mental welfare commission for scotland

Mental Welfare Commission Report Summary Easy Read

May 2021

1. What is this report?

Mental Welfare Commission

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This report is about the rights of some people who were moved from hospitals to care homes.

This report is about people who this happened to during the COVID-19 pandemic.

2. Who is this report about?

Mental Welfare Commission

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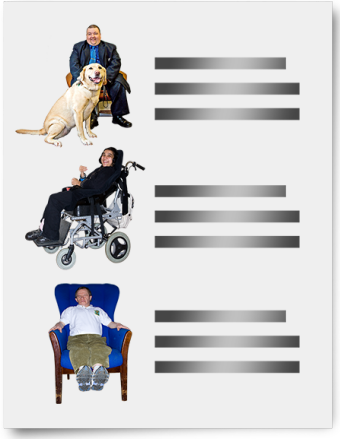
We think of adults as people who can make decisions about their own lives.

But some adults can't make those decisions.

We call these 'adults with incapacity'.



This could be because of:

- A brain injury
- A mental illness
- A stroke
- A learning disability

Many people in Scotland who cannot make decisions for themselves have dementia.

Mental Welfare Commission

2. Who is this report about?

Adults with incapacity still know what is going on around them.

They should be fully involved in their life decisions.

There is an important law that sets out the rights of ‘adults with incapacity.’

It is called the Adults with Incapacity Act.

During the COVID-19 pandemic a lot of adults with incapacity were in hospitals and care homes.

3. Who has written this report?

Mental Welfare Commission

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The Mental Welfare Commission wrote this report.

The Scottish Government
Riaghaltas na h-Alba

The Mental Welfare Commission was set up by mental health law.

Its job is to make sure that the rights of people who cannot make decisions are always respected.

They make sure that the rules for this in the law are being followed.

Mental Welfare Commission

3. Who has written this report?

Some people contacted the Mental Welfare Commission to say that they were worried that the law was not being used properly.

They said that the law was not being followed when adults with incapacity were being moved from hospitals to care homes at the start of the COVID-19 pandemic.

So the Mental Welfare Commission decided to look into it.

4. What did the Mental Welfare Commission do?

Mental Welfare Commission

4. What did the Mental Welfare Commission do?

They wrote to all the Health and Social Care Partnerships in Scotland.

They are the people who have the job of keeping people safe.

Most of them sent an answer back.

Only one area did not get back in touch in time.

They told us about 731 people who had been moved out of hospital and into a care home over a few months.

This is a small number of the people who were moved during this time.

It is about 10% of the total number of people.

Mental Welfare Commission

4. What did the Mental Welfare Commission do?

They said that from this group of people 465 were adults who did not have capacity to agree to move from hospital to a care home.

The Mental Welfare Commission looked at whether the law had been followed for all of these people.

5. What does this report say?

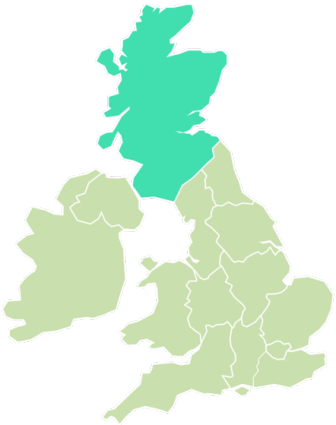
Mental Welfare Commission

5. What does this report say?

The Mental Welfare Commission says that for some of these people their move from a hospital to a care home was unlawful.

This is because for some of these people the rules of the Adults with Incapacity Act were not followed.

This was the case for 20 people.



This happened in 11 areas of Scotland.

Mental Welfare Commission

5. What does this report say?

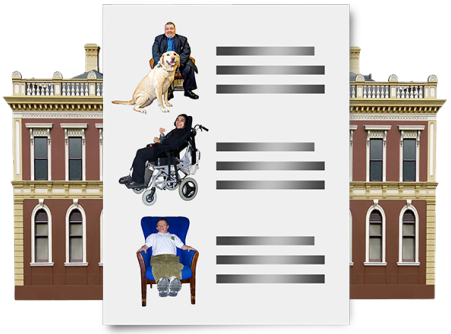
Some areas thought that the Coronavirus Act had changed the rules of the Adults with Incapacity Act.

This was wrong.

The Mental Welfare Commission thinks that this is a breach of the law which says how to make decisions for all people who were moved.

