



DELAYED DISCHARGE AND THE IMPACT
OF THE ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000



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Executive Summary

The term delayed discharge is used in situations where a patient in hospital has been assessed as being clinically ready for discharge but continues to occupy a hospital bed beyond the ready for medical discharge date. This report focusses on hospital discharges delayed due to the adult lacking the capacity to make informed decisions regarding their future care and where a need has been identified for a proxy decision maker to be formally appointed under the Adults with Incapacity (Scotland) Act 2000 (hereafter AWI Act)

An action plan around delays in hospital associated with the AWI Act was developed between Health and Social Care Scotland, the Mental Welfare Commission (MWC), Office of the Public Guardian (OPG) and the Scottish Government and discussed with the previous Cabinet Secretary for Health and Sport and COSLA.

As part of the action plan, I was commissioned to undertake an initial scoping exercise to identify the barriers being experienced in the operation of local authority processes for AWI work, and where these occurred.

All 31 Health and Social Care Partnerships (HSCPs) contributed to the gathering of information on their guidance, procedures, and reporting structures currently in place to support the identification, management, and monitoring of those adults whose discharge planning from hospital is delayed. The scoping exercise also included the examination of national data, completion of a questionnaire (See Annex A) personal interviews and the use of case studies and examples of good practice. My findings have been compiled into this report with recommendations for further action and where this could improve process flow and operational activity.

Background

Public Health Scotland reported at the June 2021 census point, there were 1,276 people delayed in hospital. The number of delays relating to complex needs which includes delays relating to AWI was 360 (36%). With the continued impact of the pandemic and future winter planning demands on services will only increase.

Any delay in a person's discharge can have a detrimental effect on their health and wellbeing. Evidence shows that the longer a person remains in hospital they are at risk of mobility loss, infection, poor mental health, and social isolation. For older adults they are also more likely to be admitted to long term care rather than returning home to their community with support.

To identify and manage delays in hospital discharge planning, there needs to be clear and effective pathways in place to coherently support these processes and to provide clarity and guidance to all staff involved with respect to expectations, roles and responsibilities. All 31 HSCPs advised that they had Standard Operating Processes in place, however, they can vary between local guidance to robust joint pathways agreed and implemented by health and social work staff.

National guidance and the AWI pilot undertaken by Edinburgh HSCP have influenced local processes with several HSCPs reporting that they had adopted some areas of practice fully or with amendments that meet the needs of their area. Some HSCPs are currently planning to review their processes.

Subsequently several HSCPs have introduced dedicated Mental Health Officer (MHO) teams or identified dedicated MHO links to be part of hospital discharge teams. Where this process has been adopted HSCPs have reported that it has improved communication, working relationships and reduced the number or length of stay in hospital for adults who lack capacity and require an intervention under the AWI Act. Several HSCP also reported that their MHOs remain actively involved in helping families navigate through the AWI process, support solicitors, and closely monitor timescales. This active involvement prevents timescales from drifting, allowing action to be taken quickly by the council if required and minimises delays in hospital discharge planning.

Some HSCPs report that they rarely have a delay in their hospital discharge planning and attribute this to:

- early identification of when an adult will require an AWI intervention,
- sufficient number of MHOs to progress applications,
- dedicated MHO linked to hospital discharge teams, therefore promoting good multi-agency communication, robust support systems for families and closely monitored timescales. A model that Perth & Kinross who rarely report delays have in place.

When an adult lacks the capacity to make decision or specific choices, either through a diagnosis of dementia or cognitive impairment, they require the additional safeguards the AWI Act provides. This legislation allows a proxy (nominated person) to make some or all decisions on the adult's behalf and ensure that their best interests, views and the least restrictive options are considered. The adult may have already nominated a Power of Attorney (PoA) to act on their behalf, however for many adult's early intervention has not been considered and they now require a Guardianship Order to safeguard their welfare and manage their financial or property affairs.

Applying for a guardianship order under the AWI Act requires the involvement of several agencies ranging from health and social work staff, MHOs, Independent Advocacy workers, Local Authority and private Solicitors, Scottish Legal Aid Board, Scottish Courts and the Office of the Public Guardian. Therefore, a delay in progressing a guardianship order can take place in any of these stages.

Issues and Barriers

The returns received from HSCPs highlight some of the following themes where difficulties and delays can arise across the AWI process:

- **The Pandemic** has played a significant part in how HSCPs have delivered services over the last year. With staff shielding or illness additional pressure was placed on an already stretched workforce. Home working and limited peer support or a familiar workplace to attend was challenging for some staff and particularly difficult for newly recruited staff.
- **Leadership** in the initial stages of the pandemic required quick decision making and a significant change in practice. There were reports that senior managers priority focussed on freeing up beds for the impact of Covid-19 and that this led to unilateral decisions where individuals were discharged home without consultation with social work staff and in some cases MHOs felt under pressure to consider

the use of s13ZA of the Social Work (Scotland) Act 1968 when they were uncomfortable with this decision.

- **MHO Services** are over stretched and HSCPs have developed different models to meet their needs. Recruitment and retention of MHOs is a long-standing issue and while most councils have workforce plans in place the ability to recruit MHOs remains difficult.

In a report published in September 2021 “Mental Health Monitoring Report” the MWC highlighted that a total of 6,699 detention episodes began in 2020/21, which was 10.5% more than in 2019/20, and higher than the average year-on-year increase in the previous years of 4.5%. With demanding timescales, this placed added pressure on MHO services.

Dedicated MHOs to support hospital discharge planning were reported as a benefit to progressing an adults discharge, however some areas do not promote this model and felt it would reduce resources in other areas of mental health (Adult Support & Protection, Mental Health (Care & Treatment) (Scotland) Act, Forensic work, Learning Disability Services) and possibly deskill MHOs from other areas of MHO work.

- **Renewal of Guardianship Orders and Section 47 Certificates** was one of the emergency measures relating to the Adults with Incapacity (Scotland) Act 2000 where the “clock was stopped” due to the impact of the pandemic. The new expiry dates were calculated by adding 176 days to the original date of expiry. While this was reassuring for families it has placed an additional burden on services to not only meet the demands of current renewal applications but the number of backdated orders. Some HSCP reported that to manage the additional workload they offered staff additional working hours or recruited temporary staff.
- **NHS System** has been under a great deal of pressure both with managing the impact of the pandemic and the increased number of adults remaining in hospital past their discharge date due to the need for an AWI intervention. While this is often out with their control some practices were identified as contributing to the delay and would benefit from further review.

The lack of an early notification from health staff that an adult required an intervention under AWI was often reported as delaying the allocation of an MHO and progressing future applications. Accessing capacity assessments to accompany guardianship applications was also very difficult due to the lack of commitment from GPs or if the adult was not known to mental health services clinicians struggled to work out with their own demanding workload. Easier access to medical reports through a more streamlined referral process is required and would help to minimise any delays and share clinical workload demands.

- **Private Guardianship Applications** is an area that nearly all councils feel is out with their control even when they have systems in place to monitor timescales and support private applicants. The AWI process is complicated, and families can struggle to navigate through this. Establishing relationships with families when they are already struggling with the loss of a loved one through dementia or other cognitive impairment takes time. Their willingness to seek legal advice in required

timescales, attend case conferences or fail to agree who is the most appropriate guardian to manage welfare, finances or property can also cause delays.

Having a linear system in place for identifying an MHO quickly, organising case conferences and supporting families, solicitor and courts through the process minimises delay and allows the council to quickly intervene as appropriate.

- **Legal systems** are difficult to navigate for families and professionals. HSCP returns highlighted legal aid applications were slow to progress. Solicitors lack of familiarity on progressing AWI applications and few requests for interim powers contributed to delays Some HSCPs reported they also do not routinely or ever request interim powers as it is not an area of practice that they or their legal services promote. Some are of the view that as the court rules state papers have to be served to relevant people and they have 21 days to respond this process should be followed.

Courts were reported as not always prioritising AWI work or that they lacked familiarity with the process. While some areas have dedicated AWI courts, they are also struggling with the backlog of applications and are not always consistent in their approach. Further reflection on the areas that work well would help to inform future practice.

- **Training** is a high priority as there is clearly a lack of understanding of each agency's role and responsibilities and their impact on the AWI process. This was a key outcome of the "Authority to Discharge" report and key recommendations that HSCP are reflecting on currently. A fully funded independent training programme that was mandatory for all agencies would help to address inconsistencies in practice and encourage organisational investment. The MWC are currently involved in discussions with NHS Education for Scotland (NES).

In summary, the number of adults whose discharge is delayed due to the need for an AWI intervention is increasing. Guardianship applications are a complex and bureaucratic process and very dependent on the cooperation of several other agencies. The AWI Act is currently under review, however it will be some time before any change in the process is made. All HSCPs showed commitment to continuous professional development and have invested their learning into improving services under very difficult circumstances.

What works

- Involvement of senior managers in daily / regular monitoring of delays provides multi-agency commitment and quick decision making. This has been highlighted by some areas as reducing bed days as they are able to intervene early, assess need and commit to service delivery promptly.(Read more on [page 20](#))
- Both "Home First" or the "Discharge to Assess" approach supports adults to return home with a committed multi-agency package of care and for assessments to be completed in a familiar environment. This approach reduces the adults time spend in hospital and on occasions the need for an AWI intervention. (Read more on [page 20](#) and [page 23](#))

- Dedicated MHO time committed to hospital discharge teams. Improves communication, staff relationships and early intervention for assessment and AWI if required.
- Sessional (retired) MHOs are employed across three HSCPs and are often used to reduce delays in hospital discharges. Their hours and role can be tailored to the needs of the service and practitioner.
- Linear systems where management overview, allocation of MHO and tracking systems reduce drift from family or services.
- Central Hubs to manage requests for medical reports, track timescales and prevent delays have been established in some areas, as well as close links / training with local solicitors.
- 13ZA is effectively used in some areas as they have robust guidance and monitoring processes in place. Close links with family, strong assessments and clear defensible decision making helps to ensure the adults rights are upheld and placements are in the best interest of the adult.

Recommendations

There are seven recommendations within this report that will hopefully help to influence how we can make the journey for adults, their families and carers and professionals less complicated. Agencies may also wish to consider the additional four areas within the report to help improve the management of adults whose discharge planning is delayed.

Based on the information provided by HSCP the following areas of improvement are recommended:

- 1. Training:** the MWC “Authority to Discharge” report recommended HSCP complete a training needs analysis and training delivery plan. It is also imperative that a national multi-agency training programme with involvement of HSCPs, MHO Services, GPs other relevant public bodies, and Third Sector providers is developed to meet the training needs of all agencies involved in promoting early intervention and delivering the AWI process. The training programme should be delivered independent of HSCPs to ensure a consistent message on the interpretation of the legislation, national policy and procedures supporting AWI and the roles and responsibilities of agencies. This training programme must be mandatory to ensure agencies invest staff time in the programme, however financial investment will be required to assist them to free up staff and continue to meet the needs of their service.
- 2. MHO Capacity:** Retention and recruitment of MHOs is an ongoing issue and a contributing factor to waiting lists and delays. Investment in training MHOs is vital to meet the demand of the service, and needs to be more attractive for staff than it is currently. To assist with recruitment there needs to be additional resources available to support staff to complete the course without the fear it will be an “add on” to their existing workload. Universities should also consider how they can increase their courses from one to two intakes per annum. To assist with retention, consideration should be given to a standardised approach to appropriate remuneration for this additional specialist role. This would reduce both “churn” as staff move from one location to another, with the resultant impact this has on service efficiency, and the loss of MHOs from the operational workforce as they move into management positions for salary reasons.
- 3. Dedicated MHOs:** HSCPs who have dedicated MHOs or MHOs with heavily weighted caseloads to support AWI intervention for adults whose discharge is delayed should be considered by HSCPs who do not have this system in place. HSCPs who have invested in this model report improvement in communication, additional support for families / carers and are confident this has assisted in the progression of guardianship applications and reduced the time someone can spend in hospital.

4. **Duty Medical Staff:** A dedicated duty system within each HSCP for medical staff to complete assessments of capacity would reduce the time MHOs and solicitors spend trying to identify and negotiate medical reports. A review of GP contracts to promote their participation in completing capacity assessments would share the burden across health partners.
5. **Legal Aid:** A review of the legal aid process should be undertaken and where there is an application for a guardianship order consideration given to it being granted immediately or no cost required. If no funding is agreed there will have to be a review on how solicitors are recompensed for their work.
6. **Sherriff Courts:** The court process should consider how it can effectively progress AWI hearings quickly. This may be through dedicated courts, with knowledgeable sheriffs and systems in place to cover absences for all AWI hearings. This would allow hearings to be held more frequently rather than set court days some time apart or when prioritised by the court system. Where HSCPs already have dedicated AWI courts a review on how effective they are should take place, particularly in light of the HSCPs who continue to experience delays.
7. **Power of Attorney Promotion:** Continued support for the promotion of early intervention campaigns (e.g. the HSCPs PoA campaign¹ is crucial as it will help to reduce the need for a lengthier guardianship processes and promote the adults choice of proxy and powers required.
8. **Review of Legislation:** Consideration should be given to different, more streamlined, approaches to providing an appropriate legal underpinning to enabling families to manage self-directed support for a person in need of care.

Further considerations

1. **Interim orders** should be considered based on the individual needs of all adults whose discharge from hospital is delayed. This would meet the adults needs and outcomes as well as offer consistency and reduce the adults time in hospital
2. **A national register of solicitors** who can be recommended to competently complete AWI applications should be available to the public. This register should be accessible through legal forums or part of local campaigns and not dependent on each HSCP willingness to provide recommendations.
3. **Delayed Discharge reporting codes** for AWIs have been increased and agreed by Public Health Scotland. They are currently being piloted by Glasgow City Council and hopefully shared across all HSCP.

