Consent Policy on Healthcare Assessment, Care and Treatment

Printed copies must not be considered the definitive version

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Lead Executive:	Medical Director		
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Summary & Aim	Key Requirements
To inform staff of NHS Dumfries and Galloway (NHS D&G) of the principles of consent; to ensure that the ethical and legal principles relating to consent are adhered to in practice and to ensure that valid consent is obtained from patients prior to any treatment, investigation or examination.	• This policy ensures NHS D&G is in keeping with national guidance that has been issued for health professionals in Scotland ("A Good Practice Guide in Consent for Health Professionals in NHS Scotland") and has its basis in Scots law and relevant Scottish and UK legislation. • All frontline staff across NHS D&G are supported in adopting best practice and guidance in respect to consent.
Target Audience	**Previous Names**
• All frontline staff across NHS Dumfries and Galloway	• None

Equality and Diversity Statement
NHS Dumfries and Galloway recognise that some communities within society are more likely than others to experience discrimination, prejudice and inequalities. The Equality Act 2010 specifically recognises the protected characteristics of **age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership**. The Fairer Scotland Duty, also requires NHS Dumfries and Galloway to actively consider how socio-economic disadvantage can be reduced when making strategic decisions. The New Armed Forces Covenant Statutory Duty places an expectation on NHS Dumfries and Galloway to consciously consider the Armed forces Covenant when developing, delivering and reviewing policies and decisions which may impact the Armed Forces community and help improve their access to public services. Consideration on all of the protected characteristics, the Fairer Scotland Duty and the Armed Forces Covenant are included within the Equality Impact Assessment process and documentation, which must be completed as part of the Policy Development Process. NHS Dumfries and Galloway is committed to promoting and advancing equality, removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those who do not. This applies both in the provision of services and as our role as a major employer. NHS Dumfries and Galloway believe that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discrimination practice.

CONTENTS

		Page
1	PURPOSE AND RATIONALE	04
2.	POLICY AIMS	04
3.	POLICY SCOPE	04
4.	DEFINITIONS	05
5.	DUTIES / RESPONSIBILITIES	05
6.	PROCESS / PROCEDURES	06
7.	CONSULTATION	14
8.	TRAINING AND SUPPORT	14
9.	MONITORING	14
10.	EQUALITY IMPACT ASSESSMENT	14
11.	DATA PROTECTION IMPACT ASSESSMENT	14
12.	DOCUMENT CONTROL SHEET	15

APPENDICES

References 16
Glossary 18
Appendix 1 - Consent process 20
Appendix 2 - NHSDG Consent Form V1 November 2024 21
Appendix 3 - It's Ok to Ask 22
Appendix 4 - Adults with Incapacity 23
Appendix 5 - Adults with Incapacity Form 24
Appendix 6 - Principle of Mental Health (Care & Treatment) (Scotland) Act 2003 25
Appendix 7 - Guidance on Consent for Children & Young People 26
Appendix 8 – Equality impact Assessment 35
Appendix 9 – Data Protection Impact Assessment Screening Tool 49

1. PURPOSE AND RATIONALE

1.1 Consent is integral to clinical interactions between healthcare staff and patients.

1.2. The principles pertaining to consent in this policy are relevant to all the health and care decisions that are made with patients about mental and physical health. This includes, but is not limited to, decisions about treatments, procedures, investigations, examinations and referrals, and applies whatever the method of communication, including remote consultations as described in 'The Seven Principles of Decision Making and Consent, GMC Guidance'

1.3. All individuals (adults aged 16 and over and children/young people under 16 who have capacity and can give valid consent), with decision-making capacity, have a fundamental legal, ethical and human right to determine what happens to their own body and capacity to consent or refuse consent is assumed unless there is evidence to the contrary. No adult can give valid consent for another unless legally authorised to do so. Valid consent to treatment is therefore absolutely central in all forms of healthcare and is also a matter of common courtesy between health professionals and patients.

2. POLICY AIMS

2.1 This policy aims to inform staff of NHS Dumfries and Galloway (NHS D&G) of the principles of consent; to ensure that the ethical and legal principles relating to consent are adhered to in practice and to ensure that valid consent is obtained from patients prior to any treatment, investigation or examination. This policy is also in keeping with national guidance that has been issued for health professionals in Scotland ("A Good Practice Guide in Consent for Health Professionals in NHS Scotland") and has its basis in Scots law and relevant Scottish and UK legislation.

3. POLICY SCOPE

3.1 Who is the Policy intended to Benefit or Affect?

3.1.1. The policy is intended to protect the rights of patients and ensure good clinical practice (Including GMC guidance) is followed to ensure shared decision making for healthcare interventions so patients will receive treatments and care of most benefit to them personally.

3.2. Who are the Stakeholders?

3.2.1 The principles of the policy apply to all healthcare staff who are interacting with patients however the main stakeholders are health professionals who are responsible for proposing, planning and ensuring delivery of treatments and care.

4. DEFINITIONS

4.1 Consent is a patient's agreement for a health professional to provide care and treatment. **Patients may indicate consent verbally, non-verbally, or in writing**. For the consent to be valid, the patient must:

- Have capacity to make the particular decision under discussion.
- Have received sufficient information to make that decision.
- Not be acting under duress.

4.2 Throughout this document the term "healthcare professional" will be used to describe the practitioner undertaking consent, such as a doctor, nurse or AHP. This ensures alignment with the language used in the NHS Guidance on consent to treatment and ensures inclusivity.

5. DUTIES / RESPONSIBILITIES

5.1 It is normally the responsibility of the doctor, nurse, midwife or other health professionals providing treatment, carrying out an investigation or performing a surgical operation or other procedure to provide all the information necessary for the patient's understanding and to obtain consent. However, it is recognised that there are circumstances where this ideal is not practicable. Obtaining consent may be delegated to a person who:

- Is suitably trained and qualified in the proposed investigation or treatment **OR**
- Has sufficient knowledge of the proposed investigation or treatment (including understanding the risk involved).
- Acts in full accordance with both this policy statement and professional codes of conduct.

5.2. Patients should be made aware that hospitals within NHS D&G are teaching hospitals which mean that procedures can be carried out by trainee professionals who are supervised by Consultants or other fully qualified professionals such as Advanced Nurse/Allied Health Practitioners (AHP). If it is not the person carrying out the procedure that is taking consent, it is important the patient is told who and what designation of staff will be performing the procedure as patients will assume it is their own consultant.

5.3. Additionally, there are situations in which it may be regarded as standard practice for one healthcare professional to refer a patient to a colleague to carry out a particular procedure or investigation or aspect of treatment, e.g. referral of a patient by a surgeon for anaesthesia or interventional radiology or procedures performed by Advanced Nurse or AHP practitioners. In these circumstances, the referring healthcare professional (in this case, the surgeon) should explain the general need for the proposed referral, possibly using additional resources such as patient information leaflets or links to appropriate web sites provided by the 'receiving' colleague and obtain written consent on that basis.

5.4. It would be for the 'receiving' healthcare professional (in this case, the anaesthetist or radiologist or ANP) to provide any (further) 'specialist' information necessary to secure the patient's full understanding and valid consent.

5.5. It would be for the relevant specialist departments to decide standard practice as to those situations when further written consent was necessary.

5.6. It remains the responsibility of the person performing the procedure to ensure that:

- The patient or their Power of Attorney has been given sufficient time and information to make an informed decision.
- Any additional support or alternative forms of information patients may need about the procedure to reach an informed choice, has been made available and offered to the patient.
- That the interpreting services are utilised if there are language barriers.
- All the other requirements of this policy have been met.

6. PROCESS / PROCEDURES

6.1 It is expected that the seven principles of decision making and consent outlined in the GMC decision making and consent guidance will be adhered to at all times. The seven principles are:

One
All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.

Two
Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

Three
All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.

Four
Medical Professionals must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

Five
Medical Professionals must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.

Six
The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.

Seven
Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.

For further guidance, please see the process in appendix 1 and refer to the associated documents in the policy appendices.

6.2 Healthcare professionals must clearly document both the patient's agreement to treatment and the discussions leading up to that decision, using either a consent form or clinical notes for verbal consent. While a signature or identification mark provides evidence of consent, it does not guarantee validity—true consent requires capacity, understanding, and voluntariness. Written consent is essential for procedures that are complex, high-risk, involve anaesthesia, are experimental, or have implications for third parties. Regardless of whether written consent is required, it is good practice to record the discussion, including BRAN questions (Benefits, Risks, Alternatives, Nothing) (see Appendix 3), and ensure patients are informed, supported, and given opportunities to ask questions. All instances where valid consent is not obtained must be documented, especially for procedures involving significant risk.

6.3 Written consent is required for complex, high-risk, or novel procedures, and must include specific details such as the procedure site. IRMER regulations mandate that sufficient patient information, including pregnancy status, be confirmed before any radiological exposure—especially in unconscious patients, where this should be addressed pre-operatively. Consent forms are regularly audited and stored in the patient's records. Any errors must be corrected before sedation, or reviewed by the clinical team if discovered after. Decisions to proceed must be based on urgency, clarity of patient

intent, and supporting documentation. All concerns and errors must be recorded and reported as clinical incidents.

