Fife Health & Social Care Partnership
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AGENDA

INTEGRATION JOINT BOARD MEETING WILL BE HELD ON
FRIDAY 20 AUGUST 2021 AT 10.00 AM
THIS WILL BE A VIRTUAL MEETING AND JOINING INSTRUCTIONS ARE INCLUDED IN THE APPOINTMENT

Participants Should Aim to Dial In at Least Ten to Fifteen Minutes Ahead of the Scheduled Start Time

NO	TITLE	PRESENTED BY	PAGE
1	CHAIRPERSON'S WELCOME / OPENING REMARKS	Rosemary Liewald	
2	CHIEF OFFICERS REPORT	Nicky Connor	
3	CONFIRMATION OF ATTENDANCE / APOLOGIES	Rosemary Liewald	
4	DECLARATION OF MEMBERS' INTERESTS	Rosemary Liewald	
5	MINUTES OF PREVIOUS MEETING 18 June 2021	Rosemary Liewald	1 – 8
6	MATTERS ARISING - Action Note 18 June 2021	Rosemary Liewald	9 – 10
7	FINANCE UPDATE	Audrey Valente	11 - 26
8	PERFORMANCE REPORT - EXECUTIVE SUMMARY	Fiona McKay	27 – 39
9	MENTAL WELFARE COMMISSION AUTHORITY TO DISCHARGE AUDIT & FINDINGS	Fiona McKay	40 – 97
10	MINUTES OF GOVERNANCE COMMITTEES / LOCAL PARTNERSHIP FORUM / ITEMS TO BE ESCALATED		98 - 130
	Clinical & Care Governance Confirmed Minute from 2 June 2021	**Tim Brett**	
	Finance & Performance Committee Confirmed Minute from 11 June 2021	**David Graham**	
	Audit & Risk Committee Confirmed Minute from 4 June 2021 Unconfirmed Minute from 9 July 2021	**Audrey Valente**	
	Local Partnership Forum Confirmed Minute from 9 June 2021	**Eleanor Haggett / Nicky Connor**	

11	**AOCB**	**ALL**	
12	**DATES OF NEXT MEETINGS** **IJB DEVELOPMENT SESSION Friday 10 September 2021 - 9.30 am** **INTEGRATION JOINT BOARD Friday 24 September 2021 - 10.00 am**		
MEMBERS ARE REMINDED THAT QUERIES ON THE DETAIL OF A REPORT SHOULD BE ADDRESSED BY CONTACTING THE REPORT AUTHORS IN ADVANCE OF THE MEETING			

Nicky Connor
Director of Health & Social Care
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Copies of papers are available in alternative formats on request from Norma Aitken, Head of Corporate Services, 4th Floor, Fife House – e:mail Norma.aitken-nhs@fife.gov.uk

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UNCONFIRMED

MINUTE OF THE FIFE HEALTH AND SOCIAL CARE – INTEGRATION JOINT BOARD HELD VIRTUALLY ON FRIDAY 18 JUNE 2021 AT 10.00 AM

Present	Councillor Rosemary Liewald (RLi) (Chair) Christina Cooper (CC) (Vice Chair) Fife Council – David Alexander (DA), Tim Brett (TBre), Dave Dempsey (DD), David Graham (DG), David J Ross (DJR) and Jan Wincott (JW) NHS Fife, Non-Executive Members – Martin Black (MB), Eugene Clarke (EC), Margaret Wells (MW) Janette Owens (JO), Nurse Director, NHS Fife Amanda Wong (AW), Associate Director, AHP's, NHS Fife Eleanor Haggett (EH)t, Staff Representative, Fife Council Ian Dall (ID), Service User Representative Kenny Murphy (KM), Third Sector Representative Morna Fleming (MF), Carer Representative Paul Dundas (PD), Independent Sector Representative Simon Fevre (SF), Staff Representative, NHS Fife
Professional Advisers	Nicky Connor (NC), Director of Health and Social Care/Chief Officer Audrey Valente (AV), Chief Finance Officer Lynn Barker (LB), Associate Director of Nursing
Attending	Bryan Davies (BD), Head of Primary & Preventative Care Services Lynn Garvey (LG), Head of Community Care Services Rona Laskowski (RLa), Head of Complex & Critical Care Services Jim Crichton (JC), Interim Divisional General Manager Joy Tomlinson (JT), Director of Public Health Fiona McKay (FM), Head of Strategic Planning, Performance & Commissioning Norma Aitken (NA), Head of Corporate Services Hazel Williamson (HW), Communications Officer Wendy Anderson (WA), H&SC Co-ordinator (Minute)

NO	HEADING	ACTION

1 CHAIRPERSON'S WELCOME AND OPENING REMARKS

The Chair welcomed everyone to the Integration Joint Board (IJB).

The Chair then welcomed Lynne Garvey, Rona Laskowski and Bryan Davies to their first IJB since taking up their permanent roles as Heads of Service and Joy Tomlinson as the new Director of Public Health for NHS Fife.

She also welcomed Tracy Harley, Locality Planning Co-ordinator and Tatiana Zorina and Ann Reynolds, two of our newly appointment Public Engagement Officers who were observing the Board meeting.

NO HEADING **ACTION**

1 CHAIRPERSON'S WELCOME AND OPENING REMARKS (Cont)

Fife was very well represented in the winners of Scottish Care's Annual Care Home Awards which took place on Friday 14 May 2021.

- Paige Stocks, who works at Raith Manor was Carer of the Year.
- Bandrum Nursing Home picked up the Learning and Development Award and their Managing Director, Rachel Payne picked up a specialist award for Positive Impact.
- Hilton Court, Rosyth picked up the specialist Unit/Service of the Year.

Members were advised that a recording pen will be in use at the meeting to assist with Minute taking and the media have been invited to listen in to the proceedings.

2 CHIEF OFFICERS REPORT

The Chair handed over to Nicky Connor for her Chief Officers Report which she began by extending a warm welcome to the three new Heads of Service and thanking Jim Crichton and Fiona McKay for their input during their time as Interim Divisional General Managers.

On Thursday 17 June 2021 a comprehensive briefing had been circulated to IJB members outlining the progress to date with the new structures and plans for moving forward.

In the next few days the first joint staff briefing will be issued from Nicky Connor, Paul Dundas and Kenny Murphy covering the voluntary, independent and managed services. Going forward this will be issued monthly and shared with IJB members.

Martin Black raised the disparity in the gender balance of the new Senior Leadership Team. Nicky Connor advised that following a robust and competitive interview process in line with Human Resource Policy the best candidates had been appointed to each role.

3 CONFIRMATION OF ATTENDANCE / APOLOGIES

Apologies had been received from David Graham, Chris McKenna, Wilma Brown, Helen Hellewell, Kathy Henwood, Katherine Paramore and Steve Grimmond.

4 DECLARATION OF MEMBERS' INTERESTS

There were no declarations of interest.

5 MINUTES OF PREVIOUS MEETING 23 APRIL 2021

The Minute of the meeting held on Friday 23 April 2021 was approved.

NO	HEADING	ACTION

5 MINUTES OF PREVIOUS MEETING 23 APRIL 2021 (Cont)

Under Item 9 – Performance Report – Executive Summary - Tim Brett raised the issue of recruitment challenges and asked if an update could be provided. Nicky Connor advised that this remains an ongoing issue and little change could be seen from meeting to meeting although work is ongoing throughout the sector to address this. Fiona McKay advised that significant work is being undertaken to attract staff into care roles both internally and in the independent sector.

Paul Dundas confirmed that is some areas recruitment challenges are becoming more critical and this concern has been raised nationally, as it is not confined to Fife. Daily and weekly meetings continue to be held to ensure we can continue to provide safe, person-centred care for those who need it.

Tim Brett asked for a report to be brought to the IJB in the Autumn on progress in this area. Nicky Connor confirmed that a report would be taken to the Finance & Performance Committee and then brought to the IJB. **FM/PD**

Close working with partners will continue across Fife to look at future requirements as the transformation agenda is moved forward.

6 MATTERS ARISING

The Action Note from the meeting held on 23 April 2021 was approved.

7 COVID 19 / REMOBILISATION UPDATE

The Chair introduced Nicky Connor and colleagues to provide updates on Covid-19 and Remobilisation. This item will be on the Agenda for the meeting in August 2021 and then will be reviewed for future meetings to support a return to business as usual processes at the Integration Joint Board. Board members were encouraged to e-mail Nicky Connor with their thoughts on the possible change in approach to this item. **NC**

Janette Owens began by updating on the increase in attendance at A&E, and a recent inspection which took place within Acute Services. The inspection showed that there was good compliance with procedures during the Covid-19 pandemic. Two new critical care bed are to be opened within Fife which will require 11 registered nurses as well as Consultant, Allied Health Professional and Pharmacy support. Newly qualified nurses have been offered positions in Fife.

Joy Tomlinson was welcomed to her first meeting. Joy advised we are currently in a more variable phase of the pandemic with the new Delta variant and rising numbers of positive cases (sitting at half of Scottish average). All advised to stick with protective measures.

Scott Garden advised that over 245,000 residents in Fife have received their first vaccination (66% of eligible adults) and over 185,000 have been fully vaccinated. This is above the national average. Vaccination of the youngest cohort (18-29 year olds) began on 11 June 2021 as over 8,000 appointments have been set up to date.

NO HEADING ACTION

7 COVID 19 / REMOBILISATION UPDATE (Cont)

Drop-in vaccination clinics have been arranged in Dunfermline, Kirkcaldy, Glenrothes and Methil for residents over 40 who have waited more than 8 weeks for their second vaccination. Work is ongoing to ensure all eligible residents are offered an appointment.

Kenny Murphy updated on work ongoing within to voluntary sector to ensure staff and service users can work safely. Fiona McKay's team are working with groups to help them remobilise. Recruitment challenges are also being faced by voluntary organisations for both volunteers and paid staff.

Paul Dundas spoke about how well Care Homes have adapted to ongoing Covid testing and visiting restrictions. Recruitment challenges continue to be an issue and these have been raised nationally. Nicky Connor advised that the Integrated Workforce group will be restarted in the coming months which should help to take this work forward.

Fiona McKay updated on the reopening of some Adult and Older People Day Centres. Ongoing support is being provided to ensure these can reopen safely. The Adult Protection Inspection has now finished and the factual report is expected in mid-July 2021. Initial feedback has been positive.

Questions followed the end of the briefing and discussion took place around the drop-in vaccination clinics, the reasons for and impact of increased A&E attendance on health and care services, the impact on mental health waiting lists of the 30 new nurses and questioning the need for 2 metre distancing for care home visits given that all staff and residents should now have been full vaccinated.

Nicky Connor thanked those who had provided an update.

8 FINANCE UPDATE

The Chair introduced Audrey Valente who presented this report which had been discussed at the Finance & Performance Committee on 11 June 2021.

The report detailed the financial position of the delegated managed services based on 31 March 2021 financial information. The forecast surplus is £7.090m. Full funding has been made available by the Scottish Government for the costs of Covid and unachieved savings over this financial year.

At 31 March 2021 the combined Health & Social Care Partnership delegated and managed services are reporting a projected outturn underspend of £7.090m.

The key areas of underspend that are contributing to the financial outturn overspend are Community Services, Older People Residential and Day Care, Children Services, Adult Supported Living, Nursing and Residential and Social Care Other.

Further one-off underspends relating to significant grant funding have led to an overall contribution to balances of £30.019m, with a large element

NO	HEADING	ACTION

8 FINANCE UPDATE (Cont)

of this being funding that will be required to cover future costs relating to COVID-19, with an estimated uncommitted balance of £6.896m.

The report provided information on in year additional funding allocations to provide clarity and transparency in terms of additional funding made available by the Scottish Government to IJB's.

Following discussion on the terminology used and recommendations within the report it was agreed that Audrey Valente would bring future reports to the Board for approval, rather than awareness and discussion.

David J Ross asked if an updated was available on set aside and the risk share for NHS Fife and Fife Council. Nicky Connor advised that these were matters for the NHS and Council to agree as part of the ongoing review of the Integration Scheme. This should be concluded later in the year and information would be available following this.

Members were reminded that they should contact Report authors prior to meetings if they have questions relating to the content of reports. Audrey Valente offered to hold a short meeting a few days prior to each IJB meeting to allow members to raise questions relating to Finance updates. **AV**

9 DUTY OF CANDOUR ANNUAL REPORT

The Chair introduced Lynn Barker who presented this report which was discussed at the Clinical & Care Governance Committee on 2 June 2021.

As part of the Duty of Candour provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016,each organisation is required to produce and publish an annual report detailing when and how the duty has been applied.

During the reporting timeframe the incidents had been investigated fully and feedback on learning from each incident had been taken account of.

Members noted the report contents.

10 COMMISSIONING STRATEGY

The Chair introduced Fiona McKay who presented this report which was discussed at a Clinical & Care Governance Committee on 2 June 2021, a Finance & Performance Committee on 11 June 2021 and a special Clinical & Care Governance Committee on 16 June 2021. Finance & Performance Committee fully supported the Strategy, Clinical & Care Governance Committee.

The Commissioning Strategy is linked directly to the Strategic Plan for Fife and takes forward dedicated work which will ensure that we meet the requirements set out in the plan and develop aprogramme of review and feedback on the proposed strategic way forward.

The Strategy incorporates the National health and Wellbeing outcomes along with the core national indicators for integration and allows the partnership to focus onthe work required within the next few years which will impact on our

10 COMMISSIONING STRATEGY (Cont)

workforce, work with our partner organisations and consideration of the landscape around commissioning of services

The Strategy is a fully developed document with detailsof planning of service provision and considering the challenges faced in respect ofdemography and finance, the strategy also links directly to our work in localities and ensures that future work is dedicated to these areas to allow a bottom up approach considering the voice of the service user and/or carer.

The report highlights our commissioning intentions and the key areas within the strategic plan that support to progress with pace.

Following discussion it was agreed that Fiona McKay would look at the language within the report and consider points raised by Board members.

This Board discussed and approved the report.

11 NEW CARERS ACT INVESTMENT 2021/22

The Chair introduced Fiona McKay who presented this report which was discussed at the Finance & Performance Committee on 11 June 2021.

Unpaid carers play a significant role in supporting the most vulnerable people in our communities and their contribution has been even more needed and impactfulduring the Covid-19 pandemic. It is clear from the last year without opportunities for respite and access to practical support that unpaid carers need support to continue to lift the burden from the statutory sector. This paper offers a range of opportunities to invest in carers' support based on what carers and the professionals who help them have told us they want and need to make their caringrole sustainable. The options presented meet the obligations laid down in the Carers Act, support the delivery of the HSCP strategic plan and deliver on the outcomes committed to in the Carers strategies.

The Carers (Scotland) Act 2016 was introduced in April 2018. Since then the Scottish Government has increased the funding baseline intended to be used to support local authorities to meet the Duties laid down in the Act.

The options presented in this paper at Appendix A added to the baseline of support agreed in previous years to support unpaid carers.

These new options presented for consideration and agreement in Appendix B provide information about the largest of the options, namely investment in self-directed support for carers in their own right. Appendix C was the statement of scoring rationale for each of the proposals in Appendix A.

The paper was detailed and welcome. Questions were asked around the Fife share of funding available, the rationale behind the Community Chest and reservations on the potential number of carers who could be recruited. Fiona McKay will check the share of funding and provide an update. The Community Chest will provide a small pot of money for each locality and

11 NEW CARERS ACT INVESTMENT 2021/22 (Cont)

criteria will be in place to ensure fairness in distribution. The Participation and Engagement Officers will work to encourage carers to engage in a more fluid and less formal way.

The Board for considered the report and Approved the proposal for new investment to support unpaid carers in 2021/22.

12 LOCAL PARTNERSHIP FORUM (LPF) ANNUAL REPORT

The Chair introduced Jim Crichton who presented this report which was discussed at the Finance & Performance Committee on 11 June 2021.

Nicky Connor advised that the LPF has been making significant progress over the last year in supporting our workforce through the Covid-19 pandemic and it was important to highlight this work to Board members.

The report has been developed in partnership and brings together the work of the LPF in delivering on its key objectives of:

- Advising on the delivery of staff governance and employee relations issues.
- Informing thinking around priorities on health and social care issues.
- Informing and testing the delivery and the implementation of strategic plans, and commissioning intentions.
- Advising on workforce planning and development.
- Promoting equality and diversity and;
- Contributing to the wider strategic organisational objectives of the Integration Joint Board (IJB).

The 7 key areas of work for the LPF are Staff Communication, Staff Health and Wellbeing, Promoting Attendance, Staff Training and Development, Health and Safety, Equality and Fairness and Staff Engagement.

Simon Fevre thanked Jim Crichton for the work which had gone into co-ordinating the contributions to the Annual Report which summarises the work the LPF have done in the past year. Remobilisation means increasing activity in hospitals, vaccination centres and within test and protect and this is having an impact on staffing. LPF members are fully committed to supporting staff through this time.

The Board noted the content of the report.

13 MINUTES OF GOVERNANCE COMMITTEES / LOCAL PARTNERSHIP FORUM AND ITEMS TO BE ESCALATED

The Chair asked David Graham, Eugene Clarke and Simon Fevre for any items from governance committees / Local Partnership Forum that they wish to escalate to the IJB.

NO	HEADING	ACTION

13 MINUTES OF GOVERNANCE COMMITTEES / LOCAL PARTNERSHIP FORUM AND ITEMS TO BE ESCALATED (Cont)

Tim Brett – Clinical & Care Governance Committee (C&CG) – 16 April 2021 (Confirmed)

Tim Brett highlighted the Primary Care Update and the Chief Social Worker's Report.

David Graham – Finance & Performance Committees (F&P) – 8 April 2021 (Confirmed)

David Graham had been unable to join today's meeting, in his absence Audrey Valente had no issues to escalate to the Board.

Eugene Clarke – Audit & Risk Committee (A&R) – 17 March 2021 (Confirmed)

Eugene Clarke highlighted the work which is being undertake on Risk Appetite and the governance for the Annual Accounts, which would continue to be approved by the IJB. This was Eugene's final report to the IJB and he thanked colleagues on A&R and staff who had helped him over this time on the IJB.

Local Partnership Forum (LPF) – 14 April 2021 and 12 May 2021 (Confirmed)

Simon Fevre highlighted the Access Therapies website, which is available to all staff, the Whistleblowing Standards which will be discussed at future LPF meetings and the continuing Health and Safety updates which form part of each LPF meeting.

14 AOCB

Eugene Clarke and Margaret Wells were both attending their final IJB meeting prior to stepping down from the NHS Fife Board. Rosemary Liewald thanked them both and passed on the good wishes of Board members.

15 DATES OF NEXT MEETINGS

IJB DEVELOPMENT SESSION – Friday 6 August 2021 at 9.30 am

INTEGRATION JOINT BOARD – Friday 20 August 2021 at 10.00 am

ACTION NOTE – INTEGRATION JOINT BOARD – FRIDAY 18 JUNE 2021

REF	ACTION	LEAD	TIMESCALE	PROGRESS
1	**Finance Update –** provide an update on Direct Payments to a future Development Session.	**Audrey Valente**	**Development Session during 2021**	This will be added to a development session
2	**Finance Update-** a further discussion on Alcohol and Drug Partnership funding would be brought back to a future IJB meeting	**Audrey Valente / Fiona McKay / Kathy Henwood**	**TBC**	
3	**SUGGESTED DEVELOPMENT SESSION TOPICS** **Covid-19/Remobilisation Update** **Planning with People** **Digital – Use of Technology** **Acute Set Aside** **i**n response to concerns raised on the number of topics suggested for future Development Sessions, Rosemary Liewald and Nicky Connor agreed to have a discussion on the items which have been suggested and would tailor a programme of issues to be discussed at the remaining Development Sessions in 2021.	**Rosemary Liewald/ Nicky Connor**	**Next Meeting 18/06/21**	All proposed development session topics will be added to this financial years development sessions.
4	**Minutes of Previous Meeting – 23/04/21 -** Item 9 – Performance Report – Executive Summary - Tim Brett asked if an update report on recruitment challenges be brought to the IJB in the Autumn.	**Fiona McKay / Paul Dundas**	**TBC**	
5	**Covid 19 / Remobilisation Update** – to be reviewed for future meetings with consideration to a briefing approach as we move back to business as usual	**Nicky Connor / Rosemary Liewald**	**September Meeting**	
6	**Finance Update –** short meeting to be arranged to allow Board members to ask questions on Finance papers.	**Audrey Valente**	**Prior to each IJB meeting**	

COMPLETED ITEMS

Performance Report - Paul Dundas advised that Scottish Care have arranged a Teams meeting on Wednesday 28 April 2021 entitled Recruitment – Creating Pathways to Social Care, which IJB members would be able to attend. Paul will circulate details.	**Paul Dundas**	**ASAP**	**Completed 23/04/21**

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Meeting Title:	**Integration Joint Board**
Meeting Date:	**20 August 2021**
Agenda Item No:	**7**
Report Title:	**Finance Update**
Responsible Officer:	**Nicky Connor, Director of Health & Social Care**
Report Author:	**Audrey Valente, Chief Finance Officer**

1 Purpose

This Report is presented to the Board for:

- Discussion
- Decision

This Report relates to which of the following National Health and Wellbeing Outcome*:*

9 Resources are used effectively and efficiently in the provision of health and social care services.

This Report Aligns to the following Integration Joint Board 5 Key Priority:

- Managing resources effectively while delivering quality outcomes.

2 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- NHS Fife Finance Team
- Fife Council Finance Team
- Finance & Performance Committee – 13 August 2021 – at this Committee the following was discussed:-
  - Adult packages were discussed by the Finance and Performance Committee and it was agreed that further analysis is required to understand future demographics . It was noted that the Chief Finance Officer and SLT need to review the information with some urgency to establish whether efficiencies are achievable.

- In terms of unachieved savings the committee asked for a paper to be brought back to the Finance and Performance Committee providing detail of the delivery plan, and any next steps.
- It was agreed that a recovery plan is required to be brought back to a future committee.

3 Report Summary

3.1 Situation

The attached report details the financial position of the delegated and managed services based on 30 June 2021 financial information. The forecast deficit is £6.798m. It is expected that the costs of Covid-19 will be met in full through use of Reserves and further funding from Scottish Government.

3.2 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 determines those services to be delegated to the Integration Joint Board (IJB).

The IJB has a responsibility for the planning of Services which will be achieved through the Strategic Plan. The IJB is responsible for the operational oversight of Integrated Service and, through the Director of Health and Social Care, will be responsible for the operational and financial management of these services.

3.3 Assessment

At 30 June 2021 the combined Health & Social Care Partnership delegated and managed services are reporting a projected outturn overspend of £6.798m.

Five key areas of overspend that are contributing to the projected outturn overspend –

- Hospital & Long-Term Care
- Family Health Services
- Older People Residential and Day Care
- Homecare Services
- Adult Placements

The report provides information on in year additional funding allocations to provide clarity and transparency in terms of additional funding made available by the Scottish Government to IJBs.

There is also an update in relation to savings which were approved by the IJB in March 2021 and use of Reserves brought forward from 2020-21.