¹ <https://mypowerofattorney.org.uk/>

4. **Robust Quality Assurance Systems** should be in place to track and monitor the use of s13ZA, monitoring of Deprivation of Liberty issues and quality of decision making. All HSCP advised they have systems in place to consider when s13ZA is appropriate to move an adult from hospital to an alternative care setting. However, there were gaps in some HSCPs Quality Assurance Systems when tracking activity. Where Quality Assurance systems were in place they were often audited internally. HSCP may wish to consider occasionally introducing an external auditor to complement their current systems.

Introduction

The term delayed discharge is used in situations where a patient in hospital, has been assessed as being clinically ready for discharge but continues to occupy a hospital bed beyond the ready for medical discharge date. This report focusses on hospital discharges delayed due to the adult lacking the capacity to make informed decisions regarding their future care and where a need has been identified for a proxy decision maker to be formally appointed under the Adults with Incapacity (Scotland) Act 2000. (thereafter AWI Act).

Methodology

The purpose of the scoping exercise was to:

- Gather information on the guidance, procedures and reporting structures that are currently in place within each of the 31 HSCPs to support the identification, management and monitoring of patients delayed due to procedures under the Adults with Incapacity Act.
- Examine data from national sources and local partnerships to evidence the reason for delays and help identify gaps or obstacles in service delivery.
- Following on from the scoping exercise, carry out semi structure interviews with the aim of seeking confirmation and clarifying information gathered previously through survey, local guidance, and personal experiences. Also explore the ethical issues arising for staff from the use of AWI legislation or s13ZA of the 1968 Act.
- Use case studies to assist with contextualisation of systems and processes utilised by individual local authorities; the challenges experienced by staff and partnerships and to makes sense of the identified examples of good practice.

Following information noted within the Scottish Governments action plan a questionnaire (Appendix 1) was developed and circulated to each of the partnerships to gather their views. The questionnaire was targeted at

- those who manage Mental Health Officer (MHO) Services as they play a key role in assessing, co-ordinating and implementing AWI legislation once the need has been identified and granted by the courts and
- Hospital Discharge Managers, or their equivalent as they also play a key role in early identification of adults who lack capacity and who need additional support from services to meet their future care needs.

Each partnership was given a choice either

- complete the questionnaire jointly and accept a follow up Teams meeting for further clarification on any outstanding issues or
- carry out a Teams meeting and have their views minuted.

Eleven partnerships chose to be interviewed through a Teams meeting with the remaining twenty submitting their questionnaire without further telephone follow up.

I am delighted to say that all 31 HSCPs jointly responded to the questionnaire which has helped to give a balanced account of how HSCPs manage the discharge of adults who lack capacity, and require a Guardian.

Several themes were identified from both the interviews and returned questionnaires. As might be expected, some of the challenges experienced by HSCPs have been highlighted in past surveys and research around service delivery and resources and have been long standing. This does not mean they have been ignored in the past but moreover several factors continue to contribute to the difficulties faced rather than there being an easy or ultimate solution, such as: staff recruitment and retention, increased demand on services, funding restrictions and the impact of Covid-19.

The report goes on to highlight several themes, the issues arising and how HSCP have managed them or plan to develop services in the future.

The Adults with Incapacity (Scotland) Act 2000

The AWI Act is the legal framework for safeguarding the welfare and managing the finances and property of adults (age 16 and over) who lack capacity to act or make some or all decisions for themselves because of mental disorder or inability to communicate due to a physical condition. It allows family, carers or people identified by the adult to make decisions on their behalf, subject to safeguards. The main groups to benefit from this include people with dementia, people with a learning disability, people with an acquired brain injury or severe and chronic mental illness, and people with a severe sensory impairment.

One of the ways an adult can act on behalf of someone who lacks capacity is where the adult grants Power of Attorney (PoA). This is a means by which the individual, whilst he or she still has capacity, can appoint someone they trust to act in their place to make decisions about welfare and/or their property and financial concerns. PoA can be for continuing (financial) and/or welfare decisions and would be put in place to be used in the event an adult loses capacity at some time in the future

If an incapable adult has no attorney with suitable welfare powers, it may be necessary for someone to apply to the court for a guardianship order on the adult's behalf. A guardianship order provides legal authority for someone to make decisions in respect of the adult's welfare and/or their property and finances, in order to safeguard and promote their interest over a period of time.

The Act sets out the following principles which must be followed when considering an intervention.

- **Benefit** - any action or decision taken must benefit the adult and only be taken when that benefit cannot reasonably be achieved without it.
- **Minimum intervention** - any action taken should be the minimum necessary to achieve the purpose and should be the option that restricts the adult's freedom as little as possible
- **Take account of the wishes of the adult** - past and present wishes and feelings of the adult should be taken into account as far as they can be ascertained.

- **Consultation with relevant others** – where practicable the views of the adult, nearest relative, primary carer, guardian, attorney or any other person deemed to have interest should be taken into account.
- **Encourage the adult to exercise whatever skills he or she has** - the adult should be encouraged, where possible, to exercise their skills in as far as they are capable concerning their financial affairs, property and personal welfare.

Impact of a Delayed Discharges

Any delay in a person's discharge planning from hospital can have a detrimental effect on their health and wellbeing. Evidence shows that the longer a person remains in hospital they are at risk of mobility loss, infection, poor mental health, and social isolation. For older adults they are also more likely to be admitted to long term care rather than a return home to their community with support.

Delayed Discharge Census

Public Health Scotland reported in July 2021 that there was an average of 1,461 beds occupied by adults who were fit to be discharged home or to alternative care settings. 31% of those delays related to adults with complex care needs including individuals who lacked the capacity to make informed decisions about their future health and care needs and required the safeguards provided by the AWI Act.

When an adult is identified as having passed their planned date for discharge HSCP will record this daily and forward monthly statistical report to Public Health Scotland for collating. Across all HSCP areas a coding system is in place which identifies the reason(s) that the adult's discharge has been delayed. *Code 9* includes a person who lacks capacity and an intervention under the Act is required or in progress. Partnerships highlighted that the use of just one code can be misleading and does not truly reflect the different stages or complexity of the AWI process or that the reason for a delay does not always sit with the partnership, but in other areas.

They also highlighted that often they are receiving a SMART form referral for social work involvement on the actual day the person is recorded as delayed when prior notice may have prevented or reduced delay. It takes time to build a relationship with an adult and their family in order for professional social work assessments and MHO statutory reports to be completed. There is a necessity to complete this work accurately and appropriately to meet the needs of both the person and their family, as well as service led requirements and outcomes. The time allowed for this work to be completed is a necessary part of the discharge planning process but invariably will add time to the adult's hospital experience.

The Scottish Government acknowledge that a delay can happen anywhere along the patient's journey and asked Public Health Scotland to review current practices via its National Advisory Group on Delayed Discharge Information. The group agreed that sub codes for AWI should be introduced and that recommendation was included in a subsequent consultation on wider data changes.

Actions to Address

Early intervention

Promoting as early as possible the advantage of planning for the future and while a person is still able to make informed decisions will reduce the distress family or carers may experience when they are in crisis or their relative is in hospital.

There is no reason to wait until capacity is an emerging issue to embark on Power of Attorney (PoA) and the level of support from a solicitor required to appoint a PoA is significantly lower than required for Guardianship. Since 2019 a national PoA awareness campaign has been in place to help encourage early conversations with families, service users and patients around future planning.

The campaign aims to ensure front line staff have the knowledge, information and confidence to facilitate these early conversations with service users, families and carers about future planning, capacity, legal options, PoA and Guardianship.

Twenty nine of the thirty-one HSCPs have signed up to the campaign and are actively involved in promoting early intervention through staff training and public awareness events at local hospitals and public venues. This has included developing information leaflets and the use of social media to help the public understand the importance of preparing for the future and identifying someone to act on their behalf now in case they should lose capacity in the future.

The uptake of the campaign has been variable with more affluent areas willing to progress PoA applications more often than socially deprived areas. Having a disposable income to pursue PoA and an understanding of the benefits of having a proxy in place to manage their financial and property at a later stage in life is influential in the uptake.

Some of the barriers for less affluent areas not pursuing PoA are:

- Cost remained a significant issue for many people. The cost of a progressing a PoA can range from £200 to £500 in some cases.
- A lack of active family or friends (or ones willing to assume role) and using a solicitor could be unpopular.
- There were still strong perceptions (reinforced by data on actual uptake) that PoA was only relevant to much older people.
- Some people wrongly perceived that through other mechanisms such as wills or state benefit appointee they already had sufficient safeguards in place.

The campaign has been extended to February 2023 and a report will be submitted to the Scottish Government on the work undertaken and with several recommendations. One of the recommendations will be that continued funding is committed to progress the work further.

In 2018 (before the campaign) there were 57,761 PoAs registered compared to 69,217 in 2019, the first year of the campaign. This is an increase of 15.75%

Covid-19 has limited the work carried out by the campaign, however they are beginning to see a rise again in most areas. A further area of the workplan will be to improve the uptake from the more deprived areas in Scotland, particularly as a large proportion of delays in hospital discharge come from the most deprived areas.

AWI Planning

Attempts to reduce the length of stay in hospital for someone who lacks capacity has remained a key priority for the Scottish Government and Integration Joint Boards for some time. Each year Public Health Scotland data continues to highlight an increase in the numbers of people who remain in hospital past their date of discharge while waiting for an AWI intervention.

The Coronavirus pandemic also placed further challenges on Health and Social Care Partnerships as they struggled to deliver services. The legal processes under the AWI Act that were in place prior to the pandemic became significantly reduced as the courts in some areas only prioritised urgent AWI applications. This resulted in further delays for individuals waiting to be transferred from hospital to alternative care settings when a guardianship order was required.

Additional demands continue to be experienced by staff in Health and Social Work Services as a direct result of the backlog of AWI work, now that restrictions are reduced and new requests for AWI reports are being received

To help address some of the issues raised above an AWI working group was established by the Scottish Government which included representation from the Chief Officers, Law Society of Scotland, Mental Welfare Commission, Office of the Public Guardian, Royal Colleges (Psychiatrists and General Practitioners), Scottish Courts and Tribunals Service and Social Work Scotland. Discussion of AWI systems and processes was also included in the Delayed Discharge Expert Support Group.

Following the recommendations from these groups, the previous Cabinet Secretary for Health and Sport, and COSLA Health Spokesperson endorsed and supported the progression of a short-term piece of work to look at potential options to reduce the number and length of AWI delays. The group taking forward this work included Chief Officers, Mental Welfare Commission for Scotland, Scottish Government, and the Office of Public Guardian. This group continues to maintain oversight of the proposed actions and report findings, outcomes and further recommendations identified in this report.

Applying for a guardianship order under the Act requires the involvement of several agencies ranging from health and social work staff, Mental Health Officers (MHOs), Independent Advocacy workers, Local Authority and private Solicitors, Scottish Legal Aid Board, Scottish Courts and the Office of the Public Guardian. An action plan was developed which took into consideration the whole process of guardianship applications and several workstreams were commissioned to take this work forward

As part of the action plan, I was commissioned to undertake an initial scoping exercise to identify the barriers being experienced in the operation of local authority processes for AWI work, and where these occur. My findings have been compiled

into this report with recommendations for further action and where this could improve process flow and operational activity.

Ultimately, however the intention is to use the findings from this exercise as a learning process with the aim of sharing across HSCPs areas of good practice and an opportunity to improve and streamline local processes. While we have this opportunity to share good practice we must also take into consideration that the current legislative framework is likely to be with us for the next 5 years or so, pending the Scott review, so it is very important that we do the best we can within it.

Challenges

Covid-19 pandemic has had a significant impact across the country, and it would be unreasonable not to mention the impact it has had on HSCPs. Covid-19 has played a significant part in how HSCPs have been forced to review how they deliver services and manage staff safety while continuing to work effectively.

HSCP managers have had to look at how they can free up hospital beds to meet the demand of new patients diagnosed with Covid-19 as well as continuing to care for individuals who need Health and Social Care Services for other reasons. Social Work Services have also had to review how they can safely deliver services in the community once someone has been discharged or to prevent admission to hospital.

During the pandemic the impact of having reduced access to care homes, had an impact on hospital discharges, particularly for those individuals who were waiting for assessment or going through the process of AWI.

The redeployment of staff from the community to ward settings or staff moving from their community base and working from home was a significant shift in practice and relied very much on the practitioner having to adapt to their new role.

For staff working in the community a big part of their role is meeting individuals face to face to complete comprehensive assessments. This offers an opportunity to not only view how the person presents physically and mentally but also a view of how they are coping in their living environment and their family relationships. In the early stages of the public health crisis and because of national and local pandemic restrictions, virtual meetings and telephone contact were the only safe options available for staff and service users/relatives to meet and communicate. While the benefit of having access to virtual platforms allowed for the continuation of assessment processes, practitioners expressed concern that they were often dependent on information provided by family or other agencies. The use of technology often resulted in difficulties in gathering the adult's views, particularly if they were confused and unable to participate in the interview. For MHOs completing AWI reports or applications this was particularly difficult when seeking to ensure the guiding principles of the AWI Act were met.

Trying to balance home and work commitments and struggle with limited peer support or a familiar workplace to attend has, for many staff, been especially difficult and even more so for new members of staff, who no longer had access to the easy

contact with colleagues that comes from being in the same office, to assist with learning about and modelling future practice.