Mental Welfare Commission

5. What does this report say?



The Health and Social Care Partnerships said they used two different laws to move people.

Section 13ZA of the Social Work (Scotland) Act 168 was used in 23 areas to agree that people should be moved from hospital to care homes.

Welfare Power of Attorney or Adults with Incapacity laws were used in 30 areas.

Mental Welfare Commission

5. What does this report say?

The Mental Welfare Commission say that staff were not always clear on what the law said.

Sometimes staff did not check what powers were in place for attorneys or guardians.

They went ahead with the decisions, without checking this.

The Mental Welfare Commission says that this is wrong.

Mental Welfare Commission

5. What does this report say?

All of the facts should have been checked for all of the people.

This might mean that some of these people were moved unlawfully too.

The Mental Welfare Commission found that a lot of staff were confused about how to make sure the law is being followed before sending an adult with incapacity to a care home.

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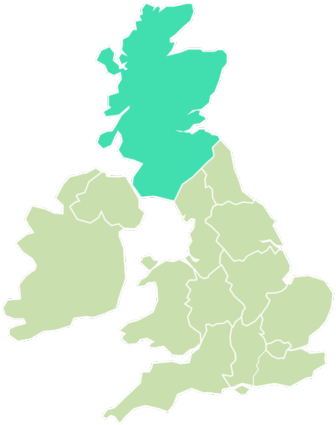
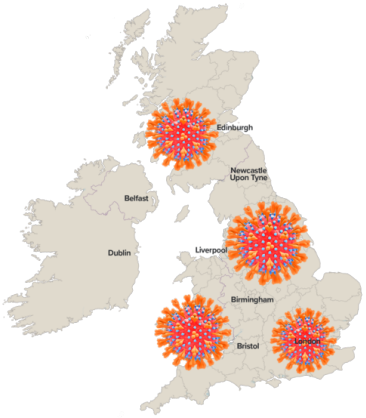
5. What does this report say?



Lots of different areas have different ways of doing it.



The Mental Welfare Commission think that this is not because of COVID-19.

They think that there were problems with how staff understand the law.

They think that there were problems with checks made to make sure the law was being followed.

Mental Welfare Commission

5. What does this report say?

They think these things have been a problem since before the COVID-19 pandemic.

They think that things need to change and get better.

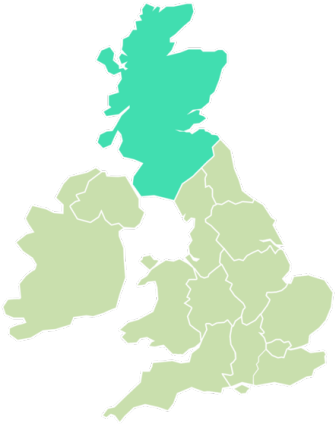
6. What should happen next?

Mental Welfare Commission

6. What should happen next?

Recommendation 1:

Staff involved in moving people from hospital should get training to make sure they understand what the law says should happen.



Recommendation 2:

The way that records are kept on people who are checked to see if they can make decisions of their own should be the same in every area.

Recommendation 3:

Staff involved in moving people out of hospital should make sure they know about what the law says about the person they are moving, and their money and property.

Mental Welfare Commission

6. What should happen next?

Recommendation 4:

Staff involved in moving people out of hospital should have copies of the information that was used to show someone is not able to make their own decisions.

Recommendation 5:

When people are checked to see if they can make their own decisions, it should look at what is important to the person and what is the best thing for them.

Recommendation 6:

There should be checks to make sure that decisions are made in the right way.

Mental Welfare Commission

6. What should happen next?

Recommendation 7:

When checking decisions, there should be information that shows how the person was involved.

There should also be information that shows how the people important to them were involved – like their carers.

Recommendation 8:

There should be strong leadership in the teams that work to help people leave hospital.

Recommendation 9:

The Care Inspectorate should think about how they will look at the records to make sure the decisions being made follow the law.

Mental Welfare Commission

6. What should happen next?

Recommendation 10:

The Care Inspectorate should use this report to think about how they can include what it says when they are checking that decisions follow the law.

The Scottish Government
Riaghaltas na h-Alba

Recommendation 11:

The Scottish Government should make sure that these recommendations happen.

They should work with Health and Social Care Partnerships and the Care Inspectorate to help make this happen over the next two years.