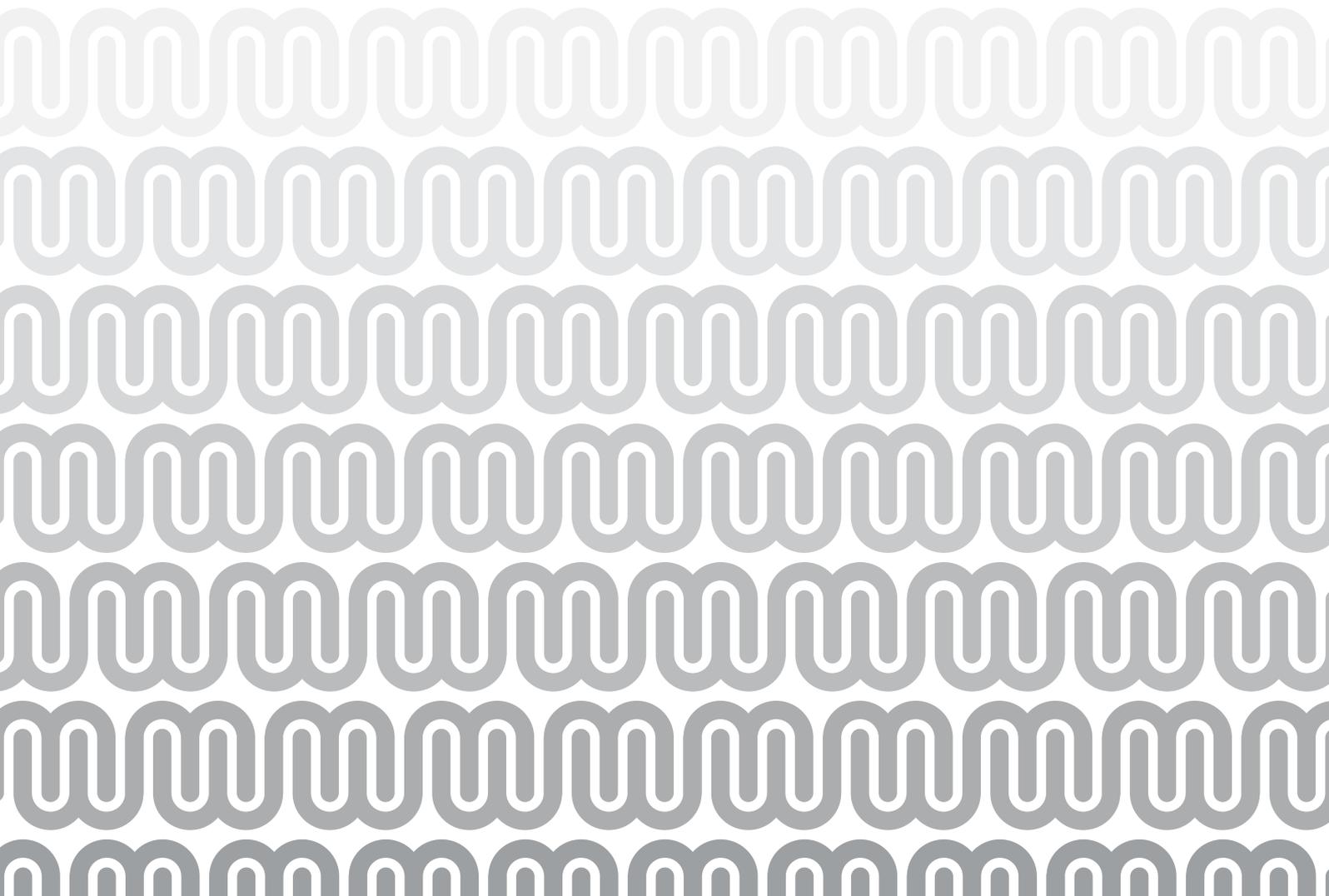




**mental welfare**  
commission for scotland

## Investigations

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## **Notes**

We acknowledge and appreciate the cooperation of all the individuals, organisations and staff who assisted us with this investigation.

The subjects of this report have been anonymised as is our practice in our published investigation reports.

As many professionals were involved in this case, we have provided a glossary as an appendix to this document explaining their roles.

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# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

## Executive summary

The case of Ms ST was first brought to our attention in January 2017 by an organisation helping Ms ST and her family to consider a service design for her support at home. Ms ST had been in hospital following a neck fracture in December 2015 and was deemed fit for discharge in March 2016. However, she remained in hospital due to prolonged disagreement between family, health professionals and the Health and Social Care Partnership (HSCP) about discharge plans.

The Commission followed the case, and in September 2017, 18 months after being fit for discharge, Ms ST was finally discharged home with a support package. Once she had been discharged, and after some preliminary work looking at the case records, the Commission decided in June 2018 to carry out a full investigation into her case. This was because we felt that she had experienced a very lengthy delay in an unsuitable environment, and this had impacted on her human rights.

Ms ST was 59 at the time of the initial referral. She has learning disabilities, cerebral palsy and diabetes and is registered blind. She has lived in the family home all her life, cared for by her mother and brother, with additional social care services funded by the HSCP and the family since 2012.

Ms ST's family wanted her to return home, and in March 2016, due to her reduced mobility, they purchased a ground floor flat to facilitate this.

The purpose of this investigation was:

- To investigate the care, treatment and support given to Ms ST by the health board, local authority and Health and Social Care Partnership from 1 January 2016 until her discharge on 15 September 2017, particularly:
  - the reasons for the delay in her discharge from hospital;
  - the process and decisions made by the local authority in the progression of a welfare guardianship application under the Adults with Incapacity (Scotland) Act 2000; and
  - the way in which the local authority met its responsibilities under the Social Care (Self-directed Support) Act 2013.
- To identify any lessons to be learned both locally and nationally.
- To make recommendations as appropriate.

The investigation looked at:

- communication between professional disciplines and with Ms ST and her family;
- risk assessment, risk management and support planning;
- legal aspects;
- implementation of self-directed support and the related policy framework; and
- decision making.

Ms ST returned home in September 2017, and remains at home at the time of writing, with waking overnight care funded by the HSCP and care during the day paid for by her family. In

addition, Ms ST's brother provides 53 hours of direct care weekly. He has been unable to return to employment due to this commitment.

## **Key findings**

### **Communication**

- Ms ST was referred to an independent advocate. In the Support Needs Assessment, the advocate states that Ms ST wanted to return home. Although her need for support with communication is noted, specialist Speech and Language services to help Ms ST to contribute further to decisions about her were not considered.
- Relationships between social work staff and Ms ST's family were difficult and even adversarial, although relationships between health staff and the family were positive. We felt that because of this unproductive relationship, mediation or reallocation of assessor should have been considered.
- We found evidence of poor communication between social work and health staff, care providers and the independent consultant chosen by the family to help design Ms ST's support, whose input was disregarded, counter to local guidance. There were delays in sharing information and unclear recording in social work records. Disputed minutes were never amended.

### **Risk assessment, risk management and support planning**

- Allocation of a care manager took several weeks; in part this seems to have been due to staff sickness.
- The evidence points to an early assumption by social work staff that Ms ST would be discharged to a care home, rather than her family home, due to her level of support needs.
- There was an intention to carry out further assessment in the care home, but carrying this out in Ms ST's home was never considered. Social work represented the care home as the safest option due to 24 hour support and the use of technology to prevent Ms ST getting out of bed unsupervised and falling. However, staffing levels at the home were not sufficient to guarantee this, and there was no consideration of the use of the same technology in Ms ST's own home.
- The risk assessment stated that a further fall could prove fatal. This was not based on medical opinion.
- The social work assessment that the risk of a return home was too great was partly based on allegations from a care provider that interference by her mother impacted on their ability to meet Ms ST's outcomes. This had never been considered sufficiently significant to investigate while she was at home. The basis of the concerns was never recorded or formally reported in the care provider organisation. Ms ST's family refute the allegations. To rely on this information, which had previously not reached a threshold for intervention and was poorly evidenced, compromised the risk assessment.

- The statutory guidance suggests a human rights-based approach to decision making in self-directed support, but was not followed. We could find no evidence of the assessment considering a rights analysis or a risk/benefits analysis. Social work did not fully consider whether the support plan was proportionate and whether it identified the shared responsibilities for safeguarding Ms ST between her family, legal guardian (once appointed) and the local authority.
- Throughout the assessment and planning process there was a fixed view of risk and how it would be managed. No risk management plans other than admission to a care home were considered. A risk enablement approach was not used because social work staff took the view that this was not possible for Ms ST because of her incapacity.

### **Legal aspects**

- Allocation of a Mental Health Officer (MHO) to provide a suitability report for the guardianship application took nine and a half weeks after the request. The Adults with Incapacity Act requires that the MHO report is provided within 21 days of a request. However, this reflects the current position across Scotland where the demand for MHO services continues to outstrip available capacity.
- The Adults with Incapacity case conference did not refer to Ms ST's wishes, in line with the principles of the Act, and her advocate was not invited.
- The independence of the MHO's suitability report was compromised by the minuted view of Team Leader A at the case conference that social work would not support the appointment of Ms ST's brother as guardian if he wished to take her home, and by the proximity of the MHO to the social work team involved.
- Disagreement with the local authority view should not in itself render an applicant unsuitable, but although Ms ST's brother met the criteria for suitability, the MHO's report concluded that he was not a suitable guardian for the powers of deciding where she should live and what care she requires.
- There was a significant delay in the family's solicitor lodging the application, due to the solicitor not obtaining the medical reports in the allowed timescale and a further delay in submission, and the papers then being lost by the court and having to be resubmitted. Altogether, this resulted in a delay of six months, to January 2017.
- As a result of the disagreement over where Ms ST should be discharged to, the guardianship process was protracted, with five hearings over a period of over five months.
- After Ms ST's brother was appointed guardian, it took another month for her to be discharged, due to further disagreement about the level and duration of support Ms ST's brother would provide.

### **Self-directed support**

- Local guidance on the process of assessment, agreement of an estimated budget, followed by support planning and agreement of a final budget, was not followed.
- Practice guidance was not followed with regard to the participation of Ms ST and her family and their independent consultant.

- Both the Support Needs Assessment (SNA) and the Outcomes Based Support Plan (OBSP) state that, “All professionals are in agreement that she requires 24 hour care with waking support overnight.” This was untrue. The differing views of other professionals were not transparently represented.
- The outcomes recorded are not reflective of any discussions of how Ms ST’s care might be delivered, are clinical and risk averse, and reflect the concerns of the assessor rather than personal outcomes for Ms ST. They do not capture what is important to Ms ST.
- The Individual Budget which was finally agreed equates to seven waking overnight shifts per week. There was an inflexibility of approach which meant that alternative proposals for a service design to manage the risks at home, using the budget alongside financial and direct care contributions from the family, were not explored. This inflexible use of the budget is not recorded or discussed within the Outcomes Based Support Plan and does not reflect the wishes of Ms ST or her family.
- The extent of the direct involvement in support and the financial contribution which would be required from Ms ST’s family was not discussed as part of the support planning process, and does not feature in the Outcomes Based Support Plan.
- The Support Needs Assessment stated that if Ms ST’s brother as guardian made any changes in the support arrangement against the assessment of social work, this would be considered under Adult Support & Protection. In our view this statement is not in the spirit of collaboration and risk enablement intended by the legislation.
- Governance and scrutiny was unclear. The Support Needs Assessment document states that it was compiled and screened by Team Leader A, thereby reducing the level of scrutiny this process was subject to.

## Decision making

- The Support Needs Assessment and the Outcomes Based Support Plan appeared to us to be based on selective interpretation of information. Information from health staff, and latterly from the safeguarder<sup>1</sup> and the independent reports the safeguarder arranged for, which might have supported a return home, was disregarded. Information from the care provider which suggested risks associated with Ms ST’s mother’s attitude to care staff was not critically evaluated. There is no evidence that the social work view that a care home placement was the best option for Ms ST was tested against further evidence in a balanced way.
- The wishes of Ms ST and her family were clearly for her to go home. These views were not given weight and ways in which this might have been achievable were not explored.

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<sup>1</sup> Section 3(4) of the Adults with Incapacity (Scotland) Act 2000 makes provision for the appointment of a 'safeguarder' by the sheriff. In all applications and proceedings under the Act, the sheriff is required to consider whether it is necessary to appoint a safeguarder. The appointment of a safeguarder is in addition to, and does not replace, any existing powers to appoint someone to represent the interests of the adult, such as a curator *ad litem*. The safeguarder’s role is to safeguard the adult’s interests where the adult does not have the capacity to instruct a legal representative, and to advise the court of the adult’s views. Safeguarders are often lawyers or social workers, and are paid to carry out the role.

- Alternative approaches suggested by the independent consultant supporting Ms ST and her family were summarily dismissed on the basis of risk. Further conversations about these alternatives could have teased out thinking around joint risk management but were never considered.
- Decision making demonstrated confirmation bias or verificationism, whereby practitioners appeared to highlight only the information that would support their view.

