

Midlothian Integration Joint Board



Thursday 17th June 2021, 2.00pm

The Mental Welfare Commission – Authority to Discharge: Report into decision making for people in hospital who lack capacity.

Item number: 5.10

Agenda number

Executive summary

This report is to ensure board members are aware of the most recent Mental Welfare Commission report - Authority to Discharge: Report into decision making for people in hospital who lack capacity and discuss the implications of the report for Midlothian.

Board members are asked to:

Note the content of the report

Accept a further report and action plan on how the Partnership will address the recommendations made within.

The Mental Welfare Commission – Authority to Discharge: Report into decision making for people in hospital who lack capacity

1 Purpose

- 1.1 This report is to ensure board members are aware of the most recent Mental Welfare Commission report - Authority to Discharge: Report into decision making for people in hospital who lack capacity and discuss the implications of the report for Midlothian.

2 Recommendations

- 2.1 As a result of this report what are Members being asked to:-

Note the content of the report

Accept a further report and action plan on how the Partnership will address the recommendations made within.

3 Background and main report

- 3.1 The Mental Welfare Commission 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).

As part of these duties the Commission carried out a review of the practice with specific reference to moves from hospital to care homes during March 2020-May 2020 and 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.

Midlothian fully participated within this process, providing full data of all moves that took place within this time frame and engaged in more detailed work with the commission about specific moves.

As a result of the MWC review a number of recommendations were made for Health and Social Care Partnerships. The responses to this will need to be made in partnership with Council and NHS.

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 *EHRC vs GGC*)^[1] 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 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.

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

There were also 3 recommendations for the Care Inspectorate which will also have an impact on the Partnership.

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.

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.

4 Policy Implications

- 4.1 It is critical that when supporting people to move between settings that we hold their human rights at the centre. It is essential when planning our services and the ongoing focus on delayed discharges and reducing occupied bed days that we do this within the Adults with Incapacity legislation framework. This report is a timely reminder of this and allows the opportunity to strengthen the already positive work within Midlothian and our focus on rights based work.

5 Directions

- 5.1 There is no requirement for new directions as a result of this report

6 Equalities Implications

- 6.1 The MWC have considered the equalities implications of this report, any changes that are required locally will be considered in line with the equalities agenda.

7 Resource Implications

- 7.1 There are no direct financial implications as a result of this report, further information would be provided in the follow report if there were impacts as a result of our response to this report.

8 Risk

- 8.1 There is a significant reputational risk if Midlothian were found to be not fully complying with the law when moving individuals. This was not found to be an issue within this report but there is an opportunity for us to strengthen our good practice in this area.

9 Involving people

- 9.1 Fundamental to the Adults with Incapacity legislation is how we involve people and their families in decisions about their future and wellbeing. Any response to this report will fully engage with all appropriate individuals.

10 Background Papers

10.1

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Appendices: The Mental Welfare Commission – Authority to Discharge: Report into decision making for people in hospital who lack capacity.