South Regional Safety and Learning Networking Forum

23 September 2025
12:00 – 14:00

@NHSResolution

Advise / Resolve / Learn

Housekeeping

- This is event is being recorded.
- Please use the chat box to submit any questions.
- Feel free to share your innovations in the chat.
- An online feedback link will be shared towards the end of the meeting and emailed after the webinar.

Agenda

NHS Resolution

Time	Item	Speaker
12:00	Introduction to the forum (5 mins)	• Chair, Ingrid Henderson, Associate Safety & Learning Lead – London & South – NHS Resolution (NHSR)
12:05	Learning from claims data & consent (10 mins)	• Caroline Latham-Parker, Safety & Learning Lead – South - NHSR
12:15	Consent & the law, how to avoid the pitfalls in clinical practice (20 mins)	• Rob Wilson, Partner - Clyde & Co LLP • Jennifer Harris, Legal Director - Capsticks LLP
12:35	Consent in general & colorectal surgery (15 mins)	• Mark Coleman, General & Colorectal Surgeon - University Hospitals Plymouth NHS Trust
12:50	Responding to consent concerns: An advisory perspective (15mins)	• Rinke Schram, Lead Assessment and Remediation Adviser, NHSR
13:05	Q&A (20 mins)	• Ed Glasgow, Partner – Kennedys
13:25	Member led breakout groups facilitated by NHSR (30 mins)	• Caroline Latham-Parker • Ingrid Henderson • Kelly Birleson
13:55	Summary and Close (5 mins)	• Caroline Latham-Parker

Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25

National & regional overview (South East & South West)

Safety & Learning Team

Presentation Overview

1. Introduction
2. National - Volume and value of Failed to Warn-Informed Consent CNST claims per year.
3. National & Regional – Status of Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25.
4. National & Regional – Top specialities for Failed to Warn-Informed Consent CNST claims volume
5. National & Regional – Top 5 Cause codes for Failed to Warn-Informed Consent CNST claims volume.

Learning Objectives: To provide an overview of the national and regional themes seen in Failed to Warn-Informed Consent claims brought under the CNST scheme.

- How does these themes compare with what you see in your local claims via the Trust scorecard?
- Do they align with your current quality metrics, e.g. complaints and patient safety events data?
- How can this help you formulate priorities for future patient safety improvement?

Introduction

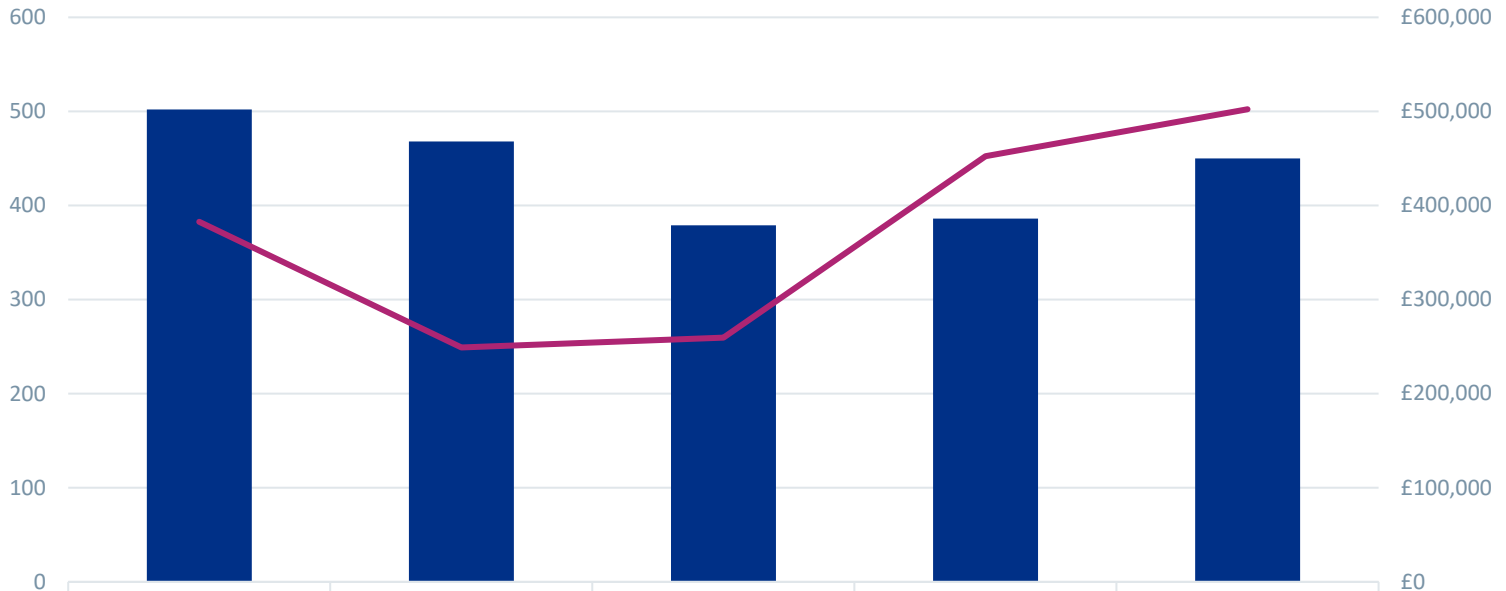
- Supporting decision making (consent) is a vital part of patient care.
- Consent claims often centre on the information, or insufficient information, provided to patients to make informed decisions about their healthcare.
- Supported decision making ensures that risks are not omitted (including the risk that treatment may not achieve its intended aims).
- Between April 2020 and March 2025, 2185, claims were reported with a cause code of ‘Fail To Warn-Informed Consent’. The estimated value of these claims is £807.7 Million.

https://resolution.nhs.uk/resources/the-benefits-of-supported-decision-making-consent/
https://resolution.nhs.uk/resource-fol-module/consent/

National - Failed to Warn-Informed Consent CNST claims per year 2020/21 to 2024/25 via claims notification date

Average total costs per claim.

