)
- Child Protection Companion (Royal College of Paediatrics and Child Health, 2006)
- 0 - 18 years: Guidance for doctors (GMC, 2007)

6.62. For specific advice in clinical situations contact the Trust’s named professionals for Safeguarding Children (contact details in Appendix E)
6.63. **Provision of information**

6.64. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

6.65. Patients and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

6.66. The following sources of patient information are available in this Trust:

6.67. **Your consent to treatment (RCHT Information Leaflet no. RCHT 1122)**

6.68. General information about consent to treatment for patients at RCHT incorporates the provisions of the DH text ‘About the consent form’.

6.69. **Patient information leaflets**

6.70. Wards, departments and clinics are expected to hold up-to-date copies of Trust patient information leaflets relating to their specialty and treatments being provided, or those from other approved sources. These must be produced and maintained in accordance with the Trust’s Patient Information Policy. All information leaflets provided should be clearly recorded on the consent to treatment form, including full title, reference number, publisher and publication date.

6.71. PALS can provide, on request, signposting to a range of services related to giving patients, relatives and carers information.

6.72. **Guidance on production of new written information**

6.73. All written information for patients, carers, relatives and other service users must be approved by the Patient Information Editorial Group and be produced in consultation with the Patient Information Officer, in the Design and Publications Department.

6.74. **Provision for patients with disabilities**

6.75. The Trust will provide information in different formats, as appropriate, to support people with sight or hearing disabilities, learning difficulties or low literacy skills, for whom existing resources may be unsuitable. For advice contact the Patient Advice and Liaison Service (PALS) on Extension 2793. Advice on accessing patient advocacy can be obtained through PALS.
6.76. **Provision for patients whose first language is not English**

6.77. This Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. Other family members or friends may be able to interpret for patients who do not speak English, however the use of children should be discouraged except in emergencies or exceptional circumstances.

6.78. Details of arrangements for accessing interpreting and translation services can be found in the RCHT Interpreting and Translation Services Policy, which is available on the Trust intranet documents library.

6.79. **Provision of printed health information in other languages can be obtained through PALS. If no existing material is available, translation can be arranged if sufficient notice is given.**

6.80. **Access to more detailed or specialist information**

6.81. Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. In the first instance such requests should be directed to the clinical staff, responsible for the procedure. PALS are also able to offer assistance to patients, relatives, carers and staff to guide them to appropriate sources of information.

6.82. **Access to health professionals between formal appointments**

6.83. After an appointment with a health professional in primary care or in outpatients, patients will often think of further questions which they would like answered before they make their decision. Written information provided to patients should include contact details to enable any further questions a patient may have to be answered by a member of the managing team either by telephone or in person. PALS is available to assist patients, relatives and carers in contacting the appropriate professional advice where required.

6.84. **Open access clinics**

6.85. Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment.

6.86. **Who is responsible for seeking consent?**

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

6.88. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

6.89. **Completing consent forms**

6.90. The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health
professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

6.91. Further details of resources available to support training of health professionals, who are involved in seeking consent but do not carry out specific procedures, are given in Section 7 of this Policy.

6.92. If the patient signs the form in advance of the procedure (for example in outpatients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

6.93. It is the responsibility of the departmental manager to ensure that health professionals ‘confirming’ the patient’s consent understand they must seek the advice of an appropriate colleague where they are personally not able to answer any remaining questions, and to ensure that an appropriate colleague is available.

6.94. Where the departmental manager is not the individual’s line manager, it is the line manager’s responsibility to ensure the individual is aware of the requirement to seek appropriate advice, and to ensure that an appropriate colleague is available.

6.95. **Responsibility of health professionals**

6.96. It is a health professional’s own responsibility:

- To ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so.
- To work within their own competence and not to agree to perform tasks which exceed that competence.

6.97. The Trust has adopted the provisions of the South West Deanery guidance on consent which sets out standards and expectations regarding the involvement of doctors in training posts when seeking consent.

6.98. If you feel that you are being pressurised to seek consent when you do not feel competent to do so you should raise the matter in the first instance with your direct line manager (or their manager if it is your direct line manager who is pressurising you). If you are unable to resolve the situation through this route you should seek advice from your Specialty or Divisional Governance Lead, or ultimately the Director of Medical Education and Medical Director.

6.99. If you have concerns about other health professionals and their competence in seeking consent you should refer initially to the healthcare professional (e.g. consultant) managing the patient’s care. If you are not satisfied with the response you should apply the RCHT Raising Concerns Policy with the help of the Human Resources Department. It may be appropriate to raise the matter with a relevant professional body such as the GMC.
6.100. The Quality and Safety Team is responsible for carrying out audits of consent.