Many staff were forced to shield at home or have been on sick leave. This depletion of staff teams placed additional demands on an already stretched workforce. While we cannot just attribute these challenges to staff in HSCPs, as the same restrictions were also relevant to other agencies and third sector services providing community support, these changes to familiar working environments and patterns have both raised some concerns for staff interviewed and have increased feelings of uncertainty about how and what the future delivery of services will look like.

Leadership

Strong leadership is essential to set the culture and attitude of the service. It is also important to take a collaborative approach to let staff feel safe, ask questions and challenge systems confidently without feeling judged, intimidated, or undervalued, particularly in a time of uncertainty.

Both health and social work services are very large organisations and will acknowledge that they can have different priorities when it comes to adults being discharged from hospital. Health has a responsibility to ensure the adult is well and can return home as soon as possible in order to meet the needs of the next patient who needs their services. Social work has the responsibility of ensuring the person returning home can do so safely and in situations where the adult requires further intervention under the AWI Act, that this is taken forward legally.

In the initial stages of the pandemic there are reports that senior managers priority focussed on how to free up beds for the impact of Covid-19 and that this led to unilateral decisions where individuals were discharged home without consultation with social work staff. One MHO stated they had highlighted the need for an AWI intervention as the adult lacked capacity, however they felt under pressure to consider the use of s13ZA of the Social Work (Scotland) Act 1968 when they were uncomfortable with this decision.

“Joint working with health staff is strained at times due to lack of understanding of both nursing staff and medical practitioners about human rights and the need to consider capacity as an intrinsic part of planning for discharge.”
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Using Section 13ZA

Section 13ZA of the Social Work (Scotland) Act 1968 took effect in March 2007. It provides a legal framework which allows a local authority to make significant care arrangements, under the powers of the Social Work (Scotland) Act 1968, where the person is not capable of making decisions about receipt of a service. The conditions state that there must be no existing proxy decision maker with relevant authority and there is no application for an order under the AWI Act with relevant powers in the process of being determined.

Intervention under s.13ZA may be appropriate where an adult does not indicate disagreement with the proposed action, either verbally or through their behaviour/actions, and it appears that they are likely to accept the care

arrangements. All interested parties, including professionals and the person's family/carer must agree with the intervention proposed.

The Coronavirus (Scotland) Act received Royal Assent on 6 April 2020 and an easement of s13ZA legislation was suggested. This would have allowed HSCP to move someone into a care setting with reduced safeguards than were in the original Act.

The Scottish Government agreed that the Mental Welfare Commission for Scotland would play a key role in ensuring a transparent scrutiny process if these emergency powers (also known as the easements to s.13ZA) were introduced, to prevent any abuse of these emergency powers. The Scottish Government subsequently confirmed that even at the height of the pandemic "the fine balance between the right to life and the right to be consulted was not such that the provisions should be brought into force". The Easement of s.13ZA was therefore never introduced and on 29 September 2020 the provisions expired through The Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020.

"The process of using 13ZA involves speaking to the adult and their family / carers, and involving advocacy. This close involvement helps everyone to fully participate in the process.

If it seems 13ZA is suitable then the social worker will make a referral to advocacy to ensure the adult's views are sought as much as possible. If at any point it seems that the adult is not agreeable to the care arrangements being proposed, then the process stops and guardianship is explored. Otherwise the social worker and health colleagues record on their database system that 13ZA is being used. A letter is sent out to the family / carer stating that 13ZA is being used to put the arrangements in place. Once the adult has been discharged, the social worker follows up with a review to ensure the adult is not expressing a disagreement with the arrangement. If this were the case then a guardianship process may be started."

The Mental Welfare Commission for Scotland (MWC) subsequently decided after long standing concerns about moves from hospitals to care homes and with a recent judicial review case they were involved in to find out more about the legality of hospital to care home moves. A report "Authority to Discharge" was made public outlining the findings of their review².

HSCPs are aware that they have a duty to consider the human rights of an individual in their care and particularly in situations where decisions may impact upon a person's liberty. There appeared to be a view in some HSCP areas that to meet the demands of the pandemic individuals who could be discharged, should be. This was not seen as a deliberate disregard of the law but was described on more than one occasion as "a life saving measure" particularly for older adults who were more susceptible to catching Covid-19 if they remained in hospital and their life could have been at greater risk. There was also the mistaken view from some staff that

² <https://mentalwelfarecommission.cmail20.com/t/r-l-tlitutud-ulurfthih-r/>

emergency legislation had been enacted and decisions taken to move an adult out with hospital into an alternative care setting was legal.

Some HSCP advised their systems for 13ZA could have been more robust particularly around how decisions were taken, recording, and reviewing processes, however they plan to review their processes to identify where areas of practice could be improved. The majority of HSCP feel they have clear guidance in place around when it is appropriate to use 13ZA instead of progressing to a guardianship order and they are confident that staff follow this guidance, however the implementation of external Quality Assurance systems around the above processes is very variable. Some HSCP will rely on their MDT/ Case Conference system to ensure the process is followed and the adult's rights upheld, some will use their annual internal review processes. One council sends all their 13ZA referrals to their Chief Social Work Officer and legal services for scrutiny.

Following the recent report published by the MWC, recommendations have been made to HSCP to review their quality assurance systems around the use of s13ZA and AWI legislation to be confident they meet the needs of the adult and decisions taken are defensible.

MHO Services

Local authorities have a duty under the Mental Health (Care & Treatment) Scotland) Act 2003 to provide a sufficient number of Mental Health Officers (MHO) to carry out functions identified within the Act

Mental Health Officers (MHOs) are social workers with a minimum of two years post qualifying experience who have gained the Mental Health Officer Award (MHOA), which trains experienced social workers to undertake the statutory role. MHOs have a unique role in supporting and protecting people who are vulnerable because of a mental disorder. Their duties include:

- protecting health, safety, welfare, finances and property
- safeguarding of rights and freedom
- duties to the court
- public protection in relation to mentally ill offenders.

MHOs are involved in the assessment of individuals experiencing mental disorder who may need compulsory measures of care, treatment and in some cases, detention. The role carries considerable autonomy and responsibility and involves working alongside medical and legal professionals³.

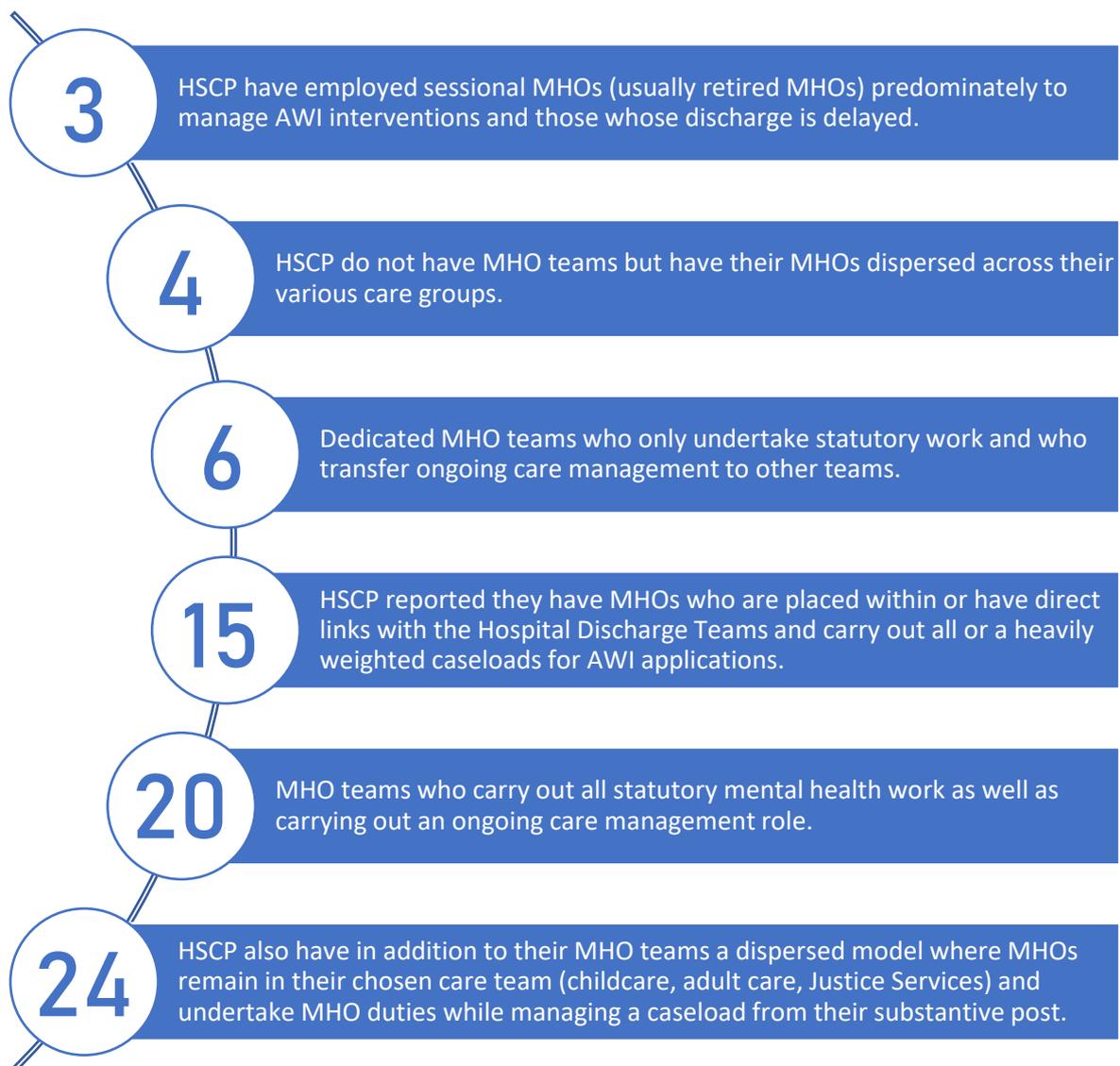
The delivery of MHO Services across Scotland is variable and is often influenced not only by geographical issues but the ability to deliver services with a limited workforce. The recruitment and retention of MHOs has been a long-standing issue and while most councils have workforce plans in place the ability to recruit MHOs remains difficult. Each HSCP reported that they recruit from within their existing service and annually place eligible candidates on the national MHO courses. Unfortunately, this has an impact on other areas of the service as staff move into

³ <https://www.sssc.uk.com/supporting-the-workforce/mental-health-officers/>

mental health posts. This system is also dependent on staff willing to undertake a complex MHO course while continuing to work in their substantive post and carry a caseload. Recruitment externally is also difficult and one HSCP gain has an impact on another HSCP.

In North Lanarkshire Council an MHO Traineeship Scheme is in operation, in which candidates joining the course are transferred from their substantive post to a Community Mental Health Team (CMHT) for the duration of training. This enables them to work alongside experienced MHO's, improve shadowing experience and focus on not only the statutory work but the assessment and care management areas of mental health social work. While this is good for the candidate it does impact on the service they leave, although backfill is provided. Once qualified the new MHO will return to their substantive post unless a vacancy is available in the MHO Service

Across the 31 HSCP there are:



While the demand for AWI work has increased significantly it is not the only work undertaken by MHOs. HSCPs have reported an increase in their statutory mental health work over the past year, including statutory roles and responsibilities within the Mental Health (Care & Treatment) (Scotland) Act 2003. This statutory work can often have more demanding timescales to meet and prioritising AWI work can be a challenge. In a report published in September 2021 "[Mental Health Monitoring Report](#)" the MWC highlighted that:

- There were 10.5% more detentions in 2020-21 compared to 2019-20, with 6,699 detentions in this year and higher than the average year on year increase in the previous years of 4.5%

The lack of an MHO presence during an assessment for detention prevents the adult from having an independent opinion on whether the grounds of the Act are met and there are no alternative options other than to detain the adult in hospital to receive appropriate care and treatment. The lack of MHO consent to a detention in many cases can be due to autonomous decision making by some medical practitioners, however there will also be occasions where the demands on an already stretched MHO service will be a contributing factor.

The Adult (Support & Protection) (Scotland) Act 2007 also has demanding timescales, and many MHO services are managing this work alongside their other statutory and non-statutory mental health responsibilities.

A recent report, published by the Scottish Social Services Council (SSSC) "2020 Mental Health Officers"⁴ shows although the number of local authorities saying they had a shortfall that had fallen to 23, they estimated an extra 1,911 hours a week for MHO work was needed – equivalent to 53 full time MHO posts (an increase of four since 2019) This reinforces that the volume of work being asked of MHOs is increasing and unfortunately while we have seen an increase in MHO hours it is still unable to meet the demands.

All HSCPS reported they have a Priority Framework in place, and they will prioritise social work involvement to adults who are experiencing unacceptably high risk in the community or when an adult in hospital has passed their date of discharge. As services begin to recover, HSCP are noting a rise in requests for private AWI reports and some councils are now being forced to operate waiting lists.

[Renewal of Guardianship Orders and Section 47 Certificates](#)

The Coronavirus (Scotland) Act was passed by the Scottish Parliament on 1 April 2020 and most of its measures came into force on 7 April. One of the emergency measures relating to the Adults with Incapacity (Scotland) Act 2000 was to 'stop the clock' on the renewal of guardianship orders and section 47 certificates, because of

⁴ <https://data.sssc.uk.com/data-publications/23-mental-health-officers-reports/260-mental-health-officers-scotland-report-2020>

concerns around the capacity of the Office of the Public Guardian and the courts, and the availability of doctors, mental health officers and solicitors.