Covers open & closed claims



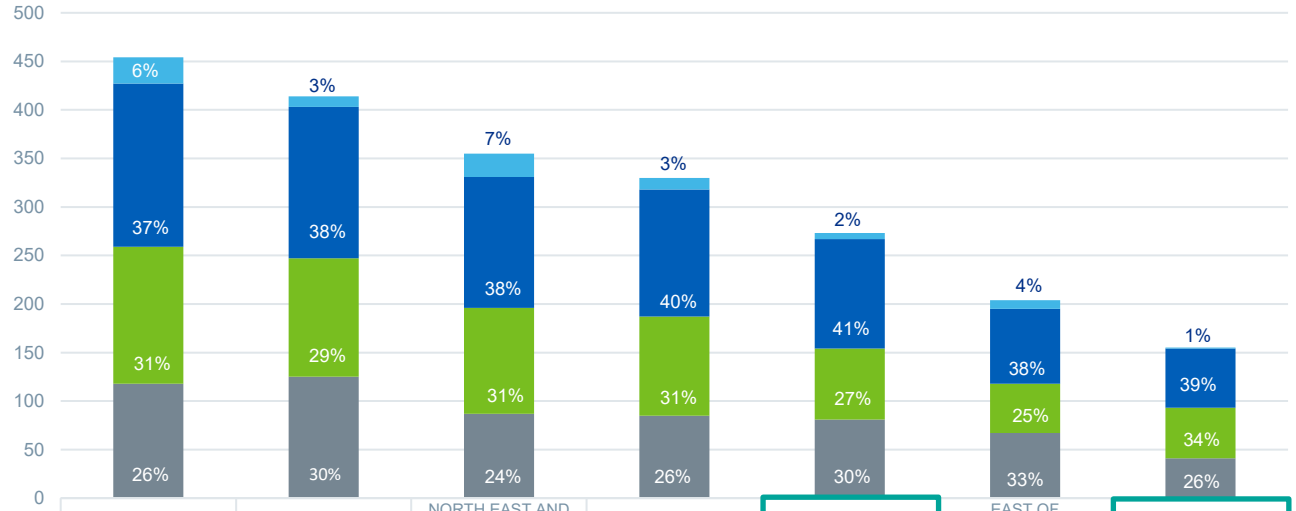
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Volume	502	468	379	386	450
Value(Average of Total Claim)	£382,626	£249,140	£259,610	£452,417	£502,312

*Data correct as of 30.06.25

Status of National & Regional Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25 via claims notification date

NHS Resolution

National	Volume
Incident	90 (4%)
Open	841 (38%)
Closed - Nil Damages	650 (30%)
Settled - Damages Paid	604 (28%)
Grand Total	2185



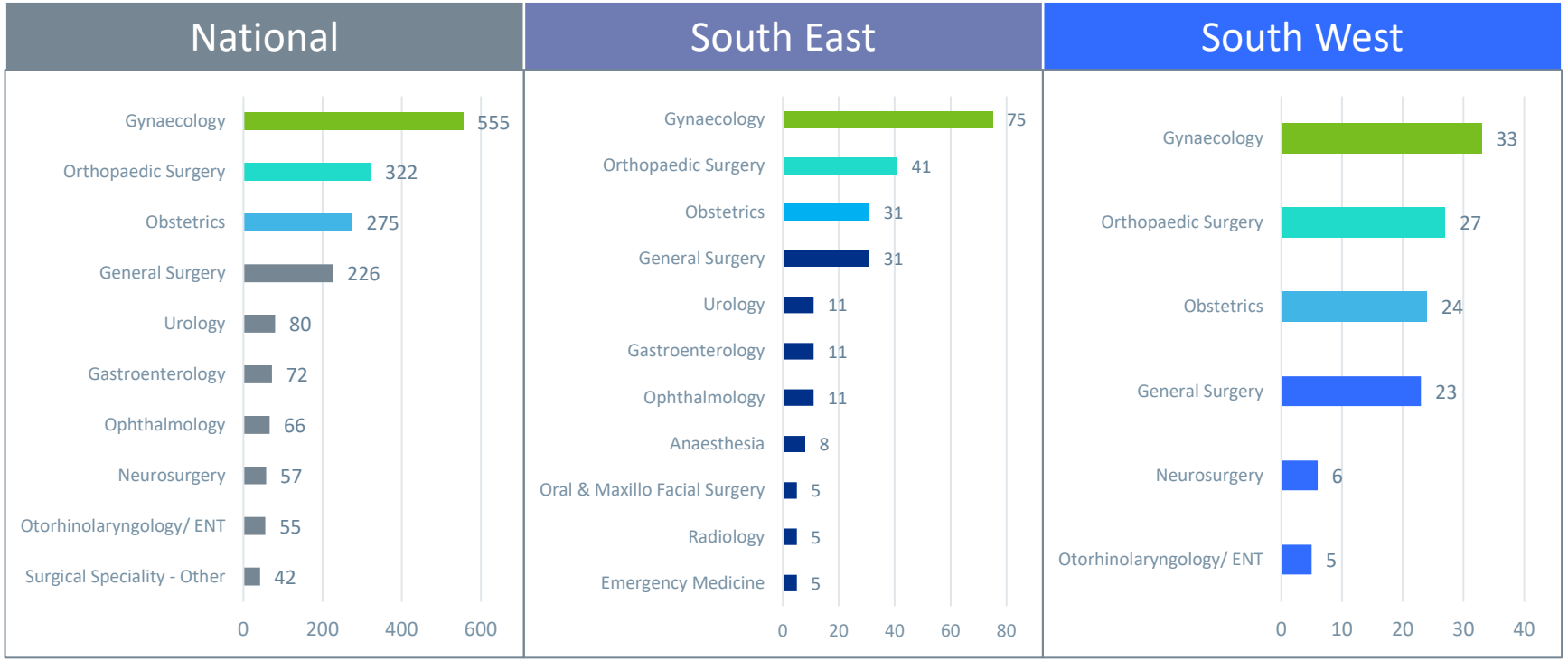
	LONDON	MIDLANDS	NORTH EAST AND YORKSHIRE	NORTH WEST	SOUTH EAST	EAST OF ENGLAND	SOUTH WEST
Incident	27	11	24	12	6	9	1
Open	168	156	135	131	113	77	61
Closed - Nil Damages	141	122	109	102	73	51	52
Settled - Damages Paid	118	125	87	85	81	67	41
Grand Total	454	414	355	330	273	204	155