6.101. The audit will be used to identify the grade and speciality of those obtaining consent for procedures. Where audit indicates that consent may have been obtained by someone not authorised to do so, it will be reported to Divisional Quality Group and followed up through Divisional Management Teams as part of the actions arising from the audit. Follow up actions may include requirements to produce evidence of competence and identification of training needs.

6.102. Refusal of treatment

6.103. 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 (see below). The situation for children is more complex: see the Department of Health’s Seeking consent: working with children for more detail. The following paragraphs apply primarily to adults.

6.104. 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, you (and where possible the patient) should note this on the form.

6.105. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

6.106. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient’s stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must, on request, be prepared to transfer the patient’s care to that health professional.

6.107. Advance decisions to refuse treatment

6.108. If a patient has made a valid and applicable advance decision to refuse particular treatment (sometimes previously referred to as a ‘living will’ or ‘advance directive’) it is legally binding and you must follow it even if it may result in the patient’s death.

6.109. For an advance decision to be valid and applicable:

- The patient must be 18 or over.
- The patient must have had capacity to make such a decision at the time they made it.
- The patient must make clear which treatments they are refusing.
- If the advance decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in healthcare notes), it must be
signed and witnessed and it must state clearly that the decision applies even if life is at risk.

- A person with capacity can withdraw their advance decision at any time.

6.110. If an advance decision is not valid or applicable to current circumstances, you must still take it into account as part of your assessment of the patient’s best interests. Advance decisions made before the Mental Capacity Act 2005 came into force may still be valid if they meet the provisions of the Act. If you have any doubts over the validity of an advance decision or feel, for any reason, that you cannot comply with it, you must seek advice from the Trust Legal Services Team in the first instance.


**6.112. Patients detained under the Mental Health Act 1983**

6.113. Although there are circumstances in which patients can be detained and treated without consent for a mental disorder under the Mental Health Act (1983) they cannot be treated for physical conditions unrelated to their mental disorder without their consent if they have capacity. Detained patients may also refuse certain specific treatments for mental disorder, such as ECT, if they have capacity.

6.114. For advice on the application of the Mental Health Act (1983) in clinical situations, contact the Psychiatric Liaison Team (Contact details in intranet on-line directory).

6.115. The Mental Health Act Code of Practice offers guidance on consent and medical treatment. See also RCHT ‘Mental Capacity Act Policy’.

**6.116. Guidance and resources relating to Human Tissue**

6.117. The Human Tissue Act 2004 introduced new legislation covering the removal, storage and use of human organs and tissue.

6.118. Consent from the living is not needed for storage and use of tissue for:

- Clinical audit.
- Education or training relating to human health (including training for research into disorders, or the functioning, of the human body).
- Performance assessment.
- Public health monitoring.
- Quality assurance.

6.119. However, patients should be made aware of the possible uses of their tissue and what they should do if they have any concerns. This information is included in the Trust information leaflet ‘Your consent to treatment’. The Trust standard consent forms contain sections where patients can indicate refusal for their tissue to be used for specific purposes.

6.120. The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises some difficult issues and has been reviewed in recent years. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and
hence improvements in healthcare for all. This Trust requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes.

6.121. Objections to the use of tissue removed during the course of a procedure for public health monitoring should be documented on the consent form in the Patient/Parent Statement section. Information for patients about this provision is contained in the RCHT leaflet ‘Your consent to treatment’ which is available through the Trust stationery ordering system. For ordering details see Appendix B. The text of this leaflet is included as Appendix G.

6.122. Tissue samples may be used for quality assurance purposes without requiring specific patient consent provided there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised.

6.123. Within RCHT clinicians are expected to refer to:

- Human Tissue Authority Code of Practice – Consent (July 2006).
- A summary of the main points of the act as they relate to research can be found in the MRC Guide: ‘Human tissue and biological samples in research’.

6.124. Clinical photography and conventional or digital video recordings

NB: This also applies to digital photographic images.

6.125. Photographic and video recordings made for clinical purposes form part of a patient’s record. Although consent to certain recordings, such as X-rays, is implicit in the patient’s consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.

6.126. Consent must be obtained in writing for ‘the original recording and for its use as a part of treatment or for teaching’. There are some exemptions to this requirement which are detailed in the Trust’s ‘Policy for Recordings and Photography’ along with more detailed information regarding the use of photographic images.