3.3.1 Quality/ Customer Care

There are no Quality/Customer Care implications for this report

3.3.2 Workforce

There are no workforce implications to this report.

3.3.3 Financial

The medium-term financial strategy has been reviewed and updated.

3.3.4 Risk/Legal/Management

Full funding may not be made available by the Scottish Government to fund the costs of Covid-19 and unachieved savings as a result of Covid-19 within 2021-22. However, any expenditure associated with Covid-19 will continue to be recorded in the Local Mobilisation Plan.

3.3.5 Equality and Diversity, including Health Inequalities

An impact assessment has not been completed and is not necessary as there are no EqIA implications arising directly from this report.

3.3.6 Other Impact

None

3.3.7 Communication, Involvement, Engagement and Consultation.

Not applicable.

3.4 Recommendation

- **Approval** – examine and consider the key actions/next steps and approve the financial monitoring update as at June 2021.

4 List of Appendices

The following appendices are included with this report:

Appendix 1 – Finance Report June 2021
Appendix 2 – Fife H&SCP Reserves
Appendix 3 – Tracking Approved 2020-21 Savings Tracker

5 Implications for Fife Council

6 Implications for NHS Fife

7 Implications for Third Sector

8 Implications for Independent Sector

9 Directions Required to Fife Council, NHS Fife or Both

Direction To:		
1	No Direction Required	✓
2	Fife Council	
3	NHS Fife	
4	Fife Council & NHS Fife	

Report Contact
Audrey Valente, Chief Finance Officer - Audrey.Valente@fife.gov.uk

www.fifehealthandsocialcare.org

APPENDIX 1

Fife Health & Social Care Partnership

NHS Fife

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Fife Council

FINANCIAL MONITORING

FINANCIAL POSITION AS AT JUNE 2021

1. Introduction

The Resources available to the Health and Social Care Partnership (H&SCP) fall into twocategories:

a) Payments for the delegated in scope functions
b) Resources used in “large hospitals” that are set aside by NHS Fife and made available to the Integration Joint Board for inclusion in the Strategic Plan.

The approved revenue budget of £555.760m for delegated and managed services was approved at the 26th March 2021 IJB. The net budget requirement exceeded the fundingavailable and a savings plan of £8.723m was approved at that same meeting.

The revenue budget of £38.134m for acute set aside was also set for 2021-22.

2. Financial Reporting

This report has been produced to provide an update on the projected financial position ofthe Health and Social Care Partnership core spend. A summary of the projected underspend at the current time is provided at Table 2. A variance analysis will be provided where the variance is in excess of £0.300m. It is critical that the H&SCP manage within the budget envelope approved in this financial year and management require to implement robust project plans to bring the partnership back in-line with this agreed position.

In addition to core information there is also an update in relation to Covid included withinparagraph 7, and the latest update in terms of mobilisation is available at paragraph 8.

3. Additional Budget Allocations for Year

Additional Budget allocations are awarded in year through Health budget allocations which are distributed to the H&SCP where applicable. The total budget for the delegatedand managed services has increased by £22.545m through additional allocations for specific projects as detailed below in Table 1 - £13.798m of this funding has been allocated to budgets and £8.747m is held and yet to be allocated.

	Funding Received 2021-22	FundingB/F	Funding Allocated	Funding to be Allocatedto Budgets	Annual recurrent award
	£	£	£	£	
Alcohol and Drug Partnership	919,723	5,056,561	3,927,099	2,049,185*	Y
Mental Health Act	344,000		332,200	11,800	Y
Integration Fund		631,442	471,582	159,860	Y
Family Nurse Partnership	1,276,288		1,276,288	0	N
Capacity Building CAMHS & PT	455,623		455,623	0	Y
Mental health innovation fund	287,601		287,601	0	Y
Veterans First Point Transition funding	116,348		116,348	0	Y
Primary Medical Services Bundle	1,717,797		0	1,717,797	N
Outcomes Framework	775,419			775,419	N
PCIF	5,440,204	1,011,130	6,451,334	0	First Tranche received
District Nurses	332,872			332,872	Earmarked recurring
Maternity & Neonatal Psychological Interventions	138,291		138,291	0	N
Mental Health Recovery	2,222,582			2,222,582	N
Redesign of Urgent Care	681,277			681,277	N
Auchtermuchty Medical Practice	48,000			48,000	N
Action 15 Mental Health Strategy	1,090,043		342,000	748,043	First Tranche received
	15,846,068	**6,699,133**	**13,798,366**	**8,746,835**	

**ADP has been fully committed since June 2021*

4. Directions

There are no Directions required for this paper as the paper provides an update on thefinancial outturn of the Health and Social Care Partnership based on the position at June 2021.

Planning for Winter will have a potential significant impact on the projected financial outturn. As in previous years, early estimates in relation to the levels of potential expenditure are included and will be refined once more clarity is available through the Winter Planning Group.

5. Financial Performance Analysis as at June 2021

The combined Health & Social Care Partnership delegated and managed services arecurrently reporting a projected outturn overspend of £6.798m as below.

Objective Summary	Opening Budget	Budget June	Forecast Outturn June	Variance as at June
	£m	£m	£m	£m
Community Services		106.610	103.509	-3.101
Hospitals and Long-Term Care		54.922	55.753	0.831
GP Prescribing		74.688	74.688	0.000
Family Health Services		105.632	106.132	0.500
Children's Services		17.318	16.918	-0.400
Resource transfer & other payment	385.844	49.718	51.885	2.167
Older People Residential and DayCare	14.640	14.640	15.120	0.480
Older People Nursing and Residential	35.663	35.663	35.917	0.254
Homecare Services	30.447	30.447	31.437	0.990
Adults Fife Wide	4.743	4.743	4.537	-0.206
Social Care Other	1.404	1.404	1.418	0.014
Adult Placements	43.947	43.947	49.726	5.779
Adult Supported Living	20.798	20.798	20.765	-0.033
Social Care Fieldwork Teams	16.745	16.745	16.268	-0.477
Housing	1.529	1.529	1.529	0.000
Total Health & Social Care	**555.760**	**578.804**	**585.602**	**6.798**

The main areas of variances are as follows:

5.1 Community Services underspend £3.101m

There is a forecast outturn of £3.101m underspend within Community Services which isdue to staff vacancies in health promotion & community dental services (Fife Wide) as well as nursing vacancies in the East. There are also forecast underspends in Sexual Health and Rheumatology drug costs.

5.2 Hospital and Long-Term Care £0.831m overspend

There is a forecast overspend of £0.831m comprising staff costs associated with additional demands relating to patient frailty/complexity. There are also staff shortagesand vacancies within Mental Health which has necessitated additional expenditure in relation to medical locums and nursing overtime, bank and agency spend.

5.3 Family Health Services £0.500m overspend

This overspend is due to the locum costs associated with 2c Practices, level of maternity & sickness costs across primary medical services.

5.4 Children's Services £0.400m underspend

This underspend is due to ongoing vacancies in health visitors, family nurses, paediatricphysiotherapy, and school nursing.

5.5 Resource Transfer £2.167m overspend

This overspend reflects the payment between the NHS and Fife Council required torealign the budget as agreed by IJB.

5.6 Older People Residential and Day Care £0.480m overspend

There are overspends on agency and staffing of £0.279m mainly due to non-Covid related absences; extra cleaning & catering charges of £0.157m, and unachieved savings on Daycare of £0.094m.

5.7 Homecare Services £0.990m overspend

The overspend mainly relates to the expectation that not all the savings targets will be achieved leading to an overspend of £0.582m on Older People Care packages and £0.089m on payments to individuals to organise their own care. In addition, there is aforecasted overspend of £0.257m due to increased staff mileage.

5.8 Adult Placements £5.779m overspend

The overspend in adult placements mainly relates to a greater number of adult packages having been commissioned than the budget available, £3.975m. Progress towards some of the savings' targets has been delayed due to COVID and these areexpected to underachieve by £0.938m. In addition to this a provision has been madewithin the projections of £900k to cover increased packages due to the transition of Service Users from Children and Families.

5.9 Social Care Fieldwork Teams – Underspend £0.477m

This underspend it due to delays in recruitment, agency staff are to be used to increase capacity.

6. Savings

A range of savings proposals to meet the budget gap was approved by the IJB as partof the budget set in March. The total value of savings approved for the 2021-22 financial year is £8.723m. The financial tracker included at Appendix 2, provides an update on all savings and highlights that anticipated savings of £6.304m (72.3%) will bedelivered against the target.

Previously approved savings which were unmet at 31 March 2021 require to be made in2021-22 to balance the budget, these total £5.484m and it is currently projected that 56% of these are achievable.

The non-delivery of savings is currently required to be reported within the Local Mobilisation Plans. As with all costs reported within the mobilisation plan there is no certainty that full funding will be made available by the Scottish Government.

7. COVID

In addition to the core financial position, there is a requirement to report spend in relation to Covid-19 and remobilisation costs. Currently the actual expenditure reported in the Local Mobilisation Plan (LMP) to June is £6.383m. Reserves for Covid-19 broughtforward from 2020-21 are to be used in the first instance to fund any 2021-22 Covid-19 related expenditure.

8. Local Mobilisation Plans (LMP)

On 11 March 2020 John Connaghan wrote to all Chief Executives of NHS Boards and Local Authorities formally requesting the production of Local Mobilisation Plans in response to Covid-19. There was a very clear understanding that the response should be on a whole system basis across all partners. A first draft of the Mobilisation Plan was submitted to the Scottish Government on the 18 March 2020. Since that date the plan and the financial return have continued to evolve, and regular updates have been provided. The returns will continue to be submitted quarterly in 2021-22.

The June submission suggests a full year projection of £29.558m. The Senior Leadership Team will endeavour to deliver the required savings in-year, but it is likely that there will be delays in implementing some of the savings and these have thereforebeen included in the LMP.

This will continue to be reported regularly to both the Finance and Performance Committee and the Integration Joint Board throughout the financial year.

9. Reserves

Reserves totalling £29.643m are held by Fife Council on behalf of the IJB. £15.108m is related to Covid-19 and a further £7.575m is ear-marked for specific use**.** Expenditure recorded in the LMP is expected to be funded in the first instance from the Covid-19 reserve.

£6.888m is currently uncommitted. A process will be developed for the use of unallocated Reserves, for consideration by SLT. Approval of use of uncommitted balances and any change of use of Earmarked balances will require to be approved by Finance & PerformanceCommittee and Integration Joint Board. We will bring this to a future meeting

An update is provided at Appendix 2

10. Risks and Mitigation

10.1 Covid

There is a risk that the costs of Covid will not be fully funded by the Scottish Government and it is essential that these costs are continually reviewed to ensure development of a robust case for investment.

The HSCP will continue to contain costs or reduce them wherever possible and to use all funding streams available to them in order to mitigate these new financial pressures.

All areas of expenditure will be reviewed, and every effort will be made to control costswithin the overall budget.

10.2 Savings

Non delivery of savings is also an area of risk. The plans that were approved in March have been impacted by Covid, as all resources have been focused on managing the pandemic.

The senior leadership have committed to keep savings under continual review anddevelop delivery plans that provide clarity in terms of delivery timescales.

10.3 Funding

The potential risk associated with not receiving full funding for mobilisation plans is immediate and requires further consideration by the Finance and Performance Committee. Only 66% of approved savings are estimated to be delivered in this financial year. The remainder will impact on the projected outturn position of the HSCP if funding is not made available. It is recommended that this specific risk is reflected in the projected outturn position with immediate effect and reported to the IJB. The committee are asked to discuss and consider the degree of risk that should be reflected, however, at this stage in the financial year it is proposed that the full value of non-achieved savings as per Appendix 1 is reflected as presented today.

10.4 Forward Planning

The impact on future year budgets and the requirement to review the financial planningassumptions will be necessary. This is work that will progress and it is anticipated that an update will be provided at the November Committee meeting.

11. Key Actions / Next Steps

The Integration Scheme advises that where there is a forecast overspend, the Director of Health and Social Care, the Chief Finance Officer of the Integration Joint Board, Fife Council's Section 95 Officer and NHS Fife Director of Finance must agree a Recovery Plan to balance the total budget. This will be brought to the next meeting of the Finance and Performance Committee.

The Senior Leadership Team (SLT) will review the medium-term financial strategy that will span the period 2022-23 to 2023-25. The SLT believe that it is important to fully engage with all stakeholders and as a result we will be holding development sessions with both Board members and the Local Partnership Forum and will continue to do so particularly in terms of the medium- term financial strategy.

Effective Financial Management remains a key priority for the Partnership. Weekly meetings to consider new and replacement posts will remain in place. The processes relating to supplementary staffing have be strengthened and a robust approval processwill continue, which will provide clarity and transparency but will also ensure that the consideration of costs is firmly embedded into the commissioning process going forward.

Additional measures to strengthen financial governance are currently being consideredin relation to areas of overspend. A further level of scrutiny will be considered and authorisation by the Heads of Service, Chief Officer and Chief Finance Officer will be required.

Audrey Valente
Chief Finance Officer
13 August 2021

APPENDIX 2

Fife H&SCP – Reserves

	2021-22	Future Years
	£m	£m
Balance at 1 April	**(29.643)**	**(6.888)**
Budgets transferred (to)/from Reserves		
*** Estimated Balance at 31 March**	**(29.643)**	
Earmarked Reserves		
PCIF	2.524	
Action 15	1.349	
District Nurses	0.030	
Fluenz	0.018	
Alcohol and Drugs Partnerships	0.315	
Community Living Change Plan	1.339	
Free Style Libre/ Other	2.000	
Covid-19	15.180	
Total Earmarked	**22.755**	
Estimated uncommitted balance at 31 March	**(6.888)**	

Earmarked Reserves	**Total Held**	**Allocated at June**	**Balance**
	£m	£m	£m
PCIF	2.524	1.513	1.011
Action 15	1.349	1.315	0.034
District Nurses	0.030		0.030
Fluenz	0.018		0.018
Alcohol and Drugs Partnerships	0.315		0.315
Community Living Change Plan	1.339		1.339
Free Style Libre/ Other	2.000	2.000	0.000
Covid-19	15.180	6.383	8.797
- Vaccines – £0.740m			
- Care Homes Nurse Support -£0.332m			
- Flu - £0.203m			
- HSCP LMP - £5.108m			
Total Earmarked	**22.755**	**11.211**	**11.544**

Uncommitted Balance	**Total Held**	**Allocated at June**	**Balance**
	£m	£m	£m
Total Uncommitted Balance	**(6.888)**		**(6.888)**

Grants held in Fife Council balances on behalf of Fife H&SCP

Self Directed Support	**0.368**

***Outturn report stated £30.019 – Final position for Annual Accounts is £29.643m – total was reduced by £0.368m for Self Directed Support which is held as a Grant Carried forward by Fife Council on behalf of HSCPso is not included in reserve. Also reduced by £0.008m as Housing underspend remained with Fife Council due to suspension of carry-forward scheme.**

Appendix 3

TRACKING APPROVED 2020-21 SAVINGS
HEALTH & SOCIAL CARE

Area	Approved Budget Year	Title of Savings Proposal	Savings Target £m	Overall Forecast £m	(Under)/ over achieved	Rag Status
All	2021-24	Travel Review	0.450	0.450	0.000	Green
All	2021-24	Supplementary Staffing and Locums	0.250	0.000	(0.250)	Amber
All	2021-24	CRES	5.429	4.804	(0.625)	Amber
Complex & Critical	2021-24	Bed Based Model	0.500	0.000	(0.500)	Amber
Prescribing	2021-24	Medicines Efficiency	0.500	0.500	0.000	Green
All	2021-24	MORSE	0.800	0.000	(0.800)	Amber
Complex & Critical	2021-24	Review of Payment Cards	0.040	0.040	0.000	Green
Community Care	2021-24	Review of Payment Cards	0.010	0.010	0.000	Green
Complex & Critical	2021-24	Review of respite services	0.130	0.070	(0.060)	Amber
Community Care	2021-24	Review of respite services	0.020	0.010	(0.010)	Amber
Complex & Critical	2021-24	Review of Alternative travel arrangements - Service Users	0.349	0.175	(0.174)	Amber
Complex & Critical	2021-24	Review of Media Team	0.045	0.045	0.000	Green
Complex & Critical	2021-24	Community Services review	0.200	0.200	0.000	Green
Grand Total			**8.723**	**6.304**	**(2.419)**	**72.3%**

Previously Approved Savings

Area	Approved Budget Year	Title of Savings Proposal	Savings Target £m	Overall Forecast £m	(Under)/ over achieved	Rag Status
Complex & Critical	2020-23	Supplementary Staffing and Locums (20/21)	0.600	0.600	0.000	Green
Community Care	2020-23	BED Based Model	1.000	1.000	0.000	Amber
Complex & Critical	2020-23	Managed General Practice Modelling	0.200	0.000	(0.200)	Amber
Complex & Critical	2020-23	Resource Scheduling (Total Mobile)	0.123	0.060	(0.063)	Amber
Community Care	2020-23	Resource Scheduling (Total Mobile)	0.627	0.320	(0.307)	Amber
Complex & Critical	2020-23	High Reserves	0.611	0.100	(0.511)	Red
Community Care	2020-23	High Reserves	0.089	0.000	(0.089)	Red
Complex & Critical	2020-23	Procurement Strategy	0.200	0.100	(0.100)	Amber
Community Care	2020-23	Review Care Packages	0.450	0.450	0.000	Green
Complex & Critical	2020-23	Re-provision of Care	0.875	0.100	(0.775)	Red
Community Care	2020-23	Re-provision of Care	0.525	0.250	(0.275)	Amber
Community Care	2019-22	Previously Approved - Day Care services	0.184	0.090	(0.094)	Amber
Grand Total			**5.484**	**3.070**	**(2.414)**	**56.0%**

Rag Status Key:-

Green - No issues and saving is on track to be delivered

Amber - There are minor issues or minor reduction in the value of saving, or delivery of the saving is delayed

Red - Major issues should be addressed before any saving can be realised

Summary			
Rag Status	Savings Target £m	Overall Forecast £m	(Under)/ over £m
Green	2.295	2.295	0.000
Amber	10.337	6.879	(3.458)
Red	1.575	0.200	(1.375)
Total	14.207	9.374	(4.833)

Fife Health & Social Care Partnership
Supporting the people of Fife together

Meeting Title:	**Integration Joint Board**
Meeting Date:	**20 August 2021**
Agenda Item No:	**8**
Report Title:	**Performance Report – Executive Summary**
Responsible Officer:	**Nicky Connor** **Director of Health & Social Care Partnership**
Report Author:	**Fiona McKay** **Head of Strategic Planning, Performance & Commissioning**

1 Purpose

This Report is presented to the Board for awareness.

This Report relates to which of the following National Health and Wellbeing Outcomes*:*

1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

2 People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5 Health and social care services contribute to reducing health inequalities.

6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

7 People who use health and social care services are safe from harm.

8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9 Resources are used effectively and efficiently in the provision of health and social care services.

This Report Aligns to the Integration Joint Board 5 Key Priorities*:*

- Working with local people and communities to address inequalities and improve health and wellbeing across Fife.
- Promoting mental health and wellbeing.
- Working with communities, partners and our workforce to effectively transform, integrate and improve our services.
- Living well with long term conditions.
- Managing resources effectively while delivering quality outcomes.

2 Route to the Meeting

Finance and Performance Committee - 13 August 2021.

The Committee highlighted that there was a concern in respect of the absence reporting from Fife Council due to a change in systems.

The Committee also recognised the ongoing pressures within the system in particular around A&E attendances and capacity with care services across the Partnership.

The Committee considered in detail waiting times performance for CAMHS and Psychological therapies and will continue to monitor closely in all Performance Reports and a detailed report will be provided in 6 months times.

3 Report Summary

3.1 Situation

The monitoring of Performance is part of the governance arrangements for the Health and Social Care Partnership.

3.2 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 determines those services to be delegated to the Integrated Joint Board. The Fife H&SCP Board has a responsibility for the planning of Services which will be achieved through the Strategic Plan. The Fife H&SCP board is responsible for the operational oversight of Integrated Services, and through the Director of Health and Social Care, will be responsible for the operational management of these services.

3.3 Assessment

The attached report provides an overview of progress and performance in relation to the following:

- National Health and Social Care Outcomes
- Health and Social Care – Local Management Information
- Health and Social Care – Management Information

3.3.1 Quality/ Customer Care

Management information is provided within the report around specific areas, for example, complaints. The report highlights performance over several areas that can impact on customer care and experience of engaging with the Health & Social Care Partnership. Where targets are not being achieved, improvements actions would be taken forward by the lead service / divisional manager.

3.3.2 Workforce

The performance report contains management information relating to the Partnership's workforce however, any management action and impact on workforce would be taken forward by the relevant Divisional General Manager.

3.3.3 Financial

No financial impact to report.

3.3.4 Risk/Legal/Management

The report provides information on service performance and targets. Any associated risks that require a risk assessment to be completed would be the responsibility of the service area lead manager and would be recorded on the Partnership Risk Register.

3.3.5 Equality and Diversity, including Health Inequalities

An EqIA has not been completed and is not necessary. The report is part of the governance arrangements for the Partnership to monitoring service performance and targets.

3.3.6 Other Impact

There are no environmental or climate change impacts related to this report.

3.3.7 Communication, Involvement, Engagement and Consultation

No consultation is required.

3.4 Recommendation

- **Awareness** – for members' information only

4 List of Appendices

The following appendices are included with this report:

- Appendix 1 - Performance Report Executive Summary – July 2021

5 Implications for Fife Council

6 Implications for NHS Fife

7 Implications for Third Sector

8 Implications for Independent Sector

9 Directions Required to Fife Council, NHS Fife or Both

Direction To:		
1	No Direction Required	x
2	Fife Council	
3	NHS Fife	
4	Fife Council & NHS Fife	

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APPENDIX 1

Fife Health & Social Care Partnership

Performance Report
Executive Summary

July 2021

NHS Fife

Supporting the people of Fife together

Fife Council

Contents

Executive Summary

Fife Health & Social Care Partnership delivers a wide range of delegated services on behalf of both NHS Fife and Fife Council as described within the Integration Scheme. The Health and Social Care Partnership is working towards delivery of the Health and Social Care Strategic Plan which is cognisant of the national outcomes of Integration, NHS Fife Clinical Strategy and the Plan for Fife.

This report details the performance relating to Partnership services which include both national and local performance as well as management performance targets. Many of these measures are already regularly included and referenced in reports to NHS Fife and Health & Social Care Partnership Committees.

We continue to see a higher number of people in hospital waiting registered as code 9 this code indicates that people have been assessed as lacking capacity to decide on a care home move were underpinned by the legal authority of a Welfare Guardianship Order or the existence of a Welfare Power of Attorney, this process also requires a court to make the final decision, due to closure of courts over the pandemic we are seeing a higher than usual delay. This is being monitored closely.

Overall, the Long Term Care population continues to fall, for the period April 2020 – June 2021.

Demand for Care at Home services has continued to rise over the last few months with capacity within the internal and external care at home to deliver stretched compared to last year at this time we are seeing a significant rise in delivery but there still remains a number of people waiting for a care package. The service has also commenced a review of all care at home services users care packages to ensure people are receiving the care, this has been delayed due to the pandemic but now in place.

