

Mental Capacity and Best Interests Policy

CATEGORY:	Policy
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PURPOSE	To set out the Trust policy for undertaking mental capacity assessments and making decisions in the best interests of patients
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1. Policy Statement

- 1.1. The purposes of this policy and its associated documentation are to:
 - 1.1.1. Ensure that University Hospitals Birmingham NHS Foundation Trust (the 'Trust') complies with its legal and regulatory obligations when assessing patients under the Mental Capacity Act 2005 ('the MCA'), and to promote the safety and well-being of any patients subject to the MCA, staff members and other patients/visitors.
 - 1.1.2. Equip relevant staff with sufficient knowledge to effectively deal with decisions regarding the best interests of patients lacking capacity as assessed under the MCA.
- 1.2. The MCA makes it a criminal offence to wilfully neglect someone without capacity. Therefore, whenever capacity is in doubt, it is essential that it is assessed, and care planned and delivered in the best interests of the patient. The care must also be necessary to prevent harm to the patient, and proportionate to the likelihood of the patient suffering harm, and how serious that harm may be.
- 1.3. The key objectives of the policy are to:
 - 1.3.1. Set out the framework for the assessment of capacity under the MCA.
 - 1.3.2. Set out the framework for making decisions regarding the best interests of patients deemed to have no capacity under the MCA.
 - 1.3.3. Ensure all staff understand their roles and responsibilities in accordance with the MCA.
 - 1.3.4. Ensure compliance with the MCA in accordance with the legal framework of the MCA, national policy and guidance.
- 1.4. This document should be read in conjunction with the 'Policy and Procedure on Consent to Treatment and Examination'.

2. Scope

- 2.1. This policy applies to all services of the Trust and all staff employed by the Trust including contractors, volunteers, students, locum, bank and agency staff and staff employed on honorary contracts.
- 2.2. The MCA applies only to patients aged 16 and over. Therefore, children aged under 16 are not subject to mental capacity assessments. However, children aged under 16 may have decisions made in their best interests.

3. Framework

- 3.1. This section describes the broad framework for undertaking capacity assessments.
- 3.2. Detailed operational instructions and guidance for the implementation of this policy are contained in the associated Mental Capacity and Best

Interests Procedures and Guidance (“the Procedures”). The Procedures may be amended by authority of the Director of Corporate Affairs and the Chief Nurse, provided that such amendments are compliant with this policy.

- 3.3. If at any point, staff are not clear on the correct process to follow, the Legal Services team can be contacted for advice. If a query is urgent and/or out of hours, the Executive on-call should be contacted for advice.
- 3.4. The following statutory principles of the MCA must be applied to all patients:
 - 3.4.1. A person¹ must be assumed to have capacity unless it is established that they lack capacity.
 - 3.4.2. A person must not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
 - 3.4.3. A person must not to be treated as unable to make a decision merely because they make an unwise decision.
 - 3.4.4. An act done, or decision made, under the Act for, or on behalf of a person who lacks capacity must be done, or made, in their best interests.
 - 3.4.5. Before an act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.
 - 3.4.6. An adult of sound mind has an absolute right to refuse to consent to any intervention or medical treatment for any reason, rational or irrational, or for no reason at all, even when this decision may lead to their own death. Treatment for a mental disorder or a physical condition that is a symptom or manifestation of a mental disorder, may be imposed without consent under the Mental Health Act 1983 (as amended 2007) (the MHA).
- 3.5. When must a capacity assessment be undertaken?
 - 3.5.1. Whenever the term ‘a patient who lacks capacity’ is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.
 - 3.5.2. A mental capacity assessment must be undertaken where there is a concern that a patient may lack capacity to make a specific decision at a specific time.

¹ All adults and children aged 16 and over.

3.5.3. These decisions may include, but are not limited to, the following:

- a. Where consent would be required for a procedure in accordance with the Trust Policy and Procedure for Consent to Examination and Treatment;
- b. Where an adult cannot consent to being accommodated and receiving care in hospital, and may be deprived of their liberty in order to receive this. In addition to a physical deprivation of liberty (DoL), this may extend to the use of other types of restraint, including mechanical. Please refer to the Trust Adult Restraint Policy and Procedure for further details;
- c. Where a person may need to be restrained to receive care and/or treatment;
- d. Where consent is required for photographic images, as detailed in the Trust Photographic and Video Recording Consent and Confidentiality Policy;
- e. Where consent is required for data protection issues or the use of patient records, as detailed in the Trust Information Governance Policy;
- f. Where consent is required for clinical trials, as detailed in the Trust Research Governance Policy;
- g. When a person is admitted to the Trust from another care provider (care facility, hospital or care home), and the handover states that the person lacks capacity in relation to their care or treatment, a new capacity assessment must be completed because attendance/ admission constitutes a new episode of care.

