CC44. Mental Welfare Commission Scotland Investigation

The committee considered a report by the Head of Integration which provided information on the Mental Welfare Commission for Scotland (MWCS) Investigation report. MWCS published their findings in relation to an investigation into the care and treatment of a woman with learning disability, whose discharge from an acute orthopaedic ward was delayed by 18 months.

A report was submitted to the Partnership Leadership Group's meeting of 3 October 2019. At that time the group recommended the establishment of a Task and Finish Group to consider the recommendations and assure around the Adults with Incapacity (AWI) processes.

The investigation considered several areas including:-

- communication between professionals and the service user and her family;
- risk assessment, risk management and care and support planning,
- legal aspects;
- implementation of self-directed support and the related policy framework, and
- decision making.

MWCS found failings in all the above areas. The report cited systemic issues with Social Work capacity in relation to delay in appointing a care manager and a lengthy delay in allocating a Mental Health Officer (MHO); delays in the guardianship process and the position taken by the HSPC in relation to the suitability of a family member for some of the powers sought.

MWCS concluded that "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". It was their view "that discharge could have been achieved within a few weeks, rather than the almost 18 months of delay she and her family experienced".

Four key recommendations for Health and Social Care Partnerships were identified:-

(1) 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 were significant difference of opinion this is clearly documented and provided to decision makers.

(2) 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) Ensure that high level scrutiny mechanisms monitoring delayed discharge do not allow cases to be put on hold due to awaiting court processes and activity to progress discharge continues, in line with the new Scottish Government guidance on discharging Adults with Incapacity.

There were a number of recommendations in respect of Local Authorities relating to MHO practice to ensure there are clear procedures in place which ensure:-

- There is a system for referral that prioritises people delayed in hospital
- The MHO independent role is respected and supported
- MHOs are always invited to AWI Case Conferences
- Disagreement with a Care Plan is not an indicator of unsuitability of an applicant for guardianship.

Decision

The committee noted the:-

(1) contents of the investigation report;

(2) progress of the Delayed Transfers of Care for AWI cases, Task and Finish Group, and

(3) outcome of the case reviews for those in a hospital setting within an AWI process.