Fiona McKay
Head of Strategic Planning, Performance and Commissioning

Performance Matrix & Information

National Health & Social Care Outcomes

The Ministerial Strategic Group for Health and Community Care (MSG) requested partnerships submitted objectives towards a series of integration indicators based on 6 high level indicators:

(1) Emergency admissions;
(2) Unscheduled hospital bed days;
(3) Emergency department activity;
(4) Delayed discharges;
(5) End of life care; and
(6) Balance of care.

The table below shows current performance against these. The table summarises the current performance of each indicator's latest rolling month's data from the previous financial year's data. It uses the newest complete month and takes the sum of the 12 months prior and compares this with the previous financial year. For example, if the latest data for an indicator is available in July 2018, this will compare the rolling year figure (sum of previous 12 months i.e. from August 2017 to July 2018) with the equivalent figure from the 2017/18 financial year.

Arrows showing comparisons from the previous financial year are shown, with Green positive, Red negative or Yellow no change (as demonstrated on the key below). Percentage differences between the two figures are also provided.

↑ ↓	Improvement of indicator from previous
↑ ↓	Worsening of indicator from previous
No diff	No change

MSG Indicator	MSG Description	Latest Available Month	Previous Rolling Year	Fife Previous Rolling Year Total	Fife Current Rolling Year*	Fife Rolling Year diff from Previous Rolling Year	% Diff
1a.1	Emergency Admissions	Mar-21	Mar-20	44,242	36,321	↓ 7,921	-17.90%
1b.1	Emergency Admissions from A&E	Mar-21	Mar-20	23,193	17,966	↓ 5,227	-22.54%
1b.2	A&E Conversion Rate (%)	Mar-21	Mar-20	23.68%	26.22%	↑ 2.55%	2.55%
2a.1	Unscheduled hospital bed days	Feb-21	Feb-20	269,712	209,411	↓ 60,301	-22.36%
2b.1	Unscheduled hospital bed days - GLS	Feb-21	Feb-20	11,513	8,314	↓ 3,199	-27.79%
2b.2	Unscheduled hospital bed days - Mental Health	Feb-21	Feb-20	95,674	76,980	↓ 18,694	-19.54%
3a	A&E Attendances	Mar-21	Mar-20	97,962	68,513	↓ 29,449	-30.06%
3b	A&E % seen within 4 hours	Mar-21	Mar-20	92.45%	93.99%	↑ 1.54%	1.54%
4.1	Delayed discharge bed days: All reasons	Apr-21	Apr-20	40,852	31,441	↓ 9,411	-23.04%
4.2	Delayed discharge bed days: Code 9	Apr-21	Apr-20	12,443	12,453	↑ 10.00	0.08%
4.3	Delayed discharge bed days: Health and Social Care Reasons	Apr-21	Apr-20	28,005	18,618	↓ 9,387	-33.52%
4.4	Delayed discharge bed days: Patient/Carer/Family-related reasons	Apr-21	Apr-20	404	370	↓ 34.00	-8.42%
5a.1	Percentage of last six months of life: Community	Jun-21	Jun-20	92.82%	94.22%	↑ 1.40%	1.40%
6.1	Percentage of population in community or institutional settings (65+)	2019/20	2018/19	92.89%	93.02%	↑ 0.13%	0.13%

* Takes the last 12 months from the date shown in column D, except for MSG 5 and 6, where the previous financial year before is taken for comparison ** Delayed discharge data definition change occurred in July 2016 - cannot use any previous financial year before Apr-18, so comparison starts after Apr-1

Improvement / Spread & Sustainability

Indicator 1:
The work that has begun with the localities will further evidence the need for a local solution, working closely with GP clusters and private/voluntary sectors to further support local people. Work on reducing Emergency Admissions will be developed in conjunction with acute colleagues.

Indictor 2:
In recognition of the Scottish Government Delivery Plan we will aim to reduce unscheduled bed days in hospital care by up to 10%. The Partnership also plan to develop our new models which originally supported delay in hospital to further roll out into the community given the evidence of success so far. Further work is required in collaboration with NHS Fife to consider appropriate interventions to reduce the number of unscheduled hospital bed days.

Indicator 3:
We are currently developing a plan to implement the recommendations of the National Out of Hours Review (Ritchie Report), which will include innovative ways of supporting people at home. The acute service continues to support a successful frailty model which will be further supported across the Partnership.

Indicator 4:
Work continues within Fife to reduce both the number of delays and the number of bed days lost to them. A range of programmes and projects has incorporated many of the models of care designed by the partnership such as:

- Short Term Assessment and Reablement (STAR)
- Short Term Assessment and Review Team (START)
- Assessment Beds

As a partnership we are planning to undertake further work on performance against the current 72-hour target for delay to ensure we are fully capturing the activity in respect of delay.

Indicator 5:
The Scottish Government Health and Social Care delivery plan includes an action to ensure that everyone who needs palliative care will get hospice, palliative or end of life care. The partnership continues working with the palliative and end of life services and external care providers to target people who wish to die at home or in a setting of their choice.

Indicator 6:
Work is being undertaken in the Partnership to shift the balance of care from an institutional setting to community resources which will support people at home or in a homely setting

Local Performance Scorecard

Indicator	Target 2020/21 ***Target to be decided/developed**	Reporting Period	Year Previous		Previous		Current		Performance Assessment/RAG
Assessment Unit Beds	42 Days	Monthly	Jun-20	64	May-21	99	Jun-21	172	73⇧
Short Term Assessment and Reablement (STAR) Beds	42 Days	Monthly	Jun-20	56	May-21	111	Jun-21	51	60⇩
START (Short Term Assessment and Review Team)	42 Days	Monthly	Jun-20	100	May-21	76	Jun-21	73	3⇩
Nursing & Residential Care Population	*	Monthly	Jun-20	2,439	May-21	2,433	Jun-21	2,422	⇩
Demand for New Care at Home Services – No of Service Users	*	Monthly	Apr-20	305	May-21	238	Jun-21	274	⇧
Demand for New Care at Home Services – Hours per week	*	Monthly	Apr-20	3,467	May-21	1,920	Jun-21	2,231	⇧
Weekly Hours of Care at Home – Externally Commissioned Services	*	Monthly	Jun-20	16,208	May-21	17,684	Jun-21	17,646	⇩
Weekly Hours of Care at Home – Internal Services	*	Monthly	Jun-20	11,866	May-21	12,661	Jun-21	12,670	⇧
Adult Packages of Care – Externally Commissioned	*	Monthly	Dec-18	771	May-21	1,115	Jun-21	1,141	⇧
Technology Enabled Care – Total Provision	*	Monthly	Jun-20	8,535	May-21	8,586	Jun-21	8,665	⇧
Technology Enabled Care – New Provision	*	Monthly	Jun-20	204	May-21	150	Jun-21	238	⇧

LDP Standards Scorecard

Indicator Summary

Performance
meets / exceeds the required Standard / on schedule to meet its annual Target
behind (but within 5% of) the Standard / Delivery Trajectory
more than 5% behind the Standard / Delivery Trajectory

Benchmarking	
●	Upper Quartile
●	Mid Range
●	Lower Quartile

Section	Measure	Target 2021/22	Reporting Period	Year Previous		Previous		Current			Reporting Period	Fife		Scotland
Operational Performance	Delayed Discharge (% Bed Days Lost)	5%	Month	May-20	4.1%	Apr-21	8.2%	May-21	9.7%	↓	QE Dec-20	5.5%	●	4.8%
	Smoking Cessation	473	YTD	Mar-20	92.4%	Feb-21	53.0%	Mar-21	52.2%	↓	FY 2019/20	92.8%	●	97.2%
	CAMHS Waiting Times	90%	Month	May-20	74.2%	Apr-21	68.4%	May-21	73.4%	↑	QE Mar-21	76.0%	●	65.1%
	Psychological Therapies Waiting Times	90%	Month	May-20	79.2%	Apr-21	78.2%	May-21	80.0%	↑	QE Mar-21	82.0%	●	80.4%

Management Information Scorecard

Indicator	Target 2020/21	Reporting Period	Year Previous		Previous		Current		Performance Assessment/RAG
Health & Social Care Absence Rolling 12-month absence % for employees of the Health and Social Care Partnership	NHS Target 4.0% FC Target 5.87%	Monthly	Dec-18	6.60%	Oct-20	NHS – 5.45 FC – 8.70%	Mar-21 (NHS only) FC Oct-20	NHS – 4.41% FC – 8.70%	N/A
Complaints and Compliments	80% of Complaints responded to within statutory timescales	Monthly	Jul-19	65%	May-21	69%	Jun-21	61%	⇩
Information requests	80% of requests responded to within statutory timescales	Monthly	Q1-19	75%	May-21	94%	Jun-21	89%	⇩

Local Performance Indicators

	Standard/Local Target	Last Achieved	Current Performance	Benchmarking	
Assessment Unit - Assessment Beds	42 Days	Apr-21	172 days	Jun-21	

This model supports people to leave hospital and finalise their assessment within a Care Home. Currently nine care homes offer 58 Assessment Beds in Fife.

Average Length of Stay on Discharge for individuals at week ending the 30th June 2021 was 172 days. This is above the service expectation, which is that an individuals' stay in an assessment unit on discharge does not exceed 42 days.
During the month of June there were 11 admissions and 12 discharges. The average length of stay on discharge continues to fluctuate. This is mainly due to a number of individual's first choice care home not having capacity to admit, resulting on a wait on this becoming available.
It is always the intention to provide an individual's first choice care home as part of a person-centred approach. This will respectively impact on the average number days on discharge being higher than the expected performance level. The average length of stay in Assessment beds has increased since March 2020 due to the Covid-19 pandemic and the result of residents not moving care home to care home

LDP Standards

	Standard/Local Target	Last Achieved	Current Performance	Benchmarking	
Smoking Cessation	473	N/a	247	Mar-21	

In 2021/22, we will deliver a minimum of 473 post 12 weeks smoking quits in the 40% most deprived areas of Fife

CURRENT CHALLENGES

Remobilising face to face delivery in a variety of settings due to venue availability and capacity
Moving from remote delivery to face to face provision, patients having confidence in returning to a medical setting
Potential for slower recovery for services as they may require to rebuild trust in the brand
Re-establishment of outreach work

Action 1 - Assess use of Near Me to train staff - Near Me has been set up and clients are being offered this service, but there has been little uptake to date, possibly due to issues with IT availability and connectivity

Action 2 - Support Colorectal Urology Prehabillitation Test of Change Initiative . Prehabilitation is a multimodal approach, which will minimise the risk of surgery being cancelled or SACT being delayed. It ensures patients are actively managed against the pathway, and is know to improve quality outcomes for patients. Patients identified as smokers and interested in quitting will have rapid access to support.

LDP Standards

	Standard/Local Target	Last Achieved	Current Performance	Benchmarking
Delayed Discharge (% of Bed Days Lost)	5%	Jan-21	9.70%	May-21

Reduce the hospital bed days lost due to patients in delay, excluding code 9, to 5% of the overall beds occupied

Capacity in the community – demand for complex packages of care has increased significantly
Information sharing – H&SC workforce having access to a shared IT, for example Trak, Clinical Portal
Workforce – Ensuring adequate and safe staffing levels to cover the additional demand to facilitate discharge from the acute setting to the community hospitals and social care provision

Progress HomeFirst model - The Oversight "Home First" group meeting with H&SC, NHS Fife, Fife Council and Scottish Care took place in April. Five subgroups will take forward the operational actions to bring together the "Home First" strategy for Fife.

Test of Change – Trusted Assessor Model (or similar) to support more timely discharges to STAR/Assessment placements in the community - A test of change is underway within our internal care homes linked to people admitted to STAR beds in care homes

Care at Home Reviews – To ensure we develop capacity within the sector. A review of all care at home services is underway .

Vacancies - The inhouse care at home service have a number of vacancies these are been progressed and we will continue with an ongoing recruitment across Fife highlighting the areas of significant pressure

Working with External Partners - Block booking of care at home services for an initial six week period to allow external care providers to grow their business without concern of gaps appearing in their rotas

Management Performance Indicators

	Standard/Local Target	Last Achieved	Current Performance	Benchmarking
Complaints and Compliments	80% *	N/a	61%	Jun-21

* 80% of Complaints responded to within statutory timescales

Response timescales have significantly increased during 2021 from 48% of complaints responded to within required timescales during December 2020, to 61% closed on time during June 2021.

During the coronavirus outbreak the Partnership followed advice received from the Scottish Government and the Scottish Public Sector Ombudsman in relation to the prioritisation of complaints and related communications. This involved identifying and prioritising, enquiries and complaints that involved COVID-19 or its impact, those that related directly to current service provision, or where we believed there was a real and present risk to public health and safety.

Please note that no legislative changes were introduced to complaint procedures or statutory timescales. Therefore, complaint performance has been measured against the usual criteria.

Fife Health & Social Care Partnership
Supporting the people of Fife together

Meeting Title:	**Integration Joint Board**
Meeting Date:	**20 August 2021**
Agenda Item No:	**9**
Report Title:	**Mental Welfare Commission Authority to Discharge Audit & Findings**
Responsible Officer:	**Nicky Connor , Director HSCP**
Report Author:	**Lynne Garvey, Head of Service, Integrated Community Care Services**

1 Purpose

This Report is presented to the Board for discussion.

This Report relates to which of the following National Health and Wellbeing Outcomes*:*

1 People are able to look after and improve their own health and wellbeing and live in good health for longer.

2 People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

This Report Aligns to which of the Integration Joint Board 5 Key Priorities*:*

- Promoting mental health and wellbeing.
- Living well with long term conditions..

2 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Senior Leadership Team (SLT) assurance.
- Mental Welfare Commission (MWC) Authority to Discharge Report (H&SCP SLWG) 12 July 2021.

- Clinical and Care Governance Committee received the report and findings at their meeting on 4 August 2021. The feedback from the committee was positive and they thanked the staff for the detailed reports. Some small amendments were asked for in respect of abbreviations this has been rectified.

3 Report Summary

3.1 Situation

Following the publication and recommendations of the ***Mental Welfare Commission for Scotland Authority to discharge: Report into decision making for people in hospital who lack capacity, May 2021***, Fife Health and Social Care Partnership convened a short life working group to consider the report, review practice with specific reference to moves from hospital to care homes between 1 March 2020 and 31 May 2020, and produce an improvement plan based on the recommendations within the report, to consider rights-based practice and legal authority supporting these moves. This report provides a summary overview of internal audit analysis and the resulting actions and identified learning needs.

3.2 Background

The *Mental Welfare Commission for Scotland Authority to Discharge (May 2021)* was an independent report in the context of concerns about moves from hospitals to care homes during the early months of pandemic restrictions (March 2020-May 2020), and the legality of hospital to care home moves. The above report was based on information submitted to the Mental Welfare Commission for Scotland by Health & Social Care Partnerships in October 2020, which highlighted cases of reported unlawful moves due to lack of capacity to make an informed decision / consent (particularly in relation to section 13ZA of the Social Work (Scotland) Act 1968), and lack of uniformity from one Health and Social Care Partnership to another.

To understand the activity in this area, and whether there are practice issues within Fife Health and Social Care Partnership which need to be addressed, a small working group was convened to develop an audit tool (Appendix 1) and audit plan (Appendix 2).

3.3 Assessment

3.3.1 Quality/ Customer Care

Fife Health and Social Care Partnership provided the Mental Welfare Commission (MCW) with the names of all adults discharged from hospital to care home following an assessment between 1 March 2020 and 31 May 2020 and provided the name and contact telephone number of the lead social work assessor.

Initial preparatory work was undertaken to identify of those who had moved: how many had moved under section 13ZA; how many had an existing proxy decision maker; and how many had capacity. Those with

Power of Attorney (POA) were not included in the initial audit, however following further communication with the MWC a sample of those moved on POA were also later audited.

Audit focus	**Number of individuals moved**	**Number audited**
Section 13ZA	15	15
Existing proxy decision maker	74	N/A
Capacity	37	33
Power of Attorney	10	10
Total audited		**58**

A team of 6 auditors were identified. From the cohorts above, it was agreed that those who had an existing proxy decision maker were least at risk of having been moved without an appropriate legal framework. Therefore, it was agreed to focus attention on those who moved on 13ZA and those who were deemed to have capacity, and then latterly Power of Attorney, to audit whether the practice in supporting them to move to a care home was rights based and consideration was made of appropriate legislation.

This audit and the recommendations received from the Mental Welfare Commission informed the production of an improvement plan for Fife's Health and Social Care Partnership (appendix 3). The improvement plan was developed by the following key stakeholders :

SLWG to review report of audit findings	
Name	**Designation**
Lynne Garvey	Head of Service, Integrated Community Care Services, fife H&SCP
Dr Helen Helliwell	Associate Medical Director, Fife H&SCP
Kathy Henwood	Chief SW officer Head of Education & Children's Services, Fife Council
Dr Aylene Kelman	Consultant Physician / Clinical Lead, Care of Elderly, NHS Fife
Jamie Kirkby	Service Manager (West), Older People's Social Work, Fife Council
Rona Laskowski	Head of Service, Complex & Clinical Care Services, Fife H&SCP
Elaine Law	Service Manager, (SW Adults East), Fife H&SCP
Tanya Lonergan	Head of Nursing, Fife H&SCP

Fiona McKay	Interim Divisional Manager, Fife H&SCP / Planning & Performance, NHS Fife
Gayle Morris	Discharge Planning Manager
Karen Nolan	Clinical Services Manager, East Division
Dr Katherine Paramore	Consultant Psychiatrist
Olivia Robertson	Head of Nursing, Fife H&SCP
Jacqui Stringer	Integrated Discharge Hub / Community Flow Manager
Jillian Torrens	Senior Manager, Mental Health & Learning Disability Service
Michelle Williamson	Clinical Service Manager, West Division

The updated report, following the submission of evidence, from the MWC indicated that Fife did **not** place anyone without consent and without a legal duty (Appendix 3) However, to ensure optimal practice an action plan (Appendix 4) was developed in line with the recommendations from the Mental Welfare Commission Authority to Discharge report of May 2021.

3.3.2 Workforce

The workforce will be supported to undertake development to understand all aspects of incapacity

3.3.3 Financial

Not applicable.

3.3.4 Risk/Legal/Management

Risk: There is a risk that evidence of capacity to understand decisions related to making choices and determining if the person does not have capacity (within that the principles of the AWI Act) have underpinned to ascertain the correct legal framework is not recorded accurately or consistently.

Mitigation: Clear guidance is required to support staff to record systematically the key issues in relation to supporting people with decision making. There is a need to be able to evidence that

3.3.5 Equality and Diversity, including Health Inequalities

An impact assessment has not been completed because no group will be disadvantaged through the improvements proposed.

3.3.6 Other Impact

Due to COVID-19 restrictions and tight timescales, there was inconsistent access to paper files which may affect the accuracy of the initial audit.

3.3.5 Communication, Involvement, Engagement and Consultation

The short life working group was a multi-disciplinary group including both health and Fife Council colleagues.

3.4 Recommendation

- **Decision** – recommend for approval and submission to Mental Welfare Committee.

4 List of Appendices

The following appendices are included with this report:

Appendix 1	Audit Findings
Appendix 2	Action Plan Following Audit of People Moved to Care Home (s13ZA)
Appendix 3	MWC Updated Report
Appendix 4	Action Plan on MWC Report Authority to Discharge (May 2021)

5 Implications for Fife Council

6 Implications for NHS Fife

7 Implications for Third Sector

8 Implications for Independent Sector

9 Directions Required to Fife Council, NHS Fife or Both

Direction To:		
1	**No Direction Required**	x
2	**Fife Council**	
3	**NHS Fife**	
4	**Fife Council & NHS Fife**	

10 To be completed by SLT member only

Lead	**Lynne Garvey**
Critical	**All SLT**
Signed Up	
Informed	

Report Contact

Lynne Garvey - Head of Service, Integration Community Care Services
Lynne.garvey@nhs.scot

AUDIT QUESTION												
1. What legislation facilitated the move to the care home (Power of Attorney (POA), Guardianship or 13za?)	**13ZA** **15**		**POA** **5**		**GUARDIANSHIP** **5**		**MENTAL HEALTH ACT** **NIL**		**NO LEGISLATION** **2**			
	Those who moved on 13za				**Those deemed to have capacity**				**Those who moved deemed not to have capacity**			
2. Was the adult's capacity to make welfare decisions assessed?	**YES** **14**		**NO** **1**		**YES** **12**		**NO** **21**		**YES** **7**		**NO** **3**	
3. Was the outcome of the assessment of capacity documented in profile notes and record of views including the details of who undertook the assessment?	**YES** **13**		**NO** **2**		**YES** **4**		**NO** **29**		**YES** **5**		**NO** **5**	
4. What was the mechanism for deciding which legislation was required? (case conference/discussion)	**DIS PLAN MEET** **1**	**CASE CONF** **3**	**ROV** **4**	**NOT CLEAR** **7**	**N/A**	**N/A**	**N/A**	**N/A**	**DIS PLAN MEET** **1**	**CASE CONF**	**ROV**	**NOT CLEAR** **9**
5. Was a Personal Outcome Support Assessment (POSA)/support plan completed?	**YES** **14**		**NO** **1**		**YES** **30**		**NO** **3**		**YES** 10		**NO**	
6. Is there evidence within the POSA and support plan of what legislative framework was used to facilitate the move?	**YES** **8**		**NO** **7**		**YES** **27**		**NO** **6**		**YES** 9		**NO** 1	
If 13za was used to facilitate a move:												
AUDIT QUESTION	**RESPONSE** *(including where evidence was recorded ie on Record of Views, POSA etc)*				**ANY FURTHER COMMENTS** *(ie good practice/areas where practice could improve ie change to existing process)*							
7. Was advocacy considered/involved and are their views recorded?	**YES** **9**		**NO** **6**		**N/A**				**N/A**			

8. Are the views of all relevant parties recorded within the record of views including the adult, their family/carer, involved professionals, advocacy or any relevant other?	**YES** **12**	**NO** **3**	**N/A**	**N/A**
9. Is there any reference to the principles of the Adults with Incapacity (Scotland) Act 2000 and how they have been applied?	**YES** **10**	**NO** **5**	**N/A**	**N/A**
10. Was the adult considered to be deprived of their liberty under Article 5 of the European Convention of the Human Rights?	**YES** **4**	**NO** **11**	**N/A**	**N/A**
11. Is there any evidence that the individual dissented to the move?	**YES** **2**	**NO** **13**	**N/A**	**N/A**
12. Were there any other indications verbal/ non-verbal that the individual did not consent to the care plan? (eg resistant to delivery of personal care)	**YES** **3**	**NO** **12**	**N/A**	**N/A**
13. Is there any indication that further intervention under the Adults with Incapacity Act was sought/considered and what the benefit of this was?	**YES** **12**	**NO** **3**	**N/A**	**N/A**
14. Do you agree that the appropriate legislation was used?	**YES** **13**	**NO** **2**	**N/A**	**N/A**
If not, what legislation should have been used and why?	**POA**	**GUARDIANSHIP** **1**	**MH ACT**	**UNSURE** **1**

Audit 13za

TASK	ACTION	LEAD	TIMESCALE
Provide Mental Welfare Commission (MWC) with a list of all those who moved to a care home from hospital between 01-Mar-2020 and 31-May-2020	• Check with information governance that request consistent with gdpr. • Check the list and send to MWC	EL EL	Completed Completed
Send list to Team Managers (TM's) in Older People/Adults to confirm what legal framework each person moved on, (including 13za)	Adults List checked and sent to JK to be merged into main list	JK	Completed
Formulate audit tool	Audit questions agreed and formatted onto an online tool.	EL/JK/WA/EH	Completed
Identify cases for audit	All those who moved on 13za to be audited first then all those who moved without a legal order	EL/JK	Completed
Identify audit team	Total of 50 audits required, 18 who moved on 13za and 32 who moved without a legal order. Audit Team identified comprising 6 team managers.	EL/JK/EH/WA	Completed
Complete audit	Ongoing; 18 completed as at 15-Dec-202. Agreed to aim to complete the remaining 32 by 22-Dec-2020. If this cannot be achieved, it will be accepted this is due to absences related to covid 19.	JK	Completed
Write audit report briefing to share with FMcK	Emma and Wendy will convene a meeting with the auditors to gather their views on the experience of the audit and feedback to EL/JK. Provide a briefing to Fiona McKay with the main themes and any learning and recommendations.	EH/WA	Completed

		EL	Completed
Update guidance for 13ZA	Applying learning from the audit and report, guidance updated and signed off by H&SCP P&P Group on 29-Apr-2021. Process added to document control with review date April 2022 and sent to SM's for assessment and care management teams Adults/OP Service Managers to send to TM's on 17-May-2021.	EL	Completed
Produce guidance for staff in relation to Power of Attorney	Guidance produced for staff on when this needs to be confirmed and what to do to ensure we are clear what the powers are, if it is activated and if so, who has authority to consent. Guidance signed off by H&SCP P&P Group on 29-Apr-2021. Process added to document control with review date April 2022 and sent to all Adults/OP Service Managers to send to TM's on 17-May-2021.	EL EL	Completed Completed
Check case recording guidance to determine whether additional detail required regarding case recording in relation to capacity and consent	Work required to take this forward is currently being designed	EL/JK	Oct/Nov 21
Check Roles and Responsibilities Document to review in relation to determining capacity to consent.	Work for this will be taken forward in the policy and procedures group.	EL/JK	Oct/Nov 21.
Review the current electronic audit tool to ensure appropriate audit of practice in relation to capacity and consent	Word copy of electronic audit tool provided by PIP to be designed linked to new system.	EL/JK	Oct/Nov 21

mental welfare commission for scotland

Authority to discharge: Report into decision making for people in hospital who lack capacity

May 2021

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Foreword – Julie Paterson, chief executive

'People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society'

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.