“Guardianship renewals are becoming an increasing consumer of MHO capacity. Consequence is that waiting list for ‘routine’ guardianships including the application of guardianship orders for adults who have moved to other care settings on s13ZA is increasing and becoming untenable.”

The clock was stopped from the point when the Act came into force on 7 April until 29 September inclusive, which is 176 days. This means that new expiry dates for guardianship order and for s47 certificates should be calculated by adding 176 days to the original date of expiry. While this was reassuring for families concerned that guardianship renewal dates would not be missed and prevented additional demands on services by the pandemic it has placed an additional burden on MHO Services to not only meet the demands of current renewal orders but those additional renewals orders due now the 176 days are ending. This will also have an impact on health staff who will be required to review s47 certificates.

Lessons learned

Discharge Pathways

To identify and manage delays in hospital discharge planning, there needs to be clear and effective pathways in place to coherently support these processes and to provide clarity and guidance to all staff involved with respect to expectations, roles and responsibilities. All 31 HSCPs advised that they had Standard Operating Processes in place. However, it became clear that these can vary between, for example, local social work guidance to robust joint pathways agreed and implemented by health and social work staff. Those HSCPs which had developed jointly agreed pathways reported that their procedures provided clarity and consistency for staff, minimised disagreement when identifying, coding, and reviewing hospital discharges and provided a smoother overall process, which staff agreed was helpful.

Three HSCPs advised that while they had Standard Operating Procedures in place to manage their hospital discharges, they were not as up to date as they should be. They acknowledged this as an important area for assuring the quality of their work and supporting staff to provide a consistent approach to hospital discharge planning. They are all currently in the process of reviewing them. One HSCP has already completed their review and have introduced a centralised system which has improved communication and co-ordination of MHO services.

“I am currently updating the AWI procedures and guidance, and this will now include specific pathways for this. There will also be specific referral forms for the hospital to use when referring to the MHO team as currently this is done somewhat informally.”

“Since recent appointment to our post of Operations Manager for Mental Health Social Work and MHO Service we have improved the centralisation of AWI reports and this role has full management/overview of the MHO team.”

Multi-Disciplinary Team (MDT) meetings were held and regular updates on adults who lacked capacity and require an intervention under the Act was a consistent feature in each area. Eighteen areas held weekly meetings, six areas held daily meetings and the remaining seven areas had systems in place which enabled health staff to refer immediately to mental health services if there was a need for urgency or the adults date of discharge had passed.

The joint systems in place appear to have improved communication, however there were reports that some of the reasons for continued delays were:

- Some NHS staffs poor understanding of capacity issues (referring to s47 certificates as AWI certificates) and the lack of referral for assessment early in the patient’s journey,
- The length of time AWI applications took to complete,
- Trying to engage with family members as early as possible in the adult’s admission and supporting them to participate in discussions regarding the hospital discharge process.

In cases, where senior managers chaired meetings or took an active oversight of the local hospital discharge processes, this resulted in prompt decision making and joint agreements where a discharge was delayed, or for early intervention because the person was identified as “not yet medically fit for discharge” and would require an AWI intervention to progress matters.

“Hospital Managers and Service Managers – along with both Heads of Health & Community Care meet weekly to discuss current delays/seek solutions for delays. Proactive section in the meeting is to discuss patients not yet medically fit, but likely to be within the next week and AWI issues.”

“Predicted Date of Discharge meetings, which includes MHO, Homecare, rehab and other key staff is held daily and chaired by Head of Service/NHS Manager. This meeting involves adults where a potential date for discharge is identified. There is a tracking spreadsheet in place which is updated daily to prevent loss of the person. This system provides early alert to Social Work and some time before adult considered as a delayed discharge (DD). This system has almost halved our DD, allows good communication between services and meetings, and has commitment from all involved.”

Since this level of leadership had been introduced it was highlighted that it has enhanced communication and engagement in the process.

All 31 HSCPs reported that their current referral processes prioritised adults whose discharge was delayed. They explained this information was passed through to their dedicated MHO who was part of the Hospital Discharge Team or their Community Mental Health Team Manager who had a liaison role to the hospital or their regular multi- disciplinary meetings where social work had an active role.

A number of HSCPs have developed services and systems to support the strategies they have in place for example:

Home First a programme designed to help people to return home from hospital as quickly as possible. It is also used to prevent an admission by introducing additional multi-agency support at a time when a person’s care needs increase. This can provide critical time and the right environment to recover confidence and independence and avoid making premature life changing decisions about future long-term care. Some HSCP have adopted a discharge to assess model which introduces a multi-agency wraparound service to manage the adult’s health and social care needs while the social work assessment was being completed. This reablement approach can reduce further stress to the adult and prevent a delay in their discharge.

“Our strategic approach is to always discharge home to complete assessment wherever possible. This reduces the number of people who become delayed in hospital awaiting guardianship. To support this, we have commissioned a social care service which provides round the clock care at home for a short assessment period to ascertain the accurate long-term need. We have good evidence that many people are much more independent once they return home than was assumed in a hospital setting. Therefore, less requirement for AWI processes.”

National Guidance

National Guidance was regularly referred to as a tool used to support local pathways or inform their development. This included *Discharging Adults with Incapacity a practical guide for health and social care practitioners involved in discharge planning from hospital* (Scottish Government, March 2019)⁵ and the Scottish Governments co-produced “Key Actions on Managing the End-to-End discharge process of adults who lack capacity including legal measures” 2020⁶.

“Discharging Adults with Incapacity, Health and Social Care Scotland, 2019 outlines the strategic approach Aberdeen City has taken.”

Information sharing processes remain variable and were in some areas dependent on good working relationships. The use of tracking systems was the main source of monitoring and sharing information and some examples were TRAK care or Electronic Delayed Discharge Systems. These systems were regularly updated and could be viewed by both health and social work staff, thus allowing each agency to pick up any issues quickly or monitor progress of AWI applications.

Continuous improvement in the development of joint information systems is crucial to enable partnerships to share information and improve communication. This is an area that will require ongoing investment.

Service Improvement

While national guidance has influenced local pathways pilot work was also undertaken by Edinburgh HSCP in 2016.

The Adults with Incapacity Pilot undertaken by Edinburgh HSCP was asked to address specific areas in the process as identified in delaying hospital discharge planning. The pilot ran for 6 months from 3rd October 2016.

The objectives of the pilot were:

- Early identification/ support for patients who may lack capacity and their main carer(s)
- Trial ways of more supportive decision making, which may reduce the need for a guardianship order
- Provide appropriate and timely information to patients/family/carers
- Provide support to the family/ carers going through the guardianship process
- Access alternative arrangements for Guardianship applications if timescales are not being met
- Work with the courts and Office of the Public Guardians Office to improve court processes.

During the pilot a number of measures were introduced including dedicated MHOs to support hospital discharges and early MHO intervention to guide family and

⁵ <https://hscotland.scot/couch/uploads/file/planning-discharge-from-hospital-adults-with-incapacity-march-2019.pdf>

⁶ <https://www.gov.scot/publications/key-actions-managing-end-end-discharge-process-adults-lack-capacity-including-legal-measures/>

solicitors. Systems were developed and shared with partner agencies to identify, implement, and track a guardianship application. Guidance was also provided to support families navigate through the AWI process and where there were delays in timescales to manage those delays and support the adults while in hospital.

A few HSCPs reported that some of the systems within the pilot were already regular practice in their area, for example dedicated MHO's, efficient tracking systems and good links with families, however many of them advised they have learned from the pilot and developed similar systems in their area. This was noted as having a positive effect on their discharge pathways.

Mental Health Service Structures

We know that all HSCP are committed to reducing the length of time an adult spends in hospital, however some areas are able to report no delays in their discharge planning or can reduce the length of time the adult remains in hospital. The aim of this report is to learn from areas who have systems in place that work for them and share this practice. While it may not work for every area, like the Edinburgh pilot there will be systems that can be replicated or adapted to meet local need. Perth & Kinross regularly report no AWI delays to Public Health Scotland. Falkirk will report they have AWI delays, however the number of days an adult remains in hospital is low.

"P&K HSCP has committed to the provision of a full-time MHO to work alongside our multi-agency partners that make up the Hospital Discharge Team so that any issues relating to capacity can be identified at an early stage so that planning and any subsequent need for legal authority is in place by the time the person is in a position to be discharged. Where a person is assessed as lacking capacity to make informed decisions regarding his or her welfare the MHO will work to ensure any legal powers necessary for discharge are put in place as quickly as possible. This includes supporting family or friends obtaining private guardianships.

P&K has set timelines which are monitored. If there are delays, appropriate action is taken as required whenever possible.

P&K is also committed to the provision of sufficient MHOs, so guardianship applications are processed timeously. Delayed discharged and the relation this has with MHO provision is reported quarterly to the senior HSCP governance group to ensure there is robust scrutiny. This ensures any issues can be identified early and appropriate action taken. It also enables any trends to be monitored which are used to influence strategic decisions. This helps ensure there is sufficient MHO capacity in the short, medium, and long term."

"Falkirk MHO Service has 5 dedicated MHO posts focussing on statutory duties only. We work very closely with the hospital team in terms of prioritising AWI referrals and hospital discharges and provide MHO attendance at each AWI case conference. There is a weekly scrutiny meeting to highlight delayed discharges with AWI interventions and what part of the process they are in. Local process are in place to progress the process if there are delays i.e. family engagement, solicitor engagement, second medical report. We have created a central hub to manage requests for Medical Reports, and ensured Solicitors are aware of fast track process for Legal Aid applications and applications for Interim Orders

are considered in each case. This process helps to minimise the number of adult whose discharge may be delayed due to AWI.”

Inverclyde are an HSCP who also report low or no delays and attribute this to their Home First approach. They also identified 6 key aspects of their discharge planning processes:

-  Early referral – point of admission
-  Rapid assessment process – assessment starts from admission and progressed as the adults health and care needs change. This included input from adult, family and medical staff.
-  Regular discharge planning meetings held to keep all staff fully up to date including community-based staff.
-  Care home identified early if required and constant contact with NHS staff on when adult fit for discharge.
-  Social work lead on the assessment / discharge process which is a shift in culture.
-  Hospital do not record a delay in discharge planning as they are fully informed of the assessment / discharge planning progress.

While it could be argued that the above processes are more manageable in smaller HSCPs there was a view that investing time to change one ward at a time is progress.

Several HSCP have introduced very linear systems, and this has also shown to improve the patient/ family’s journey, reduce the time an adult remains in hospital, improve joint working relationships and support staff.

“East Dunbartonshire has a Service Manager who manages all the mental health teams across the council both in hospital and community. This prevents disputes around allocation or passing work across teams. He can prioritise work as he has a full overview of the AWI / MHO work in the area. He chairs AWI/Case Conferences (CC) and used to have them weekly but due to increase in work they are held any day required. Staff have access to his diary so know when he is available.

Tracker systems are in place that log date of S 47 in place, Case Conference dates, 4 weeks for family to progress independent applications before discussion of whether local authority best placed to apply. Dedicated worker in place therefore is easy to track and follow up with families / legal etc.

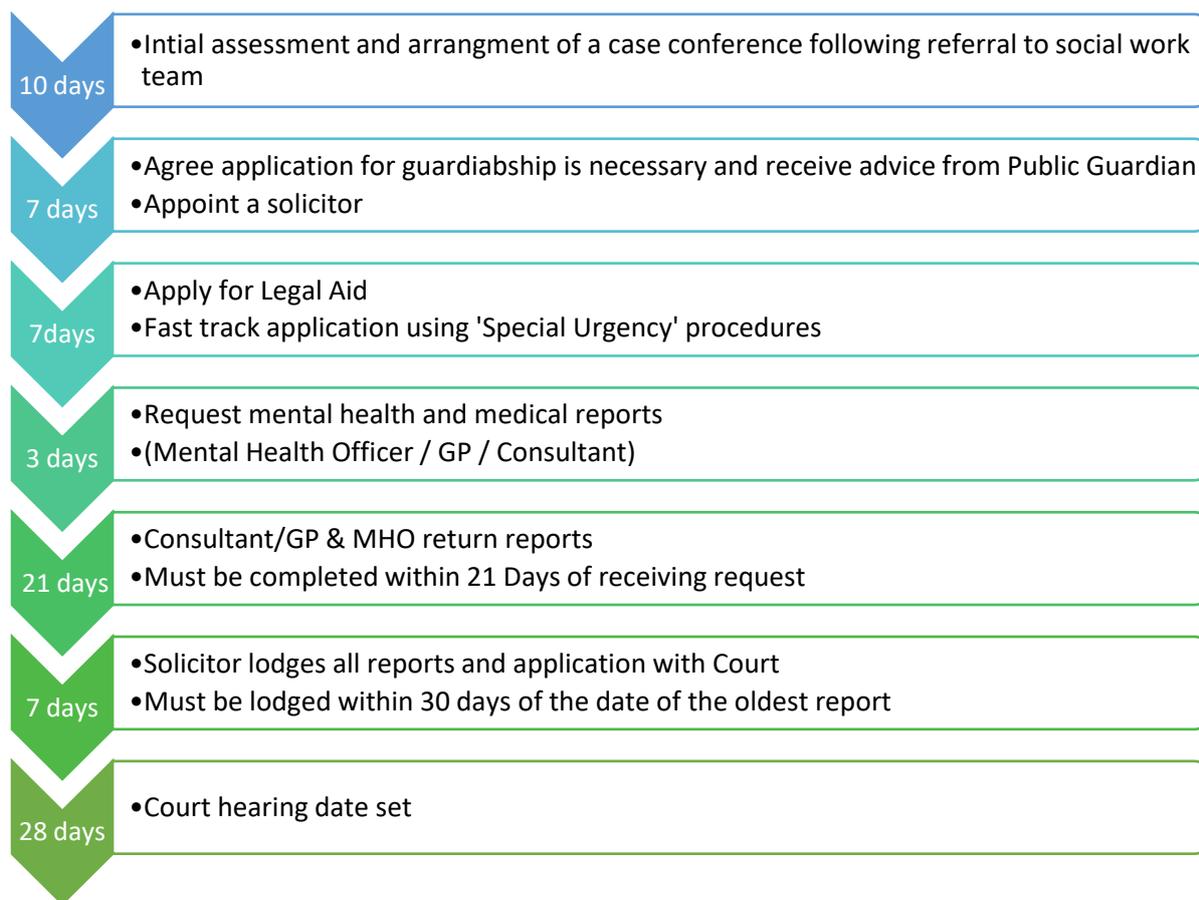
The Advocacy Service is always involved and any referral picked up and allocated within 24 hours. The independent advocate worker will support the family through the AWI journey.“