### **Health and social care integration**

- Ms ST's experience was not in line with the principles of health and social care integration; the vision of seamless coordination between health and social care was not achieved in her case.
- The lack of coordinated working contributed to the delay in her discharge, to her detriment and at significant cost to the NHS, and to the detriment of other patients requiring admission to the ward.
- There appeared to be no mechanism within the integrated agencies to address and progress fundamental differences of professional opinion.

### **Conclusion**

Some of the causes of the delay Ms ST experienced were due to systemic issues with social work capacity, in relation to the delay in appointing a care manager and the long delay in allocating an MHO.

Much of the delay related to the guardianship process. The family's solicitor did not get medical reports in the timescale, and the court lost the papers, accounting for 29 weeks of delay. The position taken by the HSCP in relation to the suitability of Ms ST's brother for some of the powers sought, led to a protracted process taking 22 weeks.

However, the principal underlying reason for Ms ST spending so long in hospital was the continuing disagreement between social work and the family on whether or not Ms ST could return home, which, eventually, she did. Had a genuinely open and collaborative planning process taken place, there might not have been a need for guardianship if a return home had been agreed and it is our view that discharge could have been achievable within a few weeks, rather than the almost 18 months of delay she and her family experienced.

### **Recommendations**

#### **Recommendations for Health and Social Care Partnerships (HSCPs)**

1. To put in place governance measures to ensure that assessment and support planning:
  - is carried out in line with national and local guidance;
  - has the rights, will and preferences of the person central to the process; and
  - that where there are significant differences of opinion this is clearly documented and provided to decision-makers.
2. To ensure that where there is a significant level of dispute, impacting on a discharge from hospital, there are formal mechanisms to address issues and agree a way forward.

3. Where the relationship between assessors and the individual and their family has broken down, to consider measures such as reallocation where possible, or mediation.
4. To ensure that high level scrutiny mechanisms monitoring delayed discharge do not allow cases to be put on hold due to awaiting court processes and that activity to progress discharge continues, in line with the new Scottish Government guidance on Discharging Adults with Incapacity.

### **Recommendations for local authorities**

5. To ensure that they have clear procedures in place in relation to Mental Health Officers (MHOs) which ensure that:
  - there is a system for MHO referrals which effectively prioritises people experiencing delayed discharge;
  - MHOs' independent role is respected and supported;
  - MHOs are always invited to Adults with Incapacity (AWI) case conferences and attend wherever possible;
  - disagreement with a care plan is not an indicator of the unsuitability of an applicant for guardianship; and
  - a negative MHO suitability report is always discussed with a manager.
6. To ensure proactive case management of private guardianship applications, and an escalation process where required, in line with the new Scottish Government guidance on Discharging Adults with Incapacity.

### **Local recommendations for the HSCP concerned**

7. To review the HSCP recording process to ensure that records are signed and dated so that they are auditable
8. To arrange refresher training for social work staff on:
  - co-production with people using services and their families and with other professionals, in line with SSSC standards;
  - risk enablement in line with the principles of self-directed support, and referral of complex cases to the risk enablement panel;
  - recording in shared multi-disciplinary notes; and
  - ensuring meetings are clearly and timeously minuted, with dissenting opinions noted.

# 1 Introduction

This investigation into the care and treatment of Ms ST was conducted under Section 11 of the Mental Health (Care and Treatment) Act 2003 by the Mental Welfare Commission for Scotland. Section 11 gives the Commission the authority to carry out investigations and make recommendations as it considers appropriate in many circumstances, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

We carry out one major investigation a year, focussing on the rights and welfare of an individual and drawing out recommendations for change for services across Scotland.

The investigation seeks to identify what lessons can be learned from the experience of Ms ST and her family, not only for the Health and Social Care Partnership concerned but for Partnerships across Scotland.

The MWC was first contacted about Ms ST's circumstances in January 2017 following contact from an organisation which promotes the development of self-directed support (SDS). Ms ST had been in a general hospital since December 2015 and ready for discharge since March 2016. The organisation had been supporting Ms ST and her family to consider a service design for support to progress her discharge but felt that an impasse had been reached, resulting in an extended period of inpatient care which was detrimental to Ms ST's health and welfare.

The key points raised by this initial referral were:

- Ms ST was an inpatient in a general hospital and had been deemed fit for discharge in March 2016. She remained in hospital 270 days later and at the time of the referral, in January 2017, there seemed to be no resolution in sight.
- Ms ST was being cared for in a single room on a busy general orthopaedic medical ward.
- Family were concerned about the impact of this prolonged admission on Ms ST's physical and mental health.
- Additional support in hospital for Ms ST was being funded by the HSCP, supplemented significantly by practical and financial support from family.
- Family had purchased ground floor, adapted accommodation to facilitate her discharge.
- The HSCP's view was that Ms ST required residential care, contrary to other professional views, the views of the family and Ms ST's wish to return home.
- There had been no discussion about what budget would be available to fund any potential care plan other than residential care.
- There had been significant delays in progressing the appointment of a proxy decision maker in light of Ms ST's assessed lack of capacity to make welfare decisions.

The Commission followed the case, and in September 2017, 18 months after being fit for discharge, Ms ST was finally discharged home with a support package, and significant additional financial and practical contribution from the family. The Commission decided in June 2018 to carry out an investigation into her case.

## 1.1 Background

At the time of referral, Ms ST was 59 years of age. She has diagnosed learning disabilities, cerebral palsy and diabetes and has limited ability to express herself verbally. She is registered blind. Ms ST has lived with and been cared for in the family home all her life. Her father died over 30 years ago and she continued to live with her mother, who is now in her late 80s, with significant care and support provided by her younger brother. In the past few years, since 2012, the family has required additional support due to an increase in Ms ST's needs and a gradual deterioration in her mother's physical ability to provide this level of care.

Prior to hospital admission, Ms ST had 57 hours per week of social care funded by the HSCP. This was supplemented by a financial contribution by the family, as well as their involvement in delivering direct care.

In December 2015, Ms ST fell at home and was admitted to hospital having broken bones in her neck. By March 2016, she was deemed fit for discharge but there ensued a prolonged period of dispute between family, health professionals and the HSCP about discharge plans.

Following a request from Ms ST's family, the HSCP agreed to fund support for Ms ST in hospital for three hours during the day by the carers who provided her support at home and who understood her communication and needs. This additional funding was agreed as an exceptional circumstance given Ms ST's complex needs, and was in recognition of Ms ST's particular needs associated with her diagnosed learning disability and her visual impairment, which would have been a challenge to manage within a busy general ward.

This was supplemented by a further four hours per day funded by the family. The additional support was highlighted as a positive by nursing staff.

The social work care manager's initial assessment concluded that Ms ST required residential care; however, both she and her family wished her to return home.

Assessments carried out by occupational therapy (OT) and physiotherapy as part of the discharge process indicated that Ms ST could be supported safely at home with appropriate care, and nursing assessments concurred. These assessments did not change the view of the social work staff involved.

At this point Ms ST's family sought support from local elected members and an MSP to highlight and challenge this fundamental disagreement. We saw responses to these enquiries which reiterated the HSCP's position that admission to a care home was the only safe option for discharge and expressed the view that until the guardianship application is heard by a Sheriff they were not in a legal position to progress with a discharge at this time. On this basis, no formal complaints processes were used at this time.

At this stage there was no proxy decision maker appointed for Ms ST. Her brother, who has been actively involved in his sister's care throughout her life, instructed a solicitor to apply for welfare and financial guardianship.

In the process of this application the HSCP, via the Mental Health Officer's (MHO) report, assessed that Ms ST's brother was not a suitable guardian to be granted powers to decide where Ms ST should live and what care she would require. This was on the basis of the MHO's view that he did not appreciate the extent of his sister's needs or accept that she should be placed in a care home rather than returning home.

Additionally, the MHO suitability report recorded that the care provider who supported Ms ST in the community before her admission to hospital was unwilling to continue their involvement. This was on the basis of reports from some care staff that Ms ST's mother's relationship with carers and her management of their activity in relation to Ms ST's care inhibited their ability to fully promote Ms ST's welfare. This was refuted by the family and the care provider holds no formal record of these concerns.

Ms ST's brother continued with his application for welfare and financial guardianship and at the initial court hearing in March 2017, a Safeguarder<sup>2</sup> was appointed, who instructed supplementary reports from an independent occupational therapist (OT) and an independent MHO.

On 1 March 2017 the local authority lodged a minute in court seeking to limit his power to decide where Ms ST should live and what care she received. This was still on the basis that he did not appreciate the extent of his sister's needs, despite having provided direct care throughout her life. The MHO report proposed that in the event that the Sheriff found the applicant to be unsuitable to be granted these powers, then consideration could be given that the Chief Social Worker should be appointed for these powers.

The Mental Welfare Commission visited Ms ST in hospital on 27 April 2017 following the referral from the independent organisation and advised that all options for providing care at home had not been exhausted. During this visit, we asked Team Leader A about what legal action the local authority had taken. We were told that advice from their legal services had been not to make their own application for guardianship but to allow Ms ST's brother to do so, and then that the local authority would ask that certain powers not be granted. We asked if consideration had been given to an interim order to expedite her discharge while the full application was pending but were told this was not considered an option given her brother's reluctance for her to move anywhere else.

Ms ST's brother continued to challenge this view and the view that the care providers were restricted in the delivery of his sister's care by his mother's influence. The legal process continued until August 2017 when the HSCP withdrew their objections and guardianship was granted in full to Ms ST's brother, but for one year only. At this point Ms ST had been in hospital for 20 months.

HSCP records indicate that their objection was withdrawn on the basis that Ms ST's brother had committed to being present every day within the family home to ensure that care was delivered without undue interference from Ms ST's mother, and that he would supplement care costs from private resources. Ms ST's brother states that he agreed to this on a transitional basis only, although this is also disputed by the HSCP.

Whilst Ms ST was in hospital the HSCP continued to fund 21 hours of care per week and the family funded a further 28 hours, as there was limited capacity on the orthopaedic ward to manage her support needs associated with her learning disability and impaired vision.

Throughout this process Ms ST and her family were supported by an independent not-for-profit organisation, who assisted them to develop alternative care plans. These were

dismissed by the HSCP as incompetent and as failing to take account of the risk of further falls for Ms ST.

Following the granting of the welfare and financial guardianship, a budget for care was agreed by the HSCP and arrangements were put in place for Ms ST to return home, 18 months after she was assessed as fit for discharge. The budget agreed equated to the cost of waking overnight care. The HSCP stipulated that this waking overnight care was mandatory and that the budget could not be utilised to provide care in any other configuration. The HSCP recorded that any changes to this overnight provision would be considered under the Adult Support and Protection framework under the category neglect or omission by others.

Ms ST returned home in September 2017, and remains at home at the time of writing, with waking overnight care funded by the HSCP and care during the day paid for by Ms ST's family. In addition, Ms ST's brother provides 53 hours of direct care weekly. He has been unable to return to employment due to this commitment.

## **1.2 Focus and lines of enquiry**

The purpose of this investigation was:

- To investigate the care, treatment and support given to Ms ST by the health board, local authority and Health and Social Care Partnership from 1 January 2016 until her discharge on 15 September 2017, particularly:
  - the reasons for the delay in her discharge from hospital;
  - the process and decisions made by the local authority in the progression of a welfare guardianship application under the Adults with Incapacity (Scotland) Act 2000; and
  - the way in which the local authority met its responsibilities under the Social Care (Self-directed Support) Act 2013.
- To identify any lessons to be learned both locally and nationally.
- To make recommendations as appropriate.

## **1.3 Investigation process**

The investigation team had access to social work records and health records, (medical, nursing and allied professional) for the period 1 January 2016 to 15 September 2017.

In addition, policy documents from the HSCP (HSCP E) were accessed in relation to:

- Personalisation and Self-directed Support Practice Guidance; and
- Risk Enablement Panel.

The team also referred to the Social Care (Self-directed Support) (Scotland) Act 2013 and accompanying statutory guidance.

Having considered these records, the investigation team then conducted interviews with key individuals who were part of the process during the period identified:

- Ms ST's brother
- Care Manager, HSCP
- Team Leader, HSCP (Team Leader A)
- Service Manager, HSCP
- Mental Health Officer, HSCP (MHO 1)
- Charge Nurse, acute hospital
- Occupational Therapist Team Leader, acute hospital
- Discharge Co-ordinator, acute hospital
- Independent Consultant supporting family
- Care Provider Manager, private provider

The team also met Ms ST and her mother in their home. At this visit, Ms ST's mother advised that she was happy for her son to represent her views during this process.

The Commission's investigation team comprised:

- Kate Fearnley, Executive Director (Engagement and Participation)
- Yvonne Bennett, Social Work Officer

In addition, the Commission sought independent operational advice in relation to Self-directed Support processes and the link between SDS and risk assessment and management.

Once the interviews had been conducted, the information was analysed using a content analysis model, using the following thematic headings:

- Communication
- Risk assessment, risk management and support planning.
- Legal aspects
- Implementation of self-directed support and the related policy framework
- Decision making

## 1.4 Chronology

**12 December 2015:** Ms ST falls out of bed and is taken to emergency department but not admitted to hospital.

**18 December 2015:** Ms ST reviewed by GP and returns to emergency department. Diagnosed with a cervical spine injury, requiring surgery to insert a halo fixation. Admitted to hospital.