Settled - Damages Paid Closed - Nil Damages Open Incident

* Data correct as of 30.06.25

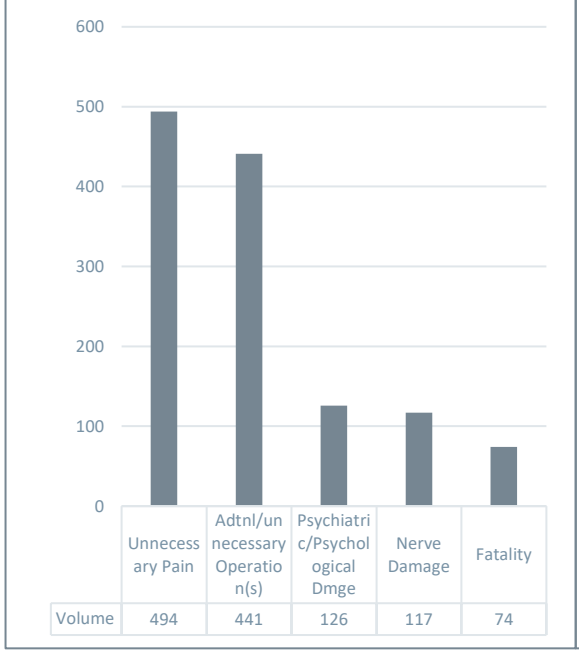
Failed to Warn-Informed Consent CNST claims by top Specialities & volume 2020/21 to 2024/25 via claims notification date

NHS Resolution

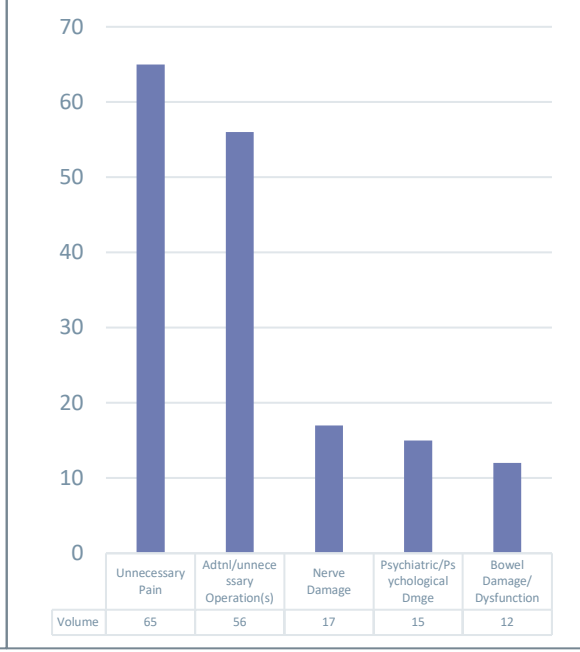


Volume of Failed to Warn-Informed Consent CNST claims by injury code 2020/21 to 2024/25 via claims notification date