In this report we decided to combine concerns about moves from hospitals to care homes during the early months of pandemic restrictions with a recent judicial review case we were involved in to find out more about the legality of hospital to care home moves.

This report is based on information submitted to us by Health and Social Care Partnerships (HSCPs).

It finds cases of reported unlawful moves.

Some of the practice concerns relate specifically to the pandemic. But, worryingly, the report also finds more endemic examples of poor practice, not specifically pandemic related. Lack of understanding of the law, lack of understanding of good practice, confusion over the nature of placements, misunderstanding over power of attorney. These findings are disappointing and may mean that many more moves were made without valid legal authority.

This report also finds a lack of uniformity from one HSCP to another, with different approaches to national legislation and guidance adopted in different areas.

Our report raises significant questions of training and approach in Health and Social Care Partnerships - issues that are dealt with in our recommendations.

Chief Officers of Health and Social Care Partnerships provided information as requested and, from the outset, shared the Mental Welfare Commission's commitment to identifying any learning and/or recommendations for improvements in practice. We hope that leaders of HSCPs and the Care Inspectorate, as regulatory body, now take recommended action to improve practice and outcomes for the most vulnerable adults in our society.

Contents

Executive Summary

The Adults with Incapacity (Scotland) Act 2000 introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves. This legislation is underpinned by principles of benefit to the adult, taking account of the person's wishes and the views of relevant others. Any action must be the least restrictive option necessary to achieve the benefit and importantly to encourage the adult to exercise whatever skills he or she has in relation to their welfare, property or financial affairs and develop new skills where possible recognising issues of capacity are not 'all or nothing', they are decision specific.

The Mental Welfare Commission has a statutory safeguarding role in respect of adults whose capacity to make decisions or to take actions to promote or safeguard their welfare is impaired due to a mental disorder. During the Coronavirus pandemic, a number of stakeholders raised concerns with the Commission regarding whether the appropriate legal authority was used to safeguard people being discharged from hospital to care homes who did not have the capacity to make an informed decision to agree to the move.

People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society. The focus of this report was to examine the detail of a sample number of hospital to care home moves of people from across Scotland, to check that those moves were done in accordance with the law during the early stages of the pandemic.

The Commission therefore undertook to make further inquiries and sought information from Health and Social Care Partnerships (HSCPs) across Scotland in relation to people who had moved from hospital to registered care home settings during the period 1 March 2020 – 31 May 2020 (our sample period). HSCPs were very responsive to our request. Only Highland did not provide information within the timescale requested.

From those returns, we asked for information about 731 people from across Scotland, 465 of whom were reported by HSCPs to have lacked capacity to agree to a move from hospital to a care home (8 of whom in turn did not fulfil the inclusion criteria for this inquiry). Whilst all individuals should receive full information as to their rights in relation to discharge from hospital and outcomes to be achieved to allow them to exercise those rights, our work focussed on those (457) people reported as lacking capacity to do so (our sample size corresponded to approximately 10% of all discharges from hospitals to care homes reported by Public Health Scotland).

It was reported to us that people had been moved during the sample period without the protection of legal authority. These unlawful moves (involving 20 people) took place across 11 Health and Social Care Partnership areas. We learned that, for some of these moves, there had been specific pandemic related reasons for this. For example, a misinterpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and was removed in September 2020. We also found that one HSCP introduced an alternative to applications for guardianship orders, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020. The Commission does not provide legal advice so we asked whether legal advice had been sought in relation to both these practices; confirmation was given that legal advice had been sought and given

The Commission's significant concern is that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of European Convention on Human Rights (ECHR).

Section 13ZA of the Social Work (Scotland) Act 1968 was reportedly used to authorise moves in 23 Health and Social Care Partnerships and either Welfare Power of Attorney or guardianship orders were used to authorise moves across 30 of the 31 Health and Social Care Partnerships.

We took further steps to analyse to assure legal rights were respected and protected beyond the 20 unlawful moves. For example, we asked questions about the 338 moves said to have been authorised using a Welfare Power of Attorney or Adults with Incapacity legislation. We found that those working in the field of hospital discharge were not always fully sighted on the powers held by attorneys or guardians (this was the case in 78 out of 267 cases of power of attorney related moves) or indeed whether the attorney's powers had been activated or guardianship orders granted. Whilst it is difficult to quantify the impact, our view is that such assumptions, rather than evidence based decision making, had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR.

We also found confusion in relation to the reported nature of the care home placement with potential impact on rights to protection of property where the person was admitted to a care home but remained liable for their property.

We established that practice was not consistent either within some HSCPs or across HSCPs. Indeed some HSCP staff had experience of working across HSCPs and reported that moving from one HSCP to another brought differences in practice into sharp focus. This is despite a range of existing guidance, policy and local arrangements to support implementation.

In summary, we found that whilst the pandemic brought significant pressures, the identified areas for improvement arising from our examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. Our findings indicate longer standing systemic issues within HSCPS which require urgent action to address in order to safeguard and uphold the rights of the most vulnerable adults in our society. To this end, we have made eleven recommendations that we hope will assist HSCPs.

Recommendations

Based on our findings we recommend the following areas for improvement:

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)[1] 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.

[1] Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Greater Glasgow and Clyde* [online] Available at: https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention (Accessed 19 April 2021).

Introduction

The Mental Welfare Commission has specific legal duties in relation to safeguarding the rights of people who are subject to the welfare provisions of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

Section 9 of the AWI Act details the Commission's safeguarding role in respect of adults whose capacity to make decisions or to take actions to promote or safeguard their welfare is impaired due to a mental disorder.

Local intelligence gathering and calls to the Commission's advice line in the early stages of the Covid-19 pandemic suggested that people who were in hospital and lacked capacity may have been moved from hospital to care homes without full understanding of the legal requirements to ensure rights are upheld and the move to care was lawful. Specific concerns related to the use or otherwise of Section 13ZA of the Social Work (Scotland) Act 1968 particularly in the context of the Coronavirus (Scotland) Act 2020 ('the Coronavirus Act').

In addition, the Mental Welfare Commission were party to a Judicial Review led by the Equality and Human Rights Commission (EHRC) during this period. This Judicial Review concluded in December 2020 when NHS Greater Glasgow and Clyde (NHSGGC) and the owner of a chain of care homes, agreed to end the practice of placing patients in care homes without legal authority.[2] As a result of this agreement and commitment by NHSGGC to work with its partner local authorities to make sure that all patients and their families know what is happening and what their rights are in relation to discharge from hospital, EHRC stopped legal proceedings.

Given the concerns raised directly with us and the context of the Judicial Review involving NHSGGC, we wrote to Chief Officers of Health and Social Care Partnerships across Scotland in October 2020 seeking information in relation to people discharged from hospital to care homes. The intention was to identify whether or not there was evidence of unlawful moves from hospitals to care homes beyond that already confirmed in NHSGGC.

The focus of our work was therefore on people who were assessed as lacking capacity, the legal authority used to facilitate their moves from hospital to care homes and the evidence which confirmed that good practice (well documented in existing policy and guidance) had continued to be followed in the context of the significant challenges faced in the first three months of the Coronavirus pandemic.

Chief Officers of Health and Social Care Partnerships provided us with all information requested and shared the Mental Welfare Commission's commitment to identifying any learning and/or recommendations for improvements in practice. The only Health and Social Care Partnership which did not provide us with information, as requested, within timescale, was Highland. Highland's information is therefore not included as part of this piece of work.

[2] Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement*

What we did

The current project aimed to explore, within a sample of all moves reported, whether there were any unlawful moves of individuals, who were assessed as lacking capacity, from hospital into care homes.

We requested information from all 31 Health and Social Care Partnerships (HSCPs) in Scotland relating to all moves from hospitals to registered care homes that took place between 1 March 2020 and 31 May 2020. The information included i) name of the individual, ii) date of birth, iii) name of the care home the individual was moved to, and iv) contact details for the key contact person or team from the HSCP.

Highland did not provide information, as requested, within the timeline required. From the submitted information from all other HSCPs, we aimed to undertake further review of 500 cases of individuals who moved during this time period and who were assessed as lacking capacity to consent to the move. This corresponded to approximately 10% of all discharges from hospitals to care homes reported by Public Health Scotland (PHS).[3]

We randomly selected cases based on geographical location and age and reviewed a total of 731 cases for inclusion (see more detailed methodology in Appendix A). Of these, it was reported to us that 465 (64%) people were assessed as lacking capacity to make an informed decision in relation to a move to a care home and 266 (36%) people reportedly had capacity to consent to the move. After excluding eight cases that ended up not fulfilling our inclusion criteria, the sample on which this report is based is 457 cases (93% of our target sample).

[3] Public Health Scotland. (2020). *Discharges from NHS Scotland hospitals to care homes*. Available at: https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/discharges-from-nhsscotland-hospitals-to-care-homes/ (Accessed 5 May 2021).

Nature of Placement

What we expected to find

We wanted to know about the individual's move from hospital to the care home placement and asked each HSCP to tell us whether the move was permanent, temporary or on a respite basis. We would not routinely expect placements from hospital to a care home to be on a respite basis.

Where an individual is ready for discharge, we would expect decisions about ongoing care and support to focus on the needs of the individual and on achieving the best possible outcome for that individual. The decisions should be made through a multi-disciplinary process in consultation with the individual, family/carer and all agencies involved in planning the discharge. The individual should receive all relevant support and information to make an informed decision about future care options, including their right to appeal discharge from hospital should they disagree with the clinical assessment.[4]

The assessment that is undertaken at this stage is a significant part of the discharge planning process that determines the level of support, care and treatment that the person will need in order to lead a fulfilling life on discharge. It is important that this discharge planning starts as early as possible during an individual's admission to hospital, maximising their participation, maximising inclusion of any family/carers (section 28 Carers (Scotland) Act 2016) and maximising the involvement of key agencies such as social work, housing and community support.

The role of social work is critical in facilitating and coordinating discharges from hospital. Social work practice is underpinned by principles of social justice, human rights and anti-discriminatory practice. It necessitates a multi-disciplinary knowledge base and skill set along with a non-judgmental and compassionate value base. Local authorities have a duty under the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 to arrange places for individuals in a care home of their choice provided that the accommodation is suitable in relation to the person's assessed needs and whether they require ongoing long term care.[5]

Where an assessment recommends that an individual requires long term care in a care home then the person must be involved in the process of choosing that care home. This would be known as a permanent move. *Choosing a Care Home* was produced in 2013 by the Scottish Government and specifically outlines guidance for staff on discharge planning and supporting people through the process.[6]

The guidance suggests that, wherever possible, decisions about long term care should not be made in an acute hospital setting. Ideally, the person should be discharged to a more appropriate non-acute setting such as a community hospital or intermediate care facility for further rehabilitation and assessment.[7]

[4] Scottish Government. (2015). *Hospital Based Complex Clinical Care*. Available at: https://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf (Accessed 5 May 2021).
[5] Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).
[6] Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).
[7] Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).

The assessments referred to above must ensure the provision of access to appropriate support so that the person's rights, will and preferences are genuinely reflected in decisions made that concern them. This should extend to those people who are assessed as lacking capacity to fully participate in the decision making about their future long term care needs and who are moving to a care home or other registered setting. This reflects the requirements of the UN Convention on the Rights of Persons with Disabilities which the Scottish Government is committed to upholding.

Whilst the circumstances during the period for which we collected data were unprecedented as a result of the pandemic, the legislative framework protecting those assessed as lacking capacity remained intact as a critical safeguard.

What we found

We found that 253 of the individuals in our sample (44%) were still in the care home they were admitted to following discharge from hospital when we made contact.

Out of our sample of 457, 337 (74%) had moved on a permanent basis, 113 (25%) had moved on a temporary basis and seven (1%) had moved on a respite basis.

Permanent placements

Of the individuals who moved to a care home on a permanent basis, 131 (39%) were no longer in the care home due to a range of the following reasons:

- re-admitted to hospital
- first choice of home became available
- placement at the care home had broken down
- the care home had closed
- the person had died.

Temporary placements

We wanted to know about moves that were identified as being temporary; 113 people moved on a temporary basis. Where a preferred choice of care home is not immediately available an individual may require to make a temporary (interim) move to another home with a suitable vacancy to wait on the care home of their choice.

Although this was the case for some of the individuals in our sample, we found that there were further reasons why the moves were classed as temporary.

HSCPs told us that there was pressure on wards to clear beds due to the pandemic and that resources had been developed in the community to support this.

We found that HSCPs were often not clear about the nature of placement as there were examples where we were told that it was a temporary placement because the person had moved to an NHS bed within a care home:

> *"A placement being referred to as a hospital placement but was actually a residential care home registered with the Care Inspectorate. It was referred to as an NHS to NHS transfer and social work services were not involved in the move until the person was required to be moved to a long-term placement. As a result this meant the person was moved from an acute hospital to an interim care home bed and then to a long-term care placement".*

We were told about other individuals who moved without the agreement of social work and social workers were advised after the event with the explanation that:

> *"These moves had been organised by health, often because wards were being cleared for Covid patients."*

We found that 43 (38%) of the 113 people who had been moved to a care home on a temporary basis were still in the same care home that they were initially moved to. Some of the reasons we were told why the move was a temporary placement are found below:

- First choice of home wasn't available
- In order for a full social work assessment to be undertaken
- Needed an interim move
- Had to move due to COVID
- Intermediate care facility to undertake assessment
- Needing rehabilitation.

Of the 43 temporary moves, we were told that 20 placements (47%) had been made permanent between the time of the move and our review. Examples of these cases were:

- Moved on a temporary four week placement to enable a full social work assessment of need. The placement was subsequently made a permanent placement.
- Moved initially as a temporary arrangement however was settled so remained there on a permanent basis.

We were told that some individual moves were temporary as the person required intermediate care. Intermediate care is a multidisciplinary service that can support people to be as independent as possible by providing support and reablement to individuals at risk of hospital admission or who have been in hospital. [8] For a care home to offer intermediate care facilities, the care home requires to register this facility/service with the Care Inspectorate. It was not always clear from HSCPs that the care home setting was registered for this specialist service, however we heard of people returning back home to live, so the outcomes were positive.

Respite placements

We were told that the nature of the placement for some individuals was identified as respite. Respite care means that the usual family/carer gets a break from their caring responsibilities, while the person cared for is looked after by someone else. However, we found that some of these individuals continued to remain at the care home and there appeared to be a lack of clarity about the nature and purpose of respite care in these instances.

Equally this too could have significant implications for a person's housing and financial affairs as they meet the costs of prolonged respite care whilst maintaining the funding for their accommodation in the community.

Identifying the nature of the placement (temporary, permanent, respite) for a person being discharged from hospital is not merely an administrative requirement - it can have significant impact on the person's welfare, property and finances. Confusion over whether placements are NHS or registered with the Care Inspectorate also has significant implications related to legal authority for moves and the human rights of the individual.

Professional holistic social work assessments are undertaken to ensure that all community care options are considered based on the unique individual needs of the person. We received feedback from HSCPs that suggested a focus on beds rather than people. This raises significant concerns in relation to the rights, will and preferences of the most vulnerable adults who lack capacity.

[8] Scottish Government. (2012). *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland.* Available at: https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/ (Accessed 5 May 2021).

Capacity to consent to the move

What we expected to find

The law recognises that each of us, as adults, has the right to make decisions for ourselves unless it is established that we lack the capacity to do so. There was no change to this law during the pandemic.

An individual may have difficulties communicating or expressing their views verbally, but this does not mean they necessarily lack the capacity to hold a view. [9] A person's capacity should be assumed unless there is evidence, despite individualised support, that they are unable to make informed decisions.[10] Capacity/incapacity is not all or nothing, it is decision specific, therefore it is important when decisions are needing to be made that it is clear in what areas the individual has capacity.

In 2019, Health and Social Care Integration, Scottish Government, produced the guide *Discharging Adults with Incapacity* which refers to what must be considered at the assessment stage if any concerns regarding capacity are raised.[11] It confirms that the individual should be referred to an appropriate clinician for a formal assessment of capacity.

We would expect that the matter of capacity to decide and agree to a move to a care home is fully considered in partnership with all adults being discharged from hospital to care homes. Where the medical assessment confirms that an adult does not have the capacity to agree to such a move, the existing legal framework should be taken into account and implemented to ensure appropriate safeguards and respect for the person's rights; human rights and social, cultural and economic rights.

What we found

Out of the 457 cases, we were told that 437 people (96%) lacked capacity and for the remaining 20 cases (4%) we were told capacity was unclear.

We found some good practice. For example, we were told of written letters on file from medical professionals confirming assessed incapacity. We also found clear recording in information systems detailing outcomes of capacity assessments and dates. However, this was not consistent across and within HSCP areas.

We were advised that it was difficult in some areas to get formal assessments of capacity carried out during the first three months of the pandemic due to other competing demands within the hospital, and that extracts from medical records were at times used to ascertain incapacity.

HSCPs advised that there was often a lack of clarity about who assessed that the person lacked capacity and when this assessment was carried out in relation to the person's ability to consent to a move to a care home. They reported that there is little in the way of guidance

[9] Mental Welfare Commission for Scotland. (2020). Working with the Adults with Incapacity Act – for people working in adult care settings. Available at: https://www.mwcscot.org.uk/sites/default/files/2020-08/WorkingWithAWI_June2020.pdf (Accessed 5 May 2021).
[10] Mental Welfare Commission for Scotland. (2021). *Supported decision making.* Available at: https://www.mwcscot.org.uk/sites/default/files/2021-02/Supported%20Decision%20Making%202021.pdf (Accessed 5 May 2021).
[11] Scottish Government. (2019). *Discharging Adults who lack capacity*. Available at: https://hscscotland.scot/couch/uploads/file/planning-discharge-from-hospital-adults-with-incapacity-march-2019.pdf (Accessed 5 May 2021).

regarding how and where incapacity is reported or recorded in practice. We were particularly concerned to hear them say that incapacity had, at times, just "been assumed".

Additionally we were given examples of where the practitioner did not consider it necessary to consider the person's capacity to decide on a move to a care home as a Power of Attorney (PoA) was in place. A PoA is granted at a point where the granter has capacity. It becomes operational only when the granter loses capacity. The existence of a PoA is therefore no indicator of incapacity and confirmation of incapacity is crucial for this legal authority to become valid.

In some cases where HSCPs had advised that the individual lacked capacity there appeared to be a degree of confusion as the HSCPs also reported that there was no need for legal intervention as the person had consented to the move. As discussed earlier, capacity is not an all or nothing concept and we would expect an assessment to be conducted specific to the individual's ability to make decisions about where they live and the type of care they receive. Lack of resistance to a proposed care plan should not be equated with consent.

Finally, there appeared to be a degree of confusion within HSCPs around terminology and the use of different parts of the AWI Act. For example, we heard consistently from HSCPs that an "AWI was in place" and that this therefore provided the legal authority for the move to a care home. On further analysis this would appear to have been a s.47 certificate which relates to decisions about medical treatment under Part 5 of the AWI Act. While this certificate is granted following an assessment of the individual's incapacity to consent to medical treatment, the authority of this certificate does not extend to decisions in relation to a significant move to a registered care setting with 24-hour supervision at all times.

Deprivation of liberty

What we expected to find

In 2014, the Mental Welfare Commission published an advice note in relation to the UK Supreme Court's view on the definition of deprivation of liberty (known as Cheshire West).[12]

The Supreme Court ruling states that deprivation of liberty is a matter of fact and does not depend on the purpose of the intervention or the nature of the person's individual circumstances. The majority of the judges agreed that the fundamental characteristics of deprivation of liberty are being "under continuous supervision and control" and "lack of freedom to leave".[13]

The Commission's advice note was clear that services should operate within the existing Scottish statutory framework, and be informed by this case law. What this means in practice is that if services are satisfied that a person who cannot consent will be deprived of their liberty, using the Cheshire West definition, then it is necessary to consider and record what lawful authority justifies that detention; not to do so is potentially a violation of a person's right to liberty.

This 2014 advice note remains relevant to date and we would expect that practitioners involved in arranging discharges from hospital and admissions to care homes would be familiar with this definition and the need for appropriate intervention to address any instances of deprivation of liberty they encounter. It is also important to note that extended unnecessary stays in hospital can also constitute a deprivation of liberty.

As part of this project we wanted to review how embedded understanding of deprivation of liberty was in practice.