**14 January 2016:** Ms ST transferred to orthopaedic ward for rehabilitation. HSCP and family jointly fund private provider to support Ms ST for seven hours per day within a side room of ward.

**23 March 2016:** Specialist Multi-disciplinary Tool (SMAT)<sup>3</sup> completed by ward staff requesting assessment for discharge; social work records note request for community care assessment as Ms ST is deemed fit for discharge from hospital.

**31 March 2016:** Family purchase ground floor flat more suitable for Ms ST's mobility.

**4 April 2016:** Initial assessment by social work notes Ms ST currently mobilising with assistance of two, discharge planned to new flat, and assessment required to establish what care will be required.

Request from family's solicitor for allocation of MHO to provide report for Guardianship application.

**9 April 2016:** Social work records note contradictory information about support required and request written reports from physiotherapy, occupational therapy and nursing staff on ward.

**11 April 2016:** Social work notes confirm receipt of SMAT form dated 23 March 2016.

Response from HSCP acknowledging request for MHO allocation and passing to Assistant Service Manager for allocation.

Call from Social Work to ward to advise case not as yet allocated and multi-disciplinary meeting to be arranged once allocated.

**20 April 2016:** Care manager allocated (this was a reallocation due to staff sickness).

**21 April 2016:** Community Occupational Therapy service visit new flat and deem it suitable; approve Home Improvement Grant to fund the installation of wet floor shower room, which is subsequently installed.

**26 April 2016:** Multi-disciplinary meeting convened. Social work recommend admission to nursing home on the basis of 2:1 care required for all transfers. Family reject this suggestion. Records note dispute within the meeting between health and social care about this level of care and Team Leader A requests a further period of rehabilitation to clarify level of support required. Nursing staff asked to keep a diary of care provided, particularly overnight. Further meeting to be convened.

**4 May 2016:** Clinical notes record no update from social work. Ward request care plan of four visits per day and two overnight visits to facilitate discharge.

**10 May 2016:** Social work request written confirmation of needs from OT, physiotherapy and nursing staff. Ward say this was provided in SMAT form of 23 March 2016.

**18 May 2016:** Reconvened multi-disciplinary meeting. Disagreement over needs continues. Social work note 2:1 support required, health note 1:1 for some activities. Outcome recorded – support required from 9am to 10pm and sleepover/alarm service overnight. Team Leader A agrees to speak with Service Manager and care provider.

At the end of this meeting, concerns raised by care provider about family interactions with care staff which may have restricted provision of care previously.

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<sup>3</sup> SMAT form is a Specialist Multi Disciplinary Tool which is completed once a patient is deemed fit for discharge. It provides current information on the needs of the patient and alerts social work that an assessment of need is required to facilitate discharge

**4 June 2016:** Minute of MDT disputed by Discharge Coordinator as not reflective of discussion within meeting.

**9 June 2016:** MHO 1 allocated.

**16 June 2016:** AWI case conference convened. Minute records that social work assessment and risk assessment concludes that Ms ST would be best placed in a care home setting and that family will not be supported in their application for guardianship, if insisting that Ms ST returns home; but that MHO 1 (who was not present) would conduct an independent assessment of suitability.

**10 August 2016:** Updated OT assessment by OT Team Leader concludes Ms ST requires assistance of one person for all activities and could be discharged home with 24 hour care and the provision of appropriate equipment (suitable seating and bed, toileting and bathing equipment.)

**17 August 2016:** OT Team Leader confirms that there is no record in the last three months of "impulsivity" in Ms ST's behaviour.

**22 August 2016:** Meeting convened between social work, family, supported by their legal representative and advocacy to track welfare guardianship process and to consider options to facilitate discharge from hospital. Family decline placement in specialist residential resource and continue to seek supports to facilitate a return to the family home

**6 October 2016:** Concerns raised at HSCP verification meeting about lack of communication from social work to ward. This is a meeting which is held regularly to monitor delayed discharge within HSCP.

**25 October 2016:** MHO 1 submits report to solicitor. Report concludes that brother is not suitable to decide where Ms ST should live but is suitable for other powers requested.

**10 December 2016:** Meeting involving family, MSP and HSCP staff– issue raised that NHS disagree with social work assessment.

**18 January 2017:** Brother's solicitor lodges guardianship application.

**1 February 2017:** Ms ST falls on ward and fractures shoulder.

**21 February 2017:** Meeting at hospital in relation to communication issues between health and social work. No conclusion reached and no referral for mediation.

**8 March 2017:** First hearing for Guardianship application by brother. HSCP lodge minute (on 1 March) stating that they have assessed Ms ST as requiring 24 hour nursing care and her needs can no longer be safely met in a home environment. Also state that if brother is appointed he would refuse to allow 24 hour care to the detriment of the adult. Court appoints Safeguarder and instructs a Supplementary MHO report to address the minute and consider the need for full Financial Guardianship.

**4 April 2017:** MHO 1 contacts ward seeking information about Ms ST's mobility. Informed she continues to require assistance of one and in opinion of nursing staff would be suitable to return home or suitable environment.

**13 April 2017:** Supplementary MHO report by MHO 1 concludes that care home required due to unpredictability of Ms ST and risk of falls.

**19 April 2017:** Second court hearing – case continued.

**23 April 2017:** Independent MHO (MHO 2) visits Ms ST to provide report to Safeguarder.

**27 April 2017:** Following referral from independent organisation supporting Ms ST and her family, the Mental Welfare Commission conduct an initial enquiry.

**2 June 2017:** Independent OT report concludes that there is sufficient evidence to determine the best placement for the adult is a discharge home to the adapted ground floor accommodation purchased by the family.

**5 June 2017:** Independent MHO report concludes that although there is a serious difference of opinion between the applicant and the local authority, there is a case to be made that it is in Ms ST's best interest if it is possible for her to return to the family environment with all reasonable precautions taken.

**8 June 2017:** Meeting on ward with social work and health to update information prior to forthcoming court hearing. Clinical notes record no written record of meeting or feedback to ward following this discussion.

**16 June 2017:** Safeguarder's report concludes that the evidence clearly points to the applicant acting as welfare and financial guardian and that there can be an opportunity for Ms ST to return home. It notes however that the continuing disagreement between the applicant and the local authority will continue to make discharge for Ms ST difficult and offers to mediate.

**28 June 2017:** Third court hearing - HSCP request a continuation to provide further risk assessment on the basis that Safeguarder report did not fully reflect views of Team Leader A.

**17 July 2017:** Care provider confirms willingness to provide package of care in the community during the day but do not provide overnight care.

**27 July 2017:** Fourth court hearing. Brother advises that he would be available to coordinate care, supplement budget and provide some direct care to support transition from hospital. HSCP agree to review their position in light of this.

**9 August 2017:** Ms ST's family meet with social work and confirm the level of support they are willing to offer on discharge.

**10 August 2017:** Local authority withdraw minute.

**15 August 2017:** Fifth court hearing – Welfare and Financial Guardianship granted to brother for a period of one year.

**12 September 2017:** Discharge planning meeting – discharge home planned for 15 September 2017.

**15 September 2017:** Ms ST discharged home with care plan of seven waking overnights, with staff awake in Ms ST's house, funded by the HSCP, and day support provided and funded by family. Waking overnight care non-negotiable and family advised that any attempt to change this will result in consideration under Adult Support and Protection procedures.

## 1.5 Impact on Ms ST and her family

We heard from Ms ST and her family how the experience of her delayed discharge had impacted on them.

Ms ST spent 18 months in a general hospital ward after she was assessed as ready for discharge. While she was well cared for on the ward, had additional support funded partly by the HSCP and partly by the family, her brother visited for several hours every day, and her mother visited, once she had recovered from a bout of ill health herself, she was in an environment which was not her own home, and she wanted to go home.

*[Ms ST] can tell you what she wants, she can tell you what she doesn't want... She stated to many people in this whole process that she wanted to go home. Brother*

We asked Ms ST's brother what the impact of the delayed discharge was on her. This is an extract of his response:

*I think she has been not been treated as a human being during that process. Her views have been totally ignored [...] one of the major impacts of that is that she lost a considerable amount of weight when she was in hospital and that was through stress. [...] As well as having a learning disability she's registered blind as well so could you imagine even yourselves spending almost two years in hospital when you can't quite understand why you're there. If you're suddenly pulled out of a structure where you've never known anything else in life [...] Every day I had to leave her around 8.30/9 o'clock at night and every day you walked away from her and you're thinking this is not right I'm walking away from somebody who doesn't know why this is happening [...] I still can't imagine what it must have been like for her to actually be left alone by people who she's trusted all her life. Brother*

The situation also had an impact on Ms ST's mother.

*Her mum who has been vilified throughout this process - an 87 year old woman who's actually been vilified, she's been slandered at I think some of the highest levels of Scotland where I believe social work were talking about issues with the family. Brother*

Ms ST's brother told us the experience had left him questioning "social work's competence, professionalism and integrity". The process clearly caused him great distress, and the eventual outcome affected his employment status and his finances, as when she was discharged, he gave up his job to provide care, and also paid for her support services during the day.

*[I] started this process as a finance professional with a job that I really liked and enjoyed and now I'm basically unemployed and maybe unemployable based on where I am at the moment so it's had a major impact. Brother*

## 2 Communication

### 2.1 Communication with Ms ST

Ms ST has a diagnosis of learning disability and requires support to communicate her needs, wishes and preferences. We heard that despite these difficulties, family and staff who know her can elicit her views with patience and interpretation of words and gestures she uses.

The Support Needs Assessment notes that Ms ST requires support with her communication and that “she will often repeat learned phrases and requires support to ensure she fully understand what is being said.” In this instance, where major life decisions were being considered, it would have been reasonable to expect the involvement of specialist speech and language services to ensure that Ms ST was able to contribute to decisions about her in as meaningful a way as her communication difficulties would allow. There is no evidence of this having been considered.

Supported decision making maximises an individual’s ability to ensure that their rights, will and preferences are at the centre of any decisions that concern them. The involvement of speech and language services, advocacy or indeed family who know and understand how the adult best communicates can contribute to this, and could have ensured for Ms ST that her rights, wills and preferences were acknowledged and contributed to decisions about her care.

Ms ST was referred to an independent advocate as part of the legal process of an application for a Welfare and Financial Guardianship. In the Support Needs Assessment, the advocate is reported as stating that Ms ST would wish to return home but this is not explored or expanded on or factored in to any decisions in relation to Ms ST’s care arrangements on discharge from hospital.

While Ms ST’s views were being represented by family, this was complicated by their fundamental disagreement with the HSCP’s recommendation of admission to a care home. We could find no evidence that her views were explicitly sought or considered.

Consideration of the wishes and feelings of the adult “in so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the adult” is a key principle of the Adults with Incapacity Act 2003, section 1(4).

Whilst the involvement of the advocate may have gone some way to meeting this requirement, the involvement of more specialist speech and language services and time afforded to understand Ms ST’s views might have meant a fuller consideration of her rights, will and preferences in relation to the choices being considered for her ongoing care.

### 2.2 Communication with the family

Until Ms ST’s brother was granted guardianship in August 2017, there was no proxy decision maker for Ms ST. Ms ST has in all probability lacked capacity to make most welfare decisions throughout her life, and these decisions have been made by her immediate family, taking into account her known wishes and preferences.

Whilst she was in hospital, Ms ST’s brother continued to advocate and represent her views on an informal basis and was the main point of contact for health and social work staff.

Local guidance for Personalisation and Self-directed Support<sup>4</sup> highlights co-production: the assessor should work with the service user, carers, legal representatives and other relevant parties at the support planning stage. During interviews, staff advised that they were aware of this guidance.

Our interviews revealed a picture of difficult relationships between social work staff and the family, while relationships between health staff and the family were positive.

Prior to her admission to hospital, Ms ST received support from two care providers at home. Around the time of her admission, one of the providers had raised concerns via the social work duty system about their ability to deliver agreed outcomes due to what they felt was undue interference from Ms ST's mother. This was only raised with the family at the discharge planning stage, as a contributing factor to a social work recommendation for admission to a care home.

The family have consistently refuted this allegation and advised that on the contrary they had previously received a letter of apology from the care provider following complaints made by the family about consistency and quality of the care being delivered. We have looked at these issues in more detail in section 3.4.2 Family factors.

This fundamental disagreement impacted significantly on communication between social work and the family.

Ms ST's brother has been viewed by health professionals during this process as a strong advocate for her.

*I think everybody had good relationships with them. There was never any bad behaviour as such, if he [Ms ST's brother] wasn't happy with something or he had concerns he was very articulate in expressing them and he wasn't wrong in what he was saying, you know you can't be perfect 100% of the time but as long as you listen but he seemed very reasonable with any solutions that you came up with. And the same with his mum but it was mostly [Ms ST's] brother who did the advocating. Charge Nurse*

Health professionals told us there seemed to be an adversarial relationship between social work and family within multi-disciplinary meetings which they found unproductive and this was the view of the independent consultant when she became involved in meetings at a later stage.