6.4 Leaflets and other materials (e.g. audio-visual), informing patients about their condition and the treatment being offered must be available to patients in a format and in a way they can interpret and understand well before proposed treatment. Any written patient information should follow NHS D&G local guidance and other national guidance standards (minimum of 14pt sans serif typeface). Where possible and dependant on individual circumstances/needs, information may need to be provided in alternative languages or via interpreters. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.

Further information can be found in the Interpretation and Translation guidance available here: Staff Guidance
Information about resources can be found here: Interpretation and Translation Home Page

6.5 Timing of Consent

Consent must be obtained at a time that allows the patient to reflect and make an informed decision. While there is no fixed minimum period between providing information and obtaining consent, more time should be given when procedures are complex or carry significant risk.

- **Urgent Procedures**: Consent may be obtained immediately before the procedure, with verbal consent documented promptly.
- **Elective Procedures**: Consent should ideally be taken during outpatient consultations when the patient is added to the waiting list, allowing time for reflection and questions.
- **Reviewing Consent**: If more than 3 months have passed since consent was given, or if the patient's condition has changed, it is good practice to confirm ongoing consent before proceeding.
- **Same-Day Consent**: Patients must receive information in advance to ensure they can give informed consent on the day of the procedure.
- **Postal Consent**: For procedures like endoscopy, consent forms and information may be sent in advance. On the day, the practitioner must confirm understanding and countersign the form.

6.6 Consent Exceptions – Special Circumstances

Consent may not be required when:

- **Emergency Treatment**: If a patient is unconscious and urgent care is needed to save life or relieve suffering, treatment can proceed without consent, limited to what the situation requires. Involvement of family or carers is encouraged when possible.

- **Statutory Examination Powers**: If law mandates an examination, it may proceed without consent, though an explanation and cooperation should still be sought.
- **Court-Ordered Treatment**: A court may authorise treatment deemed in a child's best interest.
- **Mental Health Legislation**: Treatment authorised under Part 16 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*.
- **Adults with Incapacity**: Treatment authorised under Part 5 of the *Adults with Incapacity (Scotland) Act 2000*.

6.7 Refusal of Treatment and Advance Decisions

Patients with capacity have the right to refuse treatment, including specific procedures or interventions, even if refusal may negatively impact their health. This must be clearly communicated during consent discussions, and any refusal must be fully documented along with the consequences of not proceeding.

- **Advance Statements**: These are legally binding if made by an adult with capacity and clearly applicable to the current situation. They outline treatment preferences should the patient lose capacity and must be witnessed by a qualified professional who confirms the patient understands the statement and is not under duress.
- **Limitations of Consent**: Patients may specify limits to their consent. No treatment or procedure should exceed what has been agreed.
- **Religious or Ethical Refusals**: Refusals based on beliefs (e.g. Jehovah's Witnesses declining blood products) must be clearly documented.
- **Obstetric Care**: Women have the right to refuse procedures such as caesarean sections, even if it may benefit the foetus. Practitioners must follow guidance from the Royal College of Obstetricians & Gynaecologists.
- **Children and Urgent Treatment**: If a parent refuses urgent or life-saving treatment for a child lacking capacity, and a second consultant supports the need for intervention, legal authorisation may be sought from a Court of Session judge. This must be documented and witnessed.
- **Mental Health Detention**: For patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, practitioners must be familiar with the legal safeguards and conditions for treatment without consent.

6.8. Capacity

In Scotland, adults aged 16 and over are legally presumed to have capacity to make decisions about their healthcare.

A person has capacity if they can:

- Understand the nature, purpose, benefits, risks, and alternatives of the proposed treatment.
- Understand the consequences of not receiving treatment.
- Retain information long enough to make an informed decision.
- Make a voluntary and informed choice.

Only the patient with capacity can give or refuse consent. While it is good practice to keep carers or family informed (with the patient's permission), they cannot consent on the patient's behalf.

Mental disorder does not automatically mean a person lacks capacity. Capacity must be assessed in relation to the specific decision, at the specific time.

Capacity may be temporarily affected by factors such as pain, fatigue, medication, emotional distress, or unfamiliar surroundings. These must be considered before concluding a lack of capacity.

6.9. Adults with Incapacity

Under the **Adults with Incapacity (Scotland) Act 2000**, healthcare professionals may provide treatment to adults who lack decision-making capacity, using a **Section 47 Certificate of Incapacity**. This certificate must be completed even when a proxy decision-maker (e.g. guardian, welfare attorney) is involved.

Key principles guiding treatment include:

- The intervention must benefit the adult and be the least restrictive option.
- The adult's past and present wishes should be considered.
- The views of relevant others (e.g. carers, relatives, proxies) must be taken into account where practicable.
- Capacity is decision-specific and may vary over time or due to temporary factors.

A Code of Practice has been published for persons authorised to carry out medical treatment or research under Part 5 of the Act. For treatment of adults with incapacity, the more detailed guidance contained in this Code of Practice must be used in conjunction with this policy on consent. There is a flow chart for guidance in the pad of medical treatment certificates in Appendix 4 and an example of the form in Appendix 5.

A person is considered incapable if, due to mental disorder or physical disability, they cannot:

- Act, make, communicate, understand, or retain decisions.

Communication barriers must be addressed using appropriate aids or specialist support (e.g. speech and language therapists).

Proxies must provide documentation and registration from the **Office of the Public Guardian**, which maintains a searchable register. Some treatments (e.g. sterilisation, ECT) require additional safeguards and cannot be authorised under Section 47 alone.

Disagreements between proxies, clinicians, or others involved in care may be resolved under **Section 50** of the Act.

Under the **Adults with Incapacity (Scotland) Act 2000**, a healthcare professional may issue a **Section 47 Certificate** to authorise treatment for an adult who lacks capacity. The certificate must:

- Be in the prescribed format.
- Specify a valid period (up to 1 year, or up to 3 years under specific regulations).
- Be based on the adult's condition and circumstances.

A 3-year certificate may only be issued where the adult has:

- Severe or profound learning disability,
- Severe dementia, or
- Severe neurological disorder, and where recovery is unlikely and no curative treatment is available.

Before issuing the certificate, the practitioner must:

1. Be primarily responsible for the treatment.
2. Confirm the adult lacks capacity for the specific decision.
3. Consult any known proxy with welfare powers, where practicable.
4. Ensure the proposed treatment aligns with the principles of the Act.

Certificates may cover single procedures or broader treatment plans. It is good practice to review capacity regularly and re-certify as needed. Changes in the adult's condition may require revoking or reissuing the certificate.

The certificate grants authority to carry out reasonable actions to safeguard or promote the adult's health, including post-operative care. Documentation of decisions and consultations should be recorded in the patient's medical notes.

6.10. Mental Health (Care and Treatment) (Scotland) Act 2003

Patients subject to compulsory powers under this Act may be treated for mental disorder under **Part 16**, which provides legal authority for such treatment. Mental disorder includes:

- Mental illness
- Learning disability

- Personality disorder

Informal patients (not under compulsory powers) retain the same rights as any other adult with capacity to give or refuse consent.

Certain treatments—such as **Electroconvulsive Therapy (ECT)**, **neurosurgery**, **nasogastric feeding**, and treatments administered over time—require:

- Written consent from the patient, or
- A second opinion from a Designated Medical Practitioner if the patient refuses or lacks capacity.

Treatment for physical disorders in patients lacking capacity is governed by the **Adults with Incapacity (Scotland) Act 2000**.

There is a legal requirement to observe the Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 for all patients treated under its provisions. (See Appendix 6)

6.11. Children and Young People

Under the **Age of Legal Capacity (Scotland) Act 1991**, children under 16 may consent to treatment if, in the opinion of a qualified practitioner, they understand the nature and consequences of the procedure. There is no minimum age for this assessment.

Key principles:

- A competent child's consent is valid and cannot be overridden by a parent.
- Parents or legal guardians may only consent if the child lacks capacity.
- In emergencies, treatment may proceed without parental consent.
- Age-appropriate information must be provided regardless of who signs the consent form.
- Children aged 12+ with capacity have the same rights to confidentiality and consent as adults, unless there are safeguarding concerns.
- Where multiple individuals have parental responsibility, consent from one is sufficient.

For further guidance, please see Appendix 7.

6.12. Obtaining Legal Advice

Case law in this area continues to evolve, particularly in the areas of Human Rights, Adults with Incapacity and other Mental Health legislation. It may be prudent therefore to obtain legal advice in some circumstances e.g. where there is uncertainty about a patient's capacity, which cannot be resolved by

following the direction of Adults with Incapacity legislation. This can be sought through the Central Legal Office via a member of the senior management team within each specialty 24 hours a day.