6.127. GMC Notification

6.128. Where an example of failure to follow any aspect of the requirements for valid consent is noted, this should be reported internally as a patient safety incident via the Datix Incident Reporting tool.

6.129. Incidents will be reviewed and graded in accordance with Trust Policy

6.130. This will determine the level of investigation and review of the completed investigation at Division or Corporately.

6.131. Where patient consent failures involve medical staff the GMC reporting process must also be followed in addition to internal incident reporting.
6.132. This is specifically required if the failure relates to incidences of an individual obtaining patient consent without the authorisation to do so.

7. Dissemination and Implementation

7.1. This policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.

7.2. Staff will be alerted to changes from previous versions using established staff communication channels to distribute information including:

- Letter to all consultants.
- Information sheet for all wards, departments and medical education.
- Staff newsletter item
- Staff daily bulletin.

7.3. Training

7.4. It is a health professional’s personal responsibility, according to their own professional organisation, to work within their sphere of competence and not to agree to undertake tasks which exceed that competence.

7.5. It is the responsibility of the Divisional Management Teams to ensure, through ward and department managers, that all staff in their divisions who are involved in the process of seeking consent are familiar with the procedures and documentation, and have received the appropriate training.

7.6. Consent is incorporated into all training courses provided by the Learning and Development Department that involve aspects of care, treatment or examination.

7.7. Online generic training in consent is available on the National Learning Management System (NLMS) at levels to suit the needs of the learner and can be accessed via Trust computers:

- 156 Consent to Examination, Care or Treatment Level 1
  - For non registered healthcare workers and covers the principles of valid consent for any aspect of care, treatment or examination.

- 156 Consent to Examination, Care or Treatment Level 2
  - For registered healthcare workers who need a comprehensive understanding of the consent process including case law relevant to clinical practice and of the documentation requirements.

- 156 Consent to Examination, Care or Treatment Level 3
  - For experienced Registered Healthcare Workers with some possibly working in specialist and extended roles in relation to obtaining patient consent, including doing so on behalf of another professional.

- 000 Consent - Patient Consent e-Learning
  - For Medics and Nurse Practitioners and outlines the general principles of consent focusing on the types of consent to treatment.
7.8. The Trust recognises that doctors in training posts need to be involved in the process of seeking consent. In order to allow this whilst safeguarding the highest standards, the Trust has adopted the provisions of the South West Deanery guidance ‘Taking informed consent; Guidance for Doctors in Training’. The guidance ensures that responsibility for seeking consent can only be delegated to trainee doctors who have sufficient experience and the appropriate training.

7.9. Clinical specialties that delegate responsibility for obtaining consent are responsible for providing procedure-specific consent training to the relevant staff in addition to the generic training received as part of medical education or via the NLMS. Procedure-specific training must provide assurance that valid consent is being reliably obtained and that those who receive training have been assessed, are aware of their own limitations and are subject to audit.

7.10. Specialty training will include:

- Specific knowledge of the disease and planned treatment/procedure.
- Specific knowledge of the risks and benefits of the planned treatment/procedure including not proceeding with the treatment.
- Awareness of the feasible alternatives and the risks and benefits of these.
- Methods of conveying the above information to the patient/client.
- Where the patient could access further information.
- How the health care professional can obtain further direction from a senior colleague.

8. Monitoring compliance and effectiveness

8.1. All divisions will be expected to an annual report, which will be co-ordinated by the Quality and Safety team, and may be based on either cumulative spot audits or on a retrospective review of consent practice. Results and recommended actions will be reported to the Divisional Quality Group for ratification and monitoring of the actions agreed, including stipulation of timescales for subsequent audits.

| Element to be monitored | ▪ Training of those seeking consent to the appropriate level for their role  
|                         | ▪ Timing of obtaining consent in relation to the procedure undertaken  
|                         | ▪ Profession and grade of staff seeking consent  
|                         | ▪ Provision of information about proposed procedures  
|                         | ▪ Documentation of information given and record of patients' consent |

| Lead                    | Head of Quality and Safety |
|                        |                            |
| Tool                   | Clinical audit tool based on this policy developed from previous consent audits and identification of key issues in practice. |
| Frequency              | Annually.                 |
| Reporting arrangements | The annual consent audit report will be compiled by the Quality and Safety Team and include recommendations in the form of a draft action plan for the Divisional Quality Learning Group (DQLG) to |
| Acting on recommendations and Lead(s) | The minutes of DQLG will provide the documented approval of the action plan which will be passed to Divisional Directors for implementation. Corporate actions will remain with DQLG to assign responsibilities or to refer to the appropriate committee. |
9. **Updating and Review**

9.1. This policy document will be reviewed no less than every three years or more frequently following any significant legislative changes, national policy instruction, or Trust Board decision.