*At a number of different times there was definitely a feeling that the family were demonised in this process. [Ms ST's brother] was having to defend his mum – [he] was being demonised. Independent consultant*

These communication difficulties were acknowledged during interview by Team Leader A, who recalled the Adults with Incapacity case conference as a particularly fraught meeting. During this meeting the care provider raised issues in relation to Ms ST's mother's behaviour and its impact on the care they provided. Ms ST's brother also referred to the meeting and described it as "a bit of an ambush". Reflecting during interview Team Leader A acknowledged

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<sup>4</sup> Personalisation and Self Directed Support (SDS), Practice Guidance for Staff, Version 2.9 (February 2016) HSCP E

that the discussion “wasn’t well done and what was already going to be very difficult became worse for Ms ST’s brother”.

The Care Manager told us that Ms ST’s family had said that all the problems had been caused by herself and Team Leader A, and that she had tried to discuss this with Ms ST’s brother. Ms ST’s brother told us he was unhappy with the relationship with social work staff throughout the process.

*They’d made up their mind I think very early in the process [...] to try to bully and intimidate someone to make a decision which they knew wasn’t in the best interests of their actual relative [...] at no point during this process have I ever felt any compassion from any member of social work who I’ve ever spoken to. [...] the complete lack of respect that we’ve had from social work all through this process. Brother*

The poor relationship between social work staff and the family, and the strongly-held opposing views, made the case challenging. Social workers often work with people who have fundamentally different opinions, and we accept that the views of social work staff were sincerely held, and that they found the situation difficult. However, having reviewed the records and interviewed those involved, it is our view that the family were determined to get the best for Ms ST, and we do not accept that they failed to engage, or were fundamentally impossible to work with.

### **2.3 Observation by the Commission**

Where the relationship between the assessor and the key individuals involved in compiling an Outcomes Based Support Plan is fractured to the point where it has become unproductive, consideration should be given to the potential for mediation within that relationship, or reallocation of assessor, to ensure positive outcomes for the adult.

### **2.4 Communication between professionals**

We found evidence of poor communication between social work and health, between social work and care providers and between social work and the independent consultant chosen by the family to assist them in designing Ms ST’s support.

This manifested in failure to keep all parties up to date with information, plans and timescales, a lack of trust in other professional assessments and a failure to reach a consensus on how Ms ST would be cared for on discharge from hospital.

The Nuffield Trust’s 2011 overview of integrated care considers service users to be “the organising principle of integrated care” (Shaw et al, 2011<sup>5</sup>). The need for a shared vision encompassing service user perspectives and patient experience is essential for effective multidisciplinary working.

Successful joint working requires clear, realistic and achievable aims and objectives, understood and accepted by all partners, including patients, families and carers. This shared

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<sup>5</sup> Shaw S, Rosen R, Rumbold B (2011). *What is integrated care?* London: Nuffield Trust.

understanding of a discharge plan was never reached, and contributed significantly to the lengthy delay in discharge for Ms ST.

Information flow across health and social work was disjointed and not shared in a timely fashion. Clinical notes show a number of instances where ward staff and the discharge coordinator tried to contact social work staff or were waiting for information.

*They weren't good at sharing information with us and then if you tried to contact them you were often going round houses before you found the most appropriate person to deal with and then they were off or on annual leave and you wouldn't get a call back and then suddenly six weeks had passed. Charge Nurse*

Communication could have been improved by accurate recording both in hospital patient notes and within social work records, to ensure relevant information was appropriately shared.

*If they would write down in the continuation notes, it's not just nursing notes now it's multi-disciplinary notes [...] that would be incredibly helpful. Charge Nurse*

Within social work reports, there are a number of anomalies in the chronology and content of records and it proved difficult to audit these due to a lack of dates, new information being added and not dated and no clarity around who had prepared or contributed to documents. For example, within the social work electronic system there are three care managers referred to. We heard from the Care Manager during interview that she had compiled the Support Needs Assessment and yet the name of this care manager appears nowhere on this document. Additionally there are no dates recording when the information contained within this assessment was updated and on what basis.

Local Practice Guidance for staff in relation to personalisation and self-directed support lists a number of organisations which can provide information and advice on personalisation. Ms ST's family opted to consult one of these to support them to consider different ways to meet Ms ST's identified needs. Their input and outline service designs were not considered by social work.

*I've been to three meetings – the response from social work was extremely closed and negative and at times aggressive. Independent Consultant*

When arranging a further planning meeting Ms ST's brother was advised by social work that they would facilitate a meeting with the care provider but that it would be inappropriate for the independent consultant to attend, contrary to staff practice guidance.

There was also evidence that communication between the social work assessors and care providers could have been improved. This was particularly the case in relation to the care provider's reported difficulty delivering a service due to the alleged conduct of Ms ST's mother, discussed more fully in section 3.4.2. This was a major barrier to a more timely discharge for Ms ST, but communication between social work and the provider around this issue was patchy and unclear, despite the potential implication of this for a discharge home.

## **2.5 Written communication**

Effective joint working requires accurate shared records of decisions. We heard that there were difficulties with the minutes of some key meetings. Following the planning meeting in April 2016 the Discharge Coordinator received a copy of the minute and notified social work by telephone that she disagreed with it, as it did not reflect her recollection of the discussion during the meeting, particularly in relation to overnight care and support provided by the family. She received no response and the minute remains un-amended, with no acknowledgement of dissenting views.

A further meeting in May 2016 was also minuted but partners did not receive the minute until November 2016. Again the Discharge Coordinator noted that she felt that the recorded outcome of this meeting was an inaccurate reflection of the multi-disciplinary discussion during the meeting.

This recording discrepancy further impacted on the Support Needs Assessment which records that "All professionals are in agreement that she requires 24 hour care with waking support overnight." This was disputed by nursing staff, occupational therapy and family within meetings, which they confirmed during our interview process.

### 3 Risk assessment, risk management and support planning

Until her fall in December 2015, Ms ST had been living at home in a first floor flat with her mother with formal support provided by two different care providers during the day. Evenings and overnights were supported by family, most notably Ms ST's mother, with additional regular support from her brother. Ms ST slept in a double bed with her mother who could alert any assistance, if required. Ms ST's case was unallocated to a social worker and any concerns or issues would in the first instance be referred to the social work duty system who would consider if they required allocation. Her care package at home was discontinued after seven days in hospital as per local protocol, although this was reviewed and reinstated to three hours per day funded by the HSCP, after representation by Ms ST's family.

We looked at the factors taken into account in planning Ms ST's discharge. In particular we looked at:

- the quality of the risk assessment and how different sources of information were evaluated;
- the attention given to balancing risks and benefits, and to risk enablement; and
- the options considered for support and living arrangements.

Ms ST's family wanted her to return home. Following the injury to her neck, she required a pulpit walking aid, so in March 2016, they purchased a ground floor flat with wide enough doors and all on one level. Later, following assessment by a community occupational therapist in April 2017, a Home Improvement Grant funded adapting the bathing facilities to meet Ms ST's needs. This decision was made without consultation with the care manager responsible for the assessment of Ms ST's needs.

#### 3.1 The first two discharge planning meetings

Ms ST was deemed fit for discharge on 23 March 2016 and a referral was made to social work to begin the discharge planning process. On receipt of the Specialist Multi-disciplinary Tool (SMAT) form from the hospital, social work allocated a care manager to progress discharge planning. Final allocation took several weeks; in part this seems to have been due to staff sickness.

At an initial planning meeting on 26 April 2016, social work notes record "[Team Leader A] advised that in view of all the information received today that nursing home care would be the safest model for [Ms ST]. He advised that from information given [Ms ST's] needs could not be predicted and that it would not be practical or feasible to have two staff members with her 24 hours a day."

A support plan should be based on an assessment. Ms ST's brother told us he felt that the outcome had been predetermined.

*It seemed to be that social work had already made up their mind what the outcome was actually going to be. In my view they had a very fixed view that a residential facility would be the only place for [Ms ST] that would be safe. Brother*

Team Leader A told us:

*That was a planning meeting I would say rather than a discharge meeting. We assumed that [Ms ST] was going to go back home [...] this was more about getting the professionals together so that we could inform our assessment [...] At that meeting the recommendation wasn't for nursing home care at that point. [...] it was 2:1 and this is clearly not something that can be delivered particularly in that home environment.*

However, the Care Manager is quoted in the report of the independent safeguarder appointed during the court process for guardianship as having been charged with trying to look for a new service rather than a return home.

She told us:

*It was a 24/7 care plan, so we recommended that Ms ST might be better in a residential care home setting for people with learning disabilities, that was a possibility not necessarily... we were looking at various vacancies or supported living [...] the 24/7 hour service is only really available in a supported living service or residential care setting. It's very unlikely it happens at home now. Care Manager*

The Discharge Coordinator told us she was unhappy with what transpired during this first meeting.

*There hadn't been an assessment done and there had been a recommendation made [for placement in a care home] without them having looked at things [...] the process hadn't been followed. Discharge Coordinator*

In her interview, the Care Manager said that this proposed admission would be to facilitate further assessment outwith the hospital setting.

*The hospital were giving us confusing information so we felt that she would require further assessment so even an intermediate bed where we could move [Ms ST] to and do further assessment. Care Manager*

She said that assessment in the care home would have been by community physiotherapy and OT services, and Ms ST would have been supported by the use of equipment and technology such as a falls monitor.

*A care home would have had sensors so if [Ms ST] moved the sensor would have went off and alerted the worker to go immediately, she was a falls risk and there would have been a crash mat and so there's lots more things that would have been there. [Q: Could those have been fitted in her home?] Possibly, possibly. [Q: Was that considered?] No I don't think so. Care Manager*

The recommendation for a care home placement appears to stem from information that Ms ST required assistance of two staff and that this would not be possible in a community setting. This level of need was challenged by health staff at the meeting. The recommendation was not accepted by Ms ST's family and a further period of rehabilitation was agreed to confirm Ms ST's needs.

At a further discharge planning meeting on 18 May 2016 the disagreement over support needs continued. Social work noted 2:1 support was required, but health noted 1:1 support required for some activities. The outcome of this meeting was recorded as, "Support currently 9am-5pm need to be extended to 10pm. 2:1 support for personal care. Planned support 2:1 during the day. Sleepover service or alarm service through night." Team Leader A agreed to speak with the Service Manager and care provider.

There is no clarity in the records about why this plan was not implemented. We asked about it during the interviews. It appears to have been rejected following discussion between the team leader, the service manager and the care manager.

*We couldn't deliver that level of support set in the family home, and also that there were still outstanding contradictions around 2:1 and 1:1 support. Team Leader A*

*My recall was very much that Ms ST required 24/7 and that our staff, our views were very much that she required fairly constant support and that actually overnight care would be waking night care. Service Manager*

### 3.2 The risk assessment

Within the Support Needs Assessment (SNA), Section 3 relates to risk assessment. Practice guidance for staff in relation to this states that completing a risk assessment for each service user should comply with Care Inspectorate recommendations on recording risk. This section of the SNA captures risk levels, an analysis of risk and proposed actions to reduce risk in the following areas:

- Health risks;
- Mental health risks;
- Wellbeing risks; and
- Adult Support and Protection risks.

The form notes that this is a generic risk assessment. If the risks are such that specific Risk Assessments are required the Assessor should record these separately using the appropriate risk assessment tools.

In Section 3 of the Support Needs Assessment for Ms ST, there is record of a risk of falls, impulsive behaviour and risk of pressure sores. In relation to mental health risks, there is only an "apparent risk" as a result of being unaware of hazards. Wellbeing risks record only an apparent risk of social isolation, with no risk recorded relating to loss of autonomy, loss of daily activities or routine, harm to relationships or loss of support from carer. Ms ST's views around these risk areas are absent, with no reference to how admission to nursing home care, which is the recommendation of the assessment, might impact on her wellbeing. There are no risks noted under Adult Support and Protection.

There is no doubt that Ms ST continued to be at high risk of further falls – indeed she did fall again whilst a hospital inpatient; but social work held the view that further falls could prove fatal, a view reached without recourse to medical opinion. We queried how this view was reached during interviews and heard that this was on the basis that one of the social work team members was a qualified nurse. This view was not checked or confirmed medically despite Ms ST being cared for within a specialist orthopaedic resource throughout this time. During the court process the Safeguarder asked the consultant orthopaedic surgeon for a view on this, and reported, “there is nothing specific regarding an increased risk of fractures [for Ms ST] and that he “doesn’t consider the adult to be at any more risk in terms of fractures than those with similar bone density which he would put at possibly those over 60 or over 70”. This expert opinion from a senior medical professional would have been available to social work during the delayed discharge process had they sought it.”

The assessment and support plan also did not consider the increased risk of falls should Ms ST be supported by care staff that she did not know well, and the impact of the loss of the relationships she had with her current care provider. Team Leader A told us that there was always intended to be a transition plan to the residential unit with familiar care team staff; however, this was not noted in the plan.

Given the level of dispute between the local authority and Ms ST’s brother and the implications for Ms ST in removal from the family home to a care home, a more detailed risk assessment might have offered a more holistic assessment which could have recorded the views of other professionals involved in Ms ST’s care, Ms ST’s and her family’s views and looked at potential risk management plans other than admission to a care home.