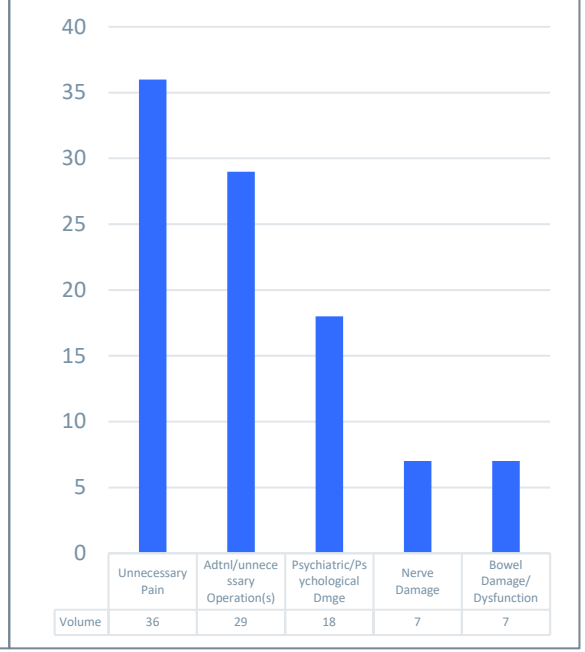
National



South East



South West



CLYDE&CO
Successful risk navigation

Capsticks

Consent and the law – how to avoid the pitfalls in clinical practice

Rob Wilson, Clyde & Co
Jennifer Harris, Capsticks

Liability

Breach of Duty – not “Bolam” in consent cases

- Failure to obtain informed consent. Not adequately explaining alternative options/risk etc.

Causation

- Had the Claimant been appropriately consented he/she would not have proceeded with the treatment

Montgomery/McCulloch

- Doctors must provide information about all material risks which a reasonable person in the patient's position would attach significance.

- Include any reasonable alternatives – as per "Bolam" – supported by a reasonable body of medical opinion.

- Doctor to make judgement about how best to explain to individual patient: a "material" risk assessment is sensitive to the patient's characteristics.

- GMC guidance

NMC Nursing & Midwifery Council

The Code

Professional standards of practice and behaviour for nurses, midwives and nursing associates

CONSENT: SUPPORTED DECISION-MAKING

Royal College of Surgeons

CONSENT: SUPPORTED DECISION-MAKING

A Guide to Good Practice

Guidance on professional standards and ethics for doctors

Decision making and consent

General Medical Council

Working with doctors Working for patients

GIRFT

GETTING IT RIGHT FIRST TIME

RCGP Royal College of General Practitioners

MRCGP RCA guidance and proforma consent form

Patient consent for recording of telephone and video consultations in general practice settings

Updated 18 June 2020

BMA

Consent and refusal by adults with decision-making capacity

A toolkit for doctors

COMMUNICATION

Informed Consent

- **Who** is responsible for getting consent?
  - Responsibility of individual performing procedure.
  - Can delegate but only if you are satisfied they are suitably qualified.

- **How** do you have the discussion?
  - Face to Face / Over the Phone / Video Link
  - Avoid Jargon, bombarding with technical information
  - Consider language / cultural barriers

Mordel v Royal Berkshire NHS Foundation Trust [2019]

COMMUNICATION

Informed Consent

- **When** should you get consent?
  - Depends on the nature of the procedure.
  - On the day / Days or Weeks in advance / Both
  - Is it invasive? High Risk? Minor or assessment only?
  - Do you need to allow time to consider the options?

Thefaut v Johnston [2017]

- **Without Pressure or Coercion**
  - Family / Religious leaders / clinicians

It is a process
Not a single point in time

Informed Consent

What does this look like in real life?

Diamond v Royal Devon & Exeter NHSFT [2017/2019]

Failure to consider the impact of options on the future

Plant v El-Amir [2020]

Even if successful will you improve the situation sufficiently to warrant taking the risk?

Thefault v Johnston [2017]

Inaccurate advice on success rates and risks.

Remember:

- ***Consider the future.***
- ***Will you achieve the patient's aims?***
- ***Get the stats right!***

Informed Consent

What does this look like in real life?

A v East Kent Hospitals University NHS Foundation Trust [2015]

"a small but well-established risk of a serious adverse outcome" is significant for the purposes of consent - GMC Guidance.

Bayley v George Eliot Hospital NHS Trust [2017]

Duty to notify of all "reasonable alternatives".

Has to be known not experimental.

Mills v Oxford University Hospitals NHS Trust [2019]

Need to highlight if a procedure is "new" and address the "standard" option too.

Remember:

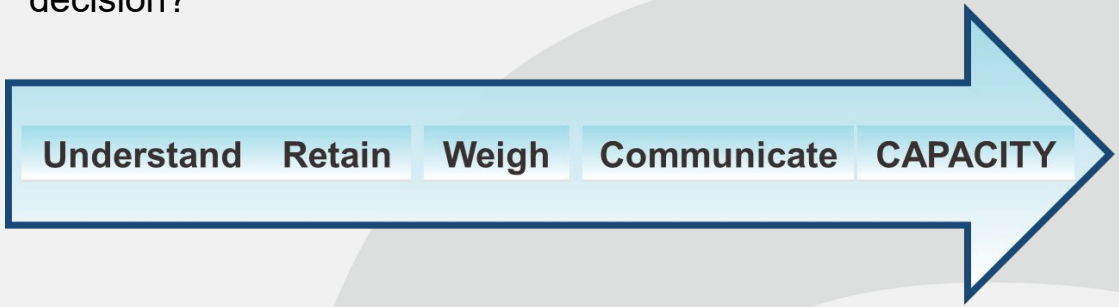
- ***Real not theoretical risk***
- ***Reasonable alternatives***
- ***Highlight innovations***

Informed Consent

CAPACITY – *Mental Capacity Act 2005*

2 Stage Test

1. Do they have an impairment of their mind or brain?
   (can be an illness or external factor such as alcohol or drugs)
2. Does the impairment mean they cannot make a specific decision?



Remember capacity can fluctuate with time & may not apply to all types of decisions

East Lancashire Hospitals NHS Trust v GH [2021]

Informed Consent

Mental Capacity Act 2005 - 5 Principles

1. A presumption of capacity

Every adult (16 yrs plus) has the right to make their own decisions and must be assumed to have capacity unless proven otherwise.

