To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**18 June 2021**
Report by:	**Chief Officer**
Heading:	**Mental Welfare Commission: 'Authority to Discharge - Report into decision making for people in hospital who lack capacity'**

1. Summary

1.1. The Adults with Incapacity (Scotland) Act 2000 introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves. This legislation is underpinned by principles of benefit to the adult, taking account of the person's wishes and the views of relevant others. Any action must be the least restrictive option necessary to achieve the benefit and importantly to encourage the adult to exercise whatever skills he or she has in relation to their welfare, property or financial affairs and develop new skills where possible recognising issues of capacity are not 'all or nothing', they are decision specific.

1.2. 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.

1.3. On 20 May 2021, the Mental Welfare Commission for Scotland published their findings 'Authority to Discharge: Report into decision making for people in hospital who lack capacity'. The report highlights that 11 HSCPs moved individuals without legal authority, this was not the case in Renfrewshire as all moves were underpinned by the legal authority of a Welfare Guardianship Order or a Welfare Power of Attorney.

1.4. During the pandemic, a number of stakeholders raised concerns with the Mental Welfare 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.

1.5. The focus of their 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 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. Only Highland did not provide information within the timescale requested.

1.6. The Commission asked for information 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), therefore the Commission focused on those 457 people reported as lacking capacity to do so.

1.7. It was reported to the Commission that 20 people had been moved during the sample period without the protection of legal authority. These moves are deemed unlaw and took place across 11 Health and Social Care Partnership areas – this practice was not undertaken in Renfrewshire. Some of these moves, were specific attributed to the pandemic e.g. a misinterpretation that easement of Section13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020, this part of the legislation was removed from the legislation in September 2020. The provision of possible 'easement' to Section 13ZA was never invoked.

1.8. 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.

1.9. The Commission's significant concern is 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).

1.10. 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. The Commission analysed this information further to assure that legal rights were respected and found that those working in a hospital discharge setting were not always fully sighted on the powers held by attorneys or guardians (this was the case in 78 out of 267 cases of power of attorney related moves) or indeed whether the attorney's powers had been activated or guardianship orders granted. Whilst it is difficult to quantify the impact, this had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR. The Commission also found confusion in relation to the 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. The Commission found that practice was not consistent either within some HSCPs or across HSCPs despite a range of guidance, policy and local arrangements to support implementation being in place. In Renfrewshire we have a robust and well established process for using the provisions of Section 13ZA to facilitate discharges from hospitals and this area is not for us an area of concern.

1.11. It is important to note that the Commission also found evidence of good practice:

- Commitment to ensure that what mattered to the individual was central to outcomes and decisions made on their behalf.
- Commitment to ensure that all efforts were made to ensure that the individual was supported to inform decision making where possible, including advocacy support and multiple direct contacts with the individual.
- Respect for multidisciplinary roles and responsibilities ensuring that health and social care/social work retained focus on individuals and not other drivers such as beds and finance.
- Embedding the role of the Mental Health Officer in discharge planning processes as a key safeguard with expertise and focus on the rights of individuals.
- Clear understanding of the requirement to ensure that reported powers under the Adults with Incapacity Act/Power of Attorney are activated, evidenced and referred to in practice.
- Interim guardianship powers sought, where appropriate, to effect timely and lawful hospital discharge.
- Increasing promotion and take up of Power of Attorney roles and responsibilities.

1.12 In summary, the Commission found that whilst the pandemic brought significant pressures, the identified areas for improvement arising from our examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. The findings suggest that 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 our society.

1.13 Following publication of the report, the Minister for Mental Wellbeing and Social Care wrote to Chief Officers to express concern and request that confirmation that the necessary legal requirements and accountability measures are in place by the end of June 2021.

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2. Recommendation

It is recommended that the IJB:

- Note the content of the Mental Welfare Commission report
- Agree the next steps as detailed in Section 4

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3. Mental Welfare Commission Recommendations

3.1 As a result of the findings the Commission have made eleven recommendations, the first eight of which are directed at HSCPs:

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.
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.
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)1 and with regards the financial and welfare implications of different types of placements for the individual.
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.
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.
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.
7. HSCPs' audit processes should extend to ensuring evidence of practice that is inclusive, maximizing contribution by the individual and their relevant others, specifically carers as per section 28 Carers (Scotland) Act 2016.
8. HSCPs should ensure strong leadership and expertise to support operational discharge teams.
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.
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.

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.

4. Next Steps

4.1 By the end of June 2021, provide the Minister for Mental Wellbeing and Social Care with confirmation that the necessary legal requirements and accountability measures are in place in Renfrewshire.

4.2 The Commission will be contacting individual Health and Social Care Partnerships to highlight both good areas of practice and areas of practice which they deem to fall short. However, they have called on all Health and Social Care Partnerships to take urgent action now in relation to the recommendations made in this report to develop both a supported, competent, confident workforce and local auditable processes to ensure implementation of good practice.

4.3 In line with the request from the Mental Welfare Commission, the HSCP will report the recommendations through existing governance arrangements – IJB; Adult Protection Committee and Public Protection Chief Officers Group, with a response to the relevant recommendations by 30 June 2021**.**

4.4 Some of the actions arising from recommendations 1-8 will require action also by other agencies for whom the HSCP has no direct responsibility i.e. Greater Glasgow & Clyde Health Board for the operation of Acute Hospitals and the staff employed there. Staff within Acute Hospitals do not come under the direct control of the HSCP and actions to improve understanding of the issues raised in this report will require to be address by the relevant Health Board.

Implications of the Report

1. **Financial –** n/a
2. **HR & Organisational Development** – n/a
3. **Community Planning** – n/a
4. **Legal –** Renfrewshire HSCP will continue to work within the legal requirements of The Adults with Incapacity (Scotland) Act 2000 and Social Work (Scotland) Act 1968
5. **Property/Assets –** property remains in the ownership of the parent bodies.
6. **Information Technology –** n/a
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations

contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health & Safety –** n/a

9. **Procurement** – procurement activity will remain within the operational arrangements of the parent bodies.

10. **Risk –** None.

11. **Privacy Impact** – n/a.

List of Background Papers – n/a

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