Reviewing MHO services has highlighted some of the following:

- Where there are dedicated MHO teams or individual MHO's linked to hospital discharge teams there appears to be a more robust systems in identifying, progressing, and tracking AWI interventions. The pilot carried out in Edinburgh and the councils above highlight that this system can reduce the time a person remains in hospital and provides increased support to family and adults involved. Feedback from HSCP who have adopted this framework and NHS colleagues supports this view.
- Continued involvement of an MHO early in the process has shown that this support for families and other professionals helps to keep everyone on track and allows action to be taken should there be any deviation from timescales. It also appears that councils who have a full complement of MHOs or closely manage any deficits in service are also in a better position to progress AWI work quickly
- While a dedicated MHO for AWI and linked workers to hospital discharge teams is highlighted as a positive move, some areas raised concern that it reduced resources in other areas of mental health (Adult Support and Protection, Mental Health (Care & Treatment (Scotland) Act, Forensic work, Learning Disability Services) and it could shift practice concerns to another area of mental health.
- Some MHO Services are confident that they can meet all their statutory responsibilities with a dispersed model and not having dedicated MHO services enables the practitioner to have a more holistic approach to their work and can prevent them from becoming “deskilled”
- Three HSCP have employed sessional MHOs to support their hospital discharge programmes as well as reduce their AWI waiting list. This is often MHOs who have retired and are happy to negotiate their working time and meets the needs of the service.
- 24 HSCP advised they operate a waiting list for “non urgent” AWI referrals. This is predominantly for independent applications. Local authority applications are prioritised along with hospital referrals.
- MHOs are viewed as providing an independent voice for the individual adult and autonomous in their decision – making although still accountable to their Council and this at times is not always respected. Pressure from external influences can impact on this, particularly if no support is provided from senior managers.

AWI Process

The AWI process can vary across HSCP and will be very dependent on the availability of MHO's, what resources each council have in place to identify, allocate and progress their AWI applications. All HSCP's have reported they will prioritise hospital discharge referrals to an MHO for assessment as soon as they receive it, however they are also dependant on the involvement of outside agencies to complete the application. Any delay in their involvement is out with their control and can often prevent council's meeting either their own or timescales identified from the pilot carried out in Edinburgh, which are noted below.



Delays can happen at any stage in the process for example:

“Some of the challenges we have experienced are when papers are not served on the adult while in hospital or care home as health or care staff are unfamiliar with the process. This recently caused a delay in an application where the court papers were sent to a care home and staff were not familiar with the process. This resulted in the F22 papers not being signed and returned within the required timescales and the solicitor having to arrange a new court date causing additional delay.”

Local Authority Applications

Case Study

Mr G's care manager discussed Guardianship with Mr G's partner as soon as he had been assessed as lacking capacity and provided them with a list of local solicitors for information. The applicant contacted a solicitor soon after and the care manager sought confirmation of this and passed the details to the MHO Team Manager who contacted the solicitor to explain the urgency. While the solicitor did expedite the legal aid application this still caused a considerable delay. However, as soon as legal aid was granted the solicitor notified the MHO Team Manager who allocated the report to an MHO. Unfortunately, during the course of the interviews, the MHO discovered that the solicitor had not realised they should have included the joint applicant in the legal application, so the process had to be halted causing a further unnecessary delay.

In this situation the solicitor had to redraft the application return it to the MHO who is required to interview the additional applicant to ensure they are a suitable person to act as guardian. Return the MHO report to the solicitor for them to organise a new

Social Work Services play a lead role when an application is being made for a guardianship order, however there can be a lack of understanding/appreciation from other agencies of the complexities involved and legal considerations that require to be met in this process, as well as the bureaucracy involved.

It is essential that an MHO is involved as early in the process as possible as this allows them to link with the adult and their family immediately and support them through a very stressful time in their life. It also enables over stretched local authority legal services to be actively involved in discussion surrounding the powers required.

Local authority application are often completed quicker than private applications. This is due to:

- Current involvement of a social worker who may know the adult and their circumstances.
- If not known to social work services allocation of a social worker and MHO will be a priority.
- Previous assessments have been completed or are in the process of completion and able to provide up to date information.
- Family may already be actively involved with services and more willing to attend an AWI case conference.
- Immediate access to local authority legal services who can participate in the case conference and provide legal advice.
- No legal aid applications required.
- In some situations, medical staff may already be involved or the MHO will know who to contact for medical reports.

However, while local authority processes are quicker the role of the MHO is increased significantly. They are required to complete assessments, organise medical reports and progress the application alongside legal services. Many HSCPs report they no longer have dedicated mental health admin support and their admin systems have been centralised.

This has resulted in delays in organising case conferences, completing competent minutes of the meetings, and circulating decisions. It was also noted that dedicated admin support was important to keep track of AWI intervention timescales, review dates and a key contact for families and other professionals.

While it is often quicker to progress an AWI intervention through the local authority they are only permitted to apply for a welfare or financial guardianship order where there is no other relevant person available or willing to act on the adult's behalf. Where families remain undecided and/or delay notifying councils that they are unable or unwilling to act for the adult the local authority is unable to progress an application.

While it is legally competent for a local authority to make an application and nominate a relative this is not common practice and places additional financial and resource implications on an already stretched service.

Private Applications

This is an area that all HSCPs felt was out with their control even where they have systems in place to monitor timescales and prompt private applicants. When a relative is admitted to hospital it is a very stressful and distressing time for families. If the adult is older and has issues around capacity, they have often acted as the main carers and spent a great deal of time organising systems to keep their relative safe and at home for as long as possible. This has often been to the detriment of their own lives and that of their families.

When the time arrives for the adult to be considered for long term care families often feel a sense of loss, guilt and can often underestimate the adults needs and the level of risk they present. All these feeling take time to process, and the role of the MHO and nursing and social care staff is crucial in supporting families to manage them and look at future planning. Relationships and trust need to be established and this takes time.

Some ward staff are familiar with PoA and will ask if there is an active PoA in place and request sight of this document early in the adults journey. Others are less confident and unfamiliar with the AWI process. Having this information allows decisions around future planning to be made quickly, however where families have no legal document to make decisions on behalf of their relative and this is not identified early in the adult admission, this can result in a delay in their discharge. The AWI process is complicated, and families can struggle to navigate through this. An MHO will provide advice and support them as best they can, however they are the only individual who can instruct a solicitor and provide the relevant information to progress an application.

While most families act in the best interest of their relative conflict can arise during this stressful time. Deciding who is best placed to act as guardian, deciding that there should be multiple guardians, or disputes on the impact of a relative and their possessions when a care home is assessed as the most appropriate course of action can all cause delays in the process.

Other areas identified as causing a delay are:

- Families not attending an AWI meeting to discuss the application and powers required. This requires a further meeting to be arranged and can take more than a week to rearrange attendance.
- Unable / unwilling to seek legal advice in required timescales and need regular prompting or encouragement.
- Not providing the appropriate information for their solicitor to progress the legal process and resulting in several visits.
- Identifying a care home or reluctant to allow their relative to move from hospital to a care home.
- Some families are dispersed across Britain or abroad which can cause delays.

Case Study

JR's daughter intended to make a private application as her father required welfare guardianship powers to facilitate 24-hour care arrangements and discharge from hospital. MHO involved at an early stage and s13ZA was identified as not being appropriate. MHO liaised with solicitor appointed by daughter in relation to progress being made with application, willingness to prepare MHO report immediately and stressed the urgent need for legal measures to be in place to facilitate care. Through liaison with the solicitor, it was identified that JR's daughter was not responding to solicitor and JR's daughter was evasive with MHO/SW when attempts were made to contact her. Parameters were set in relation to timescales whereby if JR's daughter did not contact her solicitor in relation to her application that a local authority application would be considered. JR's daughter eventually advised that she was under stress caring for her mother and withdrew her application, supporting a local authority application for Welfare Guardianship. Challenges related to lack of response from JR's daughter over some weeks leading to her father spending a longer than necessary time in hospital, this ultimately leading to a significant time passing before a local authority application was instigated

It would be unfair to claim that families are the only reason for a delay in the process as there are many families who are very proactive and eager to have their relative settled and safe. The MHO plays a key role in supporting families and assisting solicitors to progress guardianship applications which helps to reduce the adult's length of stay in hospital.

Case Study

Mrs P is an 80-year-old lady diagnosed with a mixed dementia. She fell and broke her neck of femur in February 2021 and once rehab was complete, she was moved to a more suitable ward to await placement in a care home. The AWI/MHO was involved from an early point as a result of being in regular liaison with the Flow Coordinator and allocated Care Manager.

S13ZA was not appropriate because Mrs P was inconsistent in her views about long term care and stated quite clearly that she wanted to return to her own home. Mrs P's son and daughter wanted to make application to be appointed Guardians and with guidance from the AWI/MHO quickly instructed a solicitor. On this occasion Legal Aid was processed promptly. At the same time the family were supported to choose Nursing Homes where they felt Mrs P would be happy. The AWI/MHO assisted the solicitor through the process of making the application and kept him regularly updated as to Mrs P's progress. Through the established network of relationships two doctors willing to provide the reports were identified. The MHO gave their names to the solicitor thus making this sometimes difficult to negotiate part of the process much smoother and quicker. Once the application was lodged in Court and a bed became available in one of the chosen Care Homes the AWI/MHO prompted the solicitor and family to request an Interim Order which was granted. The adult was then able to move to a home chosen by the family – involving the adult also by means of a virtual tour – and in keeping with the adult's wishes to remain in the local area.

The whole process is dependent upon several other professionals and public organisations fulfilling their role, for example:

- NHS medical assessment of capacity from GP and Psychiatrist
- Independent solicitors who act on behalf of the families
- Scottish Legal Aid application process
- Courts setting a hearing date and Sheriffs making a decision on the application, and
- The Office of the Public Guardian who register and distribute the order.

A delay in the AWI process can happen because of hold ups in any one or more of the component parts above, which combined, form an AWI application pathway from the assessment of incapacity to the conclusion with registration at the Office of the Public Guardian.

Partnerships believe it would be helpful to identify where in the process the adult's delay arises therefore allowing a more focussed approach to tackle the difficulties.

NHS

Capacity Assessments

To accompany a guardianship application there must be two medical reports. One from a doctor who is qualified under Section 22 of the Mental Health (Care & Treatment) (Scotland) Act 2003 (mental health specialist clinician) and one other, which is usually the adults GP. The medical reports will indicate if the adult has a mental disorder, or inability to communicate because of physical disability, and confirm that the person meets the criteria required under the Adults with Incapacity legislation.

Within the questionnaires received every HSCP reported difficulties in accessing medical reports. Some areas were more able to access reports from mental health specialist clinicians particularly if they were already involved in the patients care. This became more difficult when the adult was in an acute general ward and liaison with a specialist mental health clinician was required. This was further complicated if the adult was in the community and required AWI intervention and was not known to services.

Accessing a GP to complete the second medical report has become more difficult since the pandemic. A large proportion of GPs are refusing to complete second medical reports and have cited lack of training and confidence on assessing capacity, complicated paperwork, resource issues, and “not part of my contract” as a reason. This in turn places additional demand on other clinicians who are required to complete reports as part of their contract. Recruitment of clinicians within the NHS is an issue for many health boards and the increase in requests for independent psychiatrists to complete reports as a result of GP’s refusing, adds to the financial burden of the local authority.

Cost of medical reports

Funding of medical reports is also variable with some charges ranging from £150 to over £300. Several areas have a Memorandum of Understanding in place and charges are agreed in advance with medical staff, however again this practice is variable across HSCPs

Some HSCPs have noted a decline in the quality of assessments they are being asked to consider by medical colleagues and have had to challenge medical colleagues regarding this, which has significant resource implications for social work and MHO staff if this were to continue long term.

Early Notifications of capacity issues

Several mental health managers reported that the delay in health staff highlighting that an adult lacks capacity and needs an AWI intervention can prolong their time in hospital. Early notification of a clinical capacity assessment in place, or to be arranged would allow social work assessments to run parallel with the AWI process and help minimise any delay in the persons journey. There are however several HSCPs who report they have improved the systems they have in place, and this has become less of an issue. They describe good joint working processes across agencies as key.

There is however the alternative view that assessment of incapacity too early in the patient's journey can be detrimental to the adult and does not allow sufficient time for them to recover and be in a better position to make their own decisions. Any improvement of their decision making is ideal and can help to reduce the need for AWI intervention. However there remains the need to balance the adult's rights and without other legal frameworks in place, PoA or s13ZA, a transfer from acute services can be difficult.