### **3.3 Rights, risks and benefits**

According to staff guidance, the Support Needs Assessment (SNA) should be completed by the assessor in partnership with the service user or their legal representative or carers (if any), before being screened by the team leader.

In Ms ST’s case, it was recorded in the SNA that she was “unable to give a view” and “family declined to participate in this assessment”. The family refute this.

The guidance also states that the SNA form can be given to service users to complete. This might have offered an opportunity to ensure Ms ST and her family contributed to the process and could have contributed to a more comprehensive overview of the situation. Social work records on 11 May 2016 note an agreement to send a blank Support Needs Assessment to the family for completion but this was not returned, and does not seem to have been followed up. Ms ST’s brother told us he did not receive this.

The Social Care (Self-directed Support) (Scotland) Act 2013 and accompanying Statutory Guidance recognises the tensions between choice and control for individuals and the HSCP’s duty of care. The legislation highlights four legal principles that must underpin practice and recommends a human rights-based approach to assessment and support planning.

The statutory guidance suggests the application of the FAIR (human rights-based approach) to decision making:

**FAIR** - Rights based decision making

- **Facts** - What is the experience of the individual? Are they being heard? What are the important facts to understand?
- **Analysis of rights at stake** - What are the human rights at stake? Can the rights be restricted? What is justification for restricting the right? Is the restriction proportionate?
- **Identify shared responsibilities** - What changes are necessary? Who has responsibilities for making changes?
- **Review actions** - Have the actions taken been appropriately recorded and reviewed and has the individual been involved.

It does not appear that the HSCP made use of this approach. We could find no evidence of the assessment considering a rights analysis or a risk/benefits analysis for Ms ST. As such they did not fully consider whether the support plan was proportionate and identified the shared responsibilities for safeguarding Ms ST between her family, legal guardian (once appointed) and the local authority.

At the point of the fourth court hearing a further, more detailed, risk assessment was compiled by social work. It states that "it should be noted that Ms ST is unable to be involved in discussions around positive risk taking as she cannot understand the consequences for her health and safety." This view appeared to be based on the fact that Ms ST has a learning disability. There was no evidence of any attempt to help her understand or contribute to this process, either through advocacy or speech and language interventions.

Self-Directed Support – a quick guide for practitioners<sup>6</sup> states that risk enablement is central to the philosophy of self-directed support. It goes on to say that effective risk enablement practice is fundamental in achieving the right balance between protection and empowerment. The guidance advocates that a collaborative approach to supporting risk is crucial in helping move towards a culture that supports positive risk taking, and helps identify where responsibilities lie for supporting and sharing those risks.

We could find little in the way of collaboration either with Ms ST or her family but also amongst professionals who might have contributed to the risk enablement process. Team Leader A told us that the family refused to engage, but Ms ST's brother refutes this and told us that he did not recall failing to respond to emails or refusing to participate in meetings. During the investigation we received a copy of an email trail confirming Ms ST's brother's attendance at meetings. In our view there is evidence of engagement, albeit that disagreement between the parties continued.

Risk assessment is a dynamic and ever changing process but throughout the assessment and planning process for Ms ST there seems to have been a very fixed view of risk and how it would be managed (by admission to a care home) without consideration of the balance between safety, risk taking and quality of life. This is a significant omission.

During interview, we asked if a risk/benefit analysis was undertaken.

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<sup>6</sup> *Self-directed Support – a quick guide for practitioners* (April 2015), Social Work Scotland <https://socialworkscotland.org/self-directed-support-quick-guide-practitioners/>

*The risk assessment was part of the support needs assessment. [Q: And the benefit side of it?] That wasn't done. Team Leader A*

The view of the social work team was that Ms ST was in fact better off while she was in hospital than she had been at home.

*I suppose in my mind it was about safety for Ms ST at that point so safety overrode - the principles would never be dismissed but safety was the main thing. [...] We have always had the view as a team that [Ms ST's] outcomes were met better in a hospital environment with additional support than they were at home. [...] [Ms ST] actually had a better quality of life at that point when there was less restriction around care being delivered, she was out and about every day with support workers on the ward. She was very safe on the ward. Team Leader A*

As discussed in section 2.1, it is difficult to understand how this view was reached without direct communication with Ms ST; or indeed discussion with her family. Decisions appeared to be made on the basis of minimising risk and failed to consider a risk/benefit analysis which included the views of Ms ST and dimensions other than risk, such as the emotional and other aspects of quality of life she might enjoy living at home with her mother; for example, when we visited Ms ST in her home, we heard about her pet and how much she enjoyed having it sit on her.

### **3.4 Balancing the evidence**

#### **3.4.1 Assessing impulsivity**

A key concern of social work staff was that Ms ST's behaviour was impulsive and that she was at high risk of falling because she was likely to stand up and try to walk if she was not constantly supervised.

Social work based this on an OT report of 17 May 2016, and did not update their view, although in August 2016 the OT Team Leader discussed Ms ST's impulsivity with the junior OT who wrote this report, who reflected that she perhaps used this description in error and in retrospect did not feel this was an accurate depiction of her findings. However, given that this was recorded, the senior OT reviewed the past three months of the OT notes, and found that "there were no instances anywhere that I could see where there had been an incident where [Ms ST] had nearly fallen and that there had been anything impulsive". She reported this to social work colleagues, but they continued to rely on the earlier report by the junior OT.

*The lead OT came back with that assessment when very clearly the actual OT who had been involved had said the opposite [...] If they had actually gone out and engaged with [Ms ST] then yes but they didn't. So I suppose in my mind I wouldn't have called it an assessment. Team Leader A*

Nursing staff concurred that the risk had reduced, and that Ms ST could communicate her needs.

*That behaviour had settled but she knew her own mind so if you weren't coming quick enough then she would bang louder [...] she would call out and if you didn't come quick enough she would call louder [...] so I think that her behaviour had settled and she wasn't showing these impulsive behaviours as she was previous. Charge Nurse*

We enquired during interview if the risk assessment had been reviewed in light of this information from other professionals but were informed that it had not.

Given the potential risk factors, a full and comprehensive multi-disciplinary risk assessment should have been completed. This could have considered a comprehensive and chronological analysis of previous falls and risk factors to better understand and support Ms ST with any behaviour which appeared to contribute to the risks. A full risk assessment would also have captured the successful supports used within the hospital ward (such as bed sensors) which might have been transferrable for use in a home setting.

### **3.4.2 Family factors**

Another factor in the social work assessment that the risk of Ms ST returning home was too great was concern about the impact of interactions between Ms ST's mother and care provider staff. The concern was that Ms ST's outcomes could not be fully met because care staff were not allowed to carry out their role properly.

The risk assessment provided as part of the guardianship application details issues recorded on the social work information system dating back to 2005, documenting concerns about Ms ST's mother's engagement with support services. Social work records note that Ms ST's mother was at times reluctant to accept support as it was being delivered, was adamant about how this support should be delivered and was recorded as being overly prescriptive about what carers should do during support times. More recently there were reports from support workers of Ms ST's mother having been rude and verbally abusive towards them, although this was strenuously refuted by the family.

Although the purpose of this information was to illustrate difficulties in relationships and an alleged impact on Ms ST's care, there is no indication that any further intervention had ever been either considered or implemented by social work. Until Ms ST's fall in December 2015, her case was unallocated and dealt with on a duty basis.

We asked about the level of concern about the Ms ST's mother's relationship with support services prior to her admission to hospital during the interviews and were told it did not pose a risk:

*It was quite restrictive but not sufficiently so that we would have then raised more formal concerns. Service Manager*

*I don't think all of her outcomes were being met, some were being met but on balance the risk element wasn't there. There was an absolute decision not to proceed with any formal measures. Team Leader A*

Following the second discharge planning meeting, on 18 May 2016, the manager of the care provider approached social work staff to discuss concerns about what she described as "unrealistic expectations" from Ms ST's family, which she felt compromised the provider's ability to meet agreed outcomes for Ms ST. This was recorded in an email from the manager

of the provider to the social worker. However, the basis of concerns was never recorded or formally reported within the care provider organisation – no incident reports had been recorded and no management action had been taken as a result of these concerns.

This was important as this information then became a key component of ongoing decision making in relation to Ms ST's care planning. The Support Needs Assessment refers to "historical difficulties [care provider] had supporting Ms ST", relating to these reported issues with family interaction with care providers. This was poorly evidenced and in itself had not been considered as sufficient concern to investigate at the time or indeed consider allocation of a care manager. There is a list of concerns as to how Ms ST's care at home had previously been restricted due to these difficulties, and reference to the care provider requesting a review prior to Ms ST's admission due to "misuse of support" but no information about any review carried out.

Some of the issues recorded within social work notes related to Ms ST's mother's expectations that carers would also meet some of her needs, such as cooking her meal as well as Ms ST's. Given that Ms ST and her mother lived in the same house, this did not seem unreasonable.

We saw carer's assessments which had been carried out for both Ms ST's mother and brother. These assessments were generic, and did not address the different circumstances of Ms ST's elderly, retired, mother and her younger, working brother. They did not address the level of support the family regularly provided or indeed consider if the carers themselves required any support to meet their needs. The Resource Allocation Group (RAG) minute states that additional funding was agreed in recognition of carer stress but did not address whether there might be specific needs relating to the carers which might have further increased the budget and allowed an element of sharing resources to meet the family's needs overall.

During the interview process we were informed that this deficit in recording of incidents by the provider had been considered as part of a Large Scale Investigation (LSI) into the performance of the provider, conducted by the HSCP, which was instigated in March 2017, by which time Ms ST had been ready for discharge for a year. The report of this LSI in fact does not mention issues of recording, but it does mention "a general concern about under delivery of hours, low management presence, poor engagement with service users and generally poor living environments, poor staff morale", concerns dating back to 2015-16. It does not appear that these issues about the service provider were taken into account by social work staff in evaluating the provider's reported concerns about the behaviour of Ms ST's family and the impact of this on the potential for supporting Ms ST at home after discharge.

Ms ST's family refute the allegations. They told us that they had complained about the service in relation to inconsistency and quality of service provision, and that this had been investigated by the manager of the care provider who upheld the complaint and provided a written apology. The family report that at no time were issues about their conduct raised with them by providers or by social work.

During the guardianship application process, the Safeguarder interviewed care staff from the care provider in question, who had been delivering care to Ms ST prior to and during her admission to hospital and who had been named as having experienced negative interactions. These care staff denied any knowledge of these difficulties and reported that they were happy to continue to support Ms ST in the family home on discharge.

While it is the case that there may have been some challenges about the level and type of care Ms ST had been receiving at home, and she may have experienced a more restricted life than might have been achievable, it is the role of social work professionals to work with families with different views and wishes.

Without incident reports or formal records from the provider organisation, it is difficult to accept that this information should have been material to ongoing planning. To rely on this information, which had previously not reached a threshold for intervention and was poorly evidenced, compromised the risk assessment.

### 3.5 Alternative support approaches

The risk assessment provided as part of the guardianship application did not record that against the backdrop of the risks of falls and potential issues with service delivery, the family, through an independent consultant, had offered an alternative view of how care at home might be configured to mitigate these risks and offer Ms ST an opportunity to return home to “a good life”.

We discussed this alternative service design produced by the Independent Consultant suggesting approaches which might have supported Ms ST at home at interview with the writer of the risk assessment.

*There was no basis in any reality of what [Ms ST's] care needs were.[...] There was no risk assessment and effectively and I suppose from a legal sense it wasn't a competent report – [Ms ST's brother] had asked someone to do something and I didn't know who they were and we certainly didn't ask for it. Team Leader A*

Local practice guidance for staff on SDS lists a number of organisations which can provide information and advice on personalisation. One of these is the independent consultant involved with Ms ST. This was not acknowledged during the risk assessment/risk management process.

During the investigation we saw a range of risk assessments which were carried out by independent practitioners – an independent Mental Health Officer, an independent Occupational Therapist and the Safeguarder, as well as hearing from the health personnel directly involved in Ms ST's care. All of these considered views advocated a return home with an appropriate care package and took account of the risks and how these could be mitigated by the use of support, both formal and informal, and using equipment and technology. None of these, however, were considered as part of this process, nor altered the HSCP's risk assessment.

### 3.6 Proposed admission to a care home

The risk management plan throughout this process was admission to a care home which would offer 24 hour support. This plan was examined further by the independent occupational therapist and the Safeguarder appointed by the court. Both reports highlight that staff-to-resident ratios in the identified establishment would be 3:1 during the day and 8:1 at night, and

so would not have provided the 1:1 support which the Support Needs Assessment identified as necessary.

There appear to be differences in the stated purpose of admission to a care home. During interview we heard from the Care Manager and Team Leader A that this admission was to allow for further assessment within a safe environment. However, the Support Needs Assessment and Outcome Based Support Plans state that care for Ms ST could not be provided within the home environment, necessitating admission to a care placement and that a place in a particular care home had been reserved, pending the outcome of the guardianship application.