6.13. Post-Mortem, Tissue and Organs

Under the **Human Tissue (Authorisation) (Scotland) Act 2019**, individuals' wishes regarding the use of their body after death must be respected. This includes post-mortem examinations and the retention of tissues or organs.

- **Procurator Fiscal Examinations**: Do not require family consent, but families must be informed of their rights and the legal basis for retention of material. Separate consent is required for use in research or teaching.
- **Hospital Post-Mortems**: Require authorisation from the nearest relative. A senior clinician, preferably the consultant responsible during the patient's final illness, should seek this consent.
- **Specific Consent Requirements**:
- Written consent is required for retention of whole organs.
- Additional consent is needed if tissues or organs are to be used for teaching, training, or research.
- Surplus tissue from living patients also requires appropriate consent.

Clinical practitioners must follow national standards and guidance, including those from NHS Quality Improvement Scotland and the Royal College of Pathologists. Training resources are available via NHS Education for Scotland's TURAS platform.

6.14. Photography and video recordings

The generic consent form (Appendix 2) should only be used for photography and video where the recordings are implicit to the procedure (such as endoscopy, laparoscopic images or retinal screening). Recordings consented in this way form part of the patient health record; if there is no possibility that the patient might be recognised, they can also be used within the clinical setting for education or research purposes. In all other circumstances, a specific consent to photography form should be used: this provides more detailed information on the levels of consent available to the patient. It should be noted that express consent must be sought for any form of publication.

6.15. Disclosure of Personal Information

Clinical Practitioners should take all reasonable measures under their control to comply with current legislation, codes of practice and other relevant guidance regarding information security.
This includes:

- The Data Protection Act 2018
- The Caldicott standards

- NHS D&G Information sharing protocol with local authorities

Further guidance should be sought through these specific policy documents.

6.16. Research

The Research Governance Framework outlines in more detail good practice with any form of research. Informed consent is at the heart of ethical research in health. Ethics committees and all those involved in a research study must ensure that there are appropriate arrangements for obtaining consent. For more information, please see Legislation & Guidelines.

7. CONSULTATION

This policy has been shared in line with local governance and as appropriate with Area Partnership Forum, Board Management Team, Health and Social Care Leadership Group and Staff Side Representatives.

8. TRAINING AND SUPPORT

NHS Dumfries and Galloway recognises that staff responsible for implementing this policy require appropriate training. Training needs are identified through personal development planning and appraisal processes. It is the responsibility of the supervising clinician to ensure a trainee is competent and familiar with the procedure if parts of the shared decision making and informed consent process have been delegated to the trainee.

The Scottish Government Realistic Medicine Team and NHS Education for Scotland (NES) have developed a Shared Decision Making eLearning resource for everyone working in health and care in Scotland.

9. MONITORING

This policy will be implemented through the General Management structures within the organisation. It will be the responsibility of the Sectors/Directorates/Partnerships to audit policy compliance.

Monitoring the policy will be through the NHS governance structures

10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment was completed on 16/10/2024 and is attached in Appendix 8. The completion of an EIA will be considered during each subsequent review of this policy.

11. DATA PROTECTION AND CONFIDENTIALITY IMPACT ASSESSMENT

A Data Protection Impact Assessment (DPIA) screening questionnaire was completed on 24/09/24 and is attached in appendix 9. It is not a legal requirement for a full DPIA to be completed for the development of this policy. The completion of a DPIA will be considered during each subsequent review of this policy.

12. DOCUMENT CONTROL SHEET

12.1 Document Amendment History

Version	Section(s)	Reason for update
1.0	ALL	New policy

12.2 Distribution

Name	Responsibility	Version number
Area Partnership Forum	For consultation and comment	0.1
Staff side representatives	For consultation and comment	0.1
Health & Social Care Leadership Group	For consultation and comment	0.1
Board Management Team	For consultation and comment	0.1
Corporate Business Manager	Update policy register	1.0

12.3 Associated documents

Research and Development Intranet page
Research and Development Team Homepage
Research Governance Framework for Health and Community Care
Legislation & Guidelines
Health Records Management Policy
IA Policies
Consent – Supporting Guidance

12.4 Action Plan for Implementation

Action	Lead Officer	Timeframe
Update policy register	Corporate Business Manager	
Place in “latest news”	Communications	
Place on intranet		

13. References

- Advice on consent issues can be sought through their clinical line management structure.

- A Good Practice Guide on Consent for Health Professionals in NHS Scotland Scottish Executive Health Department, June 2006 https://www.publications.scot.nhs.uk/files/hdl2006-34.pdf

- SPSO Informed consent, Learning from Complaints (March 2017) https://www.spso.org.uk/sites/spso/files/csa/InformedConsent_SPSOMarch2017.pdf

- Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016 Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016 - gov.scot (www.gov.scot)

- The Royal College of Surgeons, Consent: Supported decision making – A guide to Good Practice https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/

- General Medical Council Decision Making and Consent 2020 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

- British Dental Association British Dental Association (bda.org) British Medical Association (2020) https://www.bma.org.uk/advice-and-support/ethics/seeking-consent/seeking-patient-consent-toolkit

- HCPC Standards of conduct, performance and ethics (2016) https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/

- Royal College of Obstetricians and Gynaecologists, Consent - **Guidance for healthcare professionals on obtaining consent from women and people in obstetrics and gynaecology services.** https://www.rcog.org.uk/guidance/consent/

- The Code: Professional Standards of Practice and Behaviour Nurses and Midwives Nursing & midwifery Council The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk) https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (Specifically Sections – 2.3, 2.5, 4.1, 4.2 and 4.3)

- National Education for Scotland (NES) Think Capacity, Think Consent Learning Module Clear to All Toolkit https://www.nes.scot.nhs.uk/media/fqca5enl/capacity_and_consent-interactive.pdf

- Adults with Incapacity (Scotland) Act 2000: Code of Practice for Persons Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act (2nd Edition) The Scottish Government, January 2008
- Adults with incapacity - Social care - gov.scot

- Age of Legal Capacity (Scotland) Act 1991 https://www.legislation.gov.uk/ukpga/1991/50/contents

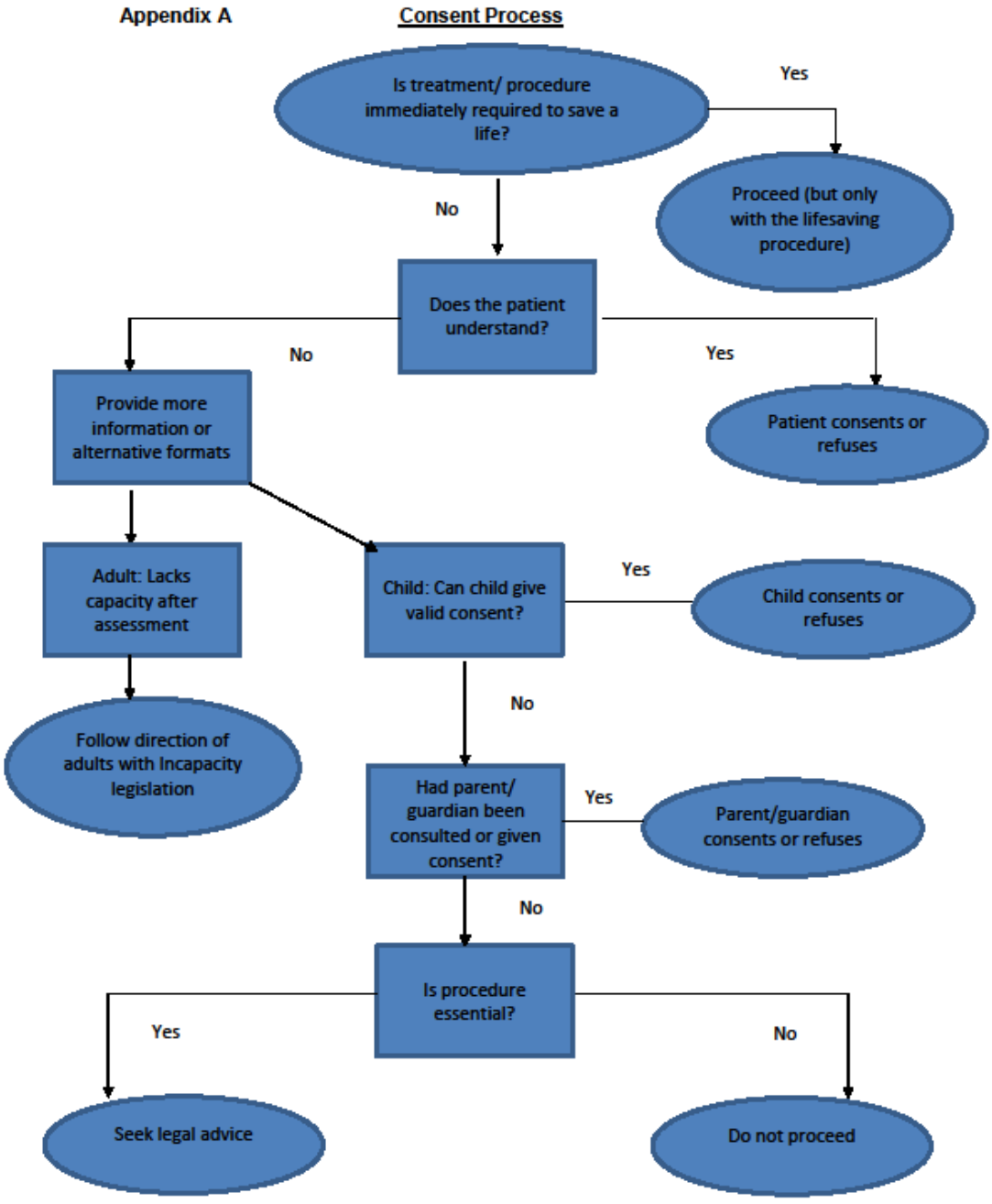
- General Medical Council, Mental Capacity Decision support tool (2016) https://www.gmc-uk.org/ethical-guidance/learning-materials/mental-capacity-tool
- Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice. https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/2/
- The Mental welfare Commission (2018) Good Practice Guide https://www.mwcscot.org.uk/sites/default/files/2019-06/consent_to_treatment_2018.pdf
- The Mental welfare Commission, Good Practice Guides https://www.mwcscot.org.uk/publications?theme=75
- Mental Health (Care and Treatment) (Scotland) Act 2015 https://www.legislation.gov.uk/asp/2015/9/contents/enacted
- Post Mortem adult leaflet https://www.nn.nhs.scot/pathology/professional/post-mortem-forms/ https://www.nhsinform.scot/care-support-and-rights/palliative-care/dying-death-and-grief/what-to-do-when-someone-dies-in-scotland
- Royal College of Pathologists Guidelines on autopsy practice Postoperative deaths Autopsy guidelines series
- Human Tissue Authorisation Scotland 2019 https://www.legislation.gov.uk/asp/2019/11/enacted
- https://learn.nes.nhs.scot/40597/human-tissue-authorisation-scotland-act2019/introducing-the-human-tissue-authorisation-scotland-act-2019-slides
- MEL (2000) Retention of Tissues and Organs at Post-Mortem Examination https://www.scot.nhs.uk/sehd/mels/2000_21.html
- Children (Scotland) Act 1995 https://www.legislation.gov.uk/ukpga/1995/36/contents
- Human Rights Act (1998) https://www.legislation.gov.uk/ukpga/1998/42/contents
- Data Protection Act Data Protection Act 2018 (legislation.gov.uk)
- National Education for Scotland (NES) Think Capacity, Think Consent Learning Module 2013
- Making and Using Visual and Audio Recordings of Patients, General Medical Council, May 2011 https://www.gmc-uk.org/professional-standards/the-professional-standards/making-and-using-visual-and-audio-recordings-of-patients