9.2. All revision activity is recorded in the Version Control Table at the beginning of this document as part of the document control process.

10. **Equality and Diversity**

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

10.2. **Equality Impact Assessment**

10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. 12 Key Points on Consent: The Law in England
(As at July 2002)

When do health professionals need consent from patients?
1. Before you examine, treat or care for competent adult patients 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 patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients 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. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient 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 override 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 patient to seek the patient'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. Patients 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 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.
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 patient 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 patient's decision, and also increasingly the discussions that have taken place. The Trust has a policy setting out when you need to obtain written consent.

Refusal of treatment
10. 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.
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 patient 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 give you 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.

12. If an incompetent patient 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.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent.
Appendix 2. Procedure Specific Consent Forms

RCHT procedure for developing, gaining approval and using procedure specific consent forms

Alongside the standard national consent forms (Consent Forms 1, 2, 3 and 4) available across the Trust, specialty services are encouraged to develop and use procedure specific consent forms that incorporate procedure specific patient information.

This guidance supports specialty team in developing these consent forms in line with the Trust’s Policy on Consent to Care and Treatment

1. Procedure specific consent forms must follow a single Trust’s template. This template contains all the content of Consent Form 1 and is presented alongside procedure specific patient information within one PDF document that is accessible through RCHT Consent Form Website.
2. The RCHT Patient Information Review Group will be the governing and authorising body for the production of these procedure specific consent forms.
3. Procedure specific consent forms will all contain three elements, when presented for approval:
   - Procedure specific patient information
   - Procedure specific consent form information
   - Procedure specific consent training package content
4. The above content will be submitted to the RCHT Patient Information Review Group (PIRG) along with a ‘consent form checklist’ which has been signed off by the Specialty Lead, confirming the content of the three elements is accurate and reflects best national practice and guidance.
5. Submitted consents forms will need to be formally presented to the PIRG for approval.
6. Once approved, a new procedure specific consent forms will be formatted into a PDF document. The four or five page document will contain the patient information leaflet followed by the consent form. For every procedure specific consent form formatted there will be a second PDF document created that will contain a second copy of the consent form (this is if the patient request a copy of the consent form for themselves).
7. Healthcare professionals taking consent will have to be clear that any modifications to the risk or the procedure discussed with the patient will have to be hand made on the consent form after printing, and repeated on the patients copy if this is requested.
8. All procedure specific consent forms containing the patient information section will have a clear prompts above the patient signature box – instructions prompting them to ask for a copy of the consent form is they wish.
9. The procedure specific consent form containing the patient information section with be the Trust legal copy of consent being given and will be filed in the legal section of the current paper based healthcare record.
10. All procedure specific consent forms will be stored and managed on the Document
Library within a 'Consent' sub-folder.

11. All procedure specific consent forms will be made available on the RCHT Consent Form Website (an Internet website). This website contains a link to the RCHT Policy on Consent to Care and Treatment; a link to the generic guidance for healthcare professionals taking consent; the links in lists to the two approved procedure specific consent forms for each procedure (one containing both the patient information and the consent form and the second containing a copy of the consent form if the patient requests a copy for themselves); links to the online training programme for healthcare professionals who are taking consent.

12. The online training programme for healthcare professionals called 'Training Tracker' allows the Trust to be assured people taking consent are competent to do so, and the procedure specific training modules enable this. Training records are stored in the Trust's Electronic Staff Record.