3.5.4. The procedure described in the Mental Capacity and Best Interests Procedure and Guidance must be followed when undertaking a mental capacity assessment.

3.6. If the patient does not have capacity, who can make the decision on their behalf?

3.6.1. Adults who lack capacity

- a. Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves; no one is able to give consent on their behalf, unless they have been authorised to do so as a donee under a registered Lasting Power of Attorney for Health and Welfare (entitled Welfare Power of Attorney if registered in Scotland)² or they have the authority to make treatment decisions as a Court appointed deputy. In addition, the decision must also be in the best interests of the patient.

² In England, an older form of Power of Attorney (an Enduring Power of Attorney) may still be valid if made and registered before a certain date. For further information, please see the Procedure.

- b. Any person may be named as a patient's next of kin, but this is not a legal status. A next of kin must not be allowed to make a decision on behalf of a patient who does not have capacity, unless they have a Lasting Power of Attorney or are a Court-appointed deputy. Further information about Lasting Power of Attorney and Court-appointed deputies can be found in sections 3.11 and 3.12 below, and the associated Mental Capacity Assessment and Best Interests Procedures and Guidance.
- c. Staff must also check whether a patient has made an Advanced Decision regarding the refusal of a particular type of treatment in anticipation of future incapacity. Further information about Advanced Decisions can be found in section 3.10 below, and the associated Mental Capacity Assessment and Best Interests Procedures and Guidance.

All decisions for adult patients in the absence of a person with Lasting Power of Attorney, a Court-appointed deputy or an Advanced Decision must be made on the basis of a best interest process and decision

- d. Further information about making decisions in the best interests of a patient can be found in section 3.7 below.

3.6.2. Children aged under 16 who lack capacity

- a. Children under 16 are not subject to the MCA. A child aged under 16 must not be allowed to make decisions, including consent to care and treatment, for themselves unless they are deemed to have Gillick Competency. Further details of this competency test and how to manage decisions made on behalf of children can be found in the Mental Capacity and Best Interests Procedures and Guidance.
- b. If a child under 16 does not have Gillick Competency, an individual with either parental responsibility or the authority of the Court of Protection, is required to make decisions on behalf of the child. However, in an emergency situation, where this individual is not available, it is appropriate to provide urgent medical care to a child without consent if it is in their best interests, and necessary and proportionate. Further information about defining who has parental responsibility, what to do if there is a dispute between Clinicians and those with parental responsibility, and about making decisions in the best interests of a patient, can be found in the Mental Capacity and Best Interests Procedures and Guidance.

3.6.3. Young People over the age of 16 who lack capacity

- a. A patient aged 16 or 17 should be presumed capable of making decisions for themselves.
- b. If for any reason a person aged 16 or 17 lacks the capacity to make a decision for themselves, an individual with parental responsibility may make this decision on their behalf. However, in accordance with the MCA, the principles of best interests still apply, and the common law also applies to certain decisions.
- c. Further information about young people who lack capacity, and information about when to refer cases to the Trust Legal Services Department can be found in the Mental Capacity and Best Interests Procedures and Guidance.

Any patient who is deemed not to have capacity, and has no appropriate family member or carer to advocate for them regarding decisions about serious medical treatment and changes of accommodation, must have an Independent Mental Capacity Advocate (IMCA). Please see the Mental Capacity and Best Interests Procedures and Guidance for details of when and how a referral should be made.

3.7. How must best interests decisions be made?

- 3.7.1. Once a patient has been assessed as lacking capacity, unless section 3.6.1 above applies, all decisions and actions, including those regarding care and treatment, must be taken in the reasonable belief that they are in the patient's best interests, and are necessary and proportionate.
- 3.7.2. It is this concept of 'best interests' which protects the decision maker from any legal action since otherwise, theoretically, even touching someone without their consent amounts to an assault.
- 3.7.3. Care and treatment includes, but is not limited, to the following:
 - a. Carrying out diagnostic examinations and tests;
 - b. Providing medical care or dental treatment;
 - c. Giving medication;
 - d. Providing nursing care;
 - e. Carrying out necessary medical procedures or therapies; and
 - f. Providing emergency care.
- 3.7.4. In determining what lies in the patient's 'best interests', medical and welfare issues, but also religious, cultural and ethical principles, which the person has expressed in the past must be

considered. Please refer to the Mental Capacity and Best Interests Procedures and Guidance for further information on making a decision in a patient's best interests.