14. Glossary

Term	Definition
Consent	A patient's agreement for a healthcare professional to provide care or treatment. It may be given verbally, non-verbally, or in writing.
Capacity	The ability of a person to understand, retain, and weigh information to make an informed decision and communicate that decision.
Valid Consent	Consent given voluntarily by a person with capacity, after receiving sufficient information and without coercion.
Proxy	A legally authorised person (e.g. welfare attorney, guardian) who can make decisions on behalf of someone who lacks capacity.
Section 47 Certificate	A legal document under the Adults with Incapacity (Scotland) Act 2000 that authorises treatment for adults who lack capacity.
BRAN Questions	A framework for shared decision-making: Benefits, Risks, Alternatives, and doing Nothing.
IRMER Regulations	Ionising Radiation (Medical Exposure) Regulations that require justification of radiation exposure, including pregnancy status.
Mental Disorder	Includes mental illness, learning disability, and personality disorder, as defined under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Term	Definition
Shared Decision Making	A collaborative process where clinicians and patients make healthcare decisions together, considering clinical evidence and patient preferences.
Emergency Consent	Consent is not required when immediate treatment is necessary to save life or prevent serious harm, and the patient is unable to consent.
Advanced Statement	A written statement made by a person with capacity outlining their preferences for future treatment should they lose capacity.
Interpretation Services	Support services that help patients with language barriers or communication difficulties understand healthcare information.
Teaching Hospital	A hospital where medical trainees may be involved in patient care under supervision. Patients must be informed of who will perform procedures.
Designated Medical Practitioner	A clinician appointed to provide a second opinion for certain treatments under mental health legislation.
Equality Impact Assessment (EIA)	A process to ensure that policies do not discriminate and promote equality across protected characteristics.
Data Protection Impact Assessment (DPIA)	A process to identify and mitigate risks to personal data in policy development and implementation.

Appendix 1 - Consent process



Appendix 2 – NHS Dumfries and Galloway Generic Consent Form

Consent to Examination or Treatment

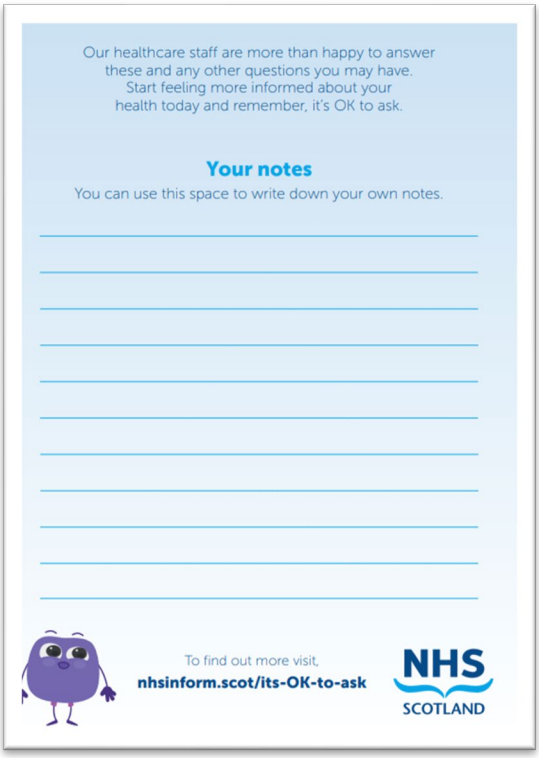
NHS Dumfries & Galloway

Patient Name **Date of Birth** **CHI Number** (or attach label here)	**Consultant or Health Professional Responsible for Your Care** **Name & Job Title**

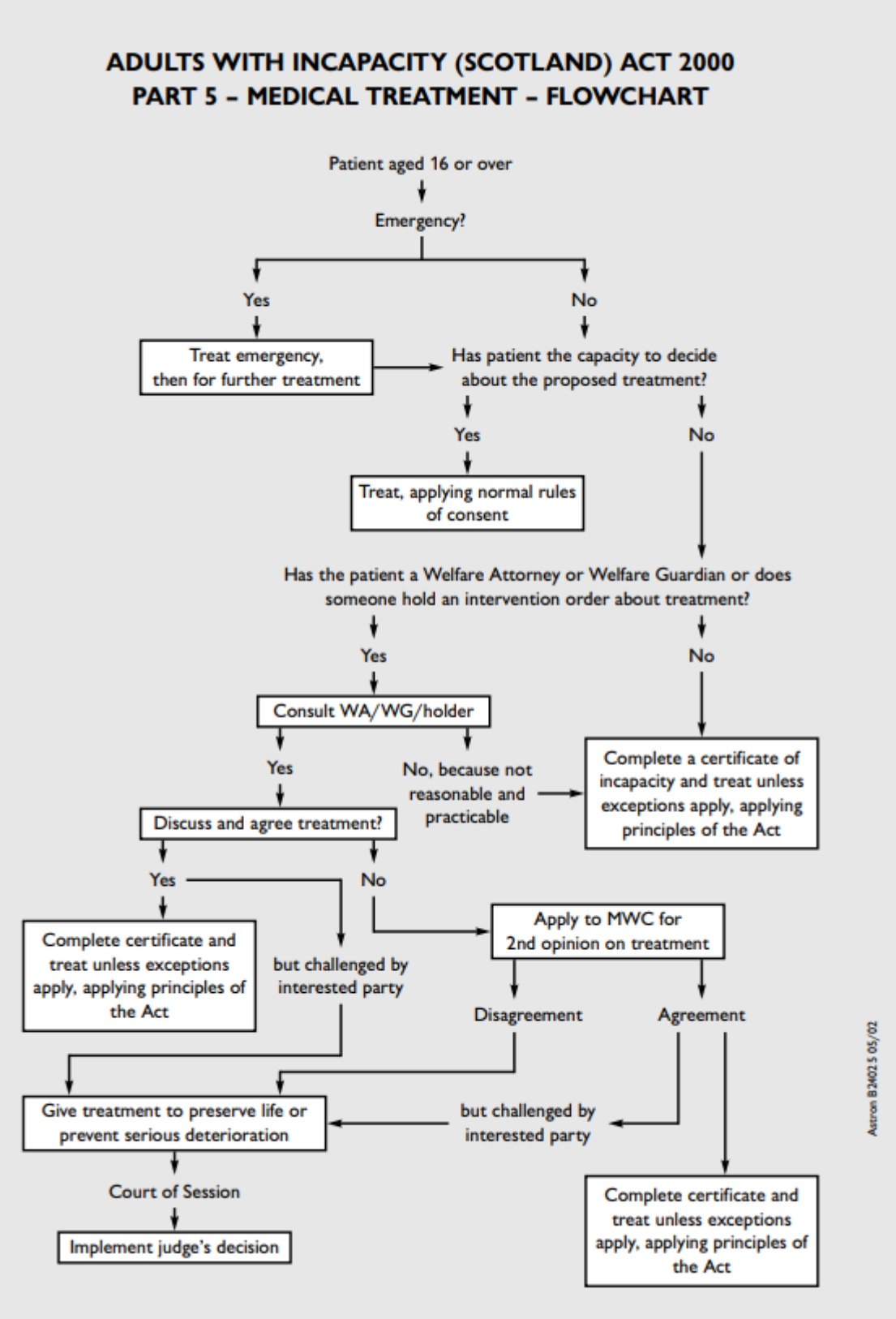
Any special requirements of the patient							
A - Name of proposed procedure or course of treatment - include brief explanation if medical term not clear							
Please tick - Patient's	**Left Side**		**Right Side**		**N/A**		
B - Statement of health professional (details of treatment, risks and benefits) 1 - With appropriate knowledge of the proposed procedure, I have explained the procedure to the patient. In particular, I have explained: a) The intended benefits of the procedure (please state)							
b) the possible risks involved. I have discussed and listed below significant, unavoidable or frequently occurring risks including any risks that may be of specific concern to the patient							
c) what the benefits and risks of alternative treatments that might be offered for this patient (including option of no treatment)							
d) any extra procedures that might become necessary during the procedure such as Blood Transfusion					or Other Procedure (please state)		
2 - The following patient information leaflet has been provided							
					Version		
or I have offered the patient information about the procedure but this has been declined					**or** no further written information		
3 This procedure will involve							
General and/or regional anaesthesia		Local anaesthesia		Sedation		None	
Signed (Health Professional)					Date		
Name (PRINT)					Time (24hr)		
Designation					Contact No.		