2. Individual supported to make their own decision

Do all you can to help the person make a decision.

3. Unwise decision

Unwise does not equal unable to make a decision.

Which includes refusal of life prolonging care.

4. Best Interests

If they lack capacity you must act in their best interests.

5. Least restrictive option

Kings College Hospital NHS Foundation Trust vs C [2015]

Re MB (Medical Treatment) [1997] ***St George's Healthcare NHS Trust v S***

Documentation

- 3 legged stool:
  - Information booklets
  - Patient-centred dialogue
  - Consent forms
- 3 exceptions:
  - Emergency
  - Lack of capacity
  - Impractical/impossible (voluntarily waived)

Thank you.

Rob Wilson, Clyde & Co
Jennifer Harris, Capsticks

Surgical Consent

University Hospitals Plymouth NHS Trust

Mark Coleman

- Consultant Surgeon University Hospitals Plymouth (UHP) NHS Trust (25 years)
- Chair of the National Joint Advisory Group for GI Endoscopy 2020-2023 (thejag.org.uk)
- Executive Council of the Association of Coloproctology GB&I 2011-2016 (acpgbi.org.uk)
- Service Line Director Colorectal Unit and Theatres UHP
- Co-Director Lapco International Consultancy

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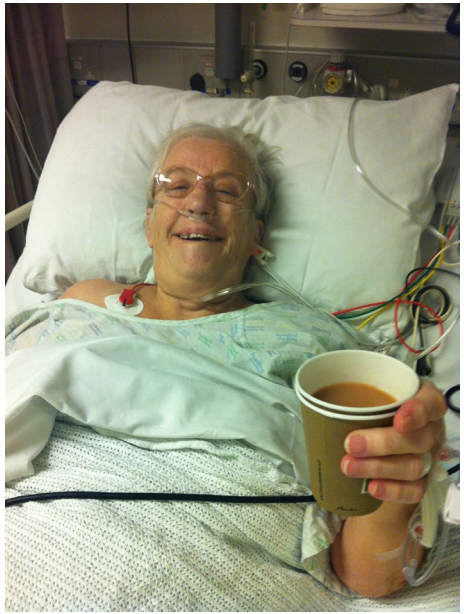
Disclosures

Introduction

- Surgical consent is a vital part of patient care
- Ensures patients are informed and voluntarily agree
- Protects patient rights and legal interests



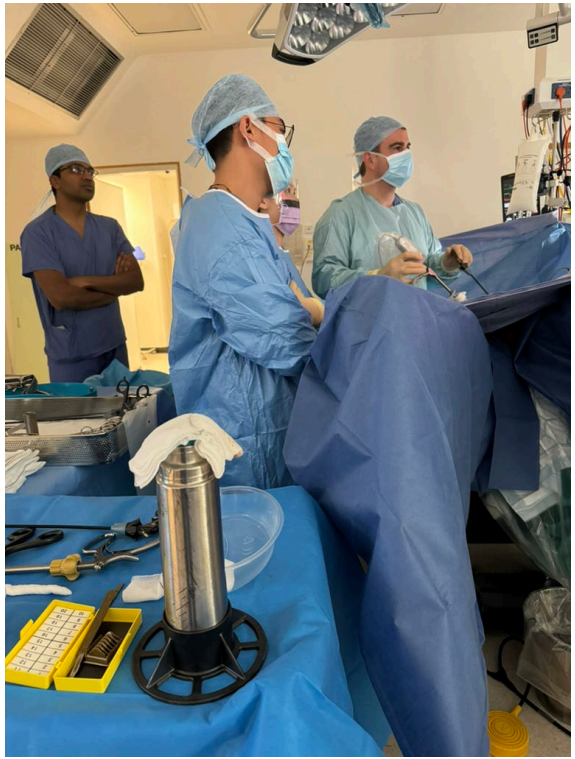
"Decisions are more important than incisions"

"a fool with a tool is still a fool"

"Patients want to know that you care before they care what you know"

Is there a problem?

Understanding of Consent	**56%–76%**	Procedure-specific forms publishing.rcseng
Time Taken for Consent	**~50% <10min, often rushed**	RCS/RCSEng guidance publishing.rcseng
Errors in Consent Forms	**>50% (paper forms)**	Concentric Health/BJS study concentric



Definition of Surgical Consent

A legal and ethical process

Permission given by a patient after understanding the procedure, risks, and alternatives

Voluntary acceptance without coercion

Importance of Surgical Consent

RESPECTS PATIENT AUTONOMY

REDUCES LEGAL RISKS FOR HEALTHCARE PROVIDERS

ENHANCES PATIENT TRUST AND SATISFACTION

STATUTORY REQUIREMENT IN HEALTHCARE

Types of Consent

Expressed Consent: Oral or written

Implied Consent: Actions indicating agreement (e.g., extending arm for injections)