- 3.7.5. Although a multidisciplinary meeting for complex cases may assist in deciding what is in the patient's best interests, the final responsibility for deciding what is indeed in the person's best interests rests with the Clinician who is responsible for the person's treatment.

A patient's health must not be allowed to deteriorate if awaiting for a best interest meeting. Escalation to senior teams is essential to ensure best clinical care is provided

- 3.8. How must best interests decisions related to withholding or withdrawing treatment be made?
- 3.8.1. Where the 'best interests' decision concerns withholding or withdrawing life-sustaining treatment, special factors must be considered.
- 3.8.2. Whoever the decision maker is in cases of withholding or withdrawing life-sustaining treatment, the decision maker must not be motivated by the desire to bring about the patient's death.
- 3.8.3. Whether treatment is classified as 'life sustaining' will depend not only on the type of treatment, but also the particular circumstances. For instance, in some situations antibiotics might be given as life sustaining treatment, whilst in others it is given to treat a non-life threatening condition. It is up to the healthcare professional providing treatment to assess whether the treatment is life-sustaining.
- 3.8.4. Please refer to the Mental Capacity and Best Interests Procedures and Guidance for further information on making the assessment of whether to withhold or withdraw treatment.
- 3.9. When should a person be deprived of their liberty?
- 3.9.1. There is no simple definition of a deprivation of liberty. It is ultimately a question which only the courts can answer. The European Court of Human Rights has drawn a distinction between a 'deprivation of liberty' and a 'restriction on the liberty of movement' which is one of degree or intensity. A whole range of factors, including type, duration, effects and manner of the implementation of the measure in question must be considered. It has therefore been recommended to picture the person concerned on a scale which moves from 'restraint' to 'deprivation'. Where an

individual is on that scale depends on the circumstances and may change over time.

3.9.2. According to P v Cheshire West [2014] the questions which ought to be asked are:

- a. Is the person under continuous supervision and control?
- b. Is the person free to leave should they wish to do so?
- c. A deprivation of liberty can occur in the following circumstances:
 - i. Where an adult cannot consent to being accommodated and receiving care in hospital, and may be deprived of their liberty in order to receive this. In addition to a physical deprivation of liberty (DoL), this may extend to the use of other types of restraint, including mechanical. Please refer to the Trust Adult Restraint Policy and Procedure for further details.
 - ii. The patient is detained under a section of the Mental Health Act and is attempting to leave Trust premises.
 - iii. It is an emergency situation, and regardless of their capacity, you have an honestly held belief that the patient poses an immediate threat to themselves or others if they leave Trust premises.

3.9.3. The Mental Capacity and Best Interests Procedures and Guidance describe the Trust processes to be followed when depriving a person of their liberty when they do not have capacity to consent to being accommodated in a Trust hospital. Please refer to the Trust Compliance with the Mental Health Act 1983 Policy and Procedure, and the Trust Adult Restraint Policy and Procedure for information on the other circumstances.

3.9.4. Depriving someone of liberty is a serious matter and therefore such a decision should not be taken lightly. The MCA introduced specific safeguards for the protection of human rights, notably the 'right to liberty' of Article 5 of the European Convention of Human Rights (ECHR). Article 5 applies to everyone regardless of age. Staff must take into account the following principles which apply to children, young persons and adults alike:

- a. Every effort should be made in both, commissioning and providing care or treatment, to prevent deprivation of liberty.
- b. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary.
- c. A person may only be deprived of their liberty:
 - i. If it is necessary and in their own interests so as to protect them from harm;

- ii. If it is a proportionate response to the likelihood and seriousness of the harm; and
 - iii. If there is no less restrictive alternative.
- 3.9.5. Under no circumstances must deprivation of liberty be used as a form of punishment or for the convenience of clinicians or others.
- 3.9.6. Any deprivation of liberty must be lawfully made. This means the 'managing authority' (i.e. hospital or care provider) must seek authorisation from a 'supervisory body', following a 'standard' or 'urgent' authorisation process. Please refer to the Mental Capacity and Best Interests Procedures and Guidance for details of how to do this.
- 3.9.7. A decision as to whether or not deprivation of liberty arises will depend on the circumstances of the case. It is neither necessary nor appropriate to apply for a deprivation of liberty for every patient in a hospital lacking capacity simply because that patient is unable to decide whether or not to be there.
- 3.9.8. With children or young persons, it is possible for a person with parental responsibility to provide consent for a deprivation of liberty. This is provided that the decision regarding the restriction accords with the degree of parenting control and supervision that would be expected for a child or young person of that age.
- 3.9.9. Where there are doubts as to whether a treatment proposed in the patient's best interests amounts to a deprivation of liberty, staff must contact the Trust Safeguarding Team.
- 3.10. When do Advance Decisions apply?
 - 3.10.1. A patient may have made an Advance Decision (AD) regarding the refusal of a particular type of treatment in anticipation of future incapacity.³
 - 3.10.2. A valid and applicable Advance Decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. In other words the Advance Decision takes precedence and it would not be appropriate to make a 'best interests' decision. However, a person with capacity can withdraw an Advance Decision at any time, even by actions.
 - 3.10.3. Advance Decisions must only apply if they are valid and applicable. Please refer to the Mental Capacity and Best Interests Procedures and Guidance for further guidance on the steps to take when considering if Advance Decisions are applicable.

