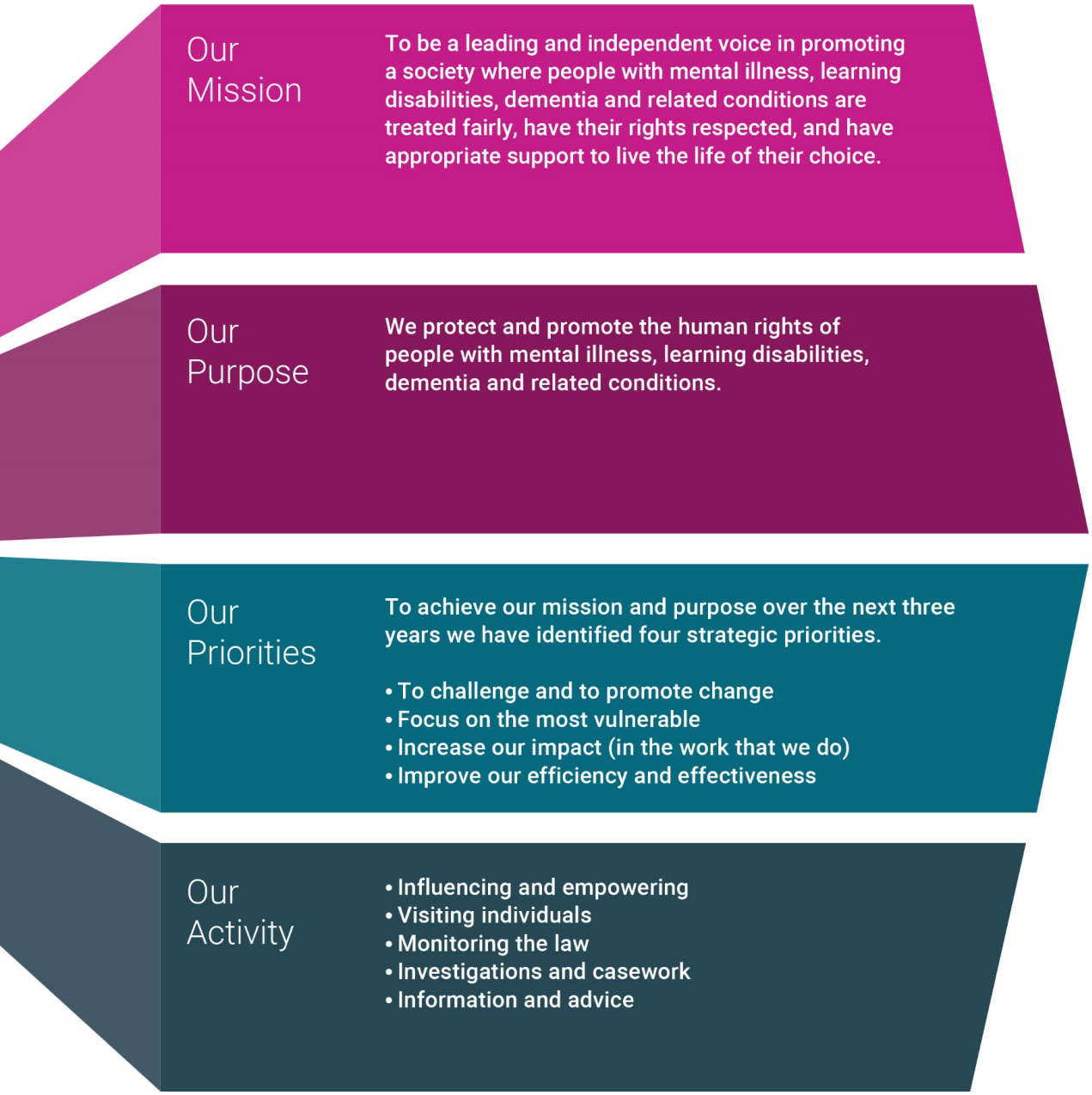
mental welfare commission for scotland

Closure report

Authority to discharge: report into decision making for people in hospital who lack capacity

May 2022

Our mission and purpose



Closure report:
Authority to discharge: report into decision making for people in hospital who lack capacity

Executive lead:
Julie Paterson, chief executive

Date of executive leadership team approval of project mandate:
Initial project mandate was further updated and agreed by the executive leadership team on 29 September 2020.

Date of commencement:
October 2020

Date of publication:
21 May 2021

Date of closure report:
12 May 2022

Purpose of a closure report
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.

