

Consent Policy

Sample policy template. This is a Verivius-authored template anchored to the statutory regulation and current CQC/professional guidance. Tenants must adapt the operational sections to their own organisation, service type, workforce, premises and professional requirements. Where this template and live law or regulator guidance diverge, the live source wins.

Statutory anchor: Regulation 11 (need for consent), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936). This policy also engages Regulation 9 (person-centred care) and Regulation 13 (safeguarding service users from abuse and improper treatment), with which consent is closely linked, and draws on the Mental Capacity Act 2005 for any person aged 16 or over who may lack capacity. **Primary source:** <https://www.legislation.gov.uk/ukxi/2014/2936/regulation/11> **Last reviewed:** 2026-06-10
Verivius pack version: v1, 2026-06-10

Policy owner: Registered Manager. **Applies to:** all clinical and direct-care staff, every regulated activity, and every consent encounter from first contact through to ongoing care.

1. What the regulation says

Care and treatment of service users must only be provided with the consent of the relevant person. (Reg 11(1): the headline duty)

The full text of the regulation is at

<https://www.legislation.gov.uk/ukxi/2014/2936/regulation/11>. Where this policy and the regulation diverge, the regulation wins.

2. Plain-English summary

You can only provide care or treatment with the consent of the relevant person. If the service user is 16 or over and lacks capacity, follow the Mental Capacity Act 2005. If Parts 4 or 4A of the Mental Health Act 1983 apply, follow that instead. Section 5 of the MCA (acts done in connection with care or treatment) still applies underneath.

The consent decision sits on three pillars in case law and statute: the patient must have capacity (MCA 2005), the consent must be informed (Montgomery v Lanarkshire Health Board 2015 standard, the patient must be told about any material risks and any reasonable

alternatives), and the consent must be voluntary. Reg 11 anchors at the regulator level; the underlying tests come from the statutes and the case law.

3. The standards this policy follows

The Service writes and operates this policy in line with:

- **Regulation 11** (need for consent), the primary duty above, together with **Regulation 9** (person-centred care) and **Regulation 13** (safeguarding), with which consent is closely linked
- the **Mental Capacity Act 2005** and its Code of Practice, for any person aged 16 or over who may lack capacity for a decision
- the **Accessible Information Standard**, so that information is given in a way the person can understand and the person is supported to make and communicate their own decision
- the **Equality Act 2010**, making reasonable adjustments so that no one is disadvantaged in giving or refusing consent
- the **UK GDPR** and the **Data Protection Act 2018**, where consent records and any consent to share information are held

4. The five principles of the Mental Capacity Act

Where a person aged 16 or over may lack capacity, the Service applies the five statutory principles:

1. a person is **assumed to have capacity** unless it is established that they lack it
2. a person is **not treated as unable to make a decision** unless all practicable steps to help them do so have been taken without success
3. a person is **not treated as unable to make a decision merely because they make an unwise decision**
4. a decision made for a person who lacks capacity must be made in their **best interests**
5. before the decision is made, regard must be had to whether the purpose can be achieved in a way that is **less restrictive** of the person's rights and freedom of action

5. Scope

This policy applies to all clinical and direct-care staff at <provider name>, every regulated activity, every consent encounter from first contact (initial consultation consent) through specific-treatment consent (procedure consent), to ongoing care consent (review consent on continuing treatment plans). It covers both verbal and written consent, the consent of children under 16 (Gillick competence), the consent of 16- and 17-year-olds, the consent of adults with fluctuating capacity, and the lawful-authority routes where consent cannot be obtained.

(Tenant updates the angle-bracket placeholder.)

6. Roles and responsibilities

- **Registered Manager:** accountable for the consent process operating across every site. Reviews any incident where consent quality is questioned. Reviews the consent audit findings quarterly.
- **Clinical Lead:** accountable for the clinical consent quality. Signs off the consent-form templates used by the service and reviews their consistency with current Montgomery-standard guidance.
- **Treating clinician:** for each consent encounter, takes the consent and is responsible for the conversation, the information disclosed, and the record made. The treating clinician is the one whose name appears on the consent record.
- **Mental Capacity Act Lead (named, where the service routinely encounters incapacitated adults):** advises clinicians on capacity-assessment best practice, best-interests-decision routes, and Deprivation of Liberty Safeguards or Court of Protection applications where in scope.
- **All staff:** know the basics of consent (capacity, information, voluntariness) at the level the role requires; do not assume consent has been taken by a colleague where the record does not show it.

(Tenant updates the named role-holders.)

7. Procedure

The consent procedure applies at every clinical encounter where care or treatment is delivered.