“Professional networks within in-patient service across the Partnership have improved, supporting a ‘whole system’ approach to early identification of patients where capacity is identified as an issue through Social Work attendance at the daily huddle and ensuring that health colleagues are supported in the use of the legislative framework of AWI Act.”

“One challenge in progressing the discharge of adults waiting for AWI interventions is the lack of early referral for a social work assessment. In some instances, social work referrals are not being made until the adult has been deemed fit for discharge. This in essence creates a delayed discharge as while medical colleges are advising the adult is fit for discharge the social work assessment process and subsequent legal work/intervention takes time.”

“Capacity to consent to treatment would be assessed early on the ward and section 47 put in place when necessary. However, we have a Tayside wide agreed set of Older People's Standards which states that a person should always be either discharged home to complete assessment or stepped down to a slower stream rehab ward when it is likely that issues requiring more intensive assessment exist. We are working to promote the idea that capacity decisions should not be made too early in the patient's journey in order to ensure they have the best opportunity for a good outcome.”

Section 47 Certificates

Section 47 certificates are completed by medical staff when an adult is admitted to hospital and they lack the capacity to agree to medical treatment. This certificate allows the medical practitioner to legally deliver their treatment and should be reassessed regularly as their condition improves. This was not always the case and the following issues were highlighted:

- Lack of understanding by health staff in acute settings that S47 relates to the adult's treatment needs only and was often referred to as an “AWI in place”. This misuse of language gives the impression that the S47 certificate includes a formal assessment of the adult's capacity to make welfare and financial decisions
- Lack of review of S47 certificates, particularly if the adult moves from one hospital setting to another. This can mislead nursing staff to think capacity is an issue when the adult may have regained some areas of decision making.

Recent Advice Notes have been issued by the MWC on the Scope and Limitations of s47⁷

⁷ The Advice Notes are available at <https://www.mwcscot.org.uk/publications?type=40>

Private Solicitors

Local private solicitors play a significant role when private AWI applications are made by families. They are responsible for:

- applying for legal aid to fund the application
- take instruction from the family which includes a history of the adult and the applicant's life
- agree what powers are required to enable decisions to be taken on behalf of the adult and draft applications
- seek two medical reports along with a MHO report which accompany the application and attendance at court.

This whole process is again dependant on external factors and delays can take place anywhere along this process.

Like everyone else the pandemic saw solicitors working from home or being furloughed. This resulted in some firms only completing urgent applications for AWI and some not taking on AWI applications at all but focussing on other work.

The questionnaire frequently highlighted that many solicitors were unfamiliar with the AWI process and at times were not seen to be prioritising applications. There is no evidence to support the view that solicitors are not prioritising AWI applications, and it has been reported by the Law Society that many of the firms giving good, experienced and well-organised services in AWI work do not have an accredited specialist, but have over the years built up experience through continued practice.

While the more experienced solicitors are confident in their roles and responsibilities it would be helpful for those less familiar with the process, and willing to continue in this area, to receive further training or have access to practice guidance.

Some solicitors who have experienced difficulties navigating through the process have highlighted issues such as obtaining MHO reports and finding suitable providers of medical reports. Non urgent guardianship applications are in many areas placed on the councils waiting list as those delayed in hospital or at significant risk in the community will take priority. Some HSCPs have developed systems to help improve relationships with local solicitors and the courts for example:

- Dumfries & Galloway advised they have eight legal practices in their area and each one has an MHO link where relationship are formed and information and advice is shared more easily.
- Falkirk have advised all solicitors on how to fast track legal aid applications in respect of hospital discharges and applications for interim orders are considered in each case.

This has supported solicitors to progress applications more timeously and assisted in some areas with reducing delays in hospital discharges. While some development may be more difficult to operate in larger areas it does offer an opportunity to improve relationships and promote good practice.

Some councils struggle with the view of recommending private solicitors or becoming involved other than to progress the MHO report as it may seem as favouring one solicitor over another or a conflict of interest. One way of managing this may be for an independent register or record of solicitors more confident in AWI practice to be available and easily accessible to the public.

Legal Aid

Legal Aid was highlighted as another area that caused delay in the AWI process. HSCPs advised that families would often report that they were waiting for their legal aid application to be granted and that their solicitor would progress the application as soon as this was confirmed. The Scottish legal Aid Board report that they are not experiencing delays in processing applications and will respond to requests for fast track applications when received.

The current system for assessing and granting legal aid applications appears to be quite complex and lengthy, a review to consider alternative models to help manage this would be worth progressing. A system where legal aid was not required for AWI interventions would reduce any perceived delay, however alternative funding streams to pay for solicitor's time would have to be taken into consideration.

Court System

A lack of consistency across Sheriffs/ Sheriff Courts let alone Sheriffdoms can be very challenging for everyone. During the pandemic most courts were only operating a system where only urgent AWI cases were being heard. Following the lifting of pandemic restrictions courts are now operating more frequently. In some areas this has helped to progress less urgent AWI applications although there are reports that some courts seem to be considerably slower in fixing AWI hearing dates, and this is attributed to trying to manage their own backlog.

Some HSCPs have set dates grouped together for AWI hearings which can be helpful however if the application is not submitted within the arranged hearing cycle there could be a delay. Dundee City advised that prior to the pandemic they had court access one afternoon a week dedicated to AWI hearing and this provided a consistent approach to decision making.

Dedicated courts for AWI hearing are in place in some HSCP however this is not common practice. There are also mixed views that some sheriffs are more knowledgeable and offer more consistency than others.

Interim hearings

For adults who are delayed in hospital and require an AWI intervention this can take several weeks if not months to progress. One way of speeding up the process is to apply for interim powers.

When a guardianship application is submitted to court a hearing will be heard within 28 days of submission. This allows the family and any other interested party or parties to lodge any objections and have their views heard at the hearing. Most applications are not contested and when someone is in hospital and they do not need to be, family are often anxious for them to move to a more appropriate care

setting as soon as possible. In those situations, an MHO or a private solicitor will request that an interim hearing date is organised and, if granted, welfare decisions can then be implemented before the full hearing date. An interim order is time limited until a full hearing can take place in court.

Interim powers are not routinely progressed by private solicitors and almost always need to be requested by the family or suggested by the MHO. A few HSCPs have reported that some sheriffs are unwilling to consider interim hearings or grant interim powers and prefer to wait until the full hearing. This may be to ensure family and other relevant parties are given time to have their views heard.

One HSCP reported that their court “regularly insists on a safeguarder being appointed for almost every case where the adult lacked capacity”. A safeguarder will then have to be identified, meet the adult and family, and complete a report for the court. This can delay the process and while it is an important safeguard for adults who lack the capacity to object to decisions being made on their behalf. Where a guardianship application is uncontested it provides no additional benefit to the adult and could be interpreted as in conflict with the least restrictive principles of the AWI Act.

Practice across HSCPs is variable and some do not routinely, or ever request interim powers. They are of the view that the full process offers additional protection to the adult, or they know their local sheriff will not consider it.

“Interim order is almost always requested, we then work with sheriff clerk to identify date of hearing and advise social worker so a suitable placement can be sought for move to care home as soon as order is granted.”

“Requesting interim orders is our default position.”

“Interim guardianship orders should be used more often and are helpful. In some local authorities this is a matter of course and some Sheriffs are open to this as it is hospital setting however not all sheriff’s in our area will accept our request.”

“Interim powers are rarely sought in our area either by solicitors or local authority legal services.”

Recommending interim orders should be the default position for adults who are in hospital and their move to alternative accommodation is delayed. This would offer safeguards to the adult and reduce their time in hospital.

Office of the Public Guardian (OPG)

The OPG have struggled to manage the backlog of registrations as they have also been under a great deal of pressure through staff shortages and the impact of Covid-19. In addition, since 2019 a public Awareness Campaign on the use of PoA has increased their workload. Without the registration documentation of guardianship orders and PoA certificates provided to families many agencies will not share information or take instruction on behalf of the adult who lacks capacity.

Some adults have been made subject to AWI interventions but are unable to move out of hospital as their application is not registered and the relevant certificates are not in place. We could argue that as soon as the Sheriff grants a guardianship order this is a legally binding decision. Some HSCPs report that they are reluctant to discharge people until proxies can produce the original copy received from the OPG.

The OPG have advised that while they have a backlog of registrations funding has been provided by the Scottish Government to employ additional staff and they are now able to report that their waiting list is reducing. They also report that should an adults circumstances change and there is a genuine need for the PoA to be urgently processed due to the granter's needs there is an application process for the order to be expedited on their website⁸.

Training

This report has highlighted that all the agencies involved in the patient's journey have, at some part of that journey, lacked knowledge around AWI legislation, the processes surrounding it or the impact a delay in discharge from hospital can have on the individual and their family and carers.

There is no doubt that training programmes for HSCPs has not been an area of priority for the past year. With Covid-19 and staffing issues it is difficult to focus resources on this area when delivering services has been a priority for all the HSCPs.

Where training programmes are continuing they are often delivered by practicing MHOs, which has an impact on service delivery. NHS staff have access to learnpro, an online system where staff can log on and complete mandatory AWI training sessions. Health and social work have a number of mandatory online courses staff have to complete and while this is helpful and offers some awareness the interactive face to face multi-agency experience cannot be underestimated. The opportunity to share experiences, question practice and debate roles and responsibilities is what makes practitioners reflect and retain information.

HSCPs have reported that AWI processes are lengthy, MHOs take considerable time to process applications, solicitors, and courts cause delays, however it can be easy to blame a system or a professional but without a full understanding of their roles and responsibilities we will continue to hold misconceptions of each others roles and

⁸ <https://www.publicguardian-scotland.gov.uk/power-of-attorney/epoar/how-long-will-it-take>

lay blame rather than fully understand what the difficulties are and try to address them.

We also must think beyond health and social work practitioners who are more actively involved in the AWI process. Early intervention is crucial and investment in staff who deliver support in the community and who have ongoing contact with the adult and their families will help to reduce the need for guardianship applications in the future. Social workers in community care teams are actively involved in assessing and organising services for adult who are at risk and who either currently lack capacity or will in the future. The need for them to be aware of AWI legislation and promote interventions prior to their need for hospital care is important. Homecare Services and third sector partners are also able to promote early intervention if they were more familiar with the legislation. Future training plans need to be broader than the service delivering it.

“We have developed a suite of training for MDT Teams which can be delivered remotely and have a specific focus on early identification.”

“The AWI Hospital Project MHOs offer information sessions to small groups of social work and health colleagues. when it becomes apparent through MDT work that a particular team has gaps in knowledge. These sessions are informal and would not cover comprehensively the legislation and the breadth of associated issues.”

“Training and development of staff in this important area of our work arguably requires increased priority and resources within the HSCP.”

Some areas have continued to provide training sessions although they may be more limited than before the pandemic. All HSCP have started to review their training plans and again investing in single and multi-agency training. As noted earlier this is often delivered by MHOs and does impact on their workload.

Learning and development of staff must be an ongoing process and not just the occasional information session. Staff and systems change as we continue to strive to improve the structures we work within.

It is imperative that we invest in training and awareness raising throughout the statutory and third sector agencies as this will help to manage some of the hospital delays through the promotion of early intervention. This should be provided and funded externally to enable agencies to fully commit to attendance and to deliver a consistent message on the interpretation of the legislation, national policy and procedures supporting AWI and the roles and responsibilities of agencies.

The training should be mandatory to ensure HSCPs, legal services, public bodies and other agencies invest staff time in the programme. However consideration will also have to be made on how staff can be freed up to attend. This will require financial investment to ensure service delivery is maintained, nevertheless the return of an informed workforce, regular consideration on early intervention and a possible reduction in hospital delays support this change.

While HSCPs will continue to endorse their own local procedures a national training programme would help to promote a more consistent approach to practice and service delivery.

Conclusion

The aim of the scoping exercise was to review what systems HSCPs had in place to support and minimise the delayed discharge of adult who lacked capacity and required a Guardianship Order, and identify areas where improvement had taken place or was underway.

One significant factor identified across the HSCPs and within the AWI process is that guardianship applications are a complex and bureaucratic process and while MHOs play a significant role, the outcome is very dependent on the actions and co-operation of several other agencies. The AWI Act is currently under review and while we hope this work will help to deliver a more streamlined process that can continue to safeguard the rights of the adult and make the journey easier for families it will be a big challenge.

Although we have legislation, national and local policy, and procedures in place HSCPs continue to provide a varied response to how they practice and manage peoples discharge from hospital. This can be confusing for agencies who deliver services across more than one HSCP.

The variances can be influenced by geography, interpretation of the legislation, language, and resources. One of the biggest challenges for MHOs across Scotland is the very different models of interventions, employee conditions of service and financial reward. Despite some areas having less than perfect systems in place, there continues to be a commitment from all HSCPs to learn from each other and improve their service delivery.

The report has highlighted that all the agencies involved in the patient's journey have, at some part of that journey, lacked knowledge around AWI legislation, the processes surrounding it or the impact a delay in discharge from hospital can have on the individual and their family and carers. Training across all the agencies is imperative to ensure consistency, promote good practice, and raise awareness of each other's role and responsibilities.

There does however need to be financial investment to identify an independent training provider that can meet the training needs of all the agencies and to ensure organisations are able to free staff to attend as well as back filling posts to ensure service delivery remains unaffected.

It is encouraging to note that all the HSCPs who took part in this exercise have reported that they have over the past year reviewed or plan to review their hospital discharge processes. In many cases this has resulted in a dedicated MHO presence either within the hospital discharge teams or an identified link to them. This has been reported by HSCPs as a positive move and helped significantly with reducing the adults stay in hospital. It has also raised awareness within hospital teams on the AWI process and improved communication.