³ These decisions are referred to as Advance Decisions in England and Wales. Other countries may use other terms, such as Advance Directives in Scotland. Please contact the Trust Legal Services Department for further advice about these types of decision made in other countries to assess their applicability in England.

3.11. What is a Lasting Power of Attorney?

3.11.1. With effect from 1 October 2007 LPAs have replaced 'Enduring Power of Attorneys' (EPAs). Any EPA which was brought into existence prior to this date continues to have legal force. However, different laws and procedures apply to LPAs and EPAs. LPA/EPAs are the mechanisms whereby a person can appoint another to act on their behalf should they lose the mental capacity to make such decisions later on. Hence, where there is a valid and applicable LPA/EPA the views of the appointed attorney must be sought when making a 'best interests' decision.

3.11.2. A valid Lasting Power of Attorney must be accepted by the Trust. For further guidance on checking the validity of an LPA, please refer to the Mental Capacity and Best Interests Procedures and Guidance.

3.12. When should referrals be made to the Court of Protection?

3.12.1. Some treatments are so serious that the Court of Protection (CoP) has to make the decision unless the person concerned has made a Lasting Power of Attorney (see section 3.10 above) or an Advance Decision (see section 3.9 above).

3.12.2. In accordance with chapter 8 of the Court of Protection's Code of Practice, the CoP must be involved to make decisions in the following situations:

- a. Proposed organ donation or bone marrow transplant where the donor is a person who lacks capacity;
- b. Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes); or
- c. All other cases, including those to withdraw artificial nutrition and hydration, where there is a doubt or dispute about whether a particular treatment will be in a person's best interest.

3.12.3. Other cases which may be referred to the CoP include the following:

- a. An experimental or innovative treatment for the benefit of a person who lacks capacity to consent to such treatment;
- b. Cases involving an ethical dilemma in an untested area (such as innovative treatments for variant Creutzfeldt-Jacob Disease - CJD);
- c. The proposed treatment or action amounts to a deprivation of liberty safeguards; or
- d. The proposed provision, withdrawal or withholding of 'serious medical treatment' which is defined as follows:

- i. In a case where a single treatment is being proposed, there is a fine balance between its benefits and burdens/risks to the patient;
 - ii. In a case where there is a choice of treatments, a decision as to which one is best for the patient is finely balanced; or
 - iii. The treatment, procedure or investigation would be likely to:
 - Cause serious and prolonged pain, distress or side effects;
 - Have potentially major consequences for the patient; or
 - Have a serious impact on the patient's future life choices.
- 3.12.4. Please refer to the Mental Capacity and Best Interests Procedures and Guidance for guidance on how to make a referral to the CoP.

4. Duties

4.1. Director of Corporate Affairs

The Director of Corporate Affairs is responsible for ensuring that:

- 4.1.1. there is a framework for reviewing compliance with this Trust policy and associated procedures; and
- 4.1.2. the policy remains fit for purpose and is reviewed as required and at least every three years.

4.2. Divisional Directors

Divisional Directors are responsible for ensuring that appropriate measures/SOPs are in place in all specialties/services within their Division so as to ensure compliance with this policy and its associated procedures;

4.3. Clinical Service Leads/Senior Nurses/Clinical Managers (Senior Nurse refers to Matron or Sister/Charge Nurse)

Clinical Service Leads or Senior Nurses are responsible for ensuring that:

- 4.3.1. Appropriate measures/SOPs are in place in their area of responsibility so as to ensure compliance with this policy and its associated procedures;
- 4.3.2. Mental capacity assessments/best interests decisions are only taken by appropriate staff;
- 4.3.3. A local procedure specific training programme is in place for staff who are to undertake mental capacity assessments and best interests decisions;
- 4.3.4. Any staff who are identified, through mental capacity audits or otherwise, as having failed to undertake a mental capacity assessment, or undertaken a mental capacity assessment or best interests decision not in accordance with this Policy and associated Procedures and Guidance, are immediately informed that they must not undertake a mental capacity assessment or

best interests decisions until they have been assessed as competent to do so;

4.4. Safeguarding Team

The Safeguarding Team is responsible for monitoring compliance with this policy and the associated procedures by conducting an audit, which will include checking mental capacity and best interests processes are being undertaken only by the appropriate staff in accordance with records of competency statements.