1. **Consent point identified.** The treating clinician confirms at the start of the encounter that consent is required for what is about to happen (a procedure, a treatment plan change, an investigation, a release of information).
2. **Capacity check.** The clinician confirms the patient has capacity for the specific decision. Capacity is decision-specific and time-specific; a patient may lack capacity for one decision while having it for another. The MCA 2005 two-stage test (does the person have an impairment of mind or brain; if so, can they understand, retain, weigh, and communicate the relevant information) is applied where any doubt exists, and who assesses capacity, when, and why is recorded.
3. **Information disclosed.** The clinician explains the proposed care or treatment, the material risks, the alternatives, and the option of no treatment, at the level of detail a reasonable patient in the patient's circumstances would want. Material risks are those of significance to the particular patient, not a one-size-fits-all list.

4. **Patient questions.** The clinician invites questions and answers them. Time for the patient to consider is offered where the decision is substantive (especially for elective procedures, cosmetic interventions, and any decision with a cooling-off expectation).
5. **Consent recorded.** The consent record is made in the clinical system: clinician name, patient name, decision agreed, information disclosed (or template referenced), patient questions raised and answered, the date and time, and the consent format (verbal, written, by-proxy). Written consent is the standard for invasive procedures, treatments under general or regional anaesthesia, and any treatment carrying a material risk of significant harm.
6. **Where the patient lacks capacity:** the MCA best-interests decision route is followed. The decision-maker (typically the treating clinician) consults relevant people (family members, attorneys or deputies, an IMCA where required, see section 8), records the consultations, weighs the factors per s4 MCA, and records the decision with reasoning. The least restrictive option is taken.
7. **Where the Mental Health Act applies:** consent under Parts 4 or 4A of the Mental Health Act 1983 follows the MHA pathway with the appropriate Section 58, 58A, or Section 62 documentation. Out of scope for most providers; for services that occasionally encounter this, the named MCA Lead refers to the on-call MHA legal advisor.
8. **Children under 16:** Gillick competence is assessed. Where the child is Gillick-competent, their consent is sufficient. Where not, parental responsibility applies; the record identifies the consenting person.
9. **Refusal and withdrawal of consent.** Consent can be refused or withdrawn at any point. A person with capacity has the right to refuse care or treatment even where the refusal may lead to harm, and the Service never delivers care or treatment that requires consent without valid consent. The refusal or withdrawal is respected and recorded, its consequences are explained sensitively, and any alternatives are offered. Where stopping immediately would itself cause harm, care is paused safely rather than stopped abruptly.
10. **Cooling-off where applicable.** For cosmetic procedures and certain elective interventions, a documented cooling-off period (typically 14 days for high-stakes cosmetic procedures per JCCP and similar professional-body guidance) sits between the consent conversation and the procedure. The cooling-off interval is recorded on the consent.

8. Advocates, attorneys and deputies

Where a person lacks capacity for a decision, the Service makes sure the right people are involved and that anyone with legal authority is identified:

- where the person has no family or friend able to represent them and the decision is serious (serious medical treatment, or a change of accommodation), the Service supports a referral for an **Independent Mental Capacity Advocate (IMCA)**

- where the person has made a **Lasting Power of Attorney for health and welfare**, the appointed attorney makes the decision within the scope of that authority; the Service checks the LPA is registered and valid before relying on it
- where the **Court of Protection** has appointed a **personal-welfare deputy**, the deputy makes the decision within the scope of the court order
- the Service records who holds authority for the decision and checks the authority is genuine before relying on it

9. Deprivation of liberty

Where the care a person needs may amount to a deprivation of their liberty and they lack the capacity to consent to it, the Service does not rely on care alone but seeks lawful authority:

- in a **care home or hospital**, authorisation is sought through the **Deprivation of Liberty Safeguards (DoLS)**
- in a person's **own home or another community setting**, DoLS do not apply and authorisation is sought from the **Court of Protection**
- any restriction is kept to the least necessary and is reviewed regularly, and a deprivation of liberty is never relied on without lawful authority (this links to Regulation 13)

The law on deprivation of liberty is in transition. The Service follows current CQC guidance and takes legal advice where a specific case is unclear, applying the lawful-authority route appropriate to the setting and the person.

10. Training requirement

- All clinical staff complete consent-fundamentals training at induction (capacity, information, voluntariness; the Montgomery standard; documenting consent) and every three years.
- All clinical staff complete Mental Capacity Act 2005 awareness training at induction and every three years; clinicians in services that routinely encounter incapacitated adults complete MCA practice training (capacity-assessment skills, best-interests decision-making).
- Staff in adult social care or service-user-restriction roles complete Deprivation of Liberty Safeguards training at the level the role requires.
- The Clinical Lead and the MCA Lead (where the role exists) complete refresher training annually.

Training records are held in the tenant's training matrix register.

11. Audit

Compliance with this policy is monitored by the Clinical Lead:

- **Quarterly consent file audit:** random sample of 5 to 10 patient records reviewed for the presence and quality of the consent record (clinician named, capacity confirmed, information disclosed, questions answered, patient signed where format requires).
- **Annual Montgomery-standard review:** the consent templates and information leaflets are re-read against current Montgomery guidance and any updated GMC, NMC, or HCPC guidance.
- **Capacity-assessment quality review:** for services that routinely encounter incapacitated adults, the MCA Lead samples capacity assessments quarterly for two-stage-test completeness, and checks that attorneys, deputies and IMCAs were involved where required.

