NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
21 October 2021

Subject:	**Mental Welfare Commission Report - Authority to Discharge**
Purpose:	To provide an overview of the Mental Welfare Commission – Authority to Discharge Report on decision making for people in hospital who lack capacity and to seek approval on the attached response from North Ayrshire Health and Social Care Partnership.
Recommendation:	IJB members are asked to note the report and the NAHSCP response to the recommendations.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
MWC	Mental Welfare Commission

1.	**EXECUTIVE SUMMARY**
1.1	This report presents the MWC Authority to Discharge report which was issued on 20 May 2021 and the NAHSCP response to the document and associated action plan. The full report can be accessed here: AuthorityToDischarge-Report_May2021.pdf (mwcscot.org.uk)
2.	**BACKGROUND**
2.1	The Mental Welfare Commission (MWC) has specific legal duties in relation to safeguarding the rights of people who are subject to the welfare provisions of the Adults with Incapacity (Scotland) Act 2000 (AWI Act) and has a statutory safeguarding role in respect of adults whose capacity to made decisions or take actions to promote or safeguard their welfare is impaired due to a mental disorder. During the pandemic a number of stakeholders raised concerns with the Commission regarding whether the appropriate legal authority was used to safeguard people being discharged from hospital to care homes who did not have the capacity to make an informed decision to agree the move. The Commission therefore carried out a review of the practice with specific reference to moves from hospital to care homes from 1 March 2020 to 31 May 2020 supported by information from HSCPs across Scotland on the moves during that period. The Commission then made further inquiries as to the rights-based practice and legal authority supporting the moves. The focus of this work was to identify any learning and to ensure that this learning takes place, where required, to support and uphold the rights of individuals.

2.2	The Commission issued their final report on 20 May 2021 to Chief Officers and Health and Social Care Partnerships (HSCPs) with the request that the recommendations are considered through existing governance arrangements with a response to the relevant recommendations returned to the Mental Welfare Commission. An extension to the deadline for responses was granted due to extreme service pressures and allow for our response to be approved by the IJB.
3.	**MWC AUTHORITY TO DISCHARGE - REPORT**
3.1	The Mental Welfare Commission has a statutory safeguarding role in respect of adults whose capacity to make decisions or to take actions to promote or safeguard their welfare is impaired due to a mental disorder. During the Coronavirus pandemic, a number of stakeholders raised concerns with the Commission regarding whether the appropriate legal authority was used to safeguard people being discharged from hospital to care homes who did not have the capacity to make an informed decision to agree to the move.
3.2	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 the 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 undertaken in accordance with the law during the early stages of the pandemic. The Commission therefore undertook to make further inquiries and sought information from Health and Social Care Partnerships (HSCPs) across Scotland in relation to people who had moved from hospital to registered care home settings during the period 1 March 2020 – 31 May 2020 (sample period).
3.3	From those returns, from the information received about 731 people from across Scotland, 465 of whom were reported by HSCPs to have lacked capacity to agree to a move from hospital to a care home (8 of whom in turn did not fulfil the inclusion criteria for this inquiry). Whilst all individuals should receive full information as to their rights in relation to discharge from hospital and outcomes to be achieved to allow them to exercise those rights, work focussed on those (457) people reported as lacking capacity to do so (sample size corresponded to approximately 10% of all discharges from hospitals to care homes reported by Public Health Scotland). It was reported that people had been moved during the sample period without the protection of legal authority. These unlawful moves (involving 20 people) took place across 11 Health and Social Care Partnership areas.
3.4	The report notes for some of these moves, there had been specific pandemic related reasons for example, a misinterpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and was removed in September 2020. One HSCP introduced an alternative to applications for guardianship orders, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020. The Commission enquired whether legal advice had been sought in relation to both these practices; confirmation was given that legal advice had been sought and given.
3.5	The Commission's significant concern was that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of European Convention on Human Rights (ECHR). Section 13ZA of the Social Work (Scotland) Act 1968 was reportedly used to authorise moves in 23 Health and Social Care Partnerships and either Welfare Power of Attorney or