4.5. All Staff

All staff undertaking mental capacity assessments and best interests decisions are responsible for ensuring that:

- 4.5.1. Mental capacity assessments and best interests decisions are valid and completed in accordance with this policy and its associated procedures.
- 4.5.2. they complete an incident form in line with the Policy for the Prevention and Management of Incidents including Serious Incidents Requiring Investigation if there is any breach of this policy and its associated procedures; and
- 4.5.3. they record evidence of the mental capacity assessment and best interests decisions processes.

5. Implementation and Monitoring

5.1. Implementation

- 5.1.1. This policy will be communicated to all relevant staff via email.
- 5.1.2. The policy itself will be made available on the Trust intranet site.
- 5.1.3. Regular taught sessions will be made available via the Trust's education department and e-learning resources will be made available via the Trust intranet.

5.2. Monitoring - Appendix A provides full details on how the policy will be monitored by the Trust

6. References

Aintree University Hospitals NHS Foundation Trust v David James (2013) EWCA Civ 65, (2013) MHLO: <http://www.bailii.org/ew/cases/EWCA/Civ/2013/65.html>

Consent patients and doctors making decisions together (GMC, 2008): www.gmc-uk.org

Consent (NMC, 2008): www.nmc-uk.org

Court of Protection: www.gov.uk/apply-to-the-court-of-protection

Court of Protection Practice Direction 9E (on 'serious medical treatment'): <http://www.judiciary.gov.uk/wp-content/uploads/2014/05/9E---Applications-relating-to-serious-medical-treatment.pdf>

Good surgical practice: relationships with patients (The Royal College of Surgeons of England, 2008): www.rcseng.ac.uk

LPA/EPA, governance summary: www.gov.uk/power-of-attorney/overview

Mental Capacity Act 2005, Code of Practice:
<http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf>

Mental Capacity Act 2005, Guidance for providers (CQC):
http://www.cqc.org.uk/sites/default/files/media/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf

Mental Capacity Act 2005 - Deprivation of liberty safeguards- Code of Practice (DH, 2008):
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Mental Health Capacity guide for practitioners:
<http://uhbhome/Downloads/pdf/EqualityMentalHealthCapacityRecordAssessment.pdf>

National clinical guidelines on the care of people in a vegetative or minimally conscious state, following severe brain injury (Royal College of Physicians, 2013):

<https://www.rcplondon.ac.uk/resources/prolonged-disorders-consciousness-national-clinical-guidelines>

Practice Direction to Part 9 of the Court of Protection Rules 2007:

<http://www.judiciary.gov.uk/wp-content/uploads/2014/05/9E---Applications-relating-to-serious-medical-treatment.pdf>

Reference guide to consent for examination or treatment (DH, 2009):
www.dh.gov.uk

Treatment and care towards the end of life (GMC, 2010): http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

7. **Associated Policy and Procedural Documentation**

Mental Capacity Assessment and Best Interests Procedures and Guidance

Policy and Procedures and Guidance for Consent to Examination or Treatment

Policy for the Prevention and Management of Incidents Including Serious Incidents Requiring Investigation

Appendix A

Monitoring Matrix

MONITORING OF IMPLEMENTATION	MONITORING LEAD	REPORTED TO PERSON/GROUP	MONITORING PROCESS	MONITORING FREQUENCY
That Mental Capacity Assessments and Best Interests are being undertaken in accordance with the policy and procedure.	Senior Manager, Corporate Affairs	Mental Health Group	Where PICs is in use: Using a report created by Informatics showing patients who had capacity assessments and then subsequent procedures or treatment, a sample audit of those patient notes will be undertaken using an audit tool. Where paper notes are in use: to be included in documentation audits	Quarterly
That DoLS applications are undertaken in accordance with the policy and procedure.	Safeguarding Team	Safeguarding Group	All DoLS applications are scrutinised by the Safeguarding Team, and the results of these are reported to the Safeguarding Group.	Quarterly