Informed Consent: Full disclosure of information

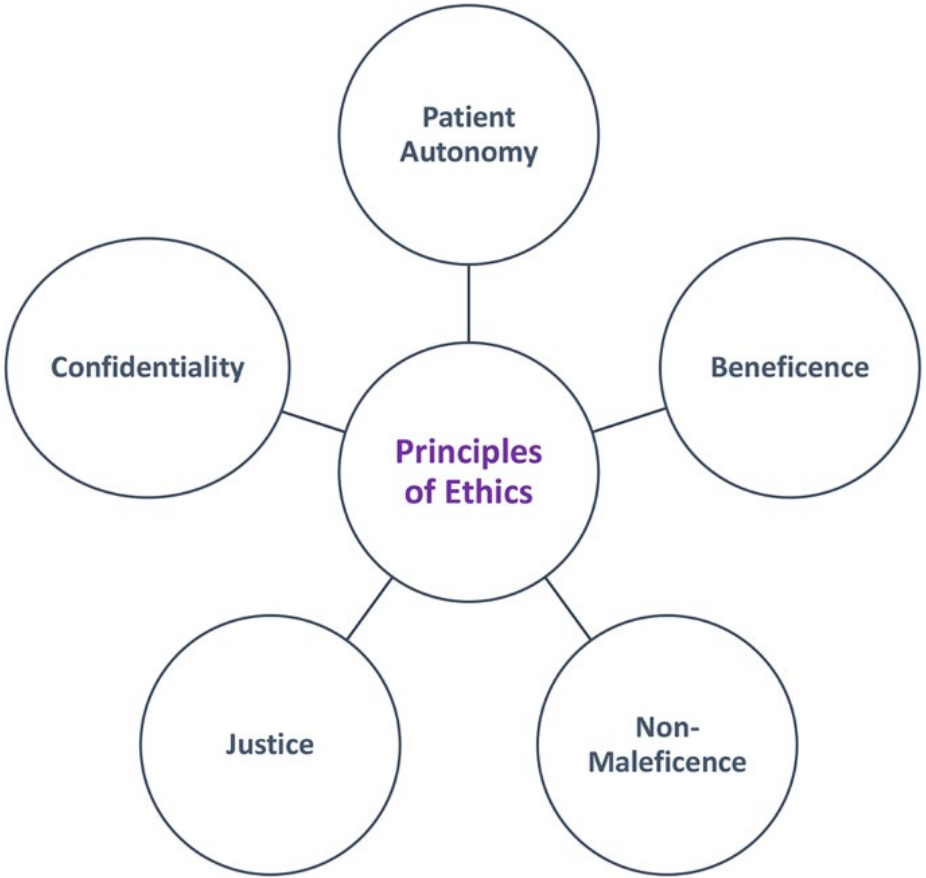
Components of Informed Consent

- Explanation of the procedure
- Risks and benefits
- Alternatives available
- Questions and clarifications
- Voluntary decision

- **BRAN?:**

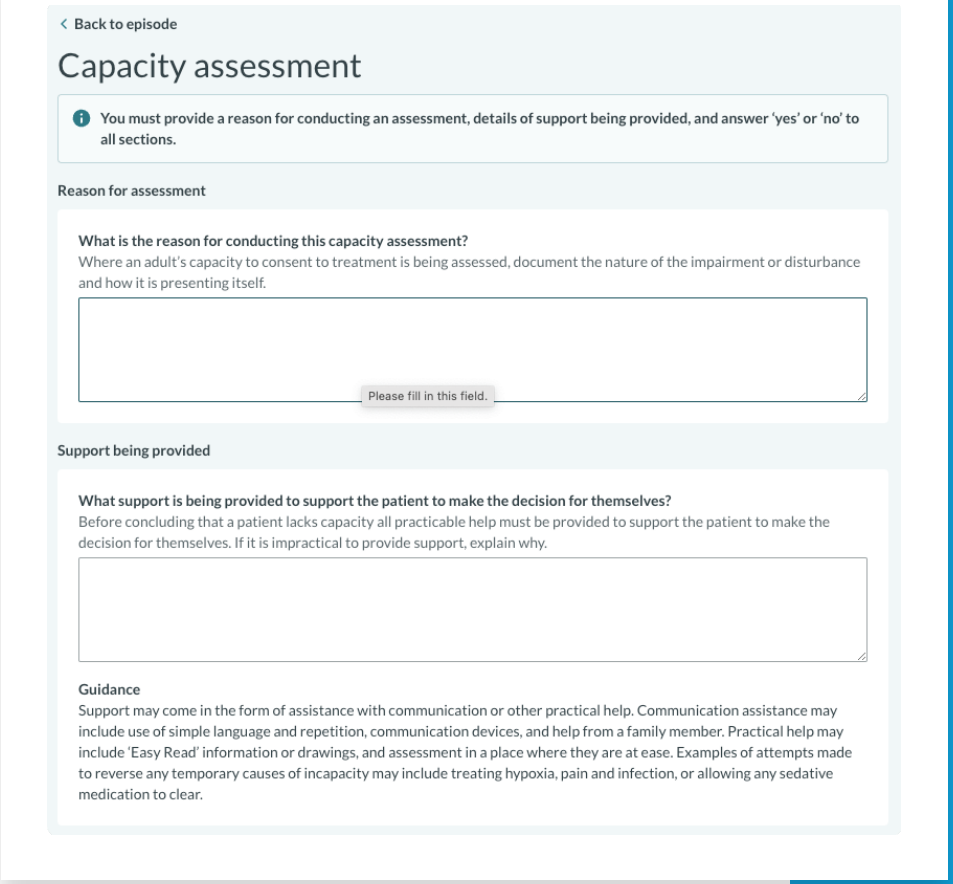
- **B**enefits
- **R**isks
- **A**lternatives
- **N**othing
- **?**Questions