Audit findings recorded in the tenant's audit register; actions logged in the improvement-actions register.

12. Record-keeping

Consent records form part of the clinical record and are held for the same retention period: a minimum of 8 years from the date of the last entry per the NHS Code of Practice on Records Management. For children, the record is retained until the child reaches the age of 25. For mental-health-related decisions, retention follows the MHA-specific retention rules where they apply.

Verivius preserves the per-record audit trail indefinitely while the workspace is active; consent records themselves typically sit in the clinical system, not the Verivius governance platform.

13. Accessible information and specialist services

The Service gives consent information in a way the person can understand, including easy-read, large print, or another language or format on request, in line with the Accessible Information Standard. A service specialising in the care of autistic people or people with a learning disability sets out how it adapts the consent process so that people can understand and make their own decisions as far as they are able.

14. Related policies in this pack

- Person-Centred Care Policy
- Mental Capacity Act and Capacity Policy ([mental-capacity-act-policy](#))
- Dignity and Respect Policy
- Safe Care and Treatment Policy ([safe-care-and-treatment-policy](#))

15. Sources and further reading

This template is based on CQC's guidance for providers and managers, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and other topic-specific legislation and guidance listed below. It is a starting point for adaptation, not a substitute for legal, clinical, HR, safeguarding or specialist professional advice.

- CQC Regulation 11: Need for consent
- CQC Regulation 9: Person-centred care
- CQC Regulation 13: Safeguarding service users from abuse and improper treatment
- GMC: decision-making and consent guidance (where clinical)
- Mental Capacity Act 2005 (<https://www.legislation.gov.uk/ukpga/2005/9>) and its Code of Practice (2007, update in consultation)
- Equality Act 2010 (<https://www.legislation.gov.uk/ukpga/2010/15>)
- UK GDPR and Data Protection Act 2018 (<https://www.legislation.gov.uk/ukpga/2018/12>)
- Accessible Information Standard (verify against the current NHS England publication before relying on a specific requirement)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (<https://www.legislation.gov.uk/uksi/2014/2936/regulation/11>)

16. When to seek further advice

Seek specialist advice where the issue involves serious harm, safeguarding, deprivation of liberty, restraint, children, professional misconduct, controlled drugs, radiation, termination of pregnancy, infection outbreak, water safety, employment dismissal, DBS barring referral, or regulatory enforcement.

17. Document control

Version	Date	Author	Changes
v1	2026-05-19	Verivius (sample)	Initial sample template.
v1.1	2026-06-01	Verivius (sample)	Filled out Sections 3 to 8 with concrete content. Strengthened the summary with the Montgomery standard and the three-pillars framing. Named the Treating Clinician + MCA Lead roles. Built a 10-step procedure covering capacity, information, recording, the best-interests route, the MHA route, Gillick competence, withdrawal, and cooling-off. Named the training tiers and audit cadence.

Version	Date	Author	Changes
v1.2	2026-06-05	Verivius (sample)	CQC content-checklist pass. Added Section 3 (the standards the policy follows: Reg 9/11/13, MCA 2005, Accessible Information Standard, Equality Act 2010, UK GDPR, DPA 2018), Section 4 (the five MCA principles), Section 8 (advocates, attorneys and deputies: IMCA triggers, Lasting Power of Attorney for health and welfare, Court of Protection deputies), Section 9 (deprivation of liberty: DoLS for care homes and hospitals, Court of Protection in the community), and Section 13 (accessible information and specialist services). Strengthened the procedure step on refusal and withdrawal (a person with capacity may refuse even where harmful; care requiring consent is never delivered without valid consent), and recorded who assesses capacity, when and why. Updated stale related-policy slugs.
v1, 2026-06-10	2026-06-10	Verivius (sample)	Re-conformed to the current Verivius policy standard, preserving the original content. Updated the disclaimer and footer to the current wording; added the verbatim Reg 11(1) quote with cite label and the manifest plain-English summary; added the header block (statutory anchor with engaged regulations, primary source, last reviewed, pack version), the policy owner / applies-to line, the Sources and further reading section, and the When to seek further advice section. Noted that the law on deprivation of liberty is in transition without restating any superseded test as current law.

This sample policy template was issued by Verivius. It is a template, not a substitute for legal advice or the tenant's own policy-development process. Where this template and live law or regulator guidance diverge, the live source wins.

An example for guidance, not a ready-to-use policy. This sample is deliberately generic and is not a finished policy. Before any service uses it, rewrite it around your own service, procedures, roles and local arrangements, and remove or replace anything you cannot actually provide (for example a reference to specific training you cannot access). It is guidance, not legal advice, and you are responsible for ensuring any policy you adopt is current.