City of Edinburgh Council

10.00am, Thursday 24 November 2022

Monitoring Officer Report – Adults with Incapacity

Executive/routine
Wards
Council Commitments

1. Recommendations

1.1 To note that a Quality Assurance report which was commissioned on behalf of the Policy and Sustainability Committee has highlighted unlawful practice in the discharge of some patients affected by incapacity from hospitals to care homes during the Covid-19 pandemic.

1.2 To note that the Council's Monitoring Officer reported this matter to Council on the B agenda in October 2022 as some of those affected by the subject matter of the report had not yet been contacted.

1.3 To note that the Council's Monitoring Officer considered that there is sufficient evidence of unlawful practice to require him to report this matter to Council.

1.4 To note that a further investigation is being instructed by the Chief Executive to establish all relevant facts and understand and inform next steps in relation to the issues identified. This is in addition to a review which is currently being undertaken by the Care Inspectorate.

1.5 The Council has also engaged with the Mental Welfare Commission in relation to this matter.

1.6 To note that a further detailed report will be submitted by the Chief Executive to Policy and Sustainability Committee on completion of the fact-finding investigation.

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Report

2. Executive Summary

2.1 A Quality Assurance review has highlighted that during the period 1 March 2020 – 4 August 2021 approximately 83 out of 268 instances of discharge of a person who lacked capacity from a hospital to a care home was carried out unlawfully. This review had been undertaken in response to a national report on Authority to Discharge undertaken by the Mental Welfare Commission which found instances of unlawful practices in several areas of Scotland, including Edinburgh.

2.2 In a wider context, the unlawfulness arose primarily as a consequence of the intense pressure on staff and resources brought about by the Covid-19 pandemic. The service has confirmed that the unlawful practice is not ongoing and service improvements are being implemented to mitigate any future risk of repetition and embed lessons learned.

2.3 The legal and practical implications of this are yet to be fully understood. A further investigation is being instructed by the Chief Executive to establish all relevant facts and understand and inform next steps in relation to the issues identified.

2.4 The Care Inspectorate are currently undertaking an inspection into social work and social care practice and this is expected to report in March 2023.

3. Background

3.1 Following consideration by Policy and Sustainability Committee in June, August and October 2021, a Quality Assurance report was commissioned by the Chief Officer of the Health and Social Care Partnership and Chief Social Work Officer for the City of Edinburgh Council in relation to the findings published by the Mental Welfare Commission for Scotland (the “MWC”). The findings related to unlawful practices by health and local authority staff discharging patients affected by incapacity from hospital to care homes during the Covid-19 pandemic. These discharges were found to have been implemented without appropriate application of the Adults with Incapacity (Scotland) Act 2000 (the “AWI Act”) and/or consideration of the European Convention on Human Rights (the “ECHR”) and the United Nations Convention of the Rights of Persons with Disabilities (the “UNCRPD”).

3.2 The AWI Act safeguards the welfare of adults who lack capacity to act or make decisions for themselves because of a mental disorder or inability to communicate. It allows other people to make decisions on their behalf, subject to certain safeguards.

3.3 The process of discharging patients who lack capacity can be complicated and lengthy, often leading to delays and excessive time spent in hospital. However,

appropriate legal frameworks must be considered to ensure lawful authority for action and respect for the person's rights.

3.4 The Quality Assurance report highlighted findings from a compliance audit. A compliance audit seeks to answer one or more specific questions relating to a standard in practice or requirements of legislation. This audit sought to establish whether hospital discharges to care homes for adults with incapacity were carried out with legal authority to do so, during the initial and subsequent waves of the Covid-19 pandemic and various lockdowns.

4. Main report

4.1 The compliance audit considered discharges from hospitals to care homes of adults with incapacity between 1 March 2020 and 4 August 2021 within Edinburgh.

4.2 Of the 268 instances examined, 83 (31%) were found to be unlawful (i.e. where practice could, on the face of it, be considered to fall outwith the principles of the AWI Act, or other legislation and/or is against the ECHR and/or UNCRPD).

4.3 It is recognised that the Covid-19 pandemic placed social work and other staff under tremendous individual pressure. There was also substantial risk to those awaiting discharge from hospital as well pressure on the acute sector hospitals too. The staff involved are acutely aware of the need to protect the rights of those who cannot protect themselves. The audit noted that it was strongly evident that officers were doing their utmost to support hospital patients, families and carers whilst working and living with a pandemic.

4.4 Whilst there is no question that staff were trying to do their best in unprecedented and very pressurised circumstances, the fact remains that the Council has in some instances acted unlawfully.

4.5 All families who have been affected by this matter have already been contacted and arrangements are being made to discuss the matter in person as appropriate and as desired by those affected. This is a complex matter given the number of people and relatives involved and affected.

4.6 The transfer of residents to or from care homes during this period is one of the activities within the remit of the Scottish COVID 19 inquiry. The Inquiry will consider the impact of strategic elements of handling of the pandemic on the exercise of Convention rights (as defined by section 1 of the Human Rights Act 1988). It therefore seems likely that the matter highlighted by our own review will be put into a more national context by the findings of the COVID 19 Inquiry in due course.

Further actions

4.7 The Quality Assurance report has identified some serious concerns about how the Council has acted, albeit in these exceptional circumstances.

4.8 A further investigation is required to establish all the facts and understand what the consequences of this are.

4.9 It is acknowledged that Council officers are acutely aware of the need to engage with affected families as considered necessary and appropriate and a focus of the f

act-finding investigation is to ascertain relevant information to enable and inform that process.

5. Next Steps

5.1 The Chief Executive will provide a follow-up report to Policy and Sustainability Committee with further detail following conclusion of the fact-finding investigation. At this stage it is not possible to advise precisely how long this will take to report, but a report will be provided on progress by March 2023.

5.2 The Council has engaged with the MWC to advise them we have identified the issue is wider spread in Edinburgh than originally understood.

6. Financial impact

6.1 There may be a resultant financial impact if legal liabilities are identified in relation to this matter.

7. Stakeholder/Community Impact

7.1 Engagement with affected families has already begun.

8. Background reading/external references

8.1 https://democracy.edinburgh.gov.uk/documents/g5600/Public reports pack 24th-Jun-2021 10.00 City of Edinburgh Council.pdf?T=10

8.2 https://democracy.edinburgh.gov.uk/documents/s35633/Item 7.8 - Edinburgh Response to the Mental Welfare Commissions Report - Authority to Discharge.pdf

8.3 Item 7.16 - Mental Welfare Commission Authority to Discharge Report - Edinburgh Improvement Plan.pdf

9. Appendices

9.1 None