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Sample policy template, generated 2026-05-31

Consent Policy

Sample policy template. This is a Verivius-authored template based on the verbatim text of the statutory source. Tenants adapt the operational sections to their own organisation. Where this template and the live regulation diverge, the live regulation wins.

Statutory anchor: Regulation 11, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936) **Primary source:** https://www.legislation.gov.uk/uksi/2014/2936/regulation/11 **Last reviewed:** 2026-06-01 **Verivius pack version:** v1.1, 2026-06-01

1. What the regulation says

> Care and treatment of service users must only be provided with the consent of the relevant person.
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> The full text of the regulation is at https://www.legislation.gov.uk/uksi/2014/2936/regulation/11. Where this policy and the regulation diverge, the regulation wins.

2. Plain British 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. 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.)

4. 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 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.)

5. 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.
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, IMCAs where required), records the consultations, weighs the factors per s4 MCA, and records the decision with reasoning.
7. **Where 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. **Withdrawal of consent.** Consent can be withdrawn at any point. Withdrawal is recorded; care that requires consent is stopped (or paused for the patient's safety where stopping immediately would itself cause harm).
0. **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.

6. 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.

7. 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.

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

8. 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.

9. Related policies in this pack

- Person-Centred Care Policy (`hscra-reg-9-person-centred-care`)
- Mental Capacity Act and Capacity Policy (`mca-2005-capacity-and-consent`)
- Dignity and Respect Policy (`hscra-reg-10-dignity-and-respect`)
- Safe Care and Treatment Policy (`hscra-reg-12-safe-care-and-treatment`)

10. 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. Section 2 strengthened with the Montgomery v Lanarkshire Health Board 2015 standard and the three-pillars framing (capacity, informed, voluntary). Section 4 names the Treating Clinician + MCA Lead roles. Section 5 expanded to a 10-step procedure covering capacity, information, recording, MCA Best-Interests route, MHA route, Gillick competence, withdrawal, and cooling-off where applicable. Section 6 names the training tiers. Section 7 names the audit cadence. Section 8 references the NHS Code of Practice.

This sample policy template was issued by Verivius as part of the Mock Inspection design partner onboarding pack. It is a template, not a substitute for legal advice or the tenant's own policy-development process. Where this template and the live regulation diverge, the live regulation wins.