Where this direct link is not in place hospital discharge co-ordinators report that the AWI process can be slow and communication across agencies problematic. Rural

area advise that where joint working and co-location is well established this is less of an issue.

The demands placed on MHO Services are significant and there is clearly an insufficient number of MHOs to meet this demand. This is an area that continues to require investment if we want change. Given the cost of adults delayed in hospital due to AWI interventions this would be a positive investment in the longer term. Hopefully the work undertaken through the MHO Recruitment Framework to increase MHO numbers by 2024 will help to address some of this.

A good communication plan across HSCPs can help to support staff to know who they should link with and what forums to communicate through. This would also be a helpful tool for patients, carers and third sector agencies.

It is proposed that this report will offer HSCPs an opportunity to share areas of good practice and assist them in developing their own services further.

Annex A – AWI Questionnaire

Delayed Discharge and AWI

Background

My name is Eileen Niblo and I am a qualified social worker and Mental Health Officer (MHO). Throughout my career I have predominately worked within mental health and adult protection services. I recently retired, however I continue to practice as a Sessional MHO.

Introduction

An action plan around delays in hospital associated with adults with incapacity (AWI) has been developed between Health & Social Care Scotland, the Mental Welfare Commission, Office of the Public Guardian and the Scottish Government, and discussed with the Cabinet Secretary for Health and Sport and COSLA.

As part of the action plan I have been asked to engage with all partnerships, particularly MHO teams and Hospital Discharge Managers, to take an in-depth look at local processes. This will allow me to gather an understanding of the underlying reasons why patients who lack capacity, and require the appointment of a Welfare/Financial Guardian, are delayed in hospital for longer than they need to be.

I have been asked to complete an initial scoping exercise to establish both where and what the barriers are in the operation of local processes and to find solutions to addressing these barriers.

Working with Partnerships, I hope to identify and share areas of good practice, support local improvement, and compile a report with recommendations for areas of /including measures for action/variations to operational activity, where this is considered helpful and required. Ultimately, the intention is to use this exercise as a learning process, share areas of good practice, see a reduction in both the number of AWI delays and the duration of these delays.

I understand that both councils and health partners currently face additional challenges with the Covid-19 restrictions, however I have tried to minimise the demands on already busy staff by providing a list of the areas and questions I would like to focus on. This will hopefully help to assist nominated officers prepare prior to contact with me and to provide consistency of approach across all partnerships.

MHO Services:

- Describe your current MHO service and what are your allocation processes for AWI / clinical assessments / joint working with community or hospital social work and health staff.
- Describe how you prioritise allocation if there are competing demands for MHO work?
- Do you have a specific strategic approach to supporting the discharge of adults who lack capacity in hospital settings?
- What pathway do you have in place to identify and manage your delayed discharges and required AWI interventions?

- What if any are the issues arising with allocation and progression of AWI applications.
- Identify a typical case showing good practice and some of the challenges experienced.
- Examples of issues arising and how they have been managed or not.

Hospital Discharge Managers:

- What pathway do you have in place to identify and manage your delayed discharges for adults who also require AWI interventions?
- What challenges are there in progressing the discharge of adults waiting for AWI interventions?
- What is your experience of the pathway flow
- At what point following admission is a person's level of capacity and attendant health conditions considered with a mind to consent to treatment and general decision making? How is this information shared with social work colleagues?
- Identify a case showing good practice and some of the challenges experienced.
- Examples of issues arising and how they have been managed or not.

Training:

- What training opportunities do you have for staff and third sector partners on AWI legislation and which can help promote early interventions before hospital admissions is required.

13ZA / Human Rights:

- What pathway do you have in place to identify and manage adults who do not require Guardianship and are suitable for the use of the s13ZA procedure.
- Are you confident that practitioners reflect on the human rights of the adult when completing this pathway and demonstrate this through their written assessments/minutes?
- Do you have systems in place to record and quality assure decisions taken under s13ZA?

I would like to thank you very much for your co-operation and participation in this exercise and hope that it has also been helpful in offering you an opportunity to reflect on the areas of good practice that you regularly provide as well as highlight some of the areas you may wish to develop further in the future.

Regards

Eileen Niblo, SW / MHO

Annex B – Practice Developments

Area	Current Practice/Future Developments
Aberdeen	<p>We have a 1 FTE post specifically dedicated to undertaking AWI work for people who are inpatient at the acute hospitals This has made a significant difference to days delayed and in the early identification of cases where the client lacks capacity. Staff across the general hospitals are more aware of the post and will come at an early stage to ask for advice and guidance.</p> <p>Recently we have employed Relief MHOs which has also helped to ease the pressure arising from AWI work – both picking up cases where the client is in hospital and in taking on the lower priority AWI cases giving the permanent MHOs the flexibility to prioritise this work when necessary.</p> <p>Our new assessment documents are outcome focused and no longer follow a deficit model with the abilities and desires of the individual being the centre of the assessment.</p>
Aberdeenshire	<p>Frailty Pathway which promotes a discharge home to assess and will be supported by a multi agency wraparound team is being developed. Delayed Discharge and Patient Flow Data is scrutinised weekly by Senior Management.</p> <p>From April 2021 we have an MHO integrated into our hospital discharge team and there are plans to increase the compliment of NHS and SW staff in the future.</p> <p>PoA Application pack will be circulated to Discharge Managers to share and promote with people on the ward as part of an early intervention programme.</p>
Argyll & Bute	<p>The partnership has recently employed an Operations Manager Post to oversee MHO / MHS across Argyll & Bute.</p> <p>This has provided a more linear process and quicker access to managers for AWI Case Conferences, this also offers consistency of decision making. She is also in the process of updating their joint Health & Social Care Partnership Standard Operating Procedures “Argyll and Bute HSCP, Discharging Adults with Incapacity from hospital” which offers a practical guide for health and social care practitioners in Argyll and Bute involved in discharge planning from hospital.</p>

	<p><i>The geographical distance can be very difficult to cover within reasonable timescales particularly during sick leave or holidays.</i></p> <p>Plan to allocate an MHO at time of admission rather than waiting for the submission of report request for private applications.</p> <p>Pursuing additional funding to pilot a Hospital at Home service using advanced practitioners which will hopefully include a Palliative Care Nurse. (OT,PHYSIO,nurse,) linking into GP's and promoting Anticipatory Care Plans, early intervention for AWI / POA.</p>
Angus	<p><i>Proactive approach to those who lack capacity in terms of early identification by ward staff of capacity issues which may require MHO input.</i></p> <p>Hospital Managers and Service Managers – along with both Heads of Health & Community Care meet weekly to discuss current delays/seek solutions for delays. Proactive section in the meeting to discuss patients not yet medically fit, but likely to be within the next week and AWI issues.</p> <p>We have developed a suite of training for MDT Teams which can be delivered remotely and have a specific focus on early identification. We are also involved in the national campaign for POA and we promote this through our teams.</p>
Dumfries & Galloway	<p>There is a single access point for referrals from health staff and this has allowed easier tracking and established good relationships / communication.</p> <p><i>If an adult is placed on S47 or lacking capacity NHS staff are alerting MHO team early allowing them to prioritise work as appropriate.</i></p> <p>Training programme under review and a very comprehensive plan is being developed to cover all agencies. Including 3rd sector.</p> <p>Legal services have developed a template for 13ZA / AWI which prevents any loss of individuals and improved tracking and quality assurance. New practice guidance on 13ZA completed and waiting for sign off.</p>
Dundee	<p><i>Approx 5 years ago we decided to take an MHO post from the dedicated team and embed it in the Hospital Discharge Team with specific focus on managing AWI work, increasing confidence in the appropriate use of 13ZA, and expediting the AWI process when guardianship orders were required)</i></p> <p>Our strategic approach is to always discharge home to complete assessment wherever possible.</p> <p><i>This reduces the number of people who become delayed in hospital awaiting guardianship. To support</i></p>

	<p><i>this, we have commissioned a social care service which provides round the clock care at home for a short assessment period to ascertain the accurate long term need. We have good evidence that many people are much more independent once they return home than was assumed in a hospital setting. Therefore less requirement for AWI processes.</i></p> <p><i>Interim Order requests are our default position. We work with sheriff clerks to identify date of hearing and advise social worker so a suitable placement can be sought for move to a care home as soon as order is granted. This prevents delay and the adults time in hospital.</i></p> <p><i>Involved with PoA campaign including - Front door modelling in local hospital where advice and information leaflets are provided to the public.</i></p>
East Ayrshire	<p><i>Reduction in delay for guardianship orders has been achieved by the involvement of an MHO at the point of referral to attend case conference and support decision making and implementation of decisions. Specific areas of positive practice relate to early involvement of an MHO:</i></p> <ul style="list-style-type: none"> <i>• MHO has helped inform the discussion around least restrictive options available including guidance and advice on Power of Attorney and the appropriate use of 13ZA where appropriate.</i> <i>• Supported the increased use of interim orders where appropriate in order to facilitate timeous discharge from hospital where an alternative more suitable placement is identified.</i> <i>• provides guidance for families in supporting them through the process of applying for a private welfare guardianship on behalf of their relative, reducing the potential for 'drift' and avoidable delay. It should however be recognised that delays may arise relating to the availability of appropriate medical reports to support AWI application processes.</i> <i>• The patient pathway has improved where care management and the requirement for legislative intervention run in tandem to support timeous discharge planning.</i> <i>• Professional networks within in-patient service across the Partnership an NHS facility (acute or downstream) site have improved, supporting a 'whole system' approach to early identification of patients where capacity is identified as an issue through Social Work attendance at the daily huddle and ensuring that health colleagues are supported in the use of the legislative framework of AWIA.</i> <i>• It is envisioned that East Ayrshire HSCP will have an 'AWI Champion' within each locality service where support and guidance will be available regarding AWI matters.</i>

East Dunbartonshire	<p>Linear system - Service Manager in place who manages all the MH teams across the council both in hospital and community. This prevents disputes around allocation / passing work across teams. Also helps with prioritising work as he has a full overview of the AWI / MHO work in the area. He also chairs AWI/CC and used to have them weekly but due to increase in work they are held daily if required. Staff have access to his diary so know when he is available for Case Conference.</p> <p>Advocacy Service always involved and referral picked up and allocated within 24 hours. The advocate will also support the family through the AWI journey.</p> <p>Have regular weekly meetings with rehab teams (D.N /PHYSIO/ Homecare team) who can alert SW team of possible admission and issues of capacity, this also enables the team to prioritise MHO allocation as appropriate.</p> <p>There are 2 intermediate care sites where adults can go for 4 weeks rehab there is also a palliative care unit , tight management systems are in place.. No one who may possibly need Long Term care allowed access unless they have a POA / GO in place and powers available to make decisions as appropriate. Prevents the system from becoming blocked and the adult is admitted with safeguards in place.</p>
East Lothian	<p>Service Manager and Team Manager for the Care Home Assessment Team (incl. hospital discharges) regularly liaise with Team Manager of MHO team regarding delayed discharge cases awaiting AWI intervention so these cases can be prioritised as appropriate. The weekly meeting identifies particular issues and monitors progress of guardianship applications. If the guardianship order is being sought to facilitate move to residential care and bed has already been identified, consideration is given to applying for interim order</p> <p>Funding has been secured to recruit a full time temp (6 month) MHO to address back-log of private guardianship applications.</p> <p>MHO team to deliver in-house training to all of Adult Social Work in East Lothian on Adults with Incapacity covering a range of issues including; legal definition of incapacity, the principles of the AWI Act, Guardianship orders (criteria, process of making an application), management of local authority guardianship orders, supervision of private guardians, supported decision making and Powers of Attorney. It is planned that this will be a rolling programme taking place annually.</p>
East Renfrewshire	<p>New post- dedicated MHO in Hospital Discharge Team has improved relationships and allocation process for adults in hospital.</p>

	<p>Advocacy Services automatically involved if AWI considered. Carers Team also provide good support to family during AWI process.</p> <p>Lead Officers are in the process of reviewing s13ZA procedures to improve paperwork and tracking systems.</p> <p>Have used interim orders and an area we want to progress.</p>
Edinburgh	<p>We currently have 2 Senior Practitioner MHOs who make up the AWI Hospital Project. They focus solely on progressing AWI applications for adults who will require these powers to enable lawful discharge from hospital with appropriate support and accommodation in place.</p> <p><i>Patients are identified through our delayed discharge management in EHSCP. Following the social work assessment, if the patient is identified as requiring a more legal structure to discharge, a referral is made directly to the AWI Project Team prior to case conference and the work is allocated immediately. The patient status is followed up through every part of the AWI pathway from liaising with families, solicitors, medics through to the court processes. Families are supported and provided with information throughout to minimise delays. AWI Project meet fortnightly with weekly updates to the Hospital Discharge Hubs to ensure transparency and actions taken to support the process where appropriate are agreed.</i></p> <p>The AWI Hospital Project which was piloted in 2016 and has run since then encapsulates the EHSCP approach to supporting the discharge of adults who lack capacity from hospital settings.</p>
Falkirk	<p>We have created a central hub to manage requests for Medical Reports. Allows tracking and prevents delays.</p> <p>All local Solicitors have been advised of the fast-track application process for Legal Aid in terms of any delayed discharges and applications for Interim Orders are considered in each case. An AWI process flowchart is in place.</p> <p>13ZA - Further to agreement by all parties the s13za agreement form is completed, incorporating the details of each party consulted and the date use of 13za was agreed. This is completed by the practitioner/care manager then reviewed and signed by the team manager. S13za agreement forms are sent to and stored centrally. This method of recording allows for collation of statistics surrounding the use of s13za and quality assurance on its use, particularly around the consultation process.</p> <p>Further quality assurance on the use of 13za in terms of a person's care planning, progress since discharge and any changes in their presentation is carried out via comprehensive review processes</p>