What we found

Within the cases we sampled we felt that all the placements, including those termed 'interim or temporary' potentially represented a deprivation of liberty for the adults who lacked capacity, thereby engaging Article 5 of the European Convention on Human Rights (ECHR) (the right to liberty); this was not a view consistently shared by practitioners however.

Within the sample, 10% of practitioners did not believe that the placement constituted a deprivation of liberty, despite involving continuous supervision of the individual and a lack of freedom to leave the care home voluntarily(for example, keypad exit/entry systems where the numbers were not shared with residents). Some explained their view that the assessed need for this level of care, and the risks to the adult without this level of care, negated this definition.

We found a lack of knowledge of the Cheshire West ruling and a lack of understanding that intention to act in the best interests may potentially be discriminatory and prevent those most vulnerable from their right to access legal and procedural safeguards.

We noted that some HSCPs explained that they were not always sure about what constituted a deprivation of liberty and were keen to receive further advice and guidance on this subject.

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[12] Mental Welfare Commission. (2014). *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision* https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf (Accessed 5 May 2021).

[13] Mental Welfare Commission. (2014). *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision* https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf (Accessed 5 May 2021)..

Where areas had deployed mental health officers to support discharge planning processes this additional expertise was welcomed. It was also suggested that those involved in discharge planning were under significant pressure to manage delayed discharges, which felt like a process of "emptying beds" and it was a "battle" to retain focus on the person. Whilst this was exemplified by the pandemic, it was explained that the pressures relating to delayed discharge processes have been long standing and challenging.

Without understanding of what may constitute a deprivation of liberty, practice may well be flawed, with consequent impact on the rights of the individual who lacks capacity. Discharges from hospital to care homes bring this into sharp focus and practitioners require high levels of training, support and leadership to fulfil their functions to ensure that any moves are lawful and compliant with an individual's human rights, as well as their economic, social and cultural rights.

Legal framework for the moves

Within our sample, we were told that 74% of the moves that took place (involving people assessed as lacking capacity to decide on a care home move) were underpinned by the legal authority of a Welfare Guardianship Order or the existence of a Welfare Power of Attorney (hereafter 'WG/PoA'). Twenty percent of moves were reported under s.13ZA of the Social Work (Scotland) Act 1968 and two per cent under other legal frameworks, namely compulsory treatment orders under the Mental Health (Care and Treatment)(Scotland) Act 2003.

From the information we received there were 20 cases (4%) where no legal framework had been in place to facilitate the commissioning of the care home placement for the individual.

Whilst we welcomed the information provided by HSCPs, further analysis of the detail would suggest that not all the moves reported met the criteria for the legal framework we were told about.

Geographical differences in legal authority used

An overview of what legal frameworks were used in each HSCP is presented in Table 3. A dot indicates that we identified moves under that legal framework within the HSCP. Due to the small numbers in many areas, we have not published them here.

We found from the information we received that moves had happened without legal authority in 11 of the 30 HSPCs (37%) that we looked at, ranging from 3% of all moves in one area to 100% of all moves in one area. S.13ZA had been used in 23 (76%) of HSCPs, which ranging 8–36% of all moves. In 14 of these HSCPs (61%), the percent of moves under s.13ZA was higher than the overall average of 20%.

This information, however, is a reflection of the information we were provided by HSCPs. In the next sections we describe what we found when we looked into cases in more detail.

Table 3. Reported legal authorities used for moves by HSCP

HSCP	13za	No legal authority	WG/POA
Aberdeen City	●	●	●
Aberdeenshire	●	●	●
Angus	●		●
Argyll and Bute	●	●	●
Borders	●	●	●
Dumfries and Galloway	●		●
Dundee	●		●
East Ayrshire	●		●
East Dunbartonshire			●
East Lothian	●		●
East Renfrewshire	●		●
Edinburgh	●	●	●
Falkirk	●		●
Fife	●		●
Glasgow City	●		●
Inverclyde	●		●
Midlothian	●		●
Moray		●	●
North Ayrshire	●	●	●
North Lanarkshire	●	●	●
Orkney		●	
Perth and Kinross	●		●
Renfrewshire			●
Shetland		●	●
South Ayrshire			●
South Lanarkshire	●		●
Stirling and Clackmannanshire	●		●
West Dunbartonshire	●		●
West Lothian	●	●	●
Western Isles			●

Note that Highland did not provide information requested within the timescale required for this report and is therefore not represented here

Welfare guardianship orders/Power of Attorney

Of all 457 moves, 338 were reported to have been authorised by either Welfare PoAs (79%) or Welfare Guardianship Orders (21%).

Power of Attorney

What we expected to find

When someone makes a power of attorney (PoA) they appoint someone else to act on their behalf. The person making the PoA is called the granter and the person appointed to act on their behalf is called an attorney.

A PoA gives the attorney the legal authority to deal with financial/property matters (financial or continuing PoA) and/or personal welfare (welfare PoA).

- Powers relating to the granter's financial/property affairs are known as 'continuing or financial powers and may be given either with the intention of taking effect immediately and continuing upon the granter's incapacity, or to begin on the incapacity of the granter.
- Powers relating to the granter's welfare are known as welfare powers and cannot be exercised until the granter has lost the capacity to make these decisions.

A PoA is drawn up when the granter has the mental capacity to do so.

Following a number of publicity drives over the past few years to raise awareness about Powers of Attorney, there has been a rise in the number of PoAs registered with the Office of the Public Guardian (OPG).

Table 4. Number of PoAs registered, by year

Year	Number registered
2017-18	2,966
2018-19	2,975
2019-20	4,706
2020-21	6788

Source: Office for the Public Guardian[14]

The PoA can only be used when registered with the OPG and the attorney should provide a certificated copy of the document to relevant parties to confirm their status as attorney.

A PoA that is to begin in the event of incapacity should have a statement confirming that the granter 'has considered how their incapacity is to be determined' and HSCP staff using a PoA as legal authority for welfare decisions must be satisfied that incapacity has been confirmed according to this statement.

Where an attorney is stating that they are acting as attorney, they should be expected to produce the certificated PoA document that has been registered with the OPG. Relatives, on occasion, may refer to themselves as having PoA when they are in fact the person's appointee for Department of Work and Pensions benefits, or they are simply the next of kin. It is important to clarify and ensure a shared understanding.

[14] Office of the Public Guardian. (2021). *Expedited Powers of Attorney* [online] available at: https://www.publicguardian-scotland.gov.uk/general/about-us/performance/power-of-attorney-performance-2020-2021 (Accessed 20 April 2021).

Whilst it is important that consultation with relevant others takes place at times of key decisions it must be remembered that it is only a welfare PoA or a welfare guardian who would have the legal authority to make welfare decisions for an adult who has lost capacity to do so.

It is therefore vital that services ask for a copy of the PoA document to ensure that it has been registered with the OPG, to check what the powers are, and to confirm how the granter wants their incapacity determined.

For instance, where it states that the PoA requires to be triggered by a written medical statement of incapacity, this should be provided along with a copy of the PoA document. It is important that staff read the PoA document with regard to the powers and any stipulation about when the attorney can act, particularly where there are contentious decisions.

What we found

Within the cases we sampled we were told that the most prevalent legal authority used to authorise a move from hospital to a care home, was a welfare PoA, with 267 moves reported to be authorised by this legal authority.

However, in a number of cases where the HSCP advised that a PoA had provided the legal authority for the move, further analysis suggested that the validity of this legal authority was not always established.

We asked when the PoA which was authorising the move was granted, and in 70 cases this information was either unknown or not recorded.

Where a PoA was the reported legal authority for the move from hospital to care home, we asked if the powers had been triggered in accordance with the clause or "trigger" in the individual's document which stipulated how incapacity would be established. Seventy seven out of 267 confirmed they were unclear if the powers had been validly triggered, while the remainder confirmed that powers were triggered. Within this remaining 190 who confirmed that powers were triggered, 33 of these had no record of how, when or by whom incapacity had been assessed so it was difficult to state with confidence that these powers had, in fact, been triggered in line with the requirements of the PoA document.

We heard in some instances that incapacity had been confirmed as evidenced by an "AWI" being in place, however, as we discussed earlier, further analysis evidenced that this would appear to have been a s.47 certificate which authorises treatment for an adult who is incapable of consenting to the particular treatment. Although this may be an indicator of cognitive impairment in relation to treatment decision making, it does not equate to an assessment of incapacity to trigger a PoA.

We found in 78 of the cases where PoA was believed to be the legal authority for the move, HSCP practitioners reported that they had not read the PoA document. A further 61 reported that they had either read the document or had been advised of the contents of the document but had not recorded any of the details on records.

We asked if there was a power included in the document which authorised decision making in relation to where the granter should live. HSCPs advised that in 231 cases there was a relevant power. However given the number of instances where the documents were either unavailable or had not been seen, it is difficult to understand how this information had been ascertained other than reports that HSCPs had assumed the existence of this power as it is a standard power contained in most PoA documents.

There were examples within the sample where PoA was cited as the legal authority for the move but on further examination was found not to be the case, for example, where the powers related only to financial decisions or where the PoA had not been registered with the OPG. This highlights the requirement for HSCPs to seek a copy of the certified PoA document to inform their intervention and for a record of the validity of this authority to act on the granter's behalf.

The landscape in which these discharges from hospital were managed was complex due to the distanced working arrangements in response to pandemic restrictions which resulted in for example, social work staff not having access to the wards, medical notes or in many cases the patient themselves. We acknowledge the complexities which were in place at this time but it is unclear if these omissions were as a result of these restricted working arrangements or indeed arose as a result of a lack of understanding for some staff effecting hospital discharges about the different elements of what constitutes a legal proxy decision maker and the scope and limitations contained within individual documents.

Recording may well have been a significant issue in HSCP practitioners accurately reflecting retrospectively on individual circumstances when approached by us as part of this piece of work. In some instances the recording of relevant information was incomplete and at times absent, leaving practitioners in doubt about the circumstances around individual discharges. One example related to a care team recognising the limitations of a PoA given the persistent opposition of the person with incapacity to the move to a care home. The recorded recommendation was to apply for an interim guardianship order to ensure appropriate safeguards and to facilitate the move. Records were subsequently absent, and the key contact had assumed that the interim order had been granted. Further analysis confirmed no order had in fact been applied for, yet the move had taken place.

HSCP staff are bound by professional codes of practice which require clear, accurate and up to date record keeping – it is difficult to ascertain if these deficits in recording were as a result of the pressures staff were under including their restricted access to information systems at the time (due to home working) but it is clear that evidencing legal authority for a number of moves was compromised as a result.

It is important to note that practice varied across Scotland. In some areas good practice was clearly evidenced where a copy of the PoA document was accessible within records, there was clarity about what was required to activate the powers, a clear record of when an assessment of incapacity had been completed and by whom and the presence of a power to decide where the adult should live.

Welfare Guardianship

What we expected to find

Guardianship under the AWI Act is a legal process that allows relatives/carers or other parties, such as local authorities, to make certain decisions or take certain actions regarding the welfare or financial affairs of adults who are assessed as lacking capacity to make these decisions themselves.

Adults mean anyone over the age of 16 years. One of the primary uses of welfare guardianship under the AWI Act is to authorise not just where a person should live, but also the care he or she should receive, and how this is delivered. The powers granted relate to those areas of a person's life in which he or she lacks the capacity to make decisions or take actions which need to be made or taken to safeguard their rights and protect their welfare.

A welfare guardian is appointed by the court to make specific welfare decisions on behalf of an individual who does not have capacity to make decisions him or herself.

The expectation is that the welfare guardian should give a copy of the order granted to relevant professionals and care/support staff. This will ensure that all relevant parties involved in the individual's care know which powers have been authorised on behalf of the individual. The order should be kept on file so that it is accessible to staff who are providing day-to-day care for the individual. The decisions the guardian can make will be specified in the guardianship order. A guardian may have the legal authority to make a number of decisions on behalf of an adult who lacks the capacity to make these decisions for him or herself. However, presumption should not be made that the guardian has the power to make all decisions about the care of the individual and it is important that practitioners check that the guardian has the power to consent to the required decisions about the person's care home placement.

When a welfare guardian (or a PoA) is making decisions, they must adhere to the principles of the AWI Act at all times. These principles include:

- Any action or decision taken must benefit the adult and only be taken when that benefit cannot reasonably be achieved without it.
- Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.
- Account shall be taken of the present and past wishes and feelings of the adult, as far as they can be ascertained.
- Where practicable, they should take the views of relevant others into account.
- They must encourage the individual to use existing skills and gain new skills. This includes helping the individual to exercise any capacity he/she has to make choices concerning their property, financial affairs and their personal welfare.

Where a guardian requires to make the decision about moving to a care home on behalf of the adult, the guardian must have the necessary power in place to authorise this and must take into account the individual's views, both past and present.

What we found

We wanted to know how many people were subject to a welfare guardianship order which legally authorised the move to a care home. We found that, in our sample, welfare guardianship orders were granted prior to the move for 71 individuals who moved to a care home.

All of these individuals had a specific power authorising the adult to move to the care home. Guardianship orders in place were a mixture of private and local authority welfare guardians.

Some of the orders granted by the court included interim powers and had specific powers that gave authority to facilitate the move for the individual before the full guardianship order was granted. An interim order is time limited until a full hearing can take place in court.

An example in one HSCP showed that interim guardianship powers were granted to the chief social work officer (CSWO) in March 2020. This included the specific power to facilitate the move for the person from hospital to a care home with the full suite of powers subsequently granted to the CSWO.

When an application is lodged in court, interim orders can be requested at that specific time, and the sheriff will consider the necessity of such interim powers. Interim orders can expedite a legally authorised discharge from hospital for an individual who lacks capacity to consent to the move.

We were told about some guardianship applications that had been lodged in court however - due to the pandemic - the applications were not heard and had been put on hold. We also heard of instances where a HSCP reviewed the decision to apply for a welfare guardianship order and revisited legal authority for the move as the individual reportedly satisfied the criteria for other authorisation e.g. initially the HSCP concluded that an application for welfare guardianship was required, but on review felt that the individual met the criteria to be moved under s.13ZA.

We also found that there were cases where the HSCP believed that an order was in place at the time of the move however further inquiry confirmed that the order was not in fact granted until the courts re-opened, that is, after the person had moved to the care home. This confusion during the pandemic period led to the individual being moved unlawfully.

In line with earlier discussion around PoA, HSCP practitioners implementing a hospital discharge for an adult who lacks capacity to consent should seek evidence of the legal guardianship powers that they intend to use to effect the discharge. Without this, there is the potential that people can be moved without due legal authority and have their rights significantly compromised.

Section 13ZA of the Social Work (Scotland) Act 1968

What we expected to find

S.13ZA took effect in March 2007. It is 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 care intervention proposed.

In 2007 the Scottish Executive issued guidance to local authorities on their powers under the 1968 Act.[15] In 2014 we, the Commission, confirmed our view that what was good practice before the Cheshire West case will, in large part, remain good practice (pending any legislative change by the Scottish Government), but that the Cheshire West decision makes it even more necessary that there is a proper and auditable process for taking decisions on care arrangements for people who lack capacity, and that this process fully reflects the principles of the AWI Act.[16]

We therefore expected to find some moves made according to s.13ZA of the Social Work (Scotland) Act 1968 within our sample, with clear auditable processes detailing the basis of decision making.

The Coronavirus (Scotland) Act received Royal Assent on 6 April 2020 and the Commission noted the significant changes to how s.13ZA might operate under emergency powers in this Act. The Scottish Government agreed that the Commission 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".[17] 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.

We therefore did not expect to find any moves to have been made based on emergency powers linked to the Coronavirus (Scotland) Act given this legislation was not enacted and no cases were brought to the Commission's attention for scrutiny as per agreed process.

[15] Scottish Executive. (2007). *Guidance for local authorities: provision of community care services to adults with incapacity*. Available at: http://www.sehd.scot.nhs.uk/publications/CC2007_05.pdf (Accessed 5 May 2021).
[16] Mental Welfare Commission (2020). *Working with the Adults with Incapacity Act for people in adult care settings*. Available at https://www.mwcscot.org.uk/node/1480 (Accessed 5 May 2021)
[17] Scottish Government (2020). Coronavirus (COVID-19): adults with incapacity guidance. Available at: https://www.gov.scot/publications/coronavirus-covid-19-adults-with-incapacity-guidance/ (Accessed 5 May 2021).

What we found

We were told that s.13ZA authorised 90 moves (20%) from hospital to care home in our sample. Whilst we were told that the majority of individuals who moved had their capacity assessed and this was confirmed by a doctor, we were told for some cases that it was unclear when the capacity assessment was conducted, but that it was recorded in the notes that the adult "lacks capacity". Other discussions with key contacts concluded that there was no evidence written in the record about the person's capacity, whilst we were told for some that "an AWI" was in place as discussed earlier, again evidencing confusion around understanding of this.

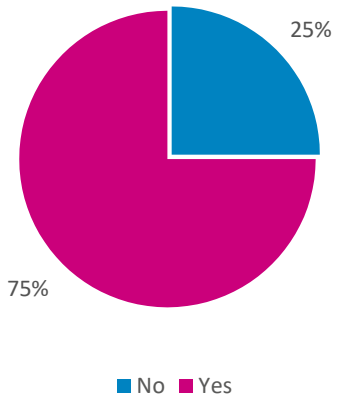
For a move to be authorised by applying s.13ZA, an adult must be incapable of making decisions about where they wish to live. If incapacity is not clear then this should be determined, following full support to maximise the person's participation in the decision making and should not be assumed.

The 2007 Scottish Executive guidance[18] highlights the requirements and processes to use when considering the use of s.13ZA as a legal framework. This includes who should be involved in discussions and what format these should take. The Scottish Executive confirmed that the views of all involved parties are important and therefore a record of the discussions and decisions reached should be maintained. As stated previously, in 2014, the Commission confirmed that Cheshire West reinforced the importance of auditable decision making processes in relation to safeguarding adults who are assessed as lacking capacity to decide on their care and support.

We found that in 70 of the cases where s.13ZA had been used (75%), a case conference and/or case discussion had taken place. Minutes of the discussion/conference were available in 60% (n=42) of these cases.

In 63% of cases where a discussion or conference had taken place, a mental health officer (MHO) had been involved, while in 33% no MHO had been involved and in 4% of cases it was unclear whether this had been the case. We heard of areas where MHOs operate within the hospital discharge teams and are involved in the majority of AWI Act/s.13ZA case conferences/discussions and this provided an additional safeguard to ensure decisions taken were compliant with legislation, rights and good practice.

Figure 2. Percent of s.13ZA cases where a case conference and/or case discussion took place



[18] Scottish Executive, *Guidance for local authorities*

In the 25% (n=20) where neither a case conference nor a case discussion had taken place, we were told that there was a record of the decision to use s.13ZA in 80% (n=16) of the cases. In the remaining four cases there was either no record of the decision or it was unclear if there was a record.

We also wanted to know if the principles of the AWI Act had been applied in cases where s.13ZA had been used. We were told that in 86% of cases (n=77) where s.13ZA had been used there was evidence that the principles of the AWI Act had been applied. However, in 10% of cases we found no evidence that this was the case and in four cases (4%) information was not provided.

We were told that due to the pandemic restrictions, most discussions/meetings took place virtually and often involved the key contact gathering the views from individuals separately due to restrictions in place and no access to wards.

We noted that individuals who lacked capacity and should have been at the centre of this process were not always seen and while we acknowledge the restrictions which were in place at this critical time of the pandemic, some areas did achieve inclusion while in other areas it seemed a fundamental omission.

We viewed some records as part of this project and saw that record of views and minutes of meetings were clear, concise and documented reasons why s.13ZA was applicable. For example:

> In Area W there were two instances when s.13ZA had been used as the legal authority to effect a transfer from hospital to a care home. Both of these were well documented on a system which was an embedded process in their IT system to ensure the relevant letters are sent to families and relevant people in the process; also decision making invoking 13ZA powers was well recorded. The two patients reviewed also had involvement from advocacy.

However, this was not always the case. We also had access to records where not all views were gathered and there was lack of detail regarding decision making and legal process. For example:

> No record of case conference or case discussion-there was a record of decision that says principles were not applied. Record in social work information system that individual was moved under s.13ZA - no record of who was involved in this decision.
>
> The adult's family were involved in the discharge decision making process. MHO and SW visited ward. There is a case note indicating that the doctor had confirmed that the person could move under s.13ZA but there was no record of a meeting/minute/manager decision. Son and daughter both involved in moving ….. to care home. No evidence of s.13ZA being properly used according to SW officer. There was a 13ZA pro-forma used but no details could be found by the social worker as the process had not been followed….

We also found occasions where s.13ZA appeared to be used inappropriately:

> S.13ZA was used to move this person, however the service user dissented ….. They moved to a permanent placement and are still in the care home. The record of views meeting shows that the service user did not agree to a move to a care home. The opposition (from the person) is described as 'soft' and due to Covid risks a 'liberal' application of 13ZA was used.

We heard from HSCPs that some areas believed that emergency legislation had in fact been implemented and that this revised version of s.13ZA had provided legal authority for some moves. For example:

> Some staff were of the understanding that emergency legislation had been enacted and as such views did not have to be taken in account. There appears to have been an e-mail from their legal department to this effect.

When section 13ZA was inserted in the Social Work Scotland Act in 2007 the intention was for the Social Work Inspection Agency to "from time to time, examine case records in relation to the application of this guidance and the use made of s.13ZA of the 1968 Act".[19] The health and social care landscape has evolved and changed considerably since 2007 and to date, this monitoring role has not been implemented.

[19] Scottish Executive, *Guidance for local authorities*

No legal authority

What we expected to find

Given the existing guidance, policy and legislation, including the Coronavirus (Scotland) Act 2020, we did not expect to find people, assessed as lacking capacity, being moved without legal authority from hospitals to care homes during the sample period.

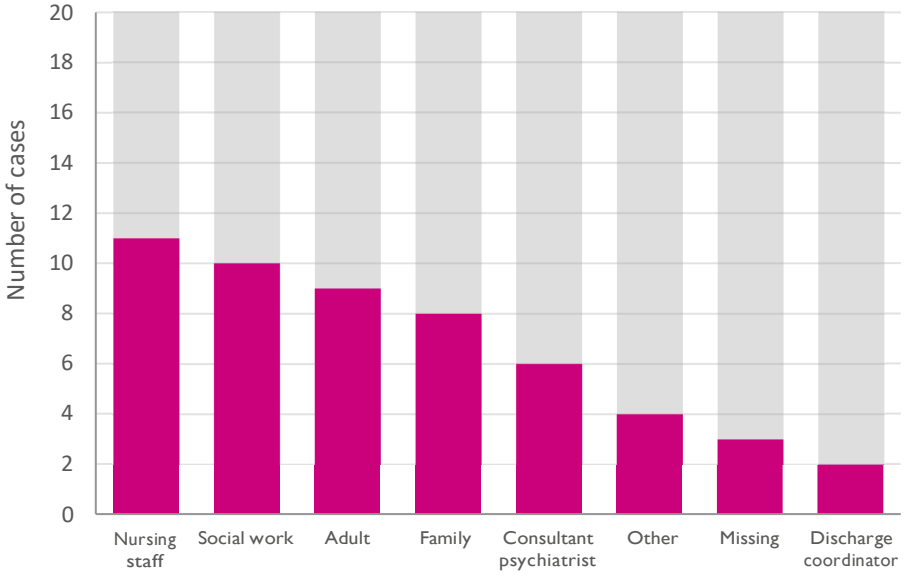
What we found

Within the data we collected, HSCPs identified 20 cases (4%) where no legal authority had been considered or been put in place to authorise the move. We wanted to explore who had been consulted about the move in these cases. Figure 3 shows that nursing staff were primarily consulted and social work staff were consulted in half of the cases. We were told that the adult who was subject to the move was consulted in only nine out of the 20 cases. Eleven people were moved without any consultation with them. There also appeared to be a lack of consultation with family and consultant psychiatrists in most cases, and a discharge coordinator had been consulted in two of the 20 cases.