1

Appendix 3 - It's Ok to Ask



Appendix 4 – Adults with Incapacity Flowchart



Appendix 5 – Adults with Incapacity Form

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I _____ (name)

of _____ (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

_____ (name)

of _____ (address) D D M M Y Y (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is _____

I have examined the patient named above on D D M M Y Y (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

_____

because of (nature of incapacity) _____

_____

_____

This incapacity is likely to continue for _____ months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

D D M M Y Y (date of examination) until D D M M Y Y, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed _____ Date D D M M Y Y

*delete as appropriate

Appendix 6 - Principle of Mental Health (Care & Treatment) (Scotland) Act 2003

Non-Discrimination	People with mental disorders should wherever possible retain the same rights and entitlements as those with other health needs.
Equality	All powers under the act should be exercised in line with responsibilities as detailed in the Equality Act (2010) and without any direct or indirect discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.
Respect for Diversity	Service users should receive care treatment and support in manner that accords respect for their individual qualities, abilities and diverse background and properly takes into account their age, gender, sexual orientation, ethnic group social cultural and religious background.
Reciprocity	Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
Informal Care	Where ever possible, care treatment and support should be provided to people with mental disorder without the use of compulsory powers.
Participation	Services users should be fully involved so far as they are able to be in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.
Respect for Carers	Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice and have their views and needs taken into account.

Appendix 7 - Guidance on Consent for Children & Young People

Introduction

Children have the right to say what they think should happen, adults are making decisions that affect them, and to have their opinions taken into account. (Article 12 UN Convention on the Rights of the Child)

The process of consenting children or young people (those aged 12 years or more) for healthcare assessment, care or treatment is different to the process for adults. The fundamental difference is set in legislation, The Age of Legal Capacity (Scotland) Act, 1991 (Section 2(4)), which states that:

"A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

In practice, this means that a child or young person under the age of 16 years may have the legal capacity to consent (or refuse), to any surgical, medical or dental treatment where, in the opinion of a qualified health care professional attending the child or young person, they are capable of understanding the proposed procedure or treatment and possible outcomes which could arise.

Information provision

Information about the proposed procedure or treatment must be given in appropriate terms which the child or young person understands e.g. the words for a 14 year old differ from those for an adult or from those for a 9 year old. Use of complex language or jargon may result in poor understanding, misunderstanding or in increased fear and anxiety.

There are different ways of passing on information including orally, in age appropriate writing, storyboards, videos (no one way suits all) and the use of paediatric preadmission programmes.

The information should include the benefits and significant risks of the proposed treatment and any relevant alternatives including not having the intervention.

All questions must be answered truthfully and if a question cannot be answered the health professional should involve a colleague who knows and then listen when the issues are discussed with the family.

Voluntariness

Consent must be given voluntarily, without pressure, deceit or undue influence from family, health professionals or others.

Once a decision is made it is still possible for the child or young person or the parent, whoever consented, to change their mind.

Verbal or written consent
With verbal or non-verbal/implied consent (e.g. holding out an arm for an injection), there is a need to be explicit about the consent process.

Written consent is not required unless the procedure involves sedation or unless there is a legal requirement for written consent (HDL page 4). It is important that the health professional and the patient/parent understand what has been agreed and also that there is documentation in the patient casenotes that verbal information has been provided and what the outcome is.

Written consent will only be required when procedures are complex, pose risk or requiring a general, regional anaesthetic or sedation are being proposed. In addition, written consent must be obtained as required by the NHSD&G Policy on Photography and Video Recording of Patients. It is good practice to record consent discussions even where there is no requirement for written consent

Who can give consent?
Under Scottish Law, young people aged 16 and over have the same right to consent or refuse as adults.

Children and young people under 16 are able to give their own consent if the qualified health care professional considers the patient capable of understanding the nature and possible consequences of the procedure or treatment, according to the Age of Legal Capacity (Scotland) Act, 1991. Where a child or young person does give their own consent, it is appropriate to discuss the details with the parent (see Section 2.6 below for definition) or the person with parental responsibility, providing confidentiality is not breached.

Responsibility for signing a consent form cannot be passed on by a competent child to a parent. If a competent child consents verbally but refuses to sign the consent form this should be fully documented noting that the verbal consent has been given and the reasons why the consent form has not been signed (there is space on the child consent form). The procedure can go ahead. In cases like this the parents should not consent on the patient's behalf; although it is good practice to involve the parent, their written consent is not legally applicable in these cases

Where a child or young person lacks capacity, consent should normally be obtained from a person with parental rights and responsibilities (See Section 2.6 below).

There are occasions where the person with parental responsibility and rights is not available. If the procedure cannot be deferred until the parent is available, the Children (Scotland) Act 1995 (Section 5) gives a person, who has care or control of the child but no parental responsibility or rights in relation to that child, the power to do what is reasonable in all circumstances to safeguard the child's health, development and welfare. This could include a step-parent, relative or child-minder but excludes teachers and others with control of a child in school. This person may

consent to any surgical, medical or dental treatment or procedure where the child cannot give his/her own consent and it is not within the knowledge of the person that a parent would refuse. (HDL (2006) 34).

Where the mother of the patient is under 16 years old, she may have the capacity to consent for her child. It is however good practice to involve the person with parental responsibility for the mother under 16 years (often the patient's grandmother) in the information provision and consent process.

Capacity or competency (to consent)
Judging capacity or competency depends on:

- Clinical judgement
- The maturity of the patient
- The complexity of the proposed intervention
- Its likely outcome
- The risks associated with it.

If the child or young person is not capable of understanding the nature of the intervention and its consequences the parent or legal carer should be asked for their consent to proceed.

Competence decisions can only be made by senior staff. If a child's capacity to consent is unclear, the medical practitioner attending the child may wish to involve an independent health professional (e.g. a paediatric clinical psychologist) but he/she will ultimately have the responsibility of deciding the child's competency. If the child's or family's capacity to consent is complicated by family or psychiatric problems, then discussion with a child or adolescent psychiatrist may be useful.

Legal definition of 'parent' (*if unclear seek advice from senior colleagues*):

- The mother whether married to the father or not.
- The child's natural father, if married to the mother, at any time from conception or subsequently.
- The child's natural father, even if divorced from the mother.
- An unmarried father whose name is on the child's birth certificate, registered on or after 04 May 2006, has full parental responsibility and rights as though married to the mother**.
- An unmarried father who has entered and registered a formal Parental Responsibilities and Parental Rights Agreement with the mother.
- A legal guardian nominated in writing by a parent before the parent's death. This appointment comes into effect automatically on the death of the parent.
- A person holding a Residence Order in relation to the child, or any other court order giving them the right to consent on the child's behalf.
- A person aged 16 or over who has care or control, unless it is within their knowledge that a parent would refuse consent. The above is covered more fully under 'New Law on Children & Medical Consent'

** This bullet point has been added as a result of the Family Law (Scotland) Act 44

When to obtain consent (elective situations)
In the elective situation, the health care professional carrying out the procedure or treatment should go through the consent procedure with the parents and child or young person.