	guardianship orders were used to authorise moves across 30 of the 31 Health and Social Care Partnerships.
3.6	The Commission also found confusion in relation to the reported nature of the care home placement with potential impact on rights to protection of property where the person was admitted to a care home but remained liable for their property. This practice was not consistent either within some HSCPs or across HSCPs.
3.7	In summary, the report found that whilst the pandemic brought significant pressures, the identified areas for improvement arising from the examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. The findings indicate longer standing systemic issues within HSCPS which require urgent action to address in order to safeguard and uphold the rights of the most vulnerable adults in society. To this end, the Commission made 11 recommendations to be considered by all HSCPs and the Care Inspectorate, it is important that the recommendations are considered by all areas and not only those with specific identified unlawful moves.
4.	**NORTH AYRSHIRE POSITION**
4.1	North Ayrshire HSCP provided the Mental Welfare Commission with detail on 47 cases, 12 of which were for individuals without legal capacity, for the period 1 March to 31 May. Overall across Scotland there were 20 from 457 reviewed cases identified where no legal framework has been in place to facilitate the commissioning of a care home placement for the individual, these cases were identified in 11 HSCP areas.
4.2	The MWC did not routinely supply detail to HSCPs of the individual identified cases, as it was not deemed to be helpful for local scrutiny or for follow up on a small sample of isolated cases. The Mental Welfare Commission have noted that the report is to inform areas of improvement in practice and is indicative and not a definitive in terms of the number of instances where individuals were moved inappropriately, and that given the scope of the report the sample of cases was relatively small and the findings in the report suggest broader issues to be addressed by all HSCPs.
4.3	North Ayrshire HSCP are noted as one of the areas identified as moving individuals without the authority to do so, the North Ayrshire HSCP have not intentionally or knowingly discharged any patients inappropriately or without the legal authority to do so. On further investigation and with clarification from the MWC there was only one specific case which led to North Ayrshire HSCP being named on the report. The case was an unintentional move as the guardianship process was believed to have been completed and the order granted at Court, in relation to this specific case the order has now been granted.
4.4	The Commission issued a letter on 20 May 2021 to all HSCPs who were asked to review and respond to the recommendations contained within report. North Ayrshire's response is attached at Appendix 1.
4.5	In responding to the recommendations North Ayrshire HSCP have attached a RAG status to each of the 8 recommendations relevant to HSCPs, a further 3 recommendations are specifically for the Care Inspectorate. The position within North Ayrshire can be summarised below with full responses attached at Appendix 1:

	• There is a robust system of recording AWI where a formal decision in respect of an adult with incapacity is agreed. • The HSCP hospital based social work team have extensive experience of discharge and the legal requirements. • Practitioner guidance is consistent with the principles of the legislation but a need has been identified to update the Management Guidelines which were last reviewed in 2014, work is underway to ensure the guidelines are updated. • There is an established learning and development programme in relation to AWI, an area for improvement is the inclusion of a refresher training programme as part of this. • Robust processes and decision making is in place for all 13za discharges, which has been reinforced during the pandemic.
4.6	There is learning from the report which will inform the improvements to our local guidelines and processes. Work is underway with support from North Ayrshire Council Legal Services and team managers to ensure our local processes are robust and will ensure all moves are made with the legal authority in place. The updated guidance will be supported by the roll out of a programme of refresher training.
	Anticipated Outcomes
4.4	The work of the Mental Welfare Commission is to support and safeguard the rights of people who lack mental capacity, the report and associated recommendations should ensure the rights of those individuals are protected.
	Measuring Impact
4.5	The North Ayrshire HSCP response to the recommendations will be monitored through the HSCP Social Work Governance Board with oversight by the Chief Social Worker.
5.	**IMPLICATIONS**

Financial:	None
Human Resources:	None
Legal:	Required compliance with provisions in the Adults with Incapacity (Scotland) Act 2000 (AWI Act)
Equality:	Focus of the report is that people who lack mental capacity have their rights respected, have equality of access to representation and are safeguarded.
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	None
Risk Implications:	Taking forward actions in relation to the recommendations minimises the risk of moving individuals with no legal capacity to do so.
Community Benefits:	N/A

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

6.	**CONCLUSION**
6.1	IJB Members are asked to (i) IJB members are asked to note the report and the NAHSCP response to the recommendations.