Given the information received from HSCPs that these discharges had not been legally authorised we wanted to know if other important parts of the discharge process had been followed.

We looked at whether a social work assessment (SWA) had been undertaken in these cases. We found that in 18 cases a SWA had been done, a copy of the assessment was available for 16 of these cases. For the two cases where no SWA had been done, the notes indicated that an assessment had been done before the admission to hospital which recommended a package of care at home and had not been updated and for the other was because social work had not been involved in the move.

Figure 3. Individuals consulted about the move



Note that these categories are not mutually exclusive

We asked how these placements were funded and were advised that funding was in place for 18 of the 20 individuals who were moved without legal authority, the majority (n=15) were local

authority funded and the remaining three were self-funded. For the two individuals who did not have funding in place we noted the following:

> Funding for Person L was agreed by local authority on [date] but backdated to the date of admission to the care home.
>
> It was viewed by the HSCP practitioner as transitional care from NHS to NHS and social work services were not involved at this time. However, on checking this out further [name of care home] is not a NHS facility.

This data in relation to people who were moved with no legal authority is based on the information reported by HSCPs during the data collection stage of this project and relates to 20 people across 11 HSCPs out of a sample of 457. Although Highland HSCP did not provide information in time for use in this report, they did provide information suggesting that, like other HSCPs, moves may have been made there without appropriate legal authority too.

It is important to note that the reality, as described throughout this report, evidences a more worrying picture with regards to the legal authority used to facilitate moves. HSCP practitioners involved at the heart of the hospital discharge process consistently reported the use of what they believed to be a valid legal authority which, following further analysis, was not always the case.

This lack of clarity and understanding about the validity, scope and limitations of the use of legislation, has the potential to leave our most vulnerable adults at risk of their rights not being upheld and being detained unlawfully in care settings.

Summary of findings

We made contact in relation to 731 people who had moved from a hospital to a care home during the period 1 March 2020 to 31 May 2020. From the information reported, we looked further into 457 cases where the individual lacked capacity to engage in decision making around the plan to arrange 24-hour care in a care home setting for them.

We found evidence of some good practice, for example:

- Commitment to ensure that what mattered to the individual was central to outcomes and decisions made on their behalf
- Commitment to ensure that all efforts were made to ensure that the individual was supported to inform decision making where possible, including advocacy support and multiple direct contacts with the individual
- Respect for multidisciplinary roles and responsibilities ensuring that health and social care/social work retained focus on individuals and not other drivers such as beds and finance.
- Embedding the role of the MHO in discharge planning processes as a key safeguard with expertise and focus on the rights of individuals.
- Clear understanding of the requirement to ensure that reported powers under the AWI Act/PoA are activated, evidenced and referred to in practice.
- Interim guardianship powers sought, where appropriate, to effect timely and lawful hospital discharge.
- Increasing promotion and take up of PoA roles and responsibilities.

However, we found that practice was not consistent either within some HSCPs or across HSCPS. This is despite a range of existing guidance, policy and local arrangements to support implementation.

Some of our findings were specifically related to the pandemic. For example, we found some evidence that there had been an interpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and indeed removed in September 2020. Although Highland HSCP did not provide us with information requested within timescale to fully inform this report, they did advise that they introduced an alternative to application for an AWI order, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020.

The Commission's significant concern is that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of ECHR. The Commission does not provide legal advice so we asked whether legal advice had been sought in relation to both of these practices; confirmation was given that legal advice had been sought and given.

Section 13ZA of the Social Work (Scotland) Act 1968 was reportedly used to authorise moves in 23 Health and Social Care Partnerships and either Welfare Power of Attorney or Welfare Guardianship was used to authorise moves across 30 of the 31 Health and Social Care Partnerships.

We took further steps to assure legal rights were respected and protected beyond the 20 unlawful moves reported and found that those working in the field of hospital discharge were

not always fully sighted on the powers held by attorneys or guardians or indeed whether the attorney's powers had been activated or guardianship orders granted. It is our view that such assumptions, rather than evidence based decision making, had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR.

We also found confusion in relation to the reported nature of the care home placement with potential impact on rights to protection of property where the person was admitted to a care home but remained liable for their property.

Evidence of poor recording practice made it difficult for HSCPs to answer some of our queries despite their best efforts to do so.

In summary, whilst we identified good areas of practice across HSCPs in Scotland we also identified significant areas of learning and improvement required. Whilst the pandemic brought unprecedented pressures to bear on HSCPs, the identified areas for improvement arising from our examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. Indeed, our findings evidence longer standing systemic issues within HSCPS which require urgent action in order to safeguard and uphold the rights of the most vulnerable adults in our society. To this end, we have made eleven recommendations that we hope will assist HSCPs.

Recommendations

Based on our findings we recommend the following areas for improvement:

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.

[20] Equality and Human Rights Commission (2020). Equality and Human Rights Commission reaches settlement

Conclusion

This piece of work aimed to explore, within a 10% sample of all moves reported, whether there were any unlawful moves of individuals from hospital into care homes during the early stages of the pandemic. Our sample size was small hence we expected any learning or outcomes to be indicative rather than definitive, that is, if we found unlawful moves in one area that would not necessarily mean that all moves had been unlawful in that area, similarly, if we found no unlawful moves in another area, that did not necessarily mean there had been no unlawful moves there.

Twenty unlawful moves, across eleven Health and Social Care Partnership areas, were reported directly to us. Further analysis suggested that there may have been more unlawful moves than reported. For example, within Health and Social Care Partnerships we found a general lack of understanding of the law used to provide legal authority to facilitate moves from hospital to care homes. We also found assumptions were made about whether legal powers were in fact in place.

When we set out to undertake this report we intended to make inquiries in relation to how the law was used to protect the most vulnerable adults in our community during the significant challenges of the pandemic period. During the course of this work we found examples of poor practice and a lack of knowledge of the law that were presented as more longstanding and endemic.

We will be contacting individual Health and Social Care Partnerships to highlight both good areas of practice and areas of practice which fall short. However we call on all Health and Social Care Partnerships to take urgent action now in relation to the 11 recommendations made in this report to develop both a supported, competent, confident workforce and local auditable processes to ensure implementation of good practice. We also ask the Care Inspectorate, the responsible regulatory body, to incorporate the findings of this report in their inspection activity.

Glossary

CSWO	Chief Social Work Officer. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions. The role provides a strategic and professional leadership role in the delivery of social work services.
ECHR	European Convention on Human Rights
EHRC	Equality and Human Rights Commission
HSCP	Health and Social Care Partnership. A Health and Social Care Partnership is not a separate organisation distinct from the council or the health board. The term Health and Social Care Partnership or HSCP refers to the joint operational arrangements that exist in a council area between the council social work services and the health care services of the local health board. All clinical, professional and support staff who work within a HSCP are employed by the health board or the council in the specific geographical area.
Key contact	An identified member of staff from the HSCP who was able to provide information about the hospital discharge
MHO	Mental Health Officer. Mental Health Officers are social workers with a minimum of two years post qualifying experience who have gained the Mental Health Officer Award (MHOA), which prepares experienced social workers to undertake the statutory role defined by the AWI Act and the Mental Health (Care and Treatment)(Scotland) Act 2003.
PHS	Public Health Scotland
PoA	Power of Attorney – someone appointed by a person with capacity to make decisions about their welfare in the event that they lose capacity to do so themselves
OPG	The Office of the Public Guardian in Scotland was created when the Adults with Incapacity (Scotland) Act 2000 received Royal Assent. It is a single information point about financial provisions contained in the Act.
s.47	Section 47 (AWI) Certificate issued by a doctor where the adult cannot consent to the treatment being given.
Welfare Guardian	A person appointed by the Sheriff Court to make decisions in relation to the welfare of a person who has been assessed as lacking capacity to make these decisions themselves.

Legislation

- Adults with Incapacity (Scotland) Act 2000
- Coronavirus (Scotland) Act 2020
- Social Work (Scotland) Act 1968
- Carers (Scotland) Act 2016
- Mental Health (Care and Treatment)(Scotland) Act 2003
- The Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020

Links

- Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Greater Glasgow and Clyde* [online] Available at: https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention (Accessed 19 April 2021).
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Appendix A – Data analysis and detailed methodology

We calculated descriptive statistics for the cases that lacked capacity, including the percentage of moves under each of the legal frameworks. For continuous variables such as age we calculated median and interquartile range (IQR)[21] in order to compare across groups. We cross-tabulated the legality of the move with individual characteristics (age, gender, diagnosis, ethnicity and HSCP) to assess whether there are any differences based on these characteristics.

We created a stratified sampling process in which we sampled cases according to HSCP (based on population size, see Table B1) and age group (based on age distribution in all moves reported by PHS, see Table B2). From the list of cases we received, we ordered the cases randomly and reviewed each case for inclusion until we reached the target number for each HSCP. Our inclusion criteria for full review of the move were: i) the individual was discharged into a registered care home and lacked capacity to consent to the move, ii) the discharge occurred between 1 March 2020 and 31 May 2020, and iii) the person was aged 16 years or older.

In total we assessed 731 cases for inclusion. Of these, 465 (64%) people were assessed as lacking capacity to make an informed decision in relation to a move to a care home and 266 (36%) people reportedly had capacity to consent to the move. A number of people who had capacity also had diagnoses of mental health related conditions. Of those people who were reported as having capacity, we asked questions of the key contact to ensure that consent had been free and informed and recorded in case records. After excluding eight cases that ended up not fulfilling our inclusion criteria, we here report on 457 cases which we reviewed in detail.

Cases where the person was assessed as having capacity to decide on the move to a care home were noted in the list of received cases to track the proportion of moves that included individuals with and without capacity, only statistical information has been retained and all personal details about individuals assessed as having capacity has now been deleted from the Commission's server.

For cases where individuals lacked capacity, we used a proforma to collect the relevant information to determine which legal authority was used. Information on individuals who lacked capacity will be stored for three months after publication of this report and then deleted from the Commission's servers.

While we aimed to include 500 cases of individuals who lacked capacity, we had issues in some areas to fill the sample. In some HSCPs, the workload and remote working meant that there were limits to the engagement with the project that key contacts could provide within the time scale.

[21] The IQR is a measure of spread of values, where the value for the third (75%) and first (25%) quartile are subtracted to indicate where there middle 50% of observed values.

Appendix B – Sampling

Table A1. Distribution of Scotland's population and corresponding numbers for target sample of N=500

HSCP	Population[a]	<64 years	65-84 years	85+ years	Total
Aberdeen City	4%	2	10	9	21
Aberdeenshire	5%	2	11	10	24
Angus	2%	1	5	5	11
Argyll and Bute	2%	1	4	3	8
Clackmannanshire and Stirling	3%	1	6	6	13
Dumfries and Galloway	3%	1	7	6	14
Dundee City	3%	1	7	6	14
East Ayrshire	2%	1	5	5	11
East Dunbartonshire	2%	1	5	4	10
East Lothian	2%	1	5	4	10
East Renfrewshire	2%	1	4	4	9
Edinburgh	10%	4	23	21	48
Falkirk	3%	1	7	6	15
Highland	4%	2	10	9	22
Inverclyde	1%	1	3	3	7
Midlothian	2%	1	4	3	8
Moray	2%	1	4	4	9
North Ayrshire	2%	1	6	5	12
Orkney Islands	0%	0	1	1	2
Renfrewshire	3%	1	8	7	16
Scottish Borders	2%	1	5	5	11
Shetland Islands	0%	0	1	1	2
South Ayrshire	2%	1	5	4	10
South Lanarkshire	6%	3	14	13	29
West Dunbartonshire	2%	1	4	3	8
West Lothian	3%	2	8	7	17
Western Isles	0%	0	1	1	2
Fife	7%	3	16	15	34
Perth and Kinross	3%	1	7	6	14
Glasgow City	12%	5	28	25	58
North Lanarkshire	6%	3	15	13	31

[a] As percentage of the overall Scotland population. Highland was included in the estimated sample needed but did not provide information within the time frame (see Methodology).

Table A2. Distribution of moves according to gender and age

Age (years)	n (%)
<64	449 (9%)
65-84	2,511 (48%)
85+	2,244 (43%)
Total	5,204 (100%)

Source: Public Health Scotland

Appendix C – Sample summary

We looked into the circumstances of moves of 457 individuals who lacked capacity. Our sample included 59% female and 41% male individuals, which reflected the distribution of moves in the report published by PHS (also 59% female). The median age of individuals was 84 years (IQR=13), similar to overall moves in the same period reported by PHS (mean=81 years). Table C1 shows a breakdown of the demographic characteristics of individuals.

Table C1. Individual characteristics (N=457)

Characteristic	Category	n (%)
Gender	Male	188 (41)
	Female	269 (59)
Age, median (IQR)	—	84 (13)
Age group	<65 years	31 (7)
	65-84 years	207 (45)
	85+ years	219 (48)
Ethnicity	White Scottish	401 (88)
	White Other British	35 (8)
	Not provided	14 (3)
	Indian	*
	White Other	*
	Pakistani	*
	White Scottish and White Other British	*
	White Scottish and Indian	*
Diagnosis	Dementia	300 (66)
	Other	84 (18)
	Multiple diagnoses	38 (8)
	ABI	14 (3)
	MI	10 (2)
	ARBD	*
	LD	*

*number suppressed due to n<5 or due to secondary suppression

We found that 55% of the individuals were still in the care home they were admitted to following discharge from hospital.

Geographical area

We sampled cases from all HSCPs, apart from Highland (see Methodology section). Table C2 shows the number of cases and percentage of the total sample from each area. The largest percentage of cases were from Glasgow City (10%), Edinburgh (9%) and Fife (9%).

Table C2. HSCP of sampled cases

HSCP	n (%)
Aberdeen City	20 (4)
Aberdeenshire	20 (4)
Angus	10 (2)
Argyll and Bute	8 (2)
Borders	10 (2)
Dumfries and Galloway	14 (3)
Dundee	14 (3)
East Ayrshire	10 (2)
East Dunbartonshire	10 (2)
East Lothian	10 (2)
East Renfrewshire	8 (2)
Edinburgh	41 (9)
Falkirk	14 (3)
Fife	42 (9)
Glasgow City	44 (10)
Inverclyde	7 (2)
Midlothian	9 (2)
Moray	9 (2)
North Ayrshire	12 (3)
North Lanarkshire	33 (7)
Orkney	*
Perth and Kinross	15 (3)
Renfrewshire	15 (3)
Shetland	*
South Ayrshire	11 (2)
South Lanarkshire	27 (6)
Stirling and Clackmannashire	13 (3)
West Dunbartonshire	9 (2)
West Lothian	16 (4)
Western Isles	*
Total	**457 (100)**

*number suppressed due to n<5 or due to secondary suppression.
Note that Highland is not represented here. For more information see Methodology section.

Individual differences in legal authority used

We looked at the individual characteristics of individuals who were moved from hospital to care home. We looked at age, gender, diagnosis and whether or not the individual passed away following the move. We excluded the 'other' framework, as it only included nine individuals and the small number meant comparing across group would be inappropriate and provide little ability to make comparisons.

Due to very small number in many diagnostic categories, we compared Dementia (the largest group) with all other diagnoses or combination of diagnoses. There were too few individuals in other ethnicity categories than White Scottish or White Other British whereby no comparison was done between the three groups.

We found that 52% of individuals moved under WG/PoA were aged 85 years or older compared to 37% among s.13za moves and 40% no legal authority, however the median age did not differ much from s.13ZA (median age of no legal authority impacted by the small number). We also found a higher percentage of females among those moved on welfare guardianship or PoA and no legal authority (60% and 60%, respectively) compared to those moved under s.13ZA (52%).

There was a higher percentage of moves under welfare guardianship or no legal authority with diagnosis of dementia (74% and 75%, respectively) compared to s.13ZA (52%), which may to some extent be a factor of a higher median age among the former. Similarly, a higher percent of individuals moved under welfare guardianship or PoA had passed away – again likely influenced by a higher mean age in this group.

Table C3. Individual characteristics of the three main legal frameworks for moves

Characteristic	Category	Legal framework (N=448)			Total
		s.13ZA	WG/PoA	None	
Age, median (IQR)	—	81 (16)	83 (11)	85 (11)	84 (13)
Age group	<65	10 (10)	17 (6)	0	27 (6)
	65-84	46 (53)	144 (40)	12 (53)	202 (43)
	85+	34 (36)	177 (54)	8 (47)	219 (50)
Gender	Male	43 (48)	134 (40)	8 (40)	185 (41)
	Female	49 (52)	204 (60)	12 (60)	263 (59)
Diagnosis[a]	Dementia	47 (52)	250 (74)	14 (75)	212 (70)
	Other	43 (48)	5 (26)	88 (25)	136 (30)
Deceased	Yes	27 (30)	122 (36)	*	151 (34)
	No/not mentioned	66 (70)	216 (64)	*	297 (66)

[a]As most diagnostic categories had too few numbers in each for comparison, we have aggregated ABI, ARBD, MI, LD, other diagnoses and multiple diagnoses. Dementia includes individuals who had a main diagnosis of dementia with any other diagnosis in addition.

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	Recommendation	Action	Lead Person(s)	Timescale	Progress
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, multi-disciplinary workforce supporting safe and lawful hospital discharge planning.	Obtain current training stats relating to compliance against think capacity / think consent to analyse what areas need targeted initially to increase training update. Develop a Training Needs Analysis (TNA) to assess workforce competence and knowledge base relating to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals Develop refresher training sessions (Authority to Discharge) for all staff involved in discharge planning arrangements.	Head of Nursing Organisational and Development Officer Head of Service Critical and Complex Care Consultant Psychiatrist	Nov 2021 implement the plan of training Deliver training across HSCP by January 2022 – possible annual refresher Nov 2021	
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.	Undertake an audit of SWIFT and Health services user management systems to assess whether there are robust systems in place of recording AWI and section 47	All Heads of Service with Professional Leads	Rolling audit with these elements to be commenced	

	Recommendation	Action	Lead Person(s)	Timescale	Progress
		through medical records and clinical systems. The audit will include assessing whether powers of attorney (including powers granted) and guardianship details are recorded within medical records along with photocopies in notes. Appraisal of current recording systems to ensure that there is a facility to record capacity assessments/decisions and financial decisions. Work with colleagues in information technology to update systems based on the findings of the audit which will provide recommendations to ensure compliance regarding consistently recording assessments of incapacity.		September 2021	
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	Re-circulate the care home booklet to all services across HSCP to raise awareness of guidance regarding finance and welfare. Practitioners to ensure that the patient/ service user, their	Head of Service Complex and Critical Care	End August 2021	Completed (attached) Care Home Contracts Service Jol

	Recommendation	Action	Lead Person(s)	Timescale	Progress
	implications of different types of placements for the individual.	Power of Attorney (PoA) or Guardian is fully under-standing of the financial implications of various placement choices. Survey to be undertaken to assess whether this is successfully being shared with patients / service users and there is an understanding of the status of care homes.	Head of Performance and Strategic Planning Service Manager SW hospital discharge team		
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.	Guidance on POA and 13ZA evidences this for Adults/Older People staff. New tool to be developed to document capacity/incapacity what powers have been granted and how the powers are enacted.	Integrated Discharge HUB/ Community Flow Manager Service Manager SW Hospital Discharge Team Clinical Lead Medicine of the Elderly (MoE) Consultant Psychiatrist	End of August 2021	**Update** Tool updated, POA info to be added  Guardianship Order template 170621.JSt

	Recommendation	Action	Lead Person(s)	Timescale	Progress
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.	Case Recording Guidance and Self-Directed Support Guidance evidence this for Adults/Older People staff. Moving On leaflets and Appeals leaflets distributed to VHK and community hospitals,	Integrated Discharge HUB/ Community Flow Manager	End of August 2021	Moving on Policy and leaflets approved and to be rolled out in all Fife inpatient areas.
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.	Standard operating procedure to be developed to ensure process, including audit recording of decisions and governance is all in place	Head of Performance and Strategic Planning Service Manager SW Hospital Discharge Team Clinical Lead MoE	End of August 2021	
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.	Audit tool will include a section to ensure that inclusive decision-making is being considered consistently.	Head of Performance and Strategic Planning	End of September 2021	

	Recommendation	Action	Lead Person(s)	Timescale	Progress
		An appraisal of the value of the funded CIRCLES project focussing on Carers understanding and inclusiveness through decision making processes will be undertaken.			
8	HSCPs should ensure strong leadership and expertise to support operational discharge teams.	Development sessions to be arranged with teams across Fife involved in discharge planning.	Service Manager SW Hospital Discharge Team Integrated Discharge HUB/ Community Flow Manager	August-November 2021	MDT team in place to provide leadership relating to discharge across all Fife hospitals. Overall leadership provided by Integrated Discharge HUB/ Community Flow Manager And SW manager. Work will continue to ensure joined up systems leadership
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.	N/A	N/A		

	Recommendation	Action	Lead Person(s)	Timescale	Progress
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.	N/A			
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.	N/A			

Fife Health & Social Care Partnership
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MINUTE OF THE CLINICAL & CARE GOVERNANCE COMMITTEE

WEDNESDAY 2 JUNE 2021 – 10.00 AM VIA MS TEAMS

Present:	Cllr Tim Brett, Fife Council (Chair) Christina Cooper, NHS Fife Board Member Martin Black, NHS Fife Board Member Cllr David J Ross, Fife Council Cllr Jan Wincott, Fife Council Wilma Brown, Employee Director, NHS Fife
Attending:	Dr Helen Hellewell, Associate Medical Director Nicky Connor, Director of Health & Social Care Cathy Gilvear, Quality Clinical & Care Governance Lead Fiona McKay, Interim Divisional General Manager James Crichton, Interim Divisional General Manager (Fifewide) Lynn Barker, Associate Director of Nursing Simon Fevre, Staff Side Representative Lynne Garvey, Divisional General Manager (West)
In Attendance:	Avril Sweeney, Manager – Risk Compliance Christopher Conroy, Interim Clinical Services Manager, NHS Fife Ruth Bennett, Health Promotion Manager Jennifer Cushnie, PA to Dr Hellewell (Minutes)
Apologies for Absence:	Chris McKenna, Medical Director Scott Garden, Director of Pharmacy and Medicines

NO	HEADING	ACTION

1.0 CHAIRPERSON'S WELCOME & OPENING REMARKS

The Chair welcomed everyone to the meeting. He advised until the new Governance Arrangements are agreed, the Agenda for C&CG shall remain in its present format.