It is often the case that patients are discharged to intermediate care, a temporary NHS placement in a facility where assessments and reablement work are carried out, with a view to the individual returning home where possible. We asked whether this was considered for Ms ST. The Service Manager told us an intermediate care bed was not an option:

*Our view really was that Ms ST's needs could be really very well met within a learning disability specific care home environment. [...] At the time she was in an acute bed the rules from the NHS point of view were we couldn't access intermediate care beds for anybody under sixty-five so that's why she remained in the acute bed. We also tried to persuade [Ms ST's brother] to accept Ms ST moving to somewhere like [care home]. [...] Really we were trying to persuade [Ms ST's brother] to test Ms ST out in a care home setting and if we could test her out in that setting and if we then found that in fact the risks were less than we were aware of that we felt then potentially she could go home from there but he wasn't in agreement with that.*

### **3.7 Observations by the Commission**

The risk assessment and support planning in the Support Needs Assessment and the Outcomes Based Support Plan appeared to us to be based on selective interpretation of information. Information from health staff which might have supported a return home was disregarded, and information from the care provider which suggested risks associated with a family member's attitude to care staff was not critically evaluated. The focus was entirely on risk, with no assessment of the potential benefits of a return home. There was an unrealistic belief in the level of overnight support provided by the proposed care home, and an inflexibility of approach which meant that alternative proposals for managing the risks at home were rejected rather than discussed. The family's years of experience in caring for Ms ST were not adequately acknowledged. There was a lack of clarity and transparency about the purpose of the proposed admission to a care home.

Practice guidance was not followed with regard to the participation of Ms ST and her family and their independent consultant.

During the process of assessment, there was a lack of trust in other professional assessments and a failure by social work to recognise the dynamic nature of ongoing assessments of Ms ST's mobility and care needs. This resulted in additional assessments being undertaken and further delay in facilitating a discharge. Alternative approaches which might have taken into account the potential for her needs to improve were never considered.

## 4 Legal aspects

Until Ms ST was admitted to hospital and plans for discharge were being considered, she was supported to make day-to-day decisions by her family on an informal basis. Once she was deemed fit for discharge and there were differing opinions about what was required to facilitate a safe discharge, a need for the appointment of a proxy decision maker was identified. In early April 2016, Ms ST's brother instructed a solicitor to make an application for him to be appointed welfare guardian.

We looked at the process of appointing a guardian for Ms ST. Our key concerns were the length of the process, which was greatly extended by the local authority's challenge to some of the powers sought by Ms ST's brother, and the crucial role of the independent MHO. Compromised autonomy in this instance appears to have reduced the opportunity to offer an objective view of Ms ST's brother's suitability as a guardian. There was an over-reliance on information which was not evidenced and which, during the course of the court process, was challenged by independent MHO and occupational therapy reports.

### 4.1 Allocation of a Mental Health Officer

The family's solicitor requested allocation of a Mental Health Officer (MHO) to provide a suitability report of the guardianship application on 4 April 2016 and this was acknowledged by the HSCP as awaiting allocation on 11 April 2016.

In terms of a private application for guardianship the code of practice of the Adults with Incapacity Act does not require a case conference to be held but one was arranged for 16 June 2016. An MHO was allocated on 9 June 2016, a delay of nine and a half weeks, but did not attend the case conference. The time taken for allocation was despite the priority of Ms ST's case.

*When I was given the case my understanding was that this one was already considered a high priority before it had even got to me at that point. MHO 1*

The Adults with Incapacity Act requires that MHO reports should be provided within 21 days of the request from the applicant, however this delay reflects the current position across Scotland where the demand for MHO services continues to outstrip available capacity.

### 4.2 Consideration of the principles of the Act

The minute of the Adults with Incapacity case conference states that the chair gave a brief outline of the framework of the principles and legislation related to Adults with Incapacity, and the need to apply the principles of the legislation, and that this includes acting in a way that involves the least restrictive action and is of benefit, whilst taking account of past and present wishes of the adult. It is therefore unfortunate that at no time throughout the rest of the meeting were the wishes of Ms ST either sought, clarified or discussed further. The independent advocate who had been involved with Ms ST was not present at the meeting, nor was the MHO who had been allocated to prepare the suitability report. This was a significant gap in any consideration of seeking a legal framework to support Ms ST.

### 4.3 Independence of the MHO

The meeting minute records that Team Leader A advised that, “social work would not support Ms ST’s brother as Guardian if he wished to take Ms ST home”. It also explained that a Mental Health Officer (MHO 1) had been appointed and would carry out an independent report.

Given the clear view expressed by Team Leader A in the minute of this AWI case conference, it is difficult to see how independent any MHO report could be. We asked MHO 1 about this. He advised that he had raised this as a concern both with his manager and the applicant and had suggested to Ms ST’s brother that there might be a conflict of interest. He noted that when he became involved the situation was a “bit entrenched” on both sides.

*It was one of the more awkward [cases I have worked with]. I think being in the same office as everybody and trying to tread that line where you're questioning stuff, but also it's your boss. Because I would go back and say why can't we look at doing – oh we can't do that because of blah. MHO 1*

### 4.4 Judgement of suitability

The MHO’s suitability report concluded that Ms ST’s brother was a suitable guardian for all of the powers except deciding where the adult should live and what care she requires.

Section 59(4) of the Adults with Incapacity Act and the code of practice for local authorities lays down clear criteria for consideration of an applicant’s suitability:

- the individual is aware of the adult's circumstances and condition and of the needs arising from such circumstances and condition;
- the individual is aware of the functions of a guardian [this would include the ability of the individual to understand and apply the principles properly];
- accessibility of the applicant to the adult and to his primary carer;
- the ability of the individual to carry out the functions of guardian [this would include such issues as professional competence];
- any likely conflict of interest between the adult and the individual;
- any undue concentration of power which is likely to arise in the individual over the adult; and
- any adverse effects which the appointment of the nominated person would have on the interests of the adult.

Disagreement with the local authority view should not in itself render an applicant unsuitable. Throughout the investigation process, Ms ST’s brother demonstrated suitability against these criteria.

Section 7.31 of the code of practice states that sometimes the local authority will take one view of the adult’s needs, but others with an interest will take a different view. This could arise where, for example, where the authority believes that the intentions of the applicant will not be to the benefit of the adult. It goes on to direct that in this instance the report writer “should assess whether objectors have a realistic alternative to the local authority’s own proposals”.

The MHO report stated that, 'the fundamental differences of opinion are such that the applicant would not be able to exercise the major powers within the application.' In our view, the disagreement between the applicant and the local authority was therefore the key reason for Ms ST's brother being viewed as unsuitable for these powers.

We found that the MHO suitability report was founded on a number of disputable issues:

1. In the conclusion, MHO 1 states that the local authority is of the opinion, given the information that it has received from assessments from hospital personnel and the care manager's own assessment, that the adult's needs can no longer be safely met in the home environment. This is inaccurate in that the health assessments all took the view that Ms ST could be managed at home with an appropriate care package. There was an over-reliance in the MHO report on the interpretation of these views by Team Leader A, which impacted significantly on the outcome of the assessment of suitability. The allocated care manager was not consulted as part of this process.

2. The conclusion relied heavily on information about the impact of Ms ST's mother's conduct, as reported verbally by the care provider. Section 3.4.2 discusses the limitations of this information: there were no written records, and no action had been taken to address the issues, as they had not been seen as significant enough to require action.

3. The code of practice states that in the event of an MHO wishing to write an adverse report, it is essential that this is discussed with a team leader to plan what alternative course of action the local authority might take to protect and safeguard the adult's interests. There was no evidence either within the report or within routine recording that this additional consultation had been considered.

In addition, the views of Team Leader A are recorded as the views of the primary carer of the adult. This is inappropriate, as he was not in a caring role, and in the light of the very active caring role of Ms ST's family throughout her stay in hospital and before.

#### **4.5 Delay in lodging the application**

There then followed a significant delay in the solicitor lodging the application. MHO 1 told us this was because the solicitor had not obtained the medical reports in the allowed timescale. This resulted in MHO 1 requiring to revisit and update the report. This accounted for a period of three months from July 2016 until October 2016. MHO 1 revisited the adult for the purposes of updating his report but did not revisit the information contained within the report. During this three month period, Ms ST's rehabilitation had continued to progress. There had been further input from the occupational therapist, who had confirmed that Ms ST needed the assistance of only one member of staff and that in the course of the preceding three months, a review of OT records had found no evidence of impulsivity in Ms ST's presentation. This was important information which was not considered as part of this report.

Despite the necessary documents being concluded by 25 October 2016, and follow-up by Ms ST's brother, the application was not lodged at court by his solicitor until 18 January 2017, again resulting in unnecessary delay. We heard that this further delay was due to a change of solicitor and paperwork being lost within the court process. We consider this to be unacceptable, given the resulting further delay in discharge for Ms ST. With intimation periods the first hearing was set for 8 March 2017.

Whilst this was a private application, the Commission's view is that there could have been a more active role for either the MHO or the Care Manager to ensure that the process was proceeding timeously to prevent additional delay in discharge. Team Leader A told us that the meeting on 22 August 2016 was in part in order to track the progress of the application, but there is no record of further activity in this regard, until he received an email from the family's solicitor on 15 November 2016 saying that the application had been lodged

This position has been helpfully clarified recently, in a guide for health & social care practitioners involved in discharge planning from hospital recently published by Health & Social Care Integration, Scottish Government<sup>7</sup> which highlights that proactive case management is essential to ensuring private guardianship applications are processed without unnecessary delay. This guide suggest agreeing clear, realistic timescales with the applicant for progressing key milestones within the process, and the allocation of a case manager who should support family throughout the application process, establish an escalation process for cases that are not progressing within a reasonable timescale and use a database to track cases and monitor progress.

#### **4.6 Local authority seek to limit guardian's powers**

Prior to this first hearing, the local authority lodged a minute seeking conditions in appointing Ms ST's brother as welfare guardian – that he should not have the power to decide where she lived or what care and support she required. This was on the basis that he did not agree with the local authority about where she should be discharged to.

The sheriff appointed a Safeguarder who instructed supplementary independent MHO and independent Occupational Therapy reports to address the minute and consider the need for full financial guardianship and a further hearing date was set for 19 April 2017 (six weeks later).

At the hearing on 19 April 2017, the case was further continued because the Safeguarder felt that assessments and decisions in relation to Ms ST were not-up-to date. The court agreed independent updated assessments should be carried out in respect of where Ms ST should reside, and a further hearing date of 28 June 2017 (ten weeks later) was set.

At this hearing in June, the Safeguarder presented her findings based on an extensive enquiry process with a range of interested parties and the independent OT and MHO reports.

In her conclusion, the Safeguarder's view was that "the matter of suitability is not relevant, instead it is the disagreement between parties which is and bring the case to the current focus and impasse and without that the applicant would have been considered suitable." The Safeguarder advised that in light of the independent reports the adult should have an opportunity to return home with a package of care, although she recognised that there would require to be further discussion between parties to effect this. In addition the Safeguarder offered to facilitate this process of negotiation but notes that, "there is no willingness on the part of the Local Authority to do so at the time of writing the report".

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<sup>7</sup> *Discharging Adults with Incapacity - A practical guide for health & social care practitioners involved in discharge planning from hospital.* (March 2019) Health & Social Care Integration, Scottish Government. <https://hscscotland.scot/couch/uploads/file/planning-discharge-from-hospital-adults-with-incapacity-march-2019.pdf>

At the hearing on 28 June, the local authority requested a continuation to provide a further risk assessment on the basis that the Safeguarder report did not fully reflect views of Team Leader A or assessment of risk in relation to a return home.

This assessment was compiled by Team Leader A and reiterated the risks discussed previously – that Ms ST was at risk of falls due to declining mobility, a further fall could prove fatal and historical issues in relation to family interaction with care providers. Interestingly, the issue of impulsivity which had been prominent in previous risk assessments does not feature in this document.

Within this risk assessment there is no further evidence which had not been addressed as part of the process to date. It includes the same anomalies in terms of a lack of medical evidence about Ms ST's declining mobility (her mobility had in fact improved over her prolonged inpatient stay, although it was poorer than before her fall) or evidence that a further fall would prove fatal (Ms ST had fallen again during the guardianship process, in February 2017, and sustained a fracture to her humerus which had since healed).

In addition, the Safeguarder submitted a supplementary report. She had interviewed the manager of the care provider again and they could produce no evidence of the concerns highlighted by social work. The Safeguarder also interviewed support workers who were delivering care to Ms ST during this process and these issues had been denied.

This might have been an opportunity for the Local Authority to seek a more independent risk assessment or indeed refer to the Risk Enablement Panel<sup>8</sup>, neither of which seem to have been considered.

At a fourth hearing on 27 July 2017, a further four weeks later, Ms ST's brother advised the court that he would make himself available to coordinate care, and was prepared to supplement the budget and provide some direct care to support transition from hospital, and the local authority agreed to review their position in light of this.

A final hearing two and a half weeks later on 15 August 2017 noted that the local authority withdrew their previous minute and the welfare and financial guardianship was granted with all the powers applied for, for a period of one year.

Throughout this process there could have been further efforts made to improve communication and resolve some of the disputes which resulted in five court hearings over more than five months, during which time Ms ST remained in an acute hospital bed which was unsuitable to meet her needs.