Legal and Ethical Principles



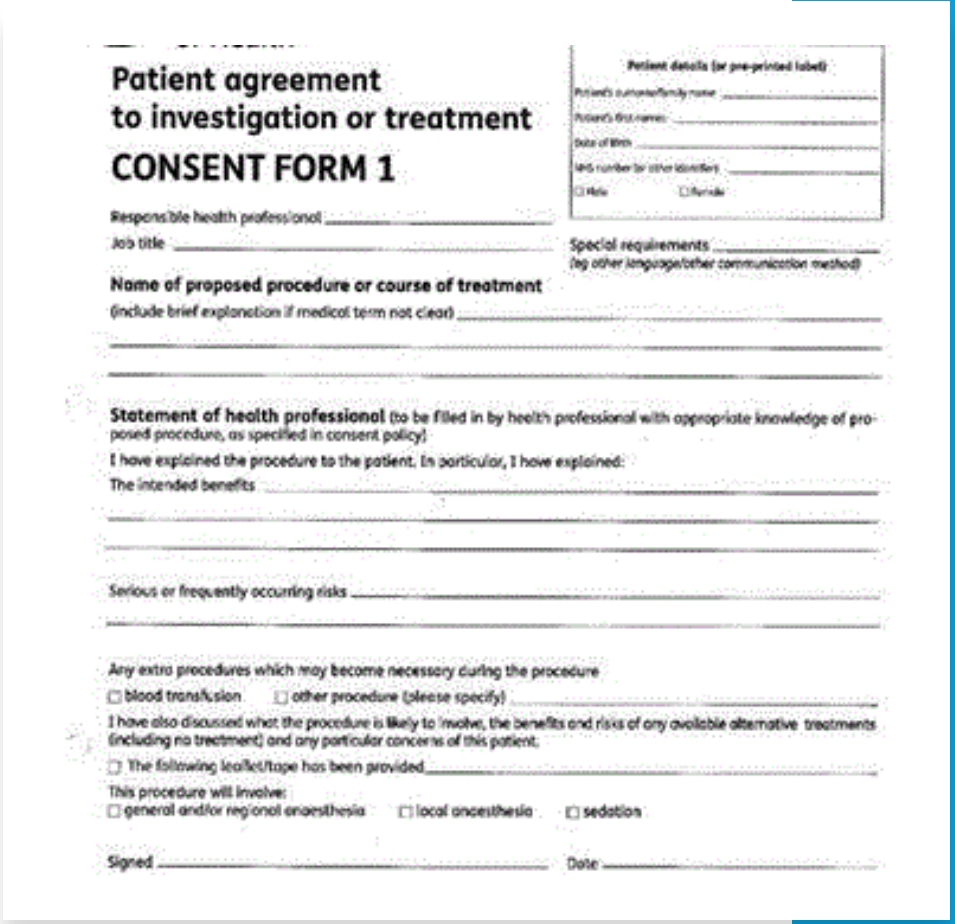
When is Consent Not Necessary?

- Emergency situations when patient is unconscious or unable to consent
- Implied consent for life-saving procedures
- Minors with parental or guardian consent



Documenting Consent

- Written consent form signed by patient
- Details of the procedure, risks, and patient understanding
- Witness signatures if required



Patient agreement
to investigation or treatment

CONSENT FORM 1

Patient details (or pre-printed label)

Responsible health professional

Job title

Special requirements
(eg other language/other communication method)

Name of proposed procedure or course of treatment
(include brief explanation if medical term not clear)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits

Serious or frequently occurring risks

Any extra procedures which may become necessary during the procedure

☐ blood transfusion ☐ other procedure (please specify)

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

☐ The following leaflet/tape has been provided

This procedure will involve:

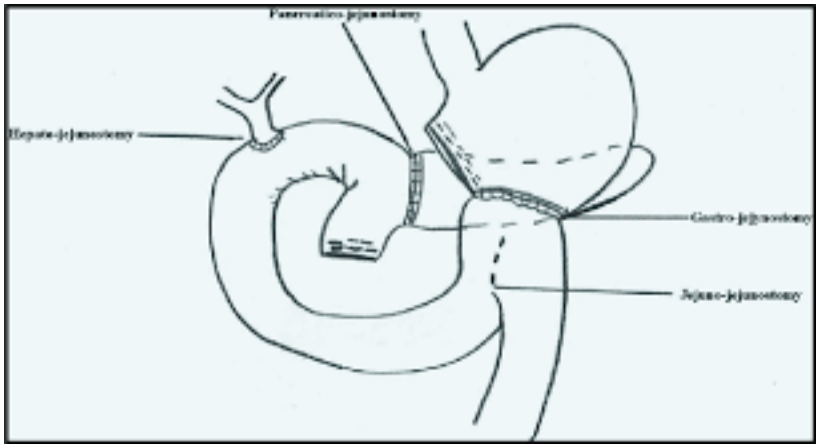
☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed Date

Challenges & Common Issues

- Language barriers
- Cognitive impairments
- Medical jargon
- Coercion or undue influence

Improving Consent Process



- Use of plain language
- Visual aids and diagrams
- Confirm understanding
- Use interpreter services if needed

Conclusion

Consent is a cornerstone of ethical surgical care

Must be voluntary, informed, and documented

Continuous communication improves outcomes

THANK YOU

Questions?

