SASW
The professional association for social work and social workers

Information on discharge from hospital:

Key Messages from the Mental Welfare Commission

15th December 2021

People are admitted to hospital for specialist care and treatment based on their health needs. When people are clinically well enough to then leave hospital, they should receive all necessary information and support to return to their home, whether that is their own house or an alternative community setting which is their home. It is not in anyone's interests to stay in hospital when there is no clinical reason to do so. Planning discharge from hospital is therefore critical to ensuring that people leave hospital fully included in decision making, fully informed and with appropriate support. For those people who do not have the capacity to fully participate in discharge planning processes, legal frameworks must be considered to ensure appropriate lawful authority and respect for the person's rights. All adults have the right to receive the right support at the right time in the right setting for them.

Adults with Incapacity: supporting discharge from hospital

The Mental Welfare Commission and Scottish Government issued a joint statement in October 2021 on supporting discharges from hospital for adults with incapacity. The statement outlines actions that can be taken to support this vulnerable group on discharge from hospital and highlights key points of the law to ensure individuals' rights are respected. It is issued at this time of pressure on the hospital system and consequent focus on delayed discharge. Read it here.

Authority to discharge: report into decision making for people in hospital

The Mental Welfare Commission published this report in May 2021, after studying the detail of 457 individual moves between March and May 2020, looking at the legal authority behind each decision to move a person who did not have capacity to decide for his or herself. Based on their findings, they produced the following recommendations:

Recommendation 1: HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in this report) to inform delivery of training programmes to ensure a confident, competent, multidisciplinary workforce supporting safe and lawful hospital discharge planning.

Recommendation 2: HSCPs should establish a consistent system for recording when an assessment of incapacity has been conducted, by whom and in relation to which areas of decision making.

Recommendation 3: HSCPs should ensure that staff facilitating hospital discharges are clear about the status of registered care home placements, in terms of law (see EHRC vs GGC)20 and with regards the financial and welfare implications of different types of placements for the individual.

Recommendation 4: HSCPs should ensure that practitioners facilitating hospital discharges have copies of relevant documents on file detailing the powers as evidence for taking action on behalf of the individual who is assessed as lacking capacity.

Recommendation 5: HSCPs should ensure that assessments reflect the person as a unique individual with focus on outcomes important to that individual and not external drivers that have the potential to compromise human rights and/or legality of moves.

Recommendation 6: HSCPs should ensure that processes are in place to audit recording of decisions and the legality of hospital discharges for adults who lack capacity in line with existing guidance and the principles of incapacity legislation.

Recommendation 7: HSCPs' audit processes should extend to ensuring evidence of practice that is inclusive, maximising contribution by the individual and their relevant others, specifically carers as per section 28 Carers (Scotland) Act 2016.

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

Recommendation 9: The Care Inspectorate should take account of the findings of this report regarding the use of s.13ZA of the Social Work (Scotland) Act 1968 and consider the scrutiny, assurance or improvement activity to take in relation to this.

Recommendation 10: The Care Inspectorate should take account of the broader findings of this report beyond use of s.13ZA and consider how this might inform future scrutiny, assurance and improvement activity in services for adults.

Recommendation 11: The Scottish Government should monitor the delivery of the above recommendations and work with Health and Social Care Partnerships and the Care Inspectorate to support consistency and address any barriers to delivery over the next two years.

The scope and limitations of the use of section 47 of the Adults with Incapacity Act – Advice Notes

Following a number of enquiries in relation to the use of section 47 of the Act, the Mental Welfare Commission published this brief advice note in October 2021, to clarify the scope and limitations of this part of the legislation.