The report must summarise the findings and recommendations made in the themed visit report and identify the organisations and individuals to whom the recommendations were made.

The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured.

The report should assess the theme in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

1. Summary of recommendations made in the report

The *Authority to discharge* project was undertaken in response to numerous concerns raised in relation to the rights of people who were not able to express their own views being moved from hospital to care homes during the pandemic period.

The purpose of the report was explained as follows: "People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society. The focus of this report was to examine the detail of a sample number of hospital to care home moves of people from across Scotland, to check that those moves were done in accordance with the law during the early stages of the pandemic."

We made 11 recommendations for improvement; eight for health and social care partnerships, two for the Care Inspectorate and one for Scottish Government. The recommendations were as follows:

Directed at health and social care partnerships (HSCPs) (with support from their respective local authorities and health boards)

Recommendation 1: HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in this report) to inform delivery of training programmes to ensure a confident, competent multidisciplinary workforce supporting safe and lawful hospital discharge planning.

Recommendation 2: HSCPs should establish a consistent system for recording when an assessment of incapacity has been conducted, by whom and in relation to which areas of decision making.

Recommendation 3: HSCPs should ensure that staff facilitating hospital discharges are clear about the status of registered care home placements, in terms of law (see Equality and Human Rights Commission vs Greater Glasgow and Clyde Health Board) and with regards the financial and welfare implications of different types of placements for the individual.

Recommendation 4: HSCPs should ensure that practitioners facilitating hospital discharges have copies of relevant documents on file detailing the powers as evidence for taking action on behalf of the individual who is assessed as lacking capacity.

Recommendation 5: HSCPs should ensure that assessments reflect the person as a unique individual with focus on outcomes important to that individual and not external drivers that have the potential to compromise human rights and/or legality of moves.

Recommendation 6: HSCPs should ensure that processes are in place to audit recording of decisions and the legality of hospital discharges for adults who lack capacity in line with existing guidance and the principles of incapacity legislation.

Recommendation 7: HSCPs audit processes should extend to ensure evidence of practice that is inclusive, maximising contribution by the individual and their relevant others, specifically carers as per Section 28 Carers (Scotland) Act 2016.

Recommendation 8: HSCPs should ensure strong leadership and expertise to support operational discharge teams.

Directed at the Care Inspectorate

Recommendation 9: The Care Inspectorate should take account of the findings of this report regarding the use of s.13ZA of the Social Work (Scotland) Act 1968 and consider the scrutiny, assurance or improvement activity to take in relation to this.

Recommendation 10: The Care Inspectorate should take account of the broader findings of this report beyond use of s.13ZA and consider how this might inform future scrutiny, assurance and improvement activity in services for adults.

Directed at Scottish Government

Recommendation 11: The Scottish Government should monitor the delivery of the above recommendations and work with health and social care partnerships and the Care Inspectorate to support consistency and address any barriers to delivery over the next two years.

2. Summary of responses

The Commission received responses from all 31 health and social care partnerships, the Care Inspectorate and the Scottish Government.

The quality of responses from health and social care partnerships varied significantly. Responses ranged from simple email correspondence confirming the report's recommendations would be taken into account to specific, measureable, achievable, realistic, time bound (SMART), robust action plans providing evidence of assurance.

All action plans were scrutinised by the Commission's project team using agreed standard criteria and where action plans were not SMART and did not give assurance, follow up contacts were made, including meetings with key people within health and social care partnerships as required.

Where follow up was required it was often evident that a number of post holders had moved on since the response was due in August 2021. There is clearly a significant challenge for health and social care partnerships given the apparent high turnover of senior managers and leaders.

The outcome is that all action plans now evidence clear objectives in relation to recommendations and timescale to delivery. Health and social care partnerships will be expected to monitor progress through their existing governance arrangements and updates will be requested by the Commission in advance of 'end of year meetings' which will resume in October 2022. The updates will include request for information regarding the governance arrangements in place supporting delivery of recommendations made by the Mental Welfare Commission where this was not originally confirmed.

The Commission has since introduced an action plan template to guide organisations in relation to the level of detail required in response to recommendations made. This template is not mandatory but intended to be helpful to ensure consistency of response and quality of response (see appendix A).

The Commission has been impressed by the commitment shown by health and social care partnerships across Scotland to ensure appropriate actions are in place to deliver on the eight recommendations.