2.0 DECLARATION OF MEMBERS' INTEREST

There were no declarations of interest.

3.0 APOLOGIES FOR ABSENCE

Apologies were noted as above.

4.0 MINUTES OF PREVIOUS MEETING

Cllr Brett asked if members were content with the previous minute of 16.04.21. No changes were requested, therefore the Committee agreed to approve the Minute.

5.0 ACTION LOG

Cllr Brett ran through the Action Log of 16.04.21. The first item relating to Urgent Care is now complete. Remaining items remain active.

6.0 GOVERNANCE

6.1 Clinical and Care Governance Update

Cllr Brett invited Dr Hellewell and Lynn Barker to give a verbal update around Clinical and Care Governance.

HH advised, as Scott Garden was unable to join the meeting, she would summarise details relating to the Vaccine Programme:

- Steadily increasing numbers of people fully vaccinated in Fife
- Cohort 11 (30-39 yo's) commenced in Fife w/c 31.05
- National self-referral portal for Cohort 12 (18-29 yo's) launched - over 1/3 already registered.
- Fife are above national average of vaccines administered.
- Vaccine supply is good with no concerns.
- Proof of vaccination portal is now open to members of the public.
- Fife doing well in DNA rate and currently sitting below national average.
- Continued work ongoing around groups who have been more difficult to reach, currently concentrating on the homeless population.

Cllr Brett queried how Cohort 12 will be reached if they do not register. HH advised a text appointment will be received when an individual registers and this is thought to be a more meaningful way to engage with this age group and is hoped to lower DNA rate. Other means of engaging are being explored to reach those who do not register.

Cllr Wincott asked which vaccine was being offered to under 30s and under 40s. HH advised a different vaccine is being offered to under 30s and under 40s. Under 30s will receive Pfizer, HH will check for under 40s and get back to Cllr Wincott.

MB asked how difficult to reach people are being engaged with, ie. people who are illiterate. He also queried reports of staff being subjected to abuse and asked the details of this. HH advised a group has been established to specifically look at reaching people who are difficult to reach, she will attain details and forward to MB. LG suggested the eqIA Policy would be useful to share with members. Agreed. **HH** **LG**

Specific details of the abuse being experienced was requested. NC advised this related to people expecting a choice of vaccine – planned communications are being released to advise this is not the case and a zero-tolerance policy to abuse is in place. LB added, senior staff are situated in every clinic to support staff.

6.0 GOVERNANCE

Cllr Ross asked if services such as SeeScape are being utilised and if the link for Cohort 12 can be shared. HH advised the link for the Cohort 12 portal is on twitter, this can be shared for further promotion. LB offered to forward the link to members. HH stated the eqIA, which will be circulated to all members, is a very comprehensive policy and she expected organisations such as SeeScape would be included, however, will check to ensure this is the case. **LB** **HH**

Cllr Brett queried when all services will resume. LG described the Group, involving Service Managers, who are submitting remobilisation plans reporting to SLT. Bringing back these services safely is a priority with 95% back to 'normality'. LG explained some of the issues around this. Questions were invited.

MB raised concerns regarding messaging to the public around reporting to Accident & Emergency, he felt many were presenting with minor ailments. HH stated local and national comms to the public is being looked at currently – this subject is more fully covered in 6.3. WB stressed remobilisation is being carried out in a planned and staged way. She disputed individuals presenting with minor injuries/concerns and advised, the majority of people are suffering from serious health issues.

6.2 Clinical Quality Report (Including Medicines Update)

Cllr Ross found the report to be challenging reading and asked HH and LB to outline highlights.

LB advised there has been a deep dive into pressure ulcers and their prevention. Cluster reviews within MH are ongoing, 70 cases have been reviewed to date with one requiring further investigation. This work has been well received and is being taken to a National MH platform to demonstrate work taking place in Fife.

LB described collaborative working within community hospitals. She advised the Safe Use of Medicine Group has restarted with a programme of auditing and incident monitoring. Patient experience, care opinion has seen an increase in uptake which has been very positive.

HH added, although the Safe Use of Medicine Group was paused during the pandemic, protocols were still in place and being worked to.

HH advised Norovirus and 'Flu infections are reduced due to measures taken to prevent transmission of Covid 19.

SF queried if the non-improvement in incidences of falls is due to lower staffing levels. This was discussed at some length and LB gave assurance safe staffing levels are always adhered to and the measures which are in place to ensure this.

Cllr Brett advised, he will discuss with HH and LB ahead of the next meeting, the possibility of future reports focussing on one particular area.

6.3 Joining Up Care – Urgent Care

LG introduced Chris Conroy, Interim Clinical Services Manager for Urgent Care. CC gave a presentation summarising the two Papers which outline the key developments within Urgent Care over the past 18 months.

CC explained the first paper focusses on Urgent Care Services as agreed by IJB during 2019, some detail of Urgent Care Services' role during the pandemic and additional detail around collaborative initiatives undertaken. The second paper focusses on the implementation of the Flow and Navigation Hub which has been delivered within the parameters of the Redesign of Urgent Care Programme.

Beginning with Report 1, Unscheduled Care Services, CC highlighted some of the key developments and gave detail of the work which has taken place since meeting with IJB in June 2019. He also explained the impact of the pandemic on some of the progress. One of the initiatives was to facilitate a dedicated Palliative Care line for family members/carers, which is available 24/7 directing them to the correct service.

CC gave examples of patient pathway experiences which highlighted good collaborative working. Patients using the service complete a feedback questionnaire, feedback shows 87% of patients felt the service to be good or very good with many positive comments made.

Report 2 focussed on the implementation of the Flow and Navigation Hub (FNH) which was established as part of the Unscheduled Care programme. The following principles have been adhered to:

- Face-face consultations, if required, appointed in a scheduled way
- General Practice to remain the principal access route for Unscheduled Care in-hours
- Emergency care accessed as before
- Communication and engagement with both workforce and public

CC gave examples of Person Pathways to illustrate how Redesigned Urgent Care works in various scenarios and outlined the next steps which are being taken within the programme.

MB raised concerns for people who cannot, and do not, have the capability to operate these systems. CC advised a comprehensive eqIA was carried out prior to the work and he would be happy to go through this for anyone. KH gave more detail of how, through Corporate Parenting and the Drugs and Alcohol Partnership, these issues will be worked through.

Cllr Brett asked for the slides to be distributed to members of the Committee. He also asked if the same systems are in operation in Tayside/Lothian, it was advised the same systems are in place. **JC**

6.0 GOVERNANCE (Cont)

6.4 Post Winter Plan Review

LG has regularly brought updates to C&CGC meetings of the Winter Plan which was submitted to Scottish Government in Nov 2020. She advised weekly meetings are held to discuss performance metrics and any concerns arising across the system, this is done via scorecards, as illustrated in Appendices.

Points of interest regarding key winter performances are:

- Some breaches within A&E reported due to above average attendance by very sick people with complex issues.
- Delayed discharge – done well this winter, avg of 300 beds/wk which is much lower than previous years. Often delays are due to guardianship issues, dialogue with Courts is taking place to move this forward.
- Excellent H&SCP performance - average improvement of 100% week on week.

A Winter Planning Event took place with key stakeholders on 12 April reviewing last winter's learnings. Key learning being taken forward are:

- trigger points in system – when should we be surging and the governance around this
- learning from flexibility in staff moving across the organisation and supporting staff's wellbeing
- IT systems/flexibility and speed of change
- Working proactively

A Home First Strategy Group has been formed, chaired by LG. The group is developing the Home First model as a whole strategy and setting out plans for the coming winter with performance targets. This will be brought to Committee by Sept 2021.

Questions were raised regarding Guardianship issues, FMcK gave an update around this and explained reasons for the delays experienced.

MB queried if the Covid vaccination programme will be incorporated into the Winter strategy. NC advised she has been appointed Senior Responsible Officer for the Vaccination Programme (Covid-19 and Flu). Scottish Government are committing resource to the Programme and learning will be taken from the work carried out during the Pandemic. A workforce plan will be agreed involving HSCP, Primary Care, Community Pharmacy and the Third Sector. Strong comms will be developed to support this work.

6.5 Suicide Prevention

JC introduced Ruth Bennett, Health Promotion Manager, to the Committee. RB advised the report is a comprehensive update on Fife H&SC's requirement to lead on the development and delivery of a local suicide prevention action plan. This plan is guided by the ten actions set out in the National Suicide Prevention Plan – Every Life Matters.

6.0 GOVERNANCE (Cont)

The work is driven by a Fife Suicide Prevention multi-agency core group who met regularly through 2020 to ensure progression. There are also several delivery groups driving the work forward. RB described some of the work taking place.

The National Leadership Suicide Prevention Group issued guidance to local Boards with four focus areas to be worked on during the pandemic. These related to closer monitoring of real-time suicide data, suicide prevention campaigns, enhanced focus on suicide crisis intervention and restricting access to means of suicide. Details of these areas is outlined in the workplan.

A process for reviewing suicide deaths is yet to be developed. Meetings have taken place to bring key people together and Guidance is expected to be published September. 2021.

Cllr Brett queried whether the Pandemic has contributed to an increase in suicide deaths. RB advised there has been an increase in calls to NHS24 and the Samaritans, however, specific data relating to deaths is not yet available. This was discussed at length. MB raised concern a caller can be told they"will receive a call back within 24hrs" he felt this to be far too long. RB advised a case-worker will be assigned to the caller and explained the steps taken. If a caller is at immediate risk, they will be directed to A&E.

The service will continue to be refined and amended. It was asked an update be provided at a future C&CGC meeting.

6.6 HSCP C&CGC Risk Register

AS presented the C&CGC Risk Register, for discussion. This Risk Register sets out the risks from the IJB Strategic Risk Register which may impact the Partnership in achieving its strategic objectives in relation C&CG. The Risk Register is usually presented every 6 months and last came to Committee on 13.11.20. All risks have been reviewed by the risk owners and are presented in the report in order of residual risk score.

AS advised the register is currently sitting with 4 high risks. The focus is on risks at a strategic level or those which can impact at a strategic level. There are other risks and risk registers being managed across the Partnership which are escalated if necessary.

COVID Risk Register

AS introduced the second paper, Covid-19 HSCP Silver Control Risk.Register. This document sets out the risks being managed by SLT relating to Covid-19. This Covid Risk Register last came to the C&CG Committee on 07.08.20.

This Register was developed at the beginning of the Pandemic in March 2020. It has been managed and regularly reviewed since. It feeds into and informs risks at Gold and EDG level in NHS Fife and also at the CET and Incident Management Team level in Fife Council.

This Register is informed by risks at Bronze Level groups. Again, risks are shown in order of residual risk score, there are 3 high risks.

Although the Bronze, Silver, Gold structure has now stepped down, these risks continue to be reviewed into the 'new normal'. Some of these risks may be merged with others on the strategic level / operational level, some may be closed and some may be retained on the register for some time.

6.7 Duty of Candour

KH introduced the report which sets out the regulations and principles around Duty of Candour Guidance, this a requirement of H&SC Services across Scotland.

KH advised, if there should be an adverse event / incident which can be seen through a lens of Duty of Candour, there is actions which Teams and Services must take forward as a critical opportunity for learning with transparency. The report has been delayed due to the Pandemic.

KH told of strategic meetings which take place quarterly to collate information, as described within the document.

6.8 HSCP Commissioning Strategy

FMcK was not available to introduce the report.

Cllr Brett queried whether the strategy was for the next 12 months and was unclear how much of last year's strategy has been achieved. He felt further discussion would be beneficial. Comments from the Committee were welcomed.

KH suggested a Workshop be held around potential joint commissioning. Information relating to where Children & Families and Education are and where Health & Social Care commissioning is, would be helpful, also looking at potential threats.

CC stated the report looks to be commissioning intentions from 2021-2023. It was agreed it would be helpful to look at past performance and goals going forward, these priorities may have changed due to Covid.

Cllr Brett suggested a meeting be arranged to discuss the Strategy with FMcK / NC. Invitation to all members of the C&CG Committee. FMcK to action.

7.0 EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES

7.1 Fife Area Drugs & Therapeutics Committee - Unconfirmed Minute 3 February 2021

HH highlighted the Fife Prescribing Forum which is a joint forum between Acute and HSCP, looking at managing prescribing governance across the two areas. Clinical effectiveness and

7.0 EXECUTIVE LEAD REPORTS & MINUTES FROM LINKED COMMITTEES (Cont)

efficiencies are looked at which HH felt is an exciting and new way of working. This forum is chaired by Scott Garden. More detail will be brought to future meetings.

7.2 Infection Control Committee - Unconfirmed Minute 3 February 2021

LB advised the focus for the Infection Control Prevention Team and Committee will be to focus on remobilising safely and adhering to PPE advice and procedures.

8.0 ITEMS FOR ESCALATION

Cllr Brett wished to highlight the Joining Up Care / Urgent Care discussion and the Clinical Quality Report current position update as very valuable. Both to be escalated to the IJB.

Cllr Brett thanked Jim Crichton for his help and guidance whilst working in Fife. JC thanked all for their support and co-operation during his time working for Fife HSCP.

9.0 ANY OTHER COMPETENT BUSINESS

No other competent business was raised.

10.0 DATE OF NEXT MEETING

The date of the next meeting is Friday 4 August 2021 at 1000hrs.

Fife Health & Social Care Partnership
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CONFIRMED MINUTE OF THE FINANCE & PERFORMANCE COMMITTEE
FRIDAY 11 JUNE 2021 AT 10.00 AM VIA MICROSOFT TEAMS

Present:	David Graham [Chair] David Alexander Margaret Wells, NHS Board Member Martin Black, NHS Board Member Rosemary Liewald
Attending:	Nicky Connor, Director of Health & Social Care Audrey Valente, Chief Finance Officer Euan Reid, Lead Pharmacist Medicines Management Fiona McKay, Interim Divisional General Manager Jim Crichton, Interim Divisional General Manager Lynne Garvey, Head of Integrated Community Care Services Norma Aitken, Head of Corporate Service, Fife H&SCP Bryan Davies, Head of Integrated Primary and Preventative Care Services Rona Laskowski, Head of Integrated Complex & Clinical Care Services Olivia Robertson, Head of Nursing West Division Tracy Hogg, Finance Officer *In attendance*: Kerry Perrie, District Charge Nurse (Shadowing Nicky Connor) Tim Bridle, Audit Scotland Carol Notman, Personal Assistant (Minutes)
Apologies for Absence:	Scott Garden, Director of Pharmacy & Medicines Helen Hellewell, Associate Medical Director

NO	HEADING	ACTION
1	**WELCOME AND APOLOGIES**	
	The Chair welcomed everyone to the meeting, in particular the new Heads of Service attending their first Finance & Performance Committee Meeting. See above for apologies provided.	
2	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
3	**MINUTES OF PREVIOUS MEETING**	
	The Minute from the meeting held on 8 April 2021 was approved.	

NO	HEADING	ACTION
4	**MATTERS ARISING / ACTION LOG**	
	The Action Log from the meeting held on 8 April 2021 was noted.	
5	**FINANCE UPDATE**	
	Audrey Valente advised this report was the regular finance update that provided an update on the actual spends of the Service. Audrey noted that the papers had been pulled together at very short notice therefore highlighted 2 small errors within the report and advised that these will be corrected before the report is submitted to the IJB. Martin Black noted concern with the underspend relating to staff and vacancies especially as services are resuming again following the pandemic. Martin wished to clarify the c.£7M Reserves, in particular he noted concern with the £350K reserves for Alcohol and Drugs Partnerships as there is a huge demand for the service within Fife and queried why there was money that had not been spent on the service. Fiona confirmed that the reserves were due to timings and that there was a plan for the full sum of money and the opportunity to carry forward the funds was beneficial to the service. Audrey confirmed that some of the reserves such as the Community Living Fund had only been announced in January 2021 therefore the funds had been placed within the reserves and carried forward to allow the SLT to investigate how best to invest the money and anticipated proposals will soon be submitted and shared with the committee. Margaret Wells queried the staffing underspend acknowledging that this is a longstanding issue and investment has been made available to the services but if there is difficulty in actually recruiting staff into the posts asked how this was going to be addressed. Nicky Connor assured the Committee that there was a recruitment drive particularly with apprenticeships to get young people looking to social care as a career path with development opportunities. Nicky assured the Committee that staff care and governance was a priority, ensuring that the service is supporting the current workforce helping to promote Fife HSCP as good employers. David Alexander noted concern that with the long-term vacancies issues and the associated savings that this brings, there is a risk that the wrong decisions could be made. Audrey confirmed there was a risk if the service retained some budgets that we know we are not going to spend and in protecting that area then cuts will require to be made elsewhere and confirmed that consideration of the risks associated with retaining these posts would be reviewed going forward. Martin Black questioned, if there was difficulties in recruiting new people, what could be done with the staff currently in post and is there capacity to promote the current staff especially in areas such as Psychology Therapies where waiting times are in excess of a year. Nicky Connor agreed that the Service needed to think in terms of attracting new workforce and developing its current workforce. She noted that in addition it was agreed 2	

	years ago that Dundee University would reopen their Mental Health Nursing Course in their Fife Campus which will eventually bring in a new cohort of staff. It was agreed that the Committee would have an in-depth look at Psychological Therapies at a future meeting and item to be added to the work plan Margaret Wells queried the difficulty of recruiting staff but noted that the Independent Sector did not seem to have this problem and asked within the in-depth look if the question of why it was more attractive to work in the independent sector could be taken into account and looked at. Cllr Graham thanked Audrey for her report and confirmed that the committee had discussed the report as recommended.	**CN**
6	**COMMISSIONING STRATEGY**	
	Fiona McKay presented this report noting that it is linked directly to the Strategic Plan; the strategy highlights the national and local targets which the Partnership are required to report on and the links to the locality work which is part of the intentions moving forward. The strategy picks up the financial element and looks at the localities and different strategies that are in place and how commissioning intentions will be taken forward. There are 6 focus areas which are linked to the Strategic Plan. • Care and Support at Home • Residential & Nursing Care • Day Support and Activities • Mental Health • Prevention and Early Intervention • Carers Support The programme will be monitored throughout the year and reports will be brought back to this committee on the progress. Martin Black noted that the report highlights the financial strategy with NHS and Fife Council and asked whether their strategic plans had been taken into account in the development of this strategy. Fiona McKay confirmed that the Commissioning Strategy is linked to the Strategic Plan which is part of the Plan for Fife which all Partners have signed up to, but noted that remobilising after the pandemic the plan will need to be reviewed to make sure that it is still aligned to the Council and NHS and joined up discussions will be required, but confirmed that these were the priorities that the IJB had agreed to take forward. Cllr Graham asked Fiona McKay to thank the team for their efforts in drafting the comprehensive Strategy and noted that the recommendations outlined within the report was awareness and discussion prior to submission to the IJB and confirmed the committee were happy to accept the recommendations.	

7	**NEW CARERS ACT INVESTMENT 2021/22**	
	Fiona McKay presented this report as signification amount of £1.6M was being allocated to the New Carers Act therefore it was important for the Committee to be aware of the investment. Fiona advised that a Project Worker was taking the 3 Year Strategy forward reinstating works within localities following the pandemic. A Carers Group has been set up that will provide feedback to the service to ensure that going forward the changes to services is carer led. Cllr Graham thanked Fiona for the report and confirmed that the report would require to be tabled at the IJB for debate as a substantial amount of the funding will be issued to the Third Sector which requires to be discussed and agreed. Rosemary Liewald noted that she was pleased to see the services being re-instigated and was pleased to see additional funding with regards the Carers Community Chest in each of the localities within Fife. Rosemary confirmed the importance of investing in the young carers ensuring that they have additional support for their learning. Martin Black asked for clarity on the 5 new projects and the funding associated to them and asked if a locality proposes a project which exceeds their budget who makes the decision as to what is finally funded. Fiona McKay noted that the community chest will be allocated to each of the localities and the Locality Group will be provided with clearly defined criteria outlining what the funds can be allocated to. Fiona confirmed that the groups will require to remain within budget as there is no additional funds available and as it is public money it needs to be spent wisely and meet all the criteria. Fiona confirmed that the Partnership will be monitoring the commissioned by the Locality Groups. Cllr Graham asked that an update report be provided to the Committee in 6 months, Carol Notman to add to the work plan. Nicky Connor recommended that this report is submitted to the IJB as there are voting members and carers/public representatives at the IJB to ensure that there is transparency. All agreed with the recommendation and for report to be amended and submitted to the IJB.	**CN** **FMcK**
8	**LOCAL PARTNERSHIP FORUM (LPF) ANNUAL REPORT**	
	Jim Crichton presented this report which was for discussion advising that previously the LPF had provided an annual action plan, but the Co-Chairs had felt that an annual report would be more appropriate outlining all that had been achieved in 2020-21. Jim advised it has been developed in Partnership and reflects the advising role of the LPF which prioritises the staff and workforce. Jim noted that the report covers some key areas, such as staff communication, health and wellbeing, training and development. It is acknowledged that during the pandemic that staff health and wellbeing and health and safety has been very prominent on the agenda with staff hubs	

	set up and mindfulness sessions being delivered along with support for managers supporting their staff. It is recognised that Covid-19 has had a detrimental impact on performance such as attendance and mandatory training. Training sessions that relied on physical contact such as restraint and manual handling had to switch to digital training and recapturing all the missed training will make 2021-22 extremely busy for the training team. Cllr Graham noted that supporting the workforce is so important as it is our finest asset. Margaret Wells confirmed that it was good to see all that has been done over the last year and noted surprise that feedback to the Staff Governance Committee within NHS Fife report despite the difficulties, staff morale has improved and staff feel well supported which is a real credit to all the efforts that were put in place to support the workforce. Martin Black noted that the response rate for NHS Fife for the Pulse Survey was lower than the national average and queried if there was a reason for this. Nicky Connor advised that there had been a technical issue which resulted in not all social care staff being included within the survey but noted that it is important to get the feedback from the staff from the survey and learning from the process will take place for future surveys. Cllr Graham confirmed that the report had been discussed as per recommendation.	
9	**WELLESLEY UNIT, RANDOLPH WEMYSS MEMORIAL HOSPITAL, BUCKHAVEN**	
	Lynne Garvey presented this report which was for awareness to update the committee on a direction to NHS Fife on the 28 August 2020 to close the Wellesley Unit in response to the safety issue that emerged as a result of the withdrawal of the Responsible Medical Officer. Lynne advised shortly after the closure, the pandemic occurred and all services agreed that the Unit, with its accessibility and parking facilities, was best placed to host the Vaccination Centre for the Levenmouth area and 30,000 vaccinations have been delivered from the Centre. Lynne Garvey confirmed that the Unit will be utilised to provide the covid booster and flu vaccinations later in the year but once the vaccination programme is completed in March 2022 there is a requirement to engage with all stakeholders to consult and support participation in the development of how the Wellesley Unit environment can be utilised to develop new models of care in the Randolph Wemyss Memorial Hospital to support the local community's health needs. Cllr Graham confirmed that the venue has been very successful for the vaccination programme and has been a very good venue in terms of car parking and transportation. Rosemary Liewald agreed that consultation going forward was vital to ensure that the Unit best served the community going forward whether this was family, community or resilience based. Nicky Connor noted as this was the first update on a Direction the feedback has been provided on the standard SBAR template but noted that following	

	feedback a standardised report will be developed to review future monitoring of directions. Cllr Graham thanked Lynne for the report and acknowledged that the committee was aware of the update.	
10	**AOCB**	
10.1	**Finance and Performance Annual Assurance Statement** The committee approved the Annual Assurance Statement, Cllr Graham to sign the document and return to Norma Aitken.	**DG**
10.2	**Farewells** Cllr Graham wished to thank Jim Crichton and Margaret Wells for all their support over the years to the Committee and the Partnership and wished them all the best.	
11	**DATE OF NEXT MEETING**	
	Friday 13 August 2021 at 10.00 am	