For more information please contact [Caroline Cameron, Director] on [01294 317723] or [carolinecameron@north-ayrshire.gov.uk]

Appendix 1

NORTH AYRSHIRE HSCP – RESPONSE TO RECOMMENDATIONS

MENTAL WELFARE COMMISSION REPORT

AUTHORITY TO DISCHARGE: REPORT INTO DECISION MAKING FOR PEOPLE IN HOSPITAL WHO LACK CAPACITY

	Recommendation	RAG Status	Comments/Actions
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 the report) to inform delivery of training programmes to ensure a confident, competent multidisciplinary workforce supporting safe and lawful hospital discharge planning.	AMBER	A programme of learning and development in relation to Adults With Incapacity is in place within NAHSCP, with two full days of training as part of the programme. The Partnership has reviewed this position and has identified an area for improvement in the provision of refresher training to bring parity with CP and ASP arrangements. Consideration is being given to including this in training programme, for a ½ to 1 day refresher course, with plans to have this in place by March 2022. Team Managers from locality adult Social Work Services are being consulted as part of this exercise and agreement and priority will be agreed through Social Work Governance Board.
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.	GREEN	Our social work information system records requests for assessment of incapacity, decisions and who carries out that assessment. The assessment is very specific in terms of recording details in relation to what specifically a person has capacity to agree to and also the timeline of the capacity assessment and outcome. The system is accessible by all social work staff and there is standard protocol for recording which is consistently followed.
3	HSCPs should ensure that staff facilitating hospital discharges are clear about the status of registered care home placements, in terms of law (see EHRC vs GGC in the report) and with regards the financial and welfare implications of different types of placements for the individual.	GREEN	All NAHSCP teams across localities and including the hospital team have extensive experience of safely discharging to care homes in terms of the law. The Senior Manager responsible for these services held a session with team managers in July 2021 to reinforce responsibilities and ensure all had a comprehensive understanding of the guidance on discharge, with particular emphasis on 13za. Any 13za discharge cannot proceed by only a social worker and requires Team Manager approval with oversight from the Senior Manager.
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.	GREEN	As detailed in NAHSCP guidance practitioners require to ensure documentation is in place and on file in regard to any evidence on capacity of individuals. The Hospital Based Social Work Team have access to the social work information system and also patient medical notes which both include information pertaining to assessment of capacity. A Team Manger has been identified to lead self evaluation of processes including collating, reviewing and developing audit frameworks in regard to AWI. In terms of those discharging from hospital into care homes, these assessments require to be agreed by two Senior Managers which ensures consistency and quality of assessment. All assessments require to be explicit in regard to the legal basis for

			discharge. This requires to be in line with NAHSCP guidance and the Adults With Incapacity (Scotland) Act 2000.
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.	**GREEN**	It is embedded into practice from Social Workers, Social Work Assistants and Team Managers that assessments require to be outcome focused and have the person who owns that assessment and/or their representative at the heart of same. Assessments have to be authorised by Team Managers before being signed by service users or their representative.
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.	**AMBER**	It was previously identified that there is a need to update the Management Guidelines for the provision of discharging individuals who lack capacity. This document dates from 2014 and forms the basis of Team Manager and Social Worker practice in terms of ensuring the rights of individuals are upheld and that those discharged from hospital who lack capacity are discharged on a legal basis. A briefing note was produced by legal colleagues in March 2021 around the use of 13za in discharges, this was circulated to all team managers with consultation through locality social work meetings. Discussions have begun with the North Ayrshire Council legal team and suggestions have been made in updating the guidance, particularly in relation to deprivation of liberty. This work is ongoing. A Team Manger has been identified to lead self-evaluation of processes including collating, reviewing and developing audit frameworks in regard to AWI. This will be strengthened by proposals to provide refresher training. This improvement work will be overseen by the Social Governance Board. (Timescales for updated Management Guidelines – by June 2022)
7	HSCPs' audit processes should extend to ensuring 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.		Refer to requirements 5 and 6
8	HSCPs should ensure strong leadership and expertise to support operational discharge teams.	**GREEN**	Operational leadership at Team Manager and Senior Manager level and skilled, experienced staff are in place to continue to ensure appropriate legislative frameworks. Enhanced Social Work Hospital Team in summer 2021 with dedicated Team Manager overseeing assessments for complex care arrangements including consistent application of guidance and legislation.
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,		n/a – Care Inspectorate Recommendation

	assurance or improvement activity to take in relation to this.		
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.		n/a – Care Inspectorate Recommendation
11	The ScottishGovernment 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 of the next two years.		n/a – Care Inspectorate Recommendation