#### **4.7 Continued disagreement**

Disagreements, however, continued and the detail of Ms ST's brother's offer of availability remained a source of dispute. Whilst he reports that he was clear that his offer to the court was made on a transitional basis to facilitate discharge, it then became clear that the local authority view as recorded in the Support Needs Assessment was that Ms ST's brother had advised he would give up his job permanently if this meant his sister could return home. In addition, the SNA records that if there were to be any changes in the support arrangement

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<sup>8</sup> A Risk Enablement Panel (REP) has been set up by the local authority as its way of helping with challenging or complex decisions which may occur as part of the allocation of Individual Budgets and support plan validation within its self-directed support processes.

against the assessment of social work, this would be considered under an Adult Support & Protection framework as neglect/acts of omission by others.

Ms ST was finally discharged home a month later, on 15 September 2017.

#### **4.8 Observations by the Commission**

The guardianship process was a very significant contribution to the delay in Ms ST's discharge. It began with a long delay in the local authority appointing an MHO. A further long delay was due to the time taken for the application to be lodged by the family's solicitor, and so was out of the hands of the local authority.

It is our view that MHO 1 was unable to exercise the level of independence expected, due to his proximity to the team involved in the case. The inflexibility and fixed opinion of the local authority in relation to where Ms ST should live was a significant hurdle in making progress towards discharge and led to the lengthy duration of the court process.

However, had social work worked collaboratively with family, care providers and health professionals, there could have been an opportunity to return Ms ST home with a package of care, pending the Guardianship application process concluding.

Proactive case management could have picked up the delay in lodging the application with the court.

It is our view that the threat to subject the family to further legal measures under Adult Support and Protection legislation if the local authority's care plan was not adhered to was contrary to the spirit of the Adults with Incapacity legislation.

## 5 Self-directed support

One focus of our investigation was on how the law and policy on self-directed support was applied in Ms ST's case. We were concerned that national and local guidance was not fully applied, and in particular that there was a lack of involvement of Ms ST and her family, and that the choice and control intended in self-directed support legislation was not provided to them.

### 5.1 The legislation

The Social Care (Self-directed Support) (Scotland) Act 2013 came into force in 2014. It places a duty on local authority social work departments to offer people eligible for social care a range of choices over how they receive it. The intention of the Act is to allow individuals and their carers and families to choose their support and how it is delivered, to meet agreed personal outcomes.

Self-directed Support (SDS) includes a range of options:

- Option 1: a Direct Payment – cash to be spent by the person on services which meet their outcomes, for example employing a personal assistant or paying a provider;
- Option 2: funding allocated to a provider chosen by the person or their representative (the council holds the budget but the person is in charge of how it is spent);
- Option 3: services arranged by the council; or
- Option 4: a mix of these options.

### 5.2 National and local guidance

The Scottish Government published Practitioner Guidance<sup>9</sup> to support implementation of the legislation. This is supplemented in the Local Authority with local Practice Guidance for Staff setting out processes and procedures. The version which applied within the timeframe of this investigation is version 2.9, published in February 2016.

This local guidance is in three parts - the Overview of the Personalisation and Self-directed Support Process, the content of each core Personalisation eForm, and the Appendices, with useful information to help staff and service users understand the personalisation and self-directed process within the area.

It is clear about the process by which this legislation is implemented – the Assessor completes the Support Needs Assessment which is screened by a team leader and presented to a Resource Allocation Group Meeting. At this meeting, the Service Manager will establish an Agreed Estimated Budget based on the information provided. Once this estimated budget is established, the next step is support planning.

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<sup>9</sup> *Self-directed Support: Practitioners Guidance: A practice guide on Self-directed Support for practitioners* (August 2014) Scottish Government <https://www.gov.scot/publications/self-directed-support-practitioners-guidance/pages/6/>

The guidance is clear that co-production is a key part of this process. The Assessor should work with the service user, carers, legal representatives and other relevant parties (providers, personal assistants, etc) at the support planning stage to draw up an Outcomes Based Support Plan (OBSP). This then goes through authorisation stages according to whether or not it is within the Agreed Estimated Budget. The OBSP may require further authorisation if additional budget is being requested, before an Individual Budget is finally agreed. The Individual Budget can combine several funding sources: social care monies, Independent Living Fund and client contribution, and can be used to design and purchase support from the public, private or voluntary sector to meet a person's assessed eligible needs, in line with their OBSP.

Appendix 3 of the guidance states that flexibility and service user choice and control are at the heart of Personalisation and Self-Directed Support.

Within the guidance it states that where the risks highlighted in the OBSP are significant, the Service Manager can make a referral to the Risk Enablement Panel following a discussion with the Head of Service.

Local processes are very clearly defined within the document. During interview the HSCP Care Manager, Team Leader A and Service Manager confirmed that they were familiar with this guidance.

The investigation has considered the process as it pertains to Ms ST against this practitioner guidance. We found that whilst the guidance is very clear, adherence to it was patchy.

### **5.3 Involvement in the assessment**

Throughout the process there was little evidence of co-production. The Support Needs Assessment states that Ms ST "requires support with her communication. She will often repeat learned phrases and requires support to ensure she fully understands what is being said" and that "due to her complex needs Ms ST is unable to give her view".

The assessment then goes on to contradict this by saying, "there is an independent advocate in place" who reports that "Ms ST has indicated that she would wish to return home."

As discussed in section 2.1, there is no evidence that speech and language therapy or other communications support expertise was used to support Ms ST in giving her views.

The Support Needs Assessment records that "family have declined to participate in this assessment". Ms ST's brother told us "I do not believe that we have ever declined to participate in any assessment with Social Work or any other discipline involved in Ms ST's care." Throughout the process Ms ST's family were supported by a solicitor and by an independent consultant associated with one of the organisations on the list in the local guidance appendix, both of whom were also available to offer a view on the family's behalf, in line with the local SDS guidance.

We asked the Independent Consultant about her involvement in this process and heard that she had spent time with Ms ST and her family as well as the nursing and OT staff within the hospital and had an opportunity to speak to the support workers who were delivering ongoing support to Ms ST in hospital. On the basis of this she produced an outline service design which was presented at discharge planning meetings. This was a detailed document which reflected

not only Ms ST's wishes but also an alternative approach to supporting Ms ST if she were to return home.

*If I'd prepared a paper or whatever they didn't really want me to take any time to go through that, to listen to it, to share it. I was just bulldozed away and back to their agenda.* Independent Consultant

*I'm not even sure at times whether social work would actually read the independent consultant's care plans.* Brother

Given the reported difficulties from social work in engaging with Ms ST and her family, this was a missed opportunity to reflect their views during a vital part of a process.

#### **5.4 Governance and scrutiny**

Although we heard from the care manager that she had carried out the Support Needs Assessment jointly with a colleague who had covered for a period whilst she was off sick, all of the documentation we have received indicates that this assessment was prepared and signed off by the Team Leader A. The SNA form records a start date of 11 May 2016, with 'Worker name' completed with the Team Leader A's name. It has a completion date of 29 September 2017, again with name of the worker completing it being that of Team Leader A. This implies that the Team Leader may have been directly involved in the assessment, rather than carrying out the screening role indicated by the local guidance. However, the Team Leader A's name is also entered in the form in the entry for 'Screened by Team Leader', with a date of 16 June 2016. This may have reduced a level of governance and scrutiny within the process, which might have picked up on the lack of representation of Ms ST's and her family's views.

The guidance says that once the Support Needs Assessment has been verified and signed off by the team leader and an initial calculation of the Estimated Budget completed using an agreed matrix, it goes to the Resource Allocation Group (RAG).

At the RAG meeting, the Service Manager discusses the Support Needs Assessment and other relevant assessment documents (such as carer's assessments, Occupational Therapy assessment, specialised risk assessment) with the Assessor. We received a copy of the minute of the Resource Allocation Group for Ms ST of 29 September 2017. It does not record access to any additional assessments or specialised risk assessment. There is a risk that without these, and with the erroneous statement in the Support Needs Assessment and the Outcomes Based Support Plan, managers would have insufficient information to form a fully-informed overview.

It is unclear from the records the date at which the budget was agreed. The start date of the RAG minute is recorded as 29 September 2017 (Ms ST was discharged on 15 September 2017). It was authorised by the Head of Service on 20 March 2018, on the basis of the information shared but without access to additional and contradictory information. The minute also, confusingly, shows it as authorised on 12 August 2018 by Team Leader A, who had apparently completed and scrutinised the Support Needs Assessment in the first instance, and who was by then Acting Service Manager. The HSCP was notified of the investigation on 2 August 2018.

It appears from this that the final Individual Budget was agreed on 20 March 2018, six months after Ms ST's discharge from hospital. Team Leader A told us that the budget was agreed at the original meeting but became a matter of dispute and remained open, and could not be concluded because of the service manager's sickness absence, and that he authorised it when acting service manager to allow payment to the provider.

On the basis of this information, it would be difficult to ascertain what budget was available at various points of the process and this uncertainty was confirmed during interview with Ms ST's brother and the independent consultant.

*At no point could we pin them down to discuss any clarity about plan – about the plan that we were putting forward or what they were saying for instance the plan would be or the budget would be. Independent Consultant*

Emails between Team Leader A and Ms ST's brother demonstrate that the budget was still being clarified in early September 2017, just before Ms ST was finally discharged.

## 5.5 Support planning using the budget

The Individual Budget which was finally agreed equates to seven waking overnight shifts per week. There is no stipulation within the RAG minute of 20 March 2018 that this is the only way this budget can be spent.

Practice guidance states that following the agreement of the Agreed Estimated Budget comes the support planning process involving the service user, carers, legal representative and/or providers. There is an expectation that the Outcome Based Support Plan (OBSP) should be completed within four weeks of the budget being established.

Guidance, both national and local, states that the assessor should ensure the service user is fully involved in the support planning stage and should provide sufficient information to allow the service user to make informed choices, in line with the statutory principles of involvement, informed choice and collaboration.

The discussion with the service user and significant others should include:

- the choices available to the service user;
- the resources that will help to deliver the service user's support plan; and
- the main risks and how the service user and others can manage these risks.

The dates of the meetings and of the entries in the SNA, and of the subsequent agreement of the budget, are confusing. This reflects the experiences of the family and the independent consultant who were unclear about what the agreed budget was likely to be (see section 5.4), and could not as a result begin to plan care with confidence and in line with an Agreed Estimated Budget.

The Agreed Estimated Budget and the final Individual Budget agreed was not sufficient to meet the cost of a 24 hour care package, as recommended by the SNA. The family worked with the Independent Consultant to look at how best the potential budget might be utilised,

alongside a commitment from Ms ST's mother and brother to supplement this both financially and by providing direct support.

Ms ST previously shared a room and a bed with her mother, who was the first line of response if she woke at night. Their previous experience had been that Ms ST would usually go back to sleep after reassurance from her mother, but support might be needed if she wanted to go to the toilet. Sharing a bed was no longer an option due to Ms ST's changed care needs, and a suggestion was made of two single beds for Ms ST and her mother in one room so that the other bedroom could be used as a sleepover room for an immediate staff response. This would be supplemented by the use of a lower bed for Ms ST, a crash mat and bed monitors which would alert the sleepover staff if Ms ST's mother was unable to reassure her so that she went back to sleep. It was acknowledged that this might need to be augmented initially with waking night cover from a support worker, to support a transition from a lengthy hospital stay, but the intention was that this could eventually change to a sleepover.

This service design was dismissed by social work, and we could find no evidence that it was fully explored.

*I don't know that there was ever a decision made for her to go home with a sleepover because the house wouldn't have facilitated that. It was a two bedroom house, a room for mum and a room for [Ms ST]. There wasn't a room for a sleepover so that was never really something we agreed that would be suitable. We couldn't put staff in there with nowhere to sleep. Care Manager*

As part of the investigation process, we visited Ms ST's home and were shown the layout of the flat. In one of the bedrooms, we judged that there was space for two single beds for Ms ST and her mother which could have left the second bedroom free for a staff sleepover room.

During the support planning process it became clear that the budget could be used only to provide seven waking overnights, and no discussions were brokered about delivering overnight care in any other way. This inflexible use of the budget is not recorded or discussed within the Outcomes Based Support Plan and does not reflect the wishes of Ms ST or her family.

The SNA notes that, "if there are to be any changes in the current arrangement (seven waking overnights) against the assessment of Social Work Services, this will then be considered under Adult Support and Protection framework as neglect/omission by others."

In our view this statement is not in the spirit of collaboration and risk enablement intended by the legislation.

The rigid stipulation of how the budget was to be spent resulted in no care being funded during the day. The family therefore had either to provide this directly or fund it privately. This was not discussed as part of the support planning process. Ms ST's family were always clear that they would continue to support Ms ST on her return home but at no time was the extent of this discussed or agreed.

*I was very keen to stress that the family were keen to play an ongoing part in [Ms ST's] support in a home environment [...] that would be from a financial point of view and it would also be from a time point of view but [...] until very much later in this process there was never any discussion what the kind of quantum of that would be. Brother*

Ms ST's brother took voluntary redundancy from his employment to facilitate Ms ST's transition home from hospital but always with a view to returning to employment.