Where consent is obtained at the outpatient clinic for surgery, and it is supported by written information, it would be wise and consistent with good practice to ensure continued understanding on admission to hospital. A member of the medical team should review the consent close to the surgery, especially where:

- significant time has elapsed between obtaining consent and the date of surgery
- there have been material changes in the patient's condition, or any aspects of proposed surgery
- new information has become available about surgical options
- the parents and child do not appear to understand clearly the procedure to be undertaken.

It is good practice to check with the parent(s) and patient that they know what procedure is to be undertaken and they still give valid consent at the time of admission. Details should be explained at a level appropriate for the maturity of the child.

Emergency situations
In an emergency, where:

- the child or young person either lacks capacity or is too ill to consent and where there is no-one with parental responsibility present
- the treatment is in the best interests of the child to prevent death or permanent damage.

Life saving treatment can be carried out immediately. The treatment given must be no more than the immediate situation requires (HDL (2006) 34). The practitioner should then seek legal advice as soon as possible.

Where consent is required in an emergency, the doctor may proceed with either verbal consent or no consent if it is in the best interest of the child. Where written consent is possible this should be obtained.

Best Interests
An assessment of 'best interests' will include, but is not limited to, what is clinically indicated in a particular case. Other factors include:

- the views of the child or young person, so far as these are ascertainable, including any previously expressed preferences
- The views of parents and others close to the child or young person
- The child's or parents' cultural, religious or other beliefs and values
- The views of other health care professionals involved in providing care to the child or young person

- Which choice, where there is more than one, will least restrict the child or young person's future options

This list is not exhaustive and any other relevant information should be considered.

Who should obtain consent?

The person obtaining consent must be properly qualified to do so. The appropriate level of seniority will therefore depend on the complexity of the procedure and any likely consequences. In many cases, especially complex ones, a medical consultant will obtain consent.

However, where a doctor obtaining the consent is more junior, he/she should be deemed by him or herself and by the consultant to be competent to do so and should be sufficiently familiar with the procedure and possible side effects to enable this to be done competently.

The consultant is not legally bound him/herself to carry out the procedure, despite having obtained consent in outpatients. This possibility should be explained by the doctor while obtaining the original consent and where possible the name of the Clinical Practitioner should be given.

There are situations where other qualified (and appropriately trained in the consent process) health professionals, e.g. Nurse Practitioners, take consent for a procedure or treatment (e.g. inoculation in special circumstances) which they will carry out (BMA 2001).

Separate consent for anaesthesia

There is no legal requirement for separate consent for anaesthesia. The anaesthetic should be explained in detail by the anaesthetist at the time of preoperative assessment and discussion recorded. There may be situations where it is appropriate to have more than one Clinical Practitioner involved in taking consent if the procedure has particularly complex implications ranging over more than one specialty (Association of Anaesthetists of Great Britain and Ireland, 1999).

When a child refuses to consent

If a child or young person is able to understand the nature, purpose and possible consequences of the proposed surgery, as well as the consequences of nontreatment, the child can refuse to undergo surgery. It should be borne in mind that:

- at age 16 a young person has the same right to consent or refuse as adults
- under age 16 children/young people may have the capacity to decide, depending on their ability to understand what is involved
- The best interests of the child or young person must not be compromised by their refusal to consent to a procedure or to treatment
- if a competent child/young person refuses treatment, those with parental responsibilities cannot authorise procedures. Legal advice may be helpful in how to deal with such cases.

Failure to respect a competent child's or young person's wishes and treating him or her without consent can, as it does with adults, leave health professionals open to criminal charges, civil actions and allegations of professional misconduct.

If consent is refused by a competent child or young person for urgent treatment, the medical practitioner should consider taking legal advice. In some circumstances, the refusal of consent by or on behalf of a child or young person may be overridden by the courts which in terms of the Children (Scotland) Act 1995 (Section 11(2)) may authorise medical treatment. Any person with an interest which could include a medical practitioner can apply to the court which will decide the matter on the basis of the best interests of the child. Such circumstances are likely to be limited but could arise in a life or death situation.

When a child or young person and their parent disagree
It is good practice to encourage children or young people to involve their parents in making healthcare decisions. Occasionally there may be a difference of opinion between the child or young person and the parent but dealing with the situation professionally and tactfully may help reach an agreement.

Where a child or young person has the capacity to make the healthcare decision in question, then the Age of Legal Capacity (Scotland) Act 1991 requires the child or young person's decision be respected, even if it is different from the parent's views or the healthcare professional's views. In other words, the decision of a competent child or young person may not be overruled by a parent or health professional.

Where to obtain advice
In the event that clarification about consent is required, advice should be sought from an experienced colleague.

If further clarification is required advice is available from:

- The Central Legal Office
- The Medical and Dental Defence Union for Scotland
- The General Medical Council
- The Child Law Centre.
- Hospital Liaison Committee (in Jehovah's Witness cases)

Confidentiality
To protect confidentiality, there are circumstances where it is appropriate to discuss matters with a young person without the parents present e.g. prior to xraying a female or preoperatively, in case of pregnancy. It is however good practice to include the parents later in the general discussion.

Literacy in the child or parent
Where there is a question about literacy in either a competent child or young person or in the parent, information giving and discussion should be carried out in the presence of a witness and documented in the casenotes.

Equality
Where there is doubt about comprehension i.e.

- the parent or carer does not understand the procedure (if the child lacks capacity)
- English is not the first language of the child or young person or of the parent
- The child or young person or the parent use British Sign Language.

Information giving and discussion should be carried out in the presence of a witness and documented in the casenotes.

To proceed with the latter two, without appropriate language support, could contravene the Race Relations (Amendment) Act, 2000 or the Disability Discrimination Act, 2005.

Special situations:
Medical photography
Section 15 of the main Policy provides the basis for consenting for Medical Photography. In addition, local policy, including the correct consent process, will provide more detail and must be followed when photographing children or young people for clinical, teaching, audit or research purposes.

Children and young people with mental health problems
See separate NHS D&G guidance covering the Mental Health (Care and Treatment) (Scotland) Act 2003.

Health care within school education
Where medical examination or treatment e.g. vaccination in the course of school education is concerned, if the child or young person has capacity then he/she must still give his/her own consent.

In the event that the child or young person lacks capacity, then parental consent should be obtained (HDL (2006) 34).

Looked after or accommodated children or young people
Where a child or young person who is looked after or accommodated by a local authority has capacity, she/she can give their own consent; no other consent is required.

If a child is accommodated by Social Work under Section 25 of the Children Scotland Act (1995) or is subject to a Child Protection Order the parent retains full responsibility for consenting to health care procedures or treatment. In such cases, the child should have a BAAF Health Record booklet which contains a section where the parent should have signed consent for urgent medical and dental treatment at the time of the child becoming accommodated. The Essential Core Record document contains a similar section. Where this is not the case, or where the

signature of the parent is required for a particular reason, the child's Social Worker should be contacted for clarification.

If a Court has made a Parental Responsibilities Order in favour of a local authority and if a child or young person lacks the capacity to consent, the consent of the authority would be required (HDL (2006) 34).

A Children's Hearing
A Children's Hearing may make a supervision requirement to oblige a child or young person to submit to any medical examination or treatment.

If the child or young person has capacity then he/she must still give their own consent.

In the event that the child or young person lacks capacity then parental consent should be obtained (HDL (2006) 34).

Consent to disclose healthcare information
A young person aged 12 years or more can given permission for either the patient themselves or for other people to see identifiable information about him/her (Data Protection Act, 1998).

In the case of a child under 12 years, the parent's written permission is needed before identifiable information about their child can be shared with other people.

There are some exceptions to the above rule which include:
- the statutory requirement to report particular events
- where a court requires a disclosure
- Clinical situations where disclosure of healthcare information may be a matter of public safety.
- Cognisance should be given to any potential child protection issues in respect of information sharing.

Non-identifiable information can be used for audit purposes and for healthcare planning without consent.

Guidance is available from Data Protection Officers, Caldicott Guardians and publications (Data Protection Act 1998, NHS Code of Practice on Protecting Patient Confidentiality).

Non therapeutic procedures
Tissue donation. In Scotland, those aged 16 or more and those under 16 years who have legal capacity can consent to non-therapeutic procedures such as tissue donation. There is BMA guidance about e.g. donation of whole organs (BMA 2001 p58).

Where non-therapeutic procedures or those of uncertain therapeutic benefit e.g. circumcision for non therapeutic reasons, the child's best interests – which may include cultural or religious benefits - must be considered. The Age of Legal Capacity (Scotland) Act 1991 applies, i.e. only one parent with parental responsibility and rights is required to consent. The GMC recommends that in the 49 case of non-therapeutic circumcision both parents should be asked to give consent where possible.