Fife	<p><i>Fife Health and Social Care Partnership have a weekly Escalation Meeting, where all delayed discharges are discussed, with representation from Fife H&SCP and NHS Fife. This meeting closely tracks progress in relation to people coded as 51X.</i></p> <p>We have weekly escalation Meeting where hospital referrals are allocated / tracked. This ensures the most appropriate person maintains contact with the applicant for a private application. Prior to the Escalation meeting the Dedicated MHO Team Manager meets with the OP Hospital Team Manager At this meeting they discuss whether 13za would be appropriate for discharge. Where this is not appropriate the Escalation Meeting ensure those making a private application are supported and encouraged to appoint a solicitor within 2 weeks. The Escalation Meeting allocates actions so individuals are clear what they have to do to keep things moving along.</p> <p><i>There is also whole system working being developed with close working with the HSCP Interim Divisional General Manager who carries responsibility for capacity and flow and the Interim Divisional General Managers leading primary care, mental health and social work. There are daily meetings in place with acute colleagues and this is a regular discussion at both the HSCP senior leadership team and also the NHS Fife Executive Directors Group. This whole system working will be key to supporting the responsibilities held by the health and social care partnership, NHS Fife and Fife Council. New heads of service take up post in June 2021 will support momentum to progressing this work.</i></p>
GCC	<p>There is a city wide social work team that processes hospital discharges and the team leader is a MHO. There are daily and weekly reporting systems for AWI to</p> <p>As part of their improvement plan Glasgow have developed an AWI tracker including code 51 (pre Guardianship Order consideration) and dashboard in place,</p> <p>Significant investment in early intervention PoA Campaign. The purpose of the campaign is to ensure the HSCP and partners front line staff have the knowledge, information and confidence to facilitate these early conversations with families, service users about future planning, capacity, legal</p>

	<p>options, POA and Guardianship. Front door modelling in local hospital where advice and information leaflets are provided to the public has taken place.</p> <p>Completion of Anticipatory Care Pathways encouraged by NHS staff.</p> <p>MHO Governance Group developing a comprehensive training agenda to include 13ZA, AWI and early intervention training for staff.</p>
Highland	<p>Plans are in place for a specialist social work post to support with AWI practice and training for non social work staff involved in supporting an adult who lacks capacity to leave hospital. This post will include auditing decision making.</p> <p>When the MHO service is made aware that an adult is a delayed discharge they will be prioritised for allocation. We have no delayed discharges on our current waiting list but the application process is itself time consuming and contributes to the problem of delayed discharge.</p>
Inverclyde	<p>The MHO service recently underwent a review which resulted in an increase in the substantive full time service from 3 to 6 MHOs with 2 positions still to be filled as well as introduction of a full time dedicated MHO Team Lead.</p> <p>The intention is for one of these posts to function as a liaison with the Discharge Team and prioritise AWIA interventions for delayed discharge cases.</p> <p>We have a history of positive performance in terms of Hospital Discharge in relation to our Home 1st Policy We look at early referral rapid assessment and discharge planning. On admission to hospital any service user who is identified as maybe requiring social care support on discharge is passed to our Discharge Hub and they are allocated or passed to the Team Lead of the appropriate team if already allocated. If AWI is required, then process is started early with appropriate referral to MHO service and arranging a case conference.</p>
Midlothian	<p>MHA work and guardianships which are required to facilitate hospital discharge are given priority. A key role for social workers will be to support families through the AWI process and this joint work with the MHO helps to progress the discharge process.</p>
Moray	<p>Home from Hospital Team has an MHO and Advanced Practitioner within the staff team and she chairs most of the AWI meetings and advises her colleagues.</p>

	<p>Developing a pathway process map – to expand guidance for staff and accessible information for families / leaflets.</p> <p>There is a strategic approach to addressing the guardianship waiting list. The backlog of cases is discussed at the MHO Governance Meeting and a decision was taken to address this by offering extra hours to MHOs who work part time and employing a sessional MHO (start date 1st June). However this does not impact on hospital discharges because of the prioritisation of hospital discharges.</p>
North Ayrshire	<p>Pilot in place - 2 retired MHO's employed on a sessional basis and 1 full time MHO for AWI work. This has helped to reduce waiting list and will continue for a further 6-9 months. - Dedicated MHO team for statutory work.</p> <p>13ZA procedures currently being reviewed / updated.</p> <p>Weekly multi agency meetings have improved communication and AWI interventions.</p>
NLC	<p>Predicted Date of Discharge meetings, which includes MHO, Homecare , rehab and other key staff is held daily and chaired by Head of Service/NHS Manager. This meeting involves adults where a potential date for discharge is identified. There is a tracking spreadsheet in place which is updated daily to prevent loss of the person. This system provides early alert to Social Work and some time before adult considered as a delayed discharge (DD). This system has almost halved our DD, allows good communication between services and meetings, and has commitment from all involved.</p> <p>Early notification of capacity - Consultants will decide if they have Capacity for Treatment and Decision making this is recorded in the patients case notes. Social work colleagues will get this information on the daily PDD calls and MDT's that they attend.</p> <p>MHO Training – nominated staff placed in CMHT during traineeship and substantive post back filled during this time.</p>
Orkney	<p>Currently updated the AWI procedures and guidance and this will now include specific pathways for hospital discharges.</p> <p>Geographical location and access to medical staff assessments can cause significant delays in hospital and, often, the MHO is only receiving the AWI1 report a few days before the legal timeframe expires.</p> <p>Information on hospital delays are shared across Adult Social Work and Health so as there are no surprises- there is mutual understanding of the pressures on each team and therefore sharing of information is key to smooth processes</p>

Perth & Kinross	<p>P&K HSCP has committed to the provision of a full-time MHO to work alongside our multi-agency partners that make up the HDT so that any issues relating to capacity can be identified at an early stage, planning and any subsequent need for legal authority is in place by the time the person is able to be discharged. There are numerous examples in the last 18 months where this has been very successful resulting in patients being discharge without any delay.</p> <p>Interim powers are sought as appropriate</p> <p>Education sessions on wards are in development (May/June 2021) which will include the need to support early discussions around capacity and more specific decision-making questions. The updated referral guidance to wards includes a prompt to ward staff to consider capacity when referring for discharge planning.</p>
Renfrewshire	<p>Allocation to MHO is immediate and all AWI Case Conferences in the HSCP are chaired by a lead officer. Close working relationships are in place with Team Manager colleagues at the Acute Hospital to manage any discharge that involves AWI. We have robust system in place to manage AWI process, which include timescales, and will closely monitor and follow up private solicitors for report request / draft applications where the case is a private application.</p> <p>We promote POA where the opportunity exists. This is being included in the work around Anticipatory Care Plans under the unscheduled care workstream.</p>
South Lanarkshire	<p>There is a dedicated MHO resource for AWI hospital patients. The dedicated MHO attends the delayed discharge call/hospital discharge discussions and can assist both with initial questions/queries or offer to provide early intervention where cases are more complex.</p> <p>Council staff have access to a comprehensive AWI and Supervising Officer virtual training. This ensures staff are aware of the principles of the legislation, the different sections, and the most prominent points within them as well as the role (and expectations of SLC on the role) of supervising officers.</p> <p>Connections with community groups such as the carer's support network, ARCH (a resource for autistic people) and other similar agencies. Some presentations have been done virtually where this has been feasible and the focus has been on the important of POA.</p> <p>SLC do not demand an MHO assessment for every 13Za use. However, since January 2021 the AWI resource has asked hospital discharge social workers to utilise the MHO available to ensure consistency, quality and appropriate use of the legislation. 13Za moves are recorded on a specific section of SWIS and as a significant event in the adult's chronology.</p>

Scottish Borders	<p>Daily reporting systems are in place and weekly meetings help to identify / manage those discharges that are delayed. We also use a Trak system which will flag up the need for AWI intervention.</p> <p>A joint NHS and SW capacity assessment tool is in place (systematic checklist) to help determine capacity issues.</p>
Shetland	<p>Work is currently ongoing in relation to the update of the discharge protocol which will include AWI.</p> <p>New structure in place includes weekly MDT meetings specifically for delayed discharges planning. Dementia Nurse Specialist employed and used to attend meetings and assist medical staff with capacity assessment advice.</p> <p>Have tracking system in place but under review to improve communication through improved Information systems. Hospital Liaison system set up by NHS to follow assessment and discharge planning.</p>
South Ayrshire	<p>We have 1 specific MHO for our hospital teams, whose main remit is to work with disciplines and service users around the AWI process. The MHO role specific to hospital discharges has only recently commenced and will be evaluated at the end of May 2021. The evaluation will focus on those individuals who required intervention under a Guardianship application and where other legislation was considered and applied i.e 13za</p> <p>We have developed pathways to support the discharge of individuals. Guidance note in place which supports a timeframe for the guardianship process for individuals in hospital and where there are private applications. The joint working focus across our hospital sites is around delayed discharge and AWI process.</p> <p>We have 3 x huddles each week which are an MDT approach to discharges, learning and, knowledge is shared at these huddles.</p> <p>Delayed Transfers of Care weekly meeting are chaired by Head of Service. In the main pathways have focussed on delayed discharges in general given these have been fairly high within South Ayrshire. In the past weeks we have seen a reduction in delays due to the MDT improvement work being undertaken. We have a number of workshops arranged to consider the patient journey/flow within the hospital, and our approach to AWI/Guardianship process will be a focus of that.</p> <p>We have leadership walk rounds in the wards to understand the patient journey every Tuesday, led by the Acute Site Director and Service Manager.</p>

Stirling	<p><i>Across the Partnership we experience lower number of AWI related delays partly due to the regular communication across the partnership and departments. Allocations for social work staff and MHO's are prioritised and AWI discussions are also prioritised which minimises delays. The good practice is in the timescales we set with all guardianship applications and the regular communication we Keep with family and agencies.</i></p> <p><i>Every medical file which has a Section 47 in place will also have extended paper work attached with also outlines the adults ability to make decisions regarding welfare and finance and outlines which aspect of capacity is impaired. This document sits at the back to the AWI certificate and is signed by the Dr and dated. This is helpful for social work staff as it offers more than a signed statement regarding medical decisions.</i></p>
West Dunbartonshire	<p><i>We issue a letter to families who are considering applying for measures under the 2000 Act, outlining the process, offering support, and highlighting the statutory obligation on the local authority to intervene where appropriate in terms of the welfare of the Adult should matters not progress timeously.</i></p> <p><i>Developed a letter for families to take to their solicitor outlining the information the solicitor will need to apply for legal aid and progress the application. This prevents additional visits and name of allocated MHO.</i></p> <p><i>We have reviewed our AWI processes and procedures, adding clearer timeframes where possible. This allows clearer pathways to escalations such as case conferences, where consideration of Local Authority applications can be discussed and actioned where appropriate.</i></p> <p><i>Increased our contact with hospital bed managers, and weekly meetings along with regular email contacts working both ways allow us to escalate concerns at earliest possible stages. Daily reports and weekly meetings are used to improve information sharing. These meetings are attended by senior managers which allow for a quicker and clearer path to escalation where required.</i></p>
West Lothian	<p><i>NHS= Introduction of a part-time Hospital based MHO in March / April 2020 has greatly assisted the process in relation to decision making and progressing 13za discussions / meetings and WGO applications.</i></p>

	<p><i>The involvement of Distressed Older Adult Team (DOAT) has also assisted SW assessments and recommendations for discharge planning and their ongoing involvement as part of the home first principles has assisted patients who are presenting with pain management issues or delirium.</i></p> <p><i>A s13za meeting pro-forma has been devised to ensure that there is uniformity in terms of recording views/decisions in relation to s13za amongst social work practitioners. Practice guidance and a flow-chart to assist practitioners in relation to the s13za/Guardianship pathway is currently in draft form.</i></p>
Western Isles	<p><i>The AWI procedures have been reissued to the Assessment and Care Management Team and have been discussed within Team Meetings to raise awareness and keep staff updated. Four Social Workers are attending further training on AWI issues.</i></p> <p><i>MHO capacity remains an issue for us, however we are trying to address this through a social worker undertaking only MHO duties; plus agency and a member of staff identified to undertake the training 21/22.</i></p>
NHS Acute Services Patricia McGinley	<p><i>The Discharge Planning Team works with councils, communities and NHS across the Glasgow and Clyde area. They record delays in someone's discharge and remove this responsibility from acute ward staff. They do not cover mental health.</i></p> <p><i>Regarding who is a delayed discharge is identified/ managed / decided jointly by NHS and SW and they agree which code to use. This offers consistency and agreement who is identified as a delayed discharge.</i></p> <p><i>Discharge Policies are in place and are all jointly agreed by the partners. A proforma is used by 9 of the 10 partnerships and electronic systems highlight fit for discharge date and not Discharge date. This offers some flexibility and early identification of need to progress.</i></p> <p><i>Some of the challenges faced by the team are the different practices for taking forward AWI across the councils. They also acknowledge that many of the delays are due to other parts of the process and not always as a delay in the allocation of an MHO.</i></p> <p><i>It was also noted that early intervention through PoA promotion and staff awareness training would help to reduce the need for guardianship orders and further delays in the adults stay in hospital.</i></p>