NHS Resolution

Case study: Lessons on consent and communication in clinical examinations

Addressing consent-related concerns about doctors: An advisory perspective.

Rineke Schram
Lead Assessment and Remediation Adviser

Case summary

NHS Resolution

Setting: GP practice – resident doctor under supervision

- Policy: Chaperone required only for intimate examinations
- Event:
- Young female patient, chest (heart) examination clinically indicated
- Allegation: Doctor touched patient's breast (over bra) during examination

Outcome:

- Immediate exclusion pending investigation
- Police investigation – no further action due to insufficient evidence
- Internal investigation discontinued

This is a fictional case, based on typical cases

Key issues raised

Consent:

- Was explicit, informed consent obtained before examination?
- Did the patient fully understand what the examination involved?

Chaperone policy:

- Does the ‘intimate examination only’ policy give sufficient protection?
- Should the chaperones be offered more widely, especially for cross gender examinations?

Communication:

- Were examination steps explained in real time?
- Was the patient given an opportunity to ask questions or refuse?

Potential preventive actions (Doctor)

Clear Pre-Examination Explanation:	Explain why the exam is needed, what areas will be touched, and duration
Explicit Consent:	Ask directly: 'Is it OK if I proceed?'
Chaperone Offer:	Offer regardless of policy when patient may feel vulnerable
During the Examination:	Describe actions before and as they occur ('I'm now going to place my hand on…')
Post-Examination Check:	Ask if the patient has any concerns or questions

Potential preventive actions (Practice)

Chaperone Policy Review:	Consider making chaperone offer standard for examinations of sensitive areas
Staff Training:	Communication skills for explaining examinations Handling and documenting consent
Documentation:	Record that consent was obtained, chaperone offered/declined, and patient's response
Patient Information:	Posters or leaflets explaining chaperone availability and patients' rights

Learning points

Even clinically appropriate examinations can lead to complaints if communication and consent are unclear

Offering a chaperone can protect both patient and clinician

Documentation of consent and chaperone discussions is critical

A proactive consent and chaperone culture supports trust and safety

Consent in Practice – Balancing Values, Judgement, and Evidence

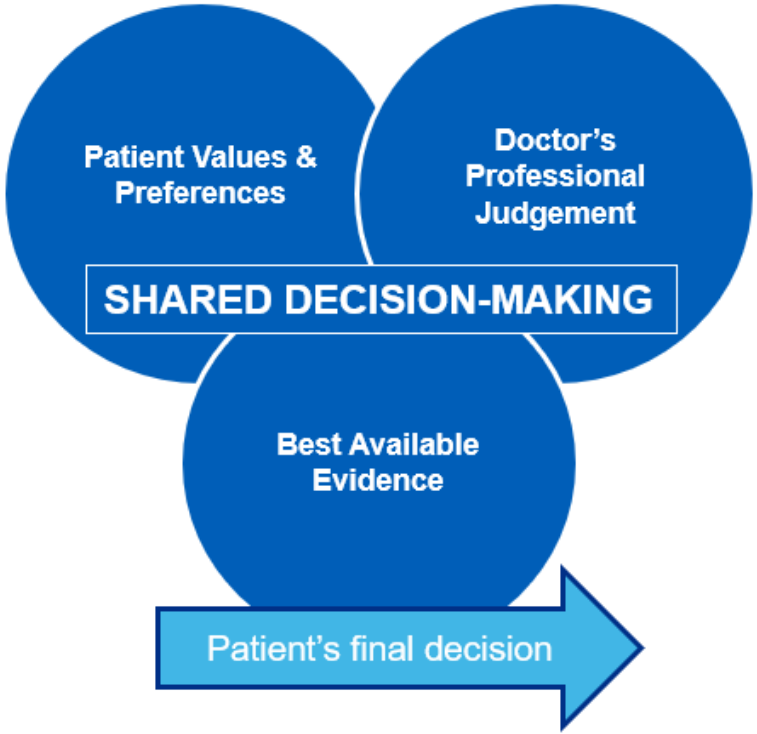
NHS Resolution

Core elements in seeking consent

- Patient – values, beliefs, lifestyle, preferences; priorities for outcomes and risks
- Doctor – professional knowledge, clinical judgement; duty to explain material risks and alternatives (Montgomery ruling)
- Evidence – clinical data, guidelines, treatment/procedure outcomes; benefits, harms, uncertainties

Shared decision-making framework

- Dialogue – open, honest exchange of information
- Understanding – patient comprehends benefits, risks, alternatives
- Respect – patient's perspective guides options discussed



Consent in Practice – Balancing Values, Judgement, and Evidence

Key principle

- Montgomery standard: Material risks are those a reasonable patient would want to know, and those the clinician should know are significant to that patient.

Final decision

- The patient is the decision-maker – the clinician advises, informs, and supports. Consent must be informed, voluntary, and given by a patient with capacity.

Contact Practitioner Performance Advice

NHS Resolution

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nhsr.advice@nhs.net

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Events team:

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https://resolution.nhs.uk

NHS Resolution

Q&A led by Ed Glasgow, Partner – Kennedys

Please complete this short survey here to help us with future events

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https://forms.office.com/e/Q9CsgWnHZs

Breakout groups

We are now going to split into three breakout groups:

1. Acute
2. Mental Health
3. Community Trust & Other

Please choose the room that reflects your organisation

Summary & Close

We hope you have found this event useful, please remember complete this short survey here to help us with future events

SCAN ME

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Thank you for your time

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