Research

There is specific national guidance on undertaking research with children of different ages and young people. See the Central Office for Research Ethics Committees (COREC) website and the Royal College of Paediatrics and Child Health website http://www.rcpch.ac.uk/ for guidance.

Involvement with the Media

Written consent is required from any child or young person and their parent having their photograph taken by/for the media or for NHS publications.

Consent forms are available from NHSD&G Communications.

Appendix 8

Impact Assessment Screening Tool

This Tool has been developed to ensure that equalities, human rights, economic, social factors and the Armed Forces Covenant Duty are being considered ahead of the implementation of any new or revised policies, provisions, criteria, functions, practices and activities, including the delivery of services. Please note for the purpose of this document these will be grouped together and simply referred to as '**activity**'.

General Information			
Name of activity	Development of the Consent Policy on Healthcare Assessment, Care and Treatment		
Lead person and job title	Kirsty Bell, Programme Manager Health and Social Care Business Support Team		
Contact Information (telephone and/or email)	kirsty.bell3@nhs.scot	Date of this assessment	Started 22/10/24
Names and roles of those involved in the impact assessment process	Kirsty Bell, Programme Manager, Health and Social Care Business Support Team Amy Sellors, Project Support Manager, Programme Management Office Liz Forsyth, Strategy Support Manager, Strategic Planning and Transformation		
Describe the activity in no more than 200 words	This assessment will focus on the development of the Consent Policy on Healthcare Assessment, Care and Treatment. This assessment aims to identify and record any potential negative and positive impact(s) on protected characteristic groups from the policy. Where possible negative impacts are identified, action will be taken to minimise or mitigate these.		
How will **people** be affected by this activity?	Healthcare Staff specifically clinical practitioners who are responsible for proposing, planning and ensuring delivery of treatments and care (and other staff who are interacting with patients) will be expected to understand and implement the policy. Patients will be affected as their consent must be obtained if they have capacity (and circumstances allow – not withstanding certain emergencies). If patients do not have capacity, their guardian, continuing attorney, welfare attorney or other proxy may have the power to grant or refuse consent.		
Who has been **involved** in the development of this activity and in what capacity?	Kirsty Bell, Programme Manager, Health and Social Care Business Support Team Amy Sellors, Project Support Manager		
Please include any evidence or relevant information that has influenced the overall decision being considered within this impact assessment	The Equality Act 2010 including Fairer Scotland Duty and Human Rights Act 1998 have been considered throughout the development of this policy. The policy specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership.		

	NHS Dumfries and Galloway has applied the Fairer Scotland Duty and actively considered if there are any potential socio-economic disadvantages when developing this policy. NHS Dumfries and Galloway to consciously consider the Armed forces Covenant when developing this policy.

Impact Assessment Questions

Please complete the table below and outline within the comments sections:

1. any evidence, relevant information or involvement that has influenced the decision on impact (this may also include demographic profiles, audits, research, health needs assessment, work based on national guidance, findings from engagement and consultation). Prompts are available on **page 6** to support discussion around potential impacts.
2. Mitigating measures that will be taken to ensure that no impact is negative

When assessing the impact on each protected characteristic, you should consider the following aims of the Public Sector Equality Duty:

- Does the proposed activity impact on the **elimination of discrimination**?
- Does the proposed activity contribute towards **advancing equality of opportunity** by removing or minimising disadvantages, meeting the needs of particular groups and encouraging participation in a particular activity?
- Does the proposed activity **foster good relations** between different groups?

Protected Characteristics/Impact Areas	Are there any positive impacts?	Are there any negative impacts?	Rationale for decision and further comments	What measures will be put into place to mitigate any negative impacts?
Age • Early years, children and young people, including care experienced young people • Working aged people • Older People	Yes	No	Scottish law (as described in the Age of Legal Capacity (Scotland) Act 1991) allows that "a person under the age of 16 years shall have legal capacity to consent on his own behalf….where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment." There is no minimum age stipulated to this direction. The policy states that parents cannot override the consent of a competent child or young person nor can the responsibility for signing a consent form be passed to a parent from a competent child or young person. The welfare of the young person is paramount. The policy states that all individuals (adults aged 16 and over and children/young people under 16 who have capacity and can give valid consent), with decision-making capacity: • Have a fundamental legal, ethical and human right to determine what happens to their own body and capacity to consent or	

			refuse consent is assumed unless there is evidence to the contrary. • Are entitled to refuse any treatment at any time leading up to or during the treatment process even when it is clinically believed that this would clearly benefit their health. If consent is withdrawn in these circumstances, no further treatment can be given unless and until the patient reconsiders.	
Disability *(This includes physical disability, learning disability, sensory impairment, long term medical conditions and mental health conditions)*	Yes	No	During development of the policy, due consideration has been given to the care of people subject to compulsory powers of the Mental Health (Care and Treatment) (Scotland) Act 2003. Patients subject to compulsory powers have additional rights and safeguards in relation to specified treatments. 'Mental disorder' is defined as one or more of the following categories: • Mental illness • Learning disability • Personality disorder People not subject to any form of compulsory power, will have the same rights as any other capable adult to give or refuse consent to any proposed treatment	

			intervention. The policy makes it clear that any patient not capable of giving or refusing consent to treatment offered for a physical disorder would be covered by the Adults with Incapacity (Scotland) Act 2000. The policy sets out that leaflets and other materials (e.g. audio-visual), informing patients about their condition and the treatment being offered must be available to patients in a format and in a way they can interpret and understand well before proposed treatment. The policy states any written patient information should follow NHS D&G local and other national guidance standards (minimum of 14pt sans serif typeface). The policy states that additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.	
Sex/Gender	No	No	The Consent Policy is unlikely to have a positive or negative impact on people specifically because of their gender/sex.	

			The policy has been developed to be inclusive regardless of gender/sex or other protected characteristics. The language and terminology used is gender neutral throughout.	
Gender reassignment and Transgender	No	No	The Consent Policy is unlikely to have a positive or negative impact on people specifically because of their gender reassignment or transgender status. The policy has been developed to be inclusive regardless of gender reassignment or transgender status or other protected characteristics. The language and terminology used is gender neutral throughout.	
Marriage and Civil Partnership	Yes	No	The Consent Policy is unlikely to have a negative impact on people specifically because of their relationship status. Throughout the policy the importance of the role of family including Civil Partners in respect of consent is recognised. This could be seen as having a positive impact in that people's relationships are recognised.	

Pregnancy and Maternity	Yes	Yes	The policy states a woman has a right to refuse a caesarean section even when it might benefit her foetus. It highlights that all Obstetric practitioners must be familiar with and abide by guidance from the Royal College of Obstetricians and Gynaecologists on this topic. A parent can refuse consent to urgent or lifesaving treatment for a child lacking capacity.	The policy ensures that where valid consent is not obtained it is recorded in the patient's case notes and appropriate documentation completed, particularly for cases involving anaesthesia and surgery or where the treatment carries substantial or unusual risk. If the Consultant has a written supporting opinion from a medical colleague that the patient's life is in danger if the treatment is withheld, consent may be obtained from a Court of Session judge, if time permits. Where a patient (or their parent if the child is lacking capacity) has refused consent for a particular intervention, practitioners must ensure that they continue to provide any other appropriate care which has been consented to. Staff will ensure the patient knows that they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.
Race *(includes Gypsy/Travellers and those whose first language is not English)*	Yes	No	The policy states that Clinical Practitioners must give consideration to, people's religious, cultural and other non-medical views that may influence the decisions they make about the overall management of	

			their care.	
Religion or belief	Yes	No	The policy states that Clinical Practitioners must give consideration to, people's religious, cultural and other non-medical views that may influence the decisions they make about the overall management of their care. The policy recognises that a patient may refuse blood or blood products on religious or other grounds and provides guidance to follow in these circumstances.	
Sexual orientation	No	No	The Consent Policy is unlikely to have a positive or negative impact on people specifically because of their sexual orientation. The policy has been developed to be inclusive regardless of sexual orientation or other protected characteristics.	
Human Rights	Yes	No	The policy states that all individuals (adults aged 16 and over and children/young people under 16 who have capacity and can give valid consent), with decision-making capacity, have a fundamental legal, ethical and human right to determine what happens to their own body and capacity to	

			consent or refuse consent is assumed unless there is evidence to the contrary. No adult can give valid consent for another unless legally authorised to do so. Valid consent to treatment is therefore absolutely central in all forms of healthcare and is also a matter of common courtesy between health professionals and patients.	
Carers	Yes	No	Carers are included throughout the policy.	
Staff: • Full time • Part time • Shift workers • Staff with protected characteristics • Staff vulnerable to falling into poverty	Yes	No	The policy sets out what is and is not expected around consent and what is and is not the responsibility of staff. The policy provides guidance for where consent or refusal should be recorded by staff along with any other appropriate documentation. This is particularly important for cases involving anaesthesia and surgery or where the treatment carries substantial or unusual risk.	
Poverty 'at risk' groups • Unemployed people • People on benefits	No	No	No positive or negative impacts specific to poverty 'at risk' groups have been identified	

• Pensioners • Care Experienced people • Those living in the most deprived communities • Remote rurality				
People with low literacy/numeracy, poorer skills and/or attainment	Yes	No	Leaflets and other materials (e.g. audio-visual), informing patients about their condition and the treatment being offered must be available to patients in a format and in a way they can interpret and understand well before proposed treatment. Additional interpreting services support must also be arranged for people with sensory impairment such as Deaf or Deafblind or for people with learning disabilities or literacy issues.	
Those involved in the criminal justice system and their families	No	No	No positive or negative impacts specific to those involved in the criminal justice system or their families have been identified	
Homelessness	No	No	No positive or negative impacts specific to homelessness have been identified	
People who are displaced incl. refugees & asylum seekers	Yes	No	Where possible and dependant on individual circumstances/needs, information can be provided in alternative languages or via interpreters.	