There has also been excellent engagement with the Care Inspectorate in response to both recommendations made. Regular meetings are now held with the Care Inspectorate to share expertise and the Care Inspectorate has committed to additional resource to address the recommendations made with regards section 13 ZA of the Social Work Scotland Act.

Likewise the Scottish Government has, thus far, taken full interest in the contents of the *Authority to discharge* report supporting best practice nationally at meetings with health boards and through submission of a joint position statement with the Commission.

3. Summary of Commission follow up activity and actions

October 2020

Given the concerns highlighted at the outset of this piece of work, the Commission issued a position statement on Section 13ZA to provide clarity sought by practitioners in relation to easement or otherwise of legislation.

August 2021-December 2021

All responses from health and social care partnerships (supported by local authorities/health boards), the Care Inspectorate and the Scottish Government were scrutinised by the Commission's project team, consulted on as required and all are now of a high and informed standard, confirming timescales to completion of actions and ownership by key officers.

August 2021

The Commission led a webinar in respect of the Authority to Discharge report where 171 people attended. The webinar report was positively received with 98.5% attendees rating the webinar as good to excellent. Attendees were asked whether the report had had an impact on their practice, with 58 out of 61 respondents indicating that the report had some to an extensive impact on their practice.

As a result of the webinar and questions posed, it was evident that staff were keen for clarity in relation to section 47 of the Act. A position statement was therefore produced and published 1 October 2021 as noted below.

1 October 2021

Following the webinar of August 2021, a position statement was published titled: "The scope and limitations of the use of section 47 of the Adults with Incapacity Act".

13 October 2021

The Mental Welfare Commission and Scottish Government issued a joint statement on supporting discharges from hospital for adults with incapacity on 13 October 2021. The statement outlined actions that can be taken to support this vulnerable group on discharge from hospital, and highlighted key points of the law to ensure individuals' rights are respected. It was issued at a time of pressure on the hospital system and consequent focus on delayed discharge.

The hope was that health and social care services would find the statement useful and informative; joint follow up meetings then took place with health boards who requested to meet and discuss.

October 2021

In response to feedback from various health and social care partnerships seeking a national approach to AWI training, a business case, jointly developed by NHS Education Scotland and the Commission was put to the Scottish Government. Agreement to this proposal was given at the end of March 2022.

Throughout the past 12 months, the Authority to Discharge report has featured at a number of events including the Judicial Institute for Scotland Training event on AWI (29 October 2021), Scottish Association of Social Workers' National Mental Health Officer (MHO) Forum (23 February 2022), various (MHO) fora including Social Work Scotland's mental health subgroup and has influenced Health and Social Care Scotland's work on streamlining Adults with Incapacity (AWI) processes with the chief executive attending as a regular member of this group.

An oral presentation, based on this report, has been accepted at the 7th World Congress on Incapacity 7-9 June 2022. The Five Nations National Adult Support and Protection Convenors Group has also approached the Commission to present in Ireland in 2022.

4. Summary of the impact of the themed report and wider learning

Media

This report gained extensive media coverage which ran for three days and instigated a parliamentary question and discussion at Holyrood. There was more coverage on the *Authority to discharge* report than any other recent Commission report. On Thursday 20 May 2021 it was the top Scottish news story on the day in print and broadcast. In the seven days following publication, it received 342 engagements on Twitter (meaning it was liked, retweeted, clicked on, or otherwise interacted with). 87 users clicked on the link to the news story, 32 users liked the tweet, and 33 retweeted it to their own followers. In its first week, it was the third-most engaged tweet of the previous 12 months.

Organisations whose accounts directly retweeted the Commission included the Society of Solicitor Advocates, Advocacy Western Isles, and Scottish Independent Advocacy Alliance.

Actions

The actions detailed above and the quality of responses received from health and social care partnerships and the Care Inspectorate in particular evidence that the content of the *Authority to discharge* report is known and understood.

The Care Inspectorate has identified additional resource to progress improvement and the outcome of a joint Commission/NES business case proposal made to the Scottish Government aimed at a national consistent approach to AWI training will now proceed.

Progress reports on actions will be sought at the Commission's 'end of year' meetings with all health and social care partnerships in the second part of 2022.

The Commission's visit activity in 2022-23 will reflect learning from *Authority to discharge* with particular focus on developing a detailed understanding of AWI legislation knowledge and application in practice including what a section 47 certificate is and is not, the difference between a power of attorney and appointee. The Commission will also support the Care Inspectorate in their scrutiny work to support the delivery of both recommendations made to them.