The OBSP for Ms ST displays no evidence of any of the above discussions. Ms ST's and her representatives' views, choices and preferences were absent. The outcomes recorded are not reflective of any discussions about or options for how Ms ST's care might be delivered, are clinical and risk averse and reflect the concerns of the assessor rather than personal outcomes for Ms ST. The SNA and OBSP documents are very similar in content and reflect a cut/paste style approach which does not fully evidence the principles set out in statute and guidance; nor does it capture what is important to Ms ST or her goals and outcomes.

The OBSP states that "All professionals are in agreement that she requires 24 hour care with waking support overnight.", which was not the case, and sets out a plan for seven nights a week of waking night support from a provider, under SDS option 3. There is no evidence in the plan of discussions with the family about any other potential ways of using the budget to keep Ms ST safe at night.

## **5.6 Observations by the Commission**

The policy framework and accompanying staff guidance were clear and explicit and crucially place the service user at the heart of the process as the spirit of the Act intended. The absence of Ms ST's views and those of significant others in her care was unacceptable and should have been picked up as the process progressed, through inbuilt and detailed governance arrangements. It is also concerning that the differing views of other professionals were not transparently represented.

These checks and balances may have been reduced by one member of staff apparently taking the roles of the assessor and team leader with opportunities for scrutiny reduced as a result.

The process should have included balanced consideration of potential alternative ways of using the Individual Budget to meet Ms ST's outcomes.

## 6 Decision making

The key decision to be taken regarding Ms ST's discharge was whether she could be safely supported at home, or whether she should be discharged to a care home, either for further assessment or long term.

Social work staff appear to have decided at an early stage that a care home was likely to be the best option for Ms ST, as is described in section 3.1. This is perhaps not unreasonable as a starting point; however there is no evidence that this decision was tested against further evidence in a balanced way. The wishes of Ms ST and her family were clearly for her to go home. Rather than giving weight to these views and exploring ways in which this might perhaps have been achievable (as indeed, ultimately happened), what seems to have happened is a selective weighing of evidence.

During the discharge planning process there was a range of evidence from the medical practitioner involved in Ms ST's care as an inpatient, nursing staff, occupational therapy, the independent consultant, family, and latterly by the safeguarder and the independent OT and MHO the safeguarder had consulted, all of which offered alternative views of Ms ST's needs and potential discharge arrangements. All of these views were dismissed by social work, in some cases described as incompetent or lacking understanding of Ms ST and her needs. This is difficult to accept given the intensity of the involvement of these other agents. The views of a senior OT were set aside in favour of the opinion of a junior OT whose assessment dated back some months.

Risk posed by the family factors described in section 3.4.2 was given significant weight, although we heard at interview that these had not been at a level which led to any action – even the allocation of a social worker – while Ms ST was supported at home for several years prior to her admission. Further investigation was not carried out by social work; but the safeguarder interviewed staff named in these allegations as having experienced negative interactions, who refuted this.

The risk of a further fall was said to be potentially fatal, without medical evidence for this. This view was not adjusted when Ms ST fell in hospital and broke her shoulder. Instead, this fall, although sustained in a hospital environment, was seen as further evidence of risk and the need for supervision in a care home.

Admission to a nursing home as a risk management measure was predicated on there being 24 hour support available, particularly overnight, to respond if Ms ST attempted to get out of bed. However, the plan failed to acknowledge that the actual staff-to-resident ratio at the care home in question was insufficient to provide the immediate response deemed to be required (see section 3.6).

Alternative approaches were suggested by the independent consultant who was supporting Ms ST and her family, but these were summarily dismissed, again on the basis of risk, which social work felt was insufficiently addressed. The use of technology was cited as a reason for care home admission, but not explored for supporting Ms ST at home. Further conversations about these alternatives could have teased out thinking around joint risk management but were never considered.

In our view, this was a missed opportunity to offer choice and progress discharge at a time where Ms ST was being cared for in an inappropriate environment.

Decision making in this instance demonstrated confirmation bias or verificationism whereby practitioners appeared to highlight only the information that would support their view. This tendency to persist in initial judgements and reframe, minimise and dismiss discordant evidence is seen in research literature as an important issue in social work. (Burton, 2009)<sup>10</sup>

O'Sullivan (2011)<sup>11</sup>, in a similar vein argues that in order to counteract this "confirmation bias", decision makers need to be reflective about the way the decision situation is framed and should not only seek to continuously question their assumptions, but also actively seek information that sheds doubt on those assumptions.

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<sup>10</sup> Burton, S. (2009) *The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?* Centre for Excellence and Outcomes in Children and Young People's Services.  
[http://www.childcentredpractice.co.uk/Websites/ccp1/files/Content/1415047/safeguarding\\_briefing\\_3.pdf](http://www.childcentredpractice.co.uk/Websites/ccp1/files/Content/1415047/safeguarding_briefing_3.pdf)

<sup>11</sup> O'Sullivan T (2005) Some Theoretical Propositions on the Nature of Practice Wisdom, *Journal of Social Work*, 5, 2, 221-242

## 7 Health and social care integration

The Public Bodies (Joint Working) (Scotland) Act 2014 established a set of nationally-agreed outcomes, which apply across health and social care, and for which NHS boards and local authorities are held jointly accountable.

It also put in place a set of integration planning principles. These include that services should be provided in a way, so far as possible, which:

- is integrated from the point of view of service-users;
- takes account of the particular needs of different service-users;
- takes account of the particular characteristics and circumstances of different service-users;
- respects the rights of service-users;
- takes account of the dignity of service-users;
- takes account of the participation by service-users in the community in which service-users live;
- protects and improves the safety of service-users; and
- makes the best use of the available facilities, people and other resources.

It could be argued that these principles were designed for an adult like Ms ST who required the support and involvement of both health and social work services; and that if applied, they would maximise her participation in the planning and design of her care. This vision would ensure that the expertise of the full range of health and social work professionals would be targeted, coordinated and seamless and expedite a smooth and safe transition from hospital back to the community.

Instead Ms ST was subject to numerous assessments, often of the same issues, as professionals repeatedly failed to trust each other's skills, expertise and findings. She remained in an unsuitable acute hospital bed whilst these differences of opinion continued. This was not in her interests. It was also at great cost to the NHS, and will have had knock-on effects for other patients requiring admission to the ward.

Although her case was considered at weekly high level Integrated Delayed Discharge meetings, held to consider all care groups, and at monthly HSCP verification meetings, in this instance, it would be fair to say that integration agenda proved to be of no benefit for Ms ST or her family and evidenced the very reasons for which integration was intended.

Additionally, there appeared to be no mechanism within the integrated agencies which could address and progress fundamental differences of professional opinion.

Within the records we received as part of the investigation process, we noted that a meeting had been held on 22 February 2017 with the NHS General Manager, members of the clinical team and Team Leader A. The purpose of this meeting was to address the issue of Ms ST's brother quoting ward staff as being in disagreement with the social work assessment despite no information coming directly to social work services.

The record of this meeting evidences continued dispute between health and social work but has no conclusion about how this would be addressed or resolved going forward.

Where there is a significant level of dispute, impacting on a discharge from hospital, it is the Commission's expectation that there would be formal mechanisms to address issues and agree a way forward.

## 8 Conclusion

Some of the causes of the delay Ms ST experienced were due to systemic issues with social work capacity:

- It took four weeks for social work to allocate a care manager on 20 April 2016 and the first planning meeting was held on 26 April (five weeks of delay). Part of this appears to have been due to the need to reallocate due to staff sickness.
- Partly concurrently, MHO allocation took nine and a half weeks (4 April to 9 June 2016).

Some of the delay related to the guardianship process:

- It took three months for the family's solicitor to get medical reports, requiring a further visit by the MHO to update his report, and the application was not lodged with the court until 18 January 2017, approximately 29 weeks after the MHO first completed his report. This was not under the control of the local authority, but there was a lack of proactive follow-up by them.
- The first court hearing was on 8 March 2017, 7 weeks after the application was lodged, and there were four further hearings due to the position taken by the local authority in relation to the suitability of Ms ST's brother for some of the powers sought, with the final hearing on 15 August 2017 – a total of 22 weeks.

There were considerable delays around planning for discharge, and poor communication between social work and health, including a lack of responsiveness from social work to health staff seeking information on progress towards discharge.

There was a further delay of a month once Ms ST's brother was appointed as her guardian, while a discharge plan was agreed.

However, the principal underlying reasons for Ms ST spending so long in hospital were the factors that led to the continuing disagreement between social work and the family on whether or not Ms ST could return home:

- Social work focussed on the potential risks of her returning home and maintained a very fixed view of risk and how it would be managed (by admission to a care home) without consideration of the balance between safety, risk taking and quality of life.
- Social work opposed Ms ST's brother being granted key guardianship powers, based on this.
- Despite the information from health staff which conflicted with the social work view, a comprehensive multi-disciplinary risk assessment was not carried out.
- Social work did not fully consider Ms ST's own wishes.
- The risk assessment was flawed and included outdated information.
- Risk assessment and support planning appeared to us to be based on selective interpretation of information. Information from health staff which might have supported a return home was disregarded, and weight was given to family factors which had not been considered significant prior to Ms ST's admission to hospital, and which were not evidenced.

- There was a very poor relationship between social work and the family.
- Social work did not follow their own self-directed support planning processes, and did not consider alternative ways of achieving Ms ST's outcomes.
- Family refused the offer of intermediate care within a care home which might have facilitated an earlier discharge; but did so on the basis that they disagreed that this model of care would meet Ms ST's needs and that the temporary nature of this option to support further ongoing assessment was not shared with them.

We have some concerns about the social work practice in this case.

Ms ST's situation was complex and, in the early months, her physical health and needs were still improving. It is unlikely that, even in an ideal world, her discharge could have been achieved immediately; time would have been needed for multi-disciplinary assessments, for agreeing a budget and for a collaborative process of self-directed support planning. Concurrently there might well still have been a guardianship process, although had all parties been in agreement and a return home agreed, this might not have been necessary.

However, it is our view that discharge could have been achievable within a few weeks, rather than the almost 18 months of delay she and her family experienced.

## **8.1 Recommendations**

### **8.1.1 Recommendations for HSCPs**

1. To put in place governance measures to ensure that assessment and support planning:
  - is carried out in line with national and local guidance;
  - has the rights, will and preferences of the person central to the process; and
  - that where there are significant differences of opinion this is clearly documented and provided to decision-makers.
2. To ensure that where there is a significant level of dispute, impacting on a discharge from hospital, there are formal mechanisms to address issues and agree a way forward.
3. Where the relationship between assessors and the individual and their family has broken down, to consider measures such as reallocation where possible, or mediation.
4. To ensure that high level scrutiny mechanisms monitoring delayed discharge do not allow cases to be put on hold due to awaiting court processes and that activity to progress discharge continues, in line with the new Scottish Government guidance on Discharging Adults with Incapacity.

### **8.1.2 Recommendations for local authorities**

5. To ensure that they have clear procedures in place in relation to Mental Health Officers (MHOs) which ensure that:
  - There is a system for MHO referrals which effectively prioritises people experiencing delayed discharge.
  - MHOs' independent role is respected and supported.

- MHOs are always invited to Adults with Incapacity (AWI) case conferences and attend wherever possible.
  - Disagreement with a care plan is not an indicator of the unsuitability of an applicant for guardianship.
  - A negative MHO suitability report is always discussed with a manager.
6. To ensure proactive case management of private guardianship applications, and an escalation process where required, in line with the new Scottish Government guidance on Discharging Adults with Incapacity.

### **8.1.3 Local recommendations for the HSCP concerned**

7. To review the HSCP recording process to ensure that records are signed and dated so that they are auditable.
8. To arrange refresher training for social work staff on:
- coproduction with people using services and their families and with other professionals, in line with SSSC standards;
  - risk enablement in line with the principles of self-directed support, and referral of complex cases to the risk enablement panel;
  - recording in shared multi-disciplinary notes; and
  - ensuring meetings are clearly and timeously minuted, with dissenting opinions noted.

## Appendix 1 – Glossary

**Care Manager** – Employed by an HSCP to assess people’s care and support needs and work with them and their families to arrange how these needs are met.

**Discharge Coordinator** – Member of health staff responsible for coordinating the discharge of patients from hospital.

**Health and Social Care Partnerships (HSCP)** – organisation formed as part of the integration of health and social care services provided by NHS boards and local authorities; jointly run by the NHS and local authority.

**Independent Consultant** – The Independent Consultant in Ms ST’s case was self-employed and working as an associate with an independent not-for-profit organisation set up to work towards self-directed support in Scotland. The role involves working with individuals and their families to design support arrangements within the budget available to them.

**Mental Health Officer** – A specialist social worker with additional training, who has specific roles under mental health and adults with incapacity legislation.

**Practitioners** – Professionals such as social workers, nurses, occupational therapist, physiotherapists etc.

**Safeguarder** – A person appointed by the Sheriff to safeguard the interests of an adult with incapacity if the adult does not have the capacity to instruct a legal representative, and to advise the court of the adult’s views. Safeguarders are often lawyers or social workers, and are paid to carry out the role.

**Service Manager** – Senior member of HSCP staff who has responsibility for a particular part of HSCP service.

**Team Leader** – Member of HSCP staff; would usually report to Service Manager.





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