Economic & Social Sustainability	No	No	No positive or negative impacts specific to Economic & Social Sustainability have been identified	
Environmental			Not sure if this should/could be undertaken for this policy. The policy is available electronically, which should help minimise printing.	
Armed Forces Personnel and Veterans	No	No	No positive or negative impacts specific to armed forces personnel have been identified.	

Does this activity require consideration of the <u>Fairer Scotland Duty</u>? If yes, please outline the steps taken to meet the needs of the duty.	*This places a legal duty on public bodies to actively consider how they can reduce inequalities of outcomes because of socio-economic disadvantage, such as low income, area deprivation and material deprivation, and to produce a written assessment of the results. This duty only applies to strategic decisions or activity. More information can be found <u>here</u>..*	
Please indicate how are you ensuring the information about the activity and around the proposed changes is accessible in terms of communication in the following formats, where relevant:	Easy Read	Not done as not public facing
	British Sign Language	Interpretation available on request
	Alternative Languages	Interpretation available on request
	Large Print	Not public facing - document produced in Arial 12pt
	Other (please specify)	

Summary Sheet	
Name of Activity	Development of the Consent Policy on Healthcare Assessment, Care and Treatment
Date of Impact Assessment	22/10/24
Key Lead Contact	Kirsty Bell, Programme Manager, Health and Social Care Business Support Team

Please summarise any identified negative impacts and associated mitigations/actions:		
Negative Impact	**Mitigation/Action**	**Responsibility/ Timescale**
A parent can refuse consent to urgent or lifesaving treatment for a child lacking capacity.	The policy ensures that where valid consent is not obtained it is recorded in the patient's case notes and appropriate documentation completed, particularly for cases involving anaesthesia and surgery or where the treatment carries substantial or unusual risk. If the Consultant has a written supporting opinion from a medical colleague that the patient's life is in danger if the treatment is withheld, consent may be obtained from a Court of Session judge, if time permits. Where a patient (or their parent if the child is lacking capacity) has refused consent for a particular intervention, practitioners must ensure that they continue to provide any other appropriate care which has been consented to. Staff will ensure the patient knows that they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.	

Monitoring	
How will you monitor the ongoing impact of the activity on all population groups?	This will be part of the ongoing review process around this policy.

Next Steps in the Impact Assessment Process
When complete, the lead person should send a copy of the full Impact Assessment Tool to the Equality and Diversity Lead by emailing it to dg.cbsteam@nhs.scot.

The impact assessment will then be published on the NHS Dumfries and Galloway public website at www.nhsdg.co.uk.

Please take 5 minutes to share your experience of completing this Impact Assessment by completing this short survey

Please note that this is a legal document stating that you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission.

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Appendix 9 – Data Protection Impact Assessment Screening Questionnaire

Assessment Details

ID 7522

Name Consent Policy on Healthcare Assessment, Care & Treatment

Organization NHS Dumfries & Galloway

Description

Approver Gillian Jamieson

Respondent amy.sellors@nhs.scot (External)

Template NHSDG - DPIA Screening Questionnaire v2.0

Creator Gillian Jamieson

Date Created 24/09/2024 11:09

Deadline

Completed Date

Date Submitted 24/09/2024 11:13

Stage Under Review

Very High Risks 0

High Risks 0

Medium Risks 0

Low Risks 0

Total Risks 0

Residual Risk Level None

Residual Risk Score 0.0

Result

Result Comments

Under Review (Gillian Jamieson - Not Reviewed) ;

Primary Record Id

Primary Record Name

Template Version 1

Open Risk Count 0

Open Info Request 0

Tags

Assessment Questions

1 Is a DPIA required?

1.1 **DPIA Screening Questionnaire**

Use the following screening questionnaire to decide if a DPIA is required.

If the process or project that you are planning has one or more of the aspects listed in Section One then it is a LEGAL REQUIREMENT to complete a DPIA at an early stage. This is because the processing / project you are reviewing is legally classified to be of a risky nature. Failure to carry out a DPIA in these circumstances is ILLEGAL.

1.2 **Description of process / project**

Please provide a brief description of the process or project you are planning.

NB - If the screening questionnaire indicates that you are required to complete a full DPIA more detailed information will need to be provided at that stage.

Response

Development of a new policy to: inform staff of NHS Dumfries and Galloway (NHS D&G) of the principles of consent; to ensure that the ethical and legal principles relating to consent are adhered to in practice and to ensure that valid consent is obtained from patients prior to any treatment, investigation or examination.

1.3 **Does the proposal involve automated processing, decision-making and/or profiling?**

*This applies when the project / proposal involves carrying out a **systematic and extensive evaluation** of people's personal details, using **automated processing (including profiling)** and/or **decisions that have a significant effect on people will be made as a result** of the processing.*

Includes:
Profiling and predicting, especially when using aspects about people's work performance, economic situation, health, personal preferences or interests, reliability or behaviour, location or movements Processing with effects on people such as exclusion or discrimination

Excludes:
Processing with little or no effect on people

Response

No

Justification

None

1.4 **Does the proposal involve large scale processing of special category data?**

*This applies when the project / process involves carrying out **large scale** processing of any of the **special categories** of personal data, or of **personal data relating to criminal convictions and offences.***

Includes:

- *Racial or ethnic origin data*
- *Political opinions data*
- *Religious or philosophical beliefs data*
- *Trade Union membership data*
- *Genetic data*
- *Biometric data for the purpose of uniquely identifying a person*
- ***Health data***
- *Sex life or sexual orientation data*
- *Data which may generally be regarded as increasing risks to people's rights and freedoms e.g. location data, financial data*
- *Data processed for purely personal or household matters whose use for any other purposes could be regarded as very intrusive*

*To decide whether processing is **large scale** you must consider:*

- *The number of people affected by the processing, either as a specific number or as a proportion of the relevant population*
- *The volume of data and/or the range of different data items being processed*
- *The duration or permanence of the processing*
- *The geographical extent of the processing activity*

Response

No

Justification

None

1.5 **Does the proposal involve monitoring of publicly accessible areas?**
*This applies when the project / proposal involves carrying out**large scale** and **systematic monitoring** of a **publicly accessible area.** It includes processing used to observe, monitor or control people.*

Response

No

Justification

None

1.6 **Does the proposal involve matching or combining datasets?**

*This applies when the project / proposal involves**matching or combining datasets** e.g. joining together data from two or more data processing activities performed for different purposes and/or by different organisations in a way that people would not generally expect; joining together data to create a very large, new data set.*

Response

No

Justification

None

1.7 **Does the proposal involve processing the data of Vulnerable Groups?**

*This applies when the project / proposal involves processing personal data about**vulnerable groups**. This includes **whenever there is a power imbalance** between the people whose data are to be used (e.g. children, the mentally ill, the elderly, asylum seekers) and the organisation using their personal data.*

Response

No

Justification

None

1.8 **Does the proposal include the use of significant innovation or new technologies?**

*This applies when the project / proposal involves**significant innovation** or **use of a new technology**.*

Examples could include combining the use of finger print and face recognition for improved physical access control; new "Internet of Things" applications.

Response

No

Justification

None

1.9 **Does the proposal required data to be transferred outside the UK?**

This applies if the project / proposal involves transferring personal data outside of the UK.

Particular attention needs to be paid to this question when a third-party provider is involved in the project (e.g. a supplier of medical software/services) because their servers or data warehouses may be in, for example, the EU or USA.

Response

No

Justification

None

1.10 **Rights denial**

*This applies where the project / proposal involves processing that will**prevent people from exercising a right** or using a service or a contract.*

Example: People being unable to use or access a public area without their presence being recorded by a video surveillance system.

Response

No

Justification

None

1.11 **DPIA not legally required**

*Based on the responses you have provided, completion of a DPIA is**not** legally required for this process/project.*

You may still wish to complete a DPIA as this is best practice (and we encourage you to do so). This is because it provides good evidence that NHS Dumfries & Galloway is undertaking 'data protection by design and default'.

If you do wish to complete a DPIA

please select 'Yes'. ***Response***

(No)

Justification

None