5. Conclusion – was the themed visit worth doing?

As noted at the outset, the purpose of the *Authority to discharge* report was explained as follows: "People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society. The focus of this report was to examine the detail of a sample number of hospital to care home moves of people from across Scotland, to check that those moves were done in accordance with the law during the early stages of the pandemic."

The report's focus was on a 10% sample of people who lacked capacity and had been moved from hospital to a care home during the early stages of the pandemic. The project considered the moves of 457 people and found that 20 people had been moved unlawfully across 11 health and social care partnership areas. The sample size was such that the information was indicative, not definitive, that is, where moves were found to be unlawful in one health and social care partnership area, this did not mean all moves had been unlawful. Likewise, where no unlawful moves were found in an area, this did not mean there had been none. The recommendations therefore were clear in their intention to have health and social care partnerships audit their own practice and satisfy themselves that their practice was lawful.

A finding that had not been anticipated was the lack of knowledge and understanding of AWI legislation in practice. Those involved in discharge planning confirmed that their confidence and competence in AWI legislation was impacted, not by the pandemic, but by a lack of investment in training and support over a number of years. As a result, the *Authority to discharge* project found some concerning interpretations of law, for example, belief that a section 47 certificate was equivalent to a guardianship order.

There is no doubt that this themed piece of work was worth doing and has highlighted significant learning and improvement to ensure the rights of the most vulnerable adults are respected, promoted and upheld. This work was undertaken in response to concerns raised by stakeholders; the value in the Commission undertaking work in direct response to concerns raised by stakeholders cannot be underestimated.

6. Outstanding actions and recommendations, and any future activity or options to satisfy these

As noted above (section 4) the Commission's annual visiting programme will reflect learning from *Authority to discharge* with particular focus on developing a detailed understanding of AWI legislation knowledge and application in practice.

The Commission will support and advise the Care Inspectorate over the next 12 months to deliver on its recommendations and its commitment to additional resource.

The joint Commission/NES proposed national AWI training programme has very recently received approval by Scottish Government and will now progress.

Appendix A

Action plan response to recommendations: suggested template and example recommendation response (Mental Welfare Commission)

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
1.HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in this report) to inform delivery of training programmes to ensure a confident, competent multidisciplinary workforce supporting safe and lawful hospital discharge planning.	The HSCP ensures that we support safe and lawful hospital discharge planning and we have up to date guidance and protocols supporting this. Our staff report that they are well informed of the rights of individuals and are able to confidently advocate on their behalf.	To support our staff further we have organised a series of extraordinary team meetings, which are already underway, to ascertain levels of training needs. This will help inform the development of a full AWI training needs analysis.	Regular 1:1 supervision is in place for front line staff will include audit of case files and practice to ensure training provided has been incorporated and embedded in practice.	By 30 September 2021	Service managers – mental health and community care older adults. This incorporates hospital teams which are multi-disciplinary.

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	The skills, experience, and expertise within the Hospital Social Work Department and Locality and Specialist Services Teams ensures that:	Following publication of the full training needs analysis a programme of training will be developed and delivered. This will be supported by a combination of webinar and e-learning which will be available to staff, with different levels of training offered based on the needs analysis/roles and responsibilities.		By 31 March 2022	Above named officers and team managers across teams facilitating discharges. Service manager – improvement.
	• Staff are familiar with capacity assessment requirements			By 30 June 2021	
	• Staff are well informed and are able to provide advice to multidisciplinary staff in areas of capacity.			By 30 November 2021	
	• Staff are sensitive to restrictions of liberty.				
	• Staff are confident in communicating with individuals with cognitive decline				
	• Staff are skilled in working with families in crisis				
	We know this because of our ongoing engagement with this staff group and their feed-back.	An immediate training session will be undertaken with the hospital teams.		Ongoing	

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	We are aware and alert to time constraints/pressure that reducing delayed discharges could have on standards of assessment and practice. However, in this HSCP we work to maintain our high standards and are flexible retaining a focus on the person at the centre.	This will be followed up with a wider training session with our colleagues in NHS, hospital team discharge nurses and co-ordinators will also be invited to participate. Incorporate legislative, policy and practice issues into annual briefings to staff.	Annual audit processes are already in place and will be adapted to ensure capture of compliance with legislation and good practice and any gaps identified within these audits will be incorporated into established training programmes		
	Locality Team supports are available to the hospital team at times of increased pressure to manage and maintain standards and focus on the individual.				

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