Worcestershire Acute Hospitals NHS Trust

Consent to Endoscopy within BCSP

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Key Documents Owner:	Emma Duggan/Felicity Eykyn	Bowel Cancer & Bowel Scope Screening Manager/Bowel Cancer Lead Nurse Specialist Screening Practitioner
Approved by:	Bowel Screening Operational Meeting	
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Date of review:	30th November 2025	

Key Amendments

Date	Amendment	Approved by
19th June 2019	Documents extended for 6 months whilst reviewed	Emma Duggan
11th Feb 2020	Documents extended for 6 months whilst review and approval is processed	Emma Duggan
27th July 2020	Documents extended for 6 months during COVID-19 period	QGC/Gold Meeting
1st March 2021	Document extended for 6 months as per Trust agreement 11/02/2021	
16th July 2021	Documents extended for 6 months whilst review and approval is processed	Emma Duggan/ Mr Stephen Lake
30th November 2022	Document approved with no amendments	SCSD Governance Meeting

Introduction:

This guideline outlines the process for obtaining consent from patients within the BCSP for endoscopic procedures and should be used in conjunction with generic WAHT Consent Guidelines.

This document applies to BCSP Screening Colonoscopists, Specialist Screening Practitioners (SSPs) working within the Herefordshire & Worcestershire Bowel Cancer Screening Programme. It should also be considered by endoscopy departments receiving BCSP patients**.**

This guideline will need to be implemented when commencing the consent pathway for colonoscopy procedures to ensure that all patients receive informed consent.

All BCSP and endoscopy staff will be notified of this documents existence and it will form part of the induction plan for new staff.

This policy can be found on the Worcestershire Acute Trust Website.

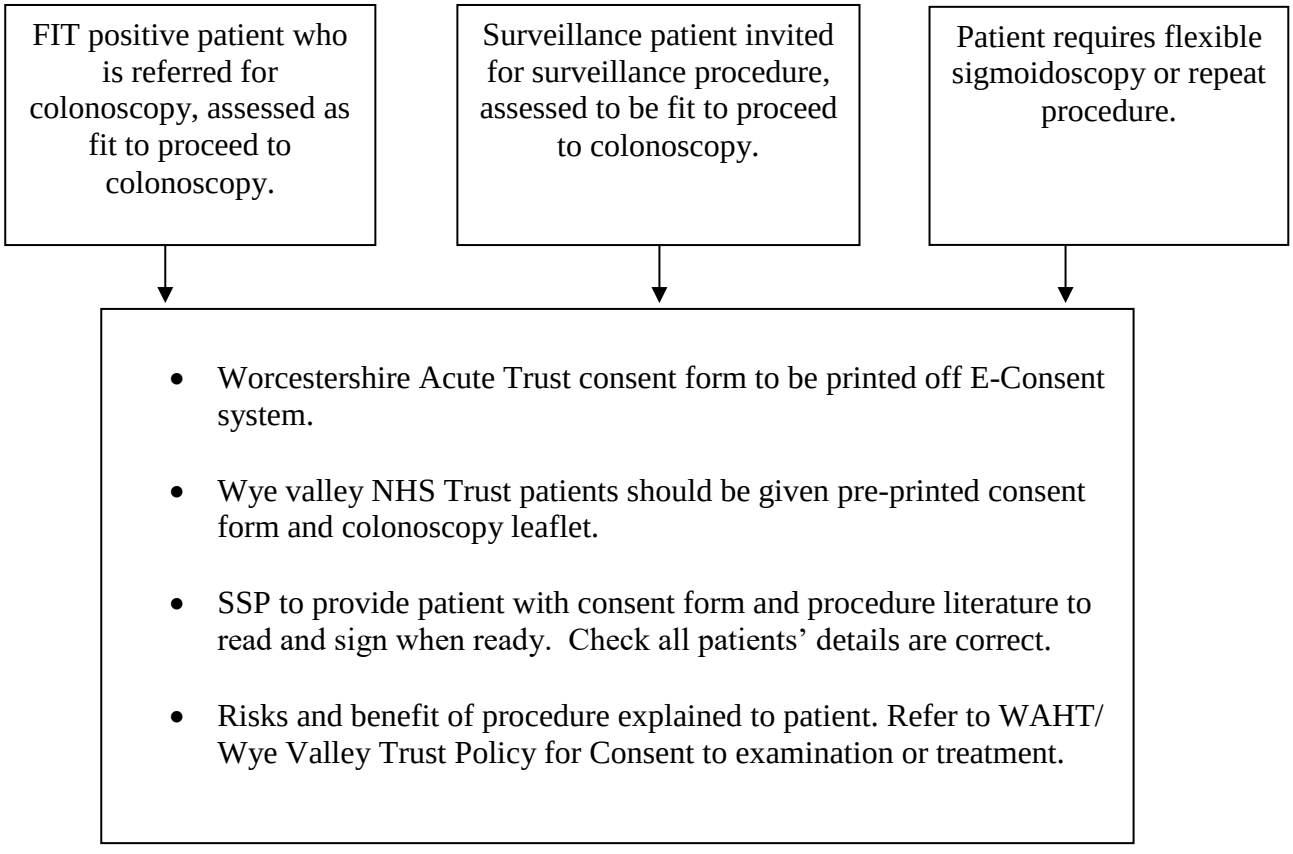
Background:

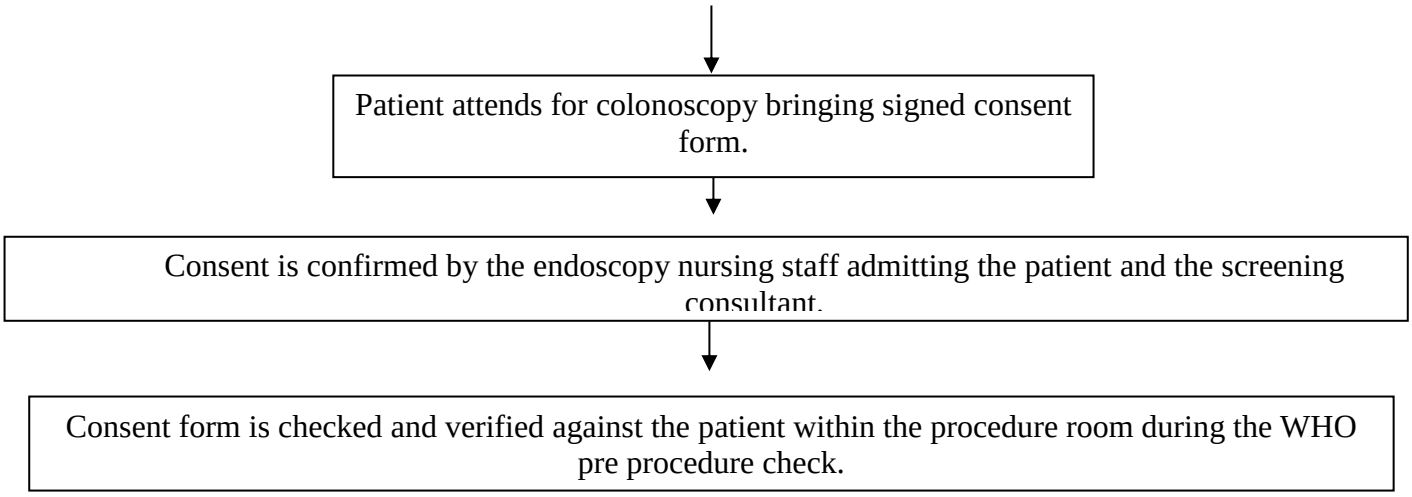
Obtaining consent is an important feature of the BCSP pathway for patients. Consent cannot be obtained solely within the procedure room (Everett et al. 2016). Each participant should be made aware of the risks and benefits of the endoscopic procedure and should receive both written and verbal instruction surrounding consent. Communication and relating to individuals whilst accounting for equity and diversity is key to consent. Each participant should be treated as an individual, some will need additional time and resources, allowing the participant to access information in a format which is

accessible to them (MDU 2017). Diversity includes communicating with patients in a way that they can understand and at a level that they can understand. Interpreters, learning disability nurses and sign language specialists all have a role to play within the consent process.

The consent process begins when the SSP is preparing for a positive assessment clinic or surveillance consultation when the SSP prepares the written consent for the screening participant. When the participant speaks to the SSP, either at Positive Assessment Clinic or during a telephone appointment, the consent will be discussed including the risks and benefits of that procedure (Everett et al. 2016). The next consent check will be either when the patient contacts the SSP to discuss any issues related to the colonoscopy or when they arrive at admissions within the endoscopy department for their procedure, allowing the understanding of the risks and benefits of the procedure to be checked prior to the procedure. The consent is further checked at the point of the WHO checklist within the endoscopy room prior to the procedure. Everett et al. (2016) also indicate that alternative procedures should also be explored under the Montgomery ruling. The Montgomery Ruling states that the medical profession has a duty to ensure that the patient is aware of any material risks involved in any recommended treatment and that any reasonable alternative variant treatments should be discussed (MDU 2017). This ruling indicates that the option of CTC scans should be offered as an alternative diagnostic test as an alternative to colonoscopy to FIT 120 positive participants.

PATIENT PATHWAY





It should be noted that valid consent can only be gained when participants have capacity to make informed decisions about their treatment. When capacity is lacking, as indicated by MCA1 and MCA2 documentation, Consent 4 has to be utilised in the best interests of the participant and is determined by the list consultant.

This document is not an exhaustible policy but should be used as a guideline by the SSP when assessed patients are deemed to have capacity to consent to treatment through BCSP and should be used in conjunction with the local WAHT policies detailing Consent to Examination or Treatment.