13. Procedure specific consent training package content will be submitted to the Trust's Consent Lead and the online training module developed. This will be uploaded onto the RCHT Consent Form Website and sit alongside the two consent forms.
Appendix 3. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Policy for Consent to Examination or Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>8 Mar 13</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>8 Mar 13</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>8 Mar 16</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Mark Scallan, Information Governance Manager Sean Dixon, Trust Consent Lead</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 258580</td>
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<tr>
<td>Brief summary of contents</td>
<td>Describes circumstances in which consent to examination, treatment and care should be sought and the framework for obtaining valid consent within RCHT.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Consent, informed consent, valid consent, capacity, competence, advance decision, information</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT, PCT, CFT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>8 Mar 13</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Policy for Consent to Examination or Treatment Version 6.1 June 2011</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Consultation: Divisional Management Teams; Divisional and Specialty Governance Leads; Senior Matrons; Learning and Development; Legal Team; Integrated Discharge Team; Resuscitation Team; Health Record User Group; Quality and Safety Team. Approval: Divisional Quality Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Medical Director</td>
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<td>Name and Post Title of additional signatories</td>
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<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet, Intranet Only</td>
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<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Consent</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>NHSLA Risk Management Standards Care Quality Commission Outcome 2</td>
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### Related Documents:
- Information governance (IG) data protection policy
- Managing health records policy
- Clinical record keeping policy
- Mental capacity act policy
- Procedure for safeguarding vulnerable adults
- Child protection and safeguarding policy and procedures
- Dignity in care policy
- Allow natural death policy
- Consent for non-coroner post mortem examination on an adult
- Policy for Recordings and Photography
- Integrated governance strategy
- Raising concerns policy
- Interpreting and translation services policy
- Patient information policy

### Training Need Identified?
Yes, see section 7 of policy

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>July 2009</td>
<td>V4</td>
<td>Detail for delegation in consent added. Appendices and templates added. Training section and references updated.</td>
<td>R D Askew Divisional Quality Facilitator</td>
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<tr>
<td>March 2011</td>
<td>V6.0</td>
<td>Reformatted. Detail regarding procedure specific forms added.</td>
<td>R D Askew DQF</td>
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<tr>
<td>June 2011</td>
<td>V6.1</td>
<td>Updated in line with revised RCHT policy template</td>
<td>R D Askew DQF</td>
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<tr>
<td>Mar 13</td>
<td>V7.0</td>
<td>Addition of ‘6.134 GMC reporting’, and Paras 6.1 to 6.15 authorisation to obtain consent.</td>
<td>Mark Scallan IG Manager</td>
</tr>
<tr>
<td>May 13</td>
<td>V7.1</td>
<td>Minor changes to wording to remove duplication. Added requirement to obtain consent for photography.</td>
<td>A. Rogers, Corporate Records Mgr</td>
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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Consent Policy
Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
**Appendix 4. Initial Equality Impact Assessment Screening Form**

| Name of service, strategy, policy or project (hereafter referred to as policy) to be assessed: RCHT Policy for Consent to Examination or Treatment |
| Directorate and service area: All Clinical Divisions and service areas | Is this a new or existing Procedure? |
| | Existing |
| Name of individual completing assessment: Mark Scallan, IGS Manager | Telephone: 01872 258580 |

1. **Policy Aim**
   To set out the circumstances in which consent to examination, treatment and care should be sought and the framework for obtaining valid consent within RCHT.

2. **Policy Objectives**
   To ensure appropriate and valid consent is sought and obtained for examination, treatment and care within RCHT.

3. **Policy – intended Outcomes**
   All patients undergoing examination, treatment or care will have given their consent in accordance with Department of Health and guidelines.

4. **How will you measure the outcome?**
   Consent audits; patient experience feedback through questionnaires.

5. **Who is intended to benefit from the Policy?**
   All patients requiring examination, treatment, or care.

6a. **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**

   | b. If yes, have these groups been consulted? |
   | c. Please list any groups who have been consulted about this procedure. |
   | No |
   | N/A |
   | N/A |

*Please see Glossary*

**7. The Impact**

Please complete the following table using ticks. You should refer to the EA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the policy could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the ‘Positive impact’ box.
- Where you think that the policy could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, tick the ‘Negative impact’ box.
- Where you think that the policy has **no impact** on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the ‘No impact’ box.
<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Reasons for decision</th>
</tr>
</thead>
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<tr>
<td>Age</td>
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<td></td>
<td>This revision strengthens and clarifies the Trust’s expectations that ensure all patients have their rights respected and individual needs met in making decisions when they need examination</td>
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<td>Disability</td>
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<td>Religion or belief</td>
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<td>Gender</td>
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<tr>
<td>Transgender</td>
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<td>Sexual Orientation</td>
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<tr>
<td>Marriage / Civil Partnership</td>
<td>✓</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- A negative impact and
- No consultation (this excludes any policies which have been identified as not requiring consultation).

8. If there is no evidence that the policy promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?

Full statement of commitment to policy of equal opportunities is included in the policy

Please sign and date this form.

Keep one copy and send a copy to Matron, Equality, Diversity and Human Rights, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Chyvean House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ

A summary of the results will be published on the Trust’s web site.

Signed ____________ Mark Scallan ____________

Date _______________ 8 Mar 13_____________