Fife Health & Social Care Partnership
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CONFIRMED MINUTES OF THE AUDIT AND RISK COMMITTEE

FRIDAY 4 JUNE 2021 - 10.00AM – VIRTUAL TEAMS MEETING

Present:	Margaret Wells (Chair), NHS Fife Board Member Eugene Clarke, NHS Fife Board Member (re-joined Meeting at 10.50am) Dave Dempsey, Fife Council David J Ross, Fife Council
Attending:	Nicky Connor, Director of Fife Health & Social Care Partnership (Fife H&SCP) Audrey Valente, Chief Finance Officer (Fife H&SCP) Norma Aitken, Head of Corporate Services (Fife H&SCP) Fiona McKay, Interim Divisional General Manager Avril Cunningham, Chief Internal Auditor (Fife Council) Tony Gaskin, Chief Internal Auditor (NHS Fife)
In Attendance:	Shona Slayford, NHS Fife Audit Carol Notman, Personal Assistant (Minutes)
Apologies:	Tim Bridle, Audit Scotland

NO	HEADING	ACTION
1	**WELCOME AND APOLOGIES**	
	Due to technical difficulties, Margaret Wells chaired the committee and welcomed everyone to the meeting. Apologies for absence are noted above.	
2	**DECLARATION OF INTEREST**	
	There were no declarations of interest.	
3	**DRAFT MINUTE AND ACTION LOG OF AUDIT AND RISK COMMITTEE HELD ON 17 MARCH 2021**	
	There were two changes requested these were: Cllr Dempsey asked for the word succession is changed to success on pg 6. Avril Cunningham asked that the 2nd last paragraph in section 4 is amended to confirm that Cllr Dempsey had received the Transformation Policy in his role as a member of the IJB and HSCP Audit and Risk Committee. With both these amendments the minutes were accepted as an accurate record of the meeting.	
4	**UPDATE ON 2020/21 AUDITS**	

	AC noted that this would be her final update, and confirmed that although it has been a difficult year for everybody the full programme of audits had been completed, both the transformation programme and the financial information audits and the self-assessment which is highlighted in more detail in Item 5. There were no questions relating to the 2020-21 Audits therefore the Chair confirmed that Members of the IJB Audit & Risk Committee had noted the update on the audits in the 2020/21 plan and the summaries of the audit reports.	
5	**GOVERNANCE ARRANGEMENTS DURING COVID-19 SELF-ASSESSMENT**	
	Avril Cunningham noted that the self-assessment was included separately to highlight that it is a self-assessment, based on the Audit Scotland guidance for audit and risk committees, rather than an audit report. It focusses on some of the challenges identified in the Audit Scotland guidance and to provide a level of assurance in the responses from the partnership as to how risk management, governance and internal controls have fared during this period. Margaret Wells noted that the self-assessment on pages 20-21 highlights how much has been achieved over the last year. Cllr Ross wished to congratulate the staff and officers and commented on how well the Partnership kept the Members of Committee's informed which helped to support the decision making Margaret Wells confirmed that the item had been discussed and requested that the recommendations were noted within the minutes: Covid-19 has impacted the IJB as highlighted in this report and it has had to adapt to new ways of working in difficult circumstances. As may be expected,there are still challenges, as identified in the responses, and further action required to build on the work already undertaken. The overall outcome of the self-assessment highlights that risk management, governance and internal controls and assurance have been key considerationsin the recovery and redesign of services, with decision making supported by financial management and reporting.	
6	**POST AUDIT REVIEW**	
	Avril Cunningham confirmed that this report covers progress with implementing audit recommendations. Following discussion, Avril confirmed that there are 48 recommendations, 13 of which have been fully implemented. Of the 35 recommendations not implemented, 14 are in progress. 7 have revised implementation dates and 12 have not yet reached their implementation date. Where timescales have slipped, revised implementation dates have been agreed.	

	Avril Cunningham confirmed that she and Tony Gaskin has been in discussion regarding her handover as Tony will be taking over the monitoring following her retiral. Tony Gaskin confirmed that he would be going through a planning process with Nicky Connor and Audrey Valente to review the recommendations as they were set before the Covid-19 pandemic. Nicky Connor advised that the content of the report does not make easy reading and noted that she wished the Services had implemented more recommendations but acknowledged that it has been a very difficult year and wished to confirm there was a drive to implement the outstanding recommendations. Margaret Wells confirmed that the Committee had noted the content and the progress that has been made.	
7	**ANNUAL AUDIT REPORT**	
	Avril Cunningham noted, in accordance with the Public Sector Internal Auditing Standards, she was required to present an Annual Audit Report as a round-up of the year on performance and compliance with the standards. Avril noted that the annual Public Sector Internal Auditing Standards self-assessment mentioned at para 3.2 of page 38 is now complete, and while it has been assessed that the Partnership fully conform in the majority of areas, some slippage has been identified in the last year in relation to recording of employee development and updating procedures. An action plan has been drawn up and all actions are scheduled for completion by 31 August 2021. Avril mentioned that Appendix 1 outlined her assurance statement for 2020/21, which is her opinion of the overall state of corporate governance and internal control in that year. Avril advised that both the pandemic and the ongoing review of the Integration Scheme had delayed progress on planned work on the underlying governance, assurance and risk areas. However, it is acknowledged that, despite the challenges, there has been some progress this year, in relation to financial management. Avril noted that in her opinion, there is a medium level of control within the Partnership and that reasonable assurance can be placed upon the adequacy and effectiveness of the corporate governance and internal control system in the year to 31 March 2021. Cllr Dempsey noted the medium level of control advising that the equivalent in Fife Council is scored medium high and queried whether NHS Fife have a similar system of rating and where does it sit? Cllr Dempsey also noted that the score of medium shows that control objectives have not been fully achieved and that there was work to be done to improve this scoring. He asked if there was a plan to get from Medium to Medium/High. Avril noted that there was a plan, acknowledging that this had been delayed due to the pandemic as well as several items being aligned to the Integration Scheme. Nicky Connor noted that the challenge of the Integration Scheme was getting full agreement with both partners which is almost complete.	

	Nicky advised that she anticipated the Integration Scheme going through the due governance structure in the next few months, but noted that work has continued in the interim through the IJB Development Sessions. Audrey Valente advised the Partnership has been working on its Transformation and there are moves to create a centralised Transformation Team in the coming months. Margaret Wells commented with regards the changes in terms of governance structures, given the role of the audit and risk committee wished to remind the group that the NHS Membership will change at the end of July. Nicky Connor confirmed that there is a meeting in July but noted that the change will result in a huge loss to this committee and the IJB and advised that she will write to the Health Board to clarify what their interim plans are and suggested that there is more in-depth discussion at the next committee. CN to add item to the next agenda. Cllr Ross advised that he raised the same point at the Development Session last week and requested that the NHS Membership is looked at as a matter of priority as the committee will have annual audit and accounts to approve therefore clarity was required imminently. Margaret Wells confirmed that the item had been discussed and requested that the recommendations were noted within the minutes: The Committee is asked to note the contents of this report, and in particular, my opinion that a medium level of control exists, and that reasonable assurance can be placed on the adequacy and effectiveness of the systems of corporategovernance and internal control in the year to 31 March 2021. However, it is acknowledged that, in spite of the challenges, some progress hasbeen made this year, particularly in relation to financial management, and progressing the planned reviews should lead to further improvements in governance, risk and control in the future.	**NC** **CN**
8	**IJB STRATEGIC RISK REGISTER**	
	Fiona McKay advised that the report sets out the IJB strategic risks and is presented at every committee meeting. She wished to highlight Section 3.3 (pg 49) which summarises the high scoring risks advising if there has been a change in the risk scoring since the last report. The only risk where the score has changed is the Financial Risk which has been reduced as a result of funding which has been received for Covid which is supporting the service going forward. Nicky Connor noted that the comments that were raised at the last committee has been incorporated into this report highlighting the changes that have been made. Cllr Dempsey noted that he still struggled with column 14, which states management actions have been updated and requested that the changes within the management actions (column 8) are also highlighted in red.	

	Fiona McKay noted that a separate box could be added highlighting the management actions that have been updated. Cllr Dempsey noted that the Finance Risk has been reduced and asked which of the factors had changed to allow this change. Nicky Connor confirmed that it would be the likelihood that that changed as the consequence rarely changes. Cllr Ross agreed that the paper was challenging to follow and asked if the score relating to delayed discharge could be clarified. Fiona Mckay advised that delayed discharges are still a risk. Although there had been good progress made with plans to introduce the home first model, it remained a risk due to the level of patients currently in hospital that are experiencing delays with their discharge. This has increased over the last few months, and the impact that this is having on the services remains a constant concern and will remain on the risk register. Fiona McKay noted that a backlog within the Fife Courts processing Guardianships has had a detrimental impact on delayed discharges and additional resources to support families when they are not able to make decisions is being put in place. Margaret Wells thanked Fiona McKay for the update and noted that the steps that have been taken to date to simplify the report has been helpful but confirmed that it is a complex report set up to capture a lot of information. She noted it was important to ensure that all members were in the best position to use the report and looking at accessibility would be helpful. Nicky Connor suggested that it might be useful to have a 'Drop In' Session with Fiona McKay and Avril Sweeny to help members understand and give them the opportunity to make any suggestions for further refining the report for ease of use. Fiona McKay advised that there was the option to put updates into the main body of the report with the appendix as additional information if Members wish to investigate the risk in more detail. Fiona advised that Fife Council are holding a Strategic Risk Register Workshop that she will be involved in which will share good practice. Margaret Wells confirmed, as the recommendation asked, that the Committee had discussed the risk register and noted that the Committee had requested further clarification to the report going forward which needs to be taken into account.	**FM** **FMcK/CN**
9	**RISK APPETITE**	
	Nicky Connor provided presentation on the Risk Appetite. It was agreed that discussion with the IJB, Senior Leadership Team and the Partners is required to agree how the risks are filtered through the services and it was felt once the new framework is in place would be a good opportunity to implement. Cllr Dempsey noted that the classifications such as low and moderate are not clear until the definitions of these risks are clearly spelt out.	

	Tony Gaskin noted that within organisations such as the HSCP it was so important to have a 'so what' culture for risk appetite. This will mean different things for different people but it should have real life implications. The Board needs to sets the Risk Appetite, and the language needs to translate. Tony advised that the Strategic Commissioning Plan informs the risk register as the Board looks at what it wants to achieve and what the risks involved are, and it is at this point when the risk appetite becomes real. Avril Cunningham noted that if the risk appetite needs to be linked to the IJB's Objectives, Planning and Performance. Avril noted that Fife Council are currently looking at their Risk Management Strategy and will be forming a Risk Management Strategy Group with key strategic risk owners and would be a good opportunity for collaborative working. Nicky Connor noted if the IJB is to implement Risk Appetite then it needs to make a difference. It needs to align the team's objectives with the strategic work of the Partnership, allowing the Partnership to hold itself accountable with the criteria outlined for who is able to access our services and how do we focus on prevention and support to the managers delivering the service. For if it is agreed that a certain criteria meets the needs of the service it is important that the Board is signed up to and agreed to the decision as there is usually financial implications and also allows the Officers and Managers to go forward with confidence. The 'so what' question and answer could add real value as well as supporting the governance framework. Fiona McKay noted that she had provided a paper to Fife Council's Scrutiny Committee with regards the eligibility criteria for the Partnership and some of the questions raised at the committee were, what would happen if it did go to substantial and what would it mean to Fife Council as an organisation, and what would the pressures be, as there is legislation for Social Work that must be complied with and taken into consideration. Fiona noted that legislation would be part of the 'so what' for the Partnership that would need to be teased out. Margaret Wells thanked Nicky for the presentation. Margaret noted that there were a couple of points that she wished to raise, the first relating to the 'Risk Universe' commenting that the IJB is in the midst of a universe where some of its risks sit, and are overseen, by the Partners which makes it critical for how the IJB sets its risk appetite and process and procedures linked to it to ensure that there is clear understanding across all organisations. Margaret noted that working through the risk appetite process with NHS Fife's Board, she advised that a Short Life Working Group had been set up that included Non-Executives and Executives to oversee the development of the risk appetite process and recommended that members of the IJB are part of the process of determining the Partnerships Risk Appetite. All agreed that the presentation provided clear and helpful points and should be presented at a future scheduled Development Session to allow full discussion to shape how the IJB will implement the framework going forward. Margaret Wells confirmed the Committee were in agreement with the proposals above.	**FM**

10	**GOVERNANCE ARRANGEMENT FOR ANNUAL ACCOUNTS**	
	Audrey Valente advised that this item had been added to the agenda following the brief discussion at the last meeting around whether the approval of accounts should take place at this committee or at the Integrated Joint Board Meeting. Audrey noted that Tim Bridle had made a recommendation that the accounts could be signed off by this committee, but it was agreed to bring back to the committee to get the Members views. Cllr Ross noted that he was interested in the reasoning why it was felt more appropriate for the Audit & Risk Committee to approve the accounts. Audrey noted that in conversation Tim had made the suggestion to mirror Fife Council's approach. Tony Gaskin asked if there was delegated authority for this committee to approve the accounts and whether it could be written into the Integration Scheme. He noted that he was used to the model where the Audit and Risk Committee had a very specific role noting that his impression was that the accounts belonged to the entire Board and the Board needs to take ownership of them as every member of the IJB is accountable for the Accounts, but confirmed that the IJB was reliant on the Audit & Risk Committee to scrutinise the accounts prior to submission. Eugene Clarke noted that this would be his understanding, the Audit & Risk Committee would review, then it would the responsibility of the IJB to accept and approve the accounts. Cllr Ross confirmed that he found Tony Gaskin's argument to be quite convincing and as the accounts are the IJB Accounts then they should have sight of them and approve them. Margaret Wells confirmed that all were in agreement that the governance route for the Accounts remains within the IJB for sign off and that it is critically important that the ownership remains with the Board.	
11	**TRANSFORMATION PROGRESS**	
	Nicky Connor advised that Audrey Valente had taken on the role of leading Transformation within the HSCP and noted that there has been discussion with the partner Chief Executives where there is an openness to change. She confirmed that further detailed discussions with the Chief Executives and Directors of Finance will be taking place post covid around agility. Audrey Valente confirmed that there was a lot of work going on behind the scenes and following the restructure, transformation will fall within her remit and she is looking to create a central team with a Project Management Officer (PMO) and Senior Responsible Owner (SRO) who will be ensuring that the transformation taking place within the HSPC is aligned to the strategic plan and strategy.	

	Audrey advised that she is working on the governance structure for a new Transformation Board Committee and is currently developing its Terms of Reference. Cllr Dempsey asked how long it would be before the committee was updated, Audrey advised that she was looking to have the high-level structure signed off by SLT and once this has been completed she anticipated bringing a presentation to the next Audit & Risk Committee. Margaret Wells agreed that this would be helpful and asked Carol Notman to add the item to the agenda for the July meeting.	**CN**
12	**ITEMS FOR ESCALATION**	
	• Highlight the Risk Appetite Development Sessions to ensure that the IJB is aware that it has been raised from this committee. • Decision that the committee has arrived at regarding the governance arrangements for the annual accounts.	
13	**AOCB**	
	Audit & Risk Assurance Statement Norma Aitken advised that the Assurance Statement for the last year has been drawn up and is now ready to be signed by the chair. **Avril Cunningham** Margaret Wells wanted to pass on the appreciation and thanks of the Committee to Avril Cunningham for all her support, hard work, patience and very clear explanations over the years and wished her all the best with her retirement.	**EC**
14	**DATE OF NEXT MEETING**	
	Friday 9 July 2021 at 10.00 am	

Fife Health & Social Care Partnership

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UNCONFIRMED MINUTES OF THE AUDIT AND RISK COMMITTEE

FRIDAY 9 JULY 2021 - 10.00AM – VIRTUAL TEAMS MEETING

Present:	Eugene Clarke (Chair), NHS Fife Board Member Margaret Wells, NHS Fife Board Member Dave Dempsey, Fife Council David J Ross, Fife Council
Attending:	Nicky Connor, Director of Fife Health & Social Care Partnership (Fife H&SCP) Audrey Valente, Chief Finance Officer (Fife H&SCP) Norma Aitken, Head of Corporate Services (Fife H&SCP) Barry Hudson, Regional Audit Manager (NHS Fife) Tracy Hogg, Interim Partnership Finance Manager (Fife H&SCP) Avril Sweeney, Risk Compliance Manager (H&SCP)
In Attendance:	Shona Slayford, Principal Auditor (NHS Fife) Carol Notman, Personal Assistant (Minutes)
Apologies:	Tim Bridle, Audit Scotland Tony Gaskin, Chief Internal Auditor (NHS Fife)

NO	HEADING	ACTION
1	**WELCOME AND APOLOGIES**	
	The Chair welcomed everyone, and introductions were made. Apologies for absence are noted above.	
2	**DECLARATION OF INTEREST**	
	There were no declarations of interest.	
3	**DRAFT MINUTE AND ACTION LOG OF AUDIT AND RISK COMMITTEE HELD ON 4 JUNE 2021**	
	The minutes were accepted as an accurate record of the meeting. The Action Log was noted.	
4	**FIFE INTEGRATION JOINT BOARD UNAUDITED ANNUAL ACCOUNTS FOR THE FINANCIAL YEAR TO MARCH 2021**	

	The Chair invited Audrey Valente to present the IJB Unaudited Annual Accounts but noted an anomaly with the statutory deadline of 30 June 2021 to submit the accounts to the external auditors with them being open to inspection from 1st July and the Committee are approving them on the 9th July. Audrey confirmed that the Annual Accounts had been submitted to Audit Scotland by the deadline and agreed that the timescale for the meetings did not align with the statutory guidelines. It was agreed that the Committee Structure would be reviewed going forward to allow the unaudited accounts to be agreed prior to submission. Cllr Dempsey noted that he assumed it would be the same regulations apply to Partnership that apply to the Council and advised that previously the Council had approved, but following investigating it was agreed that the regulations did not require their approval at this stage, just their consideration. The point of approval was when they came back from the auditor and if in future the wording was changed to consider then the issues regarding timings of the committee is not so important. Audrey Valente advised that this would be implemented for next year. Audrey Valente introduced Tracy Hogg who is currently Interim Partnership Finance Manager who has done a substantial amount of work on the accounts and wished to thank both finance teams for their help in developing the accounts. Tracy Hogg provided presentation on the unaudited accounts which confirmed that the audited accounts will not be completed by the usual September timeline and noted that it would the December IJB Meeting. The chair wished to thank Tracy Hogg for the detailed presentation and thanked the team for the hard work in reaching the deadline. Cllr Ross queried a couple of comments referred to in the presentation and report that he had not heard of before, these being Mission 2024 and TeamFife which he would like to hear more about and he commented that it notes that the budget was approved at a meeting on the 27th March 2020 but his recollection was that it was approved via email as the meeting had been cancelled due to the pandemic and wished that this be clarified within the report. Audrey confirmed that she would clarify and ensure the detail regarding the approval is corrected in the final accounts. Audrey Valente noted that Mission 2024 was the aim of the Senior Leadership Team, which is to be the best or most improved HSCP by 2024 with clear objective and performance measures in place. Team Fife encompasses NHS Fife, Fife Council and the Health and Social Care Partnership and Cllr Ross queried how the Partnership would measure itself to know whether it was the most improved IJB by 2024. Audrey confirmed that there were many measures confirming the importance of having something to aspire to and ensuring that the Partnership is on a continuous improvement journey with clear objectives and measures in place. Cllr Dempsey noted that he had a small number of specific questions. • Page 12 – which notes that there is reference to break even position on the set and queried whether this was automatically guaranteed under the	

	present regime? Audrey Valente confirmed that the set aside and break-even budget had an overspend of c.£2M which is fully funded by NHS Fife. • Pg 24 which notes the key pressures in the 2021 accounts is an increased demand in services and noted his surprise that the key pressure had not been the pandemic and queried whether there had been a significant effect from increasing populations? He noted surprise that the spend for Covid was £26.3M which he expected would have been higher Audrey Valente confirmed that there is an increase in adult packages and transitions from children to adult services. Tracy Hogg advised that the Partnership completed a very detailed mobilisation plan which outlined the additional costs acknowledging there was a fine line between costs associated with covid and business as usual. In addition, there were items of mitigation which reduced the expenditure and return to the Scottish Government. • The £500 Thank You payment to Health & Social Care Staff, the report notes that the funding has been requested and Cllr Dempsey asked who had the funding been requested from and had this been granted? Tracy Hogg confirmed that NHS Fife received the funding for the thank you payments for staff and this was paid to staff during 2020/21. The funding for Fife Council and external partners had not been received until 2021/22 and confirmed the funding has now been received and issued to staff. • Pg 49 there is a reference in the table to Action 15 and queried what Action 15 was? Audrey Valente confirmed that Action 15 is funding received from Scottish Government Health Department and relates to Mental Health, she confirmed that she was not aware why it is called Action 15 but noted that further funding was anticipated this year. Margaret Wells queried transitions from children to adult services and whether there was a funding stream that followed the children? Audrey Valente noted that she would be looking into all comments received and acknowledged the importance of better forward planning for those transitioning from children's services. The Chair confirm that the Committee has been made aware, discussion of unaudited accounts has taken place, and all agreed on approving the unaudited. Accounts.	
5	**TRANSFORMATION PROGRESS**	

	Audrey Valente confirmed that from the 5th July 2021 she is now the Lead for Transformation within the HSCP and talked to her presentation. Eugene Clarke noted that he was impressed with the quality of thinking and asked Audrey if she was comfortable that she had sufficient access to those who are developing the Transformation Programmes and if not, is there anything that needs to be done to change this. Eugene asked with regards to governance whether there was any thought on timescale and schedule. Audrey Valente noted in terms of Governance, the Partnership is reviewing its governance structure and it will look very different going forward but the timescales for this is not known at the moment. Nicky Connor confirmed that the timescales will be quick but wished to recognise that the service has just gone through an organisational change and was allowing teams to settle. There is operational governance and governance of IJB. In terms of the operational the Senior Leadership Team meetings will change to focus on 3 areas, Business, Assurance and how we look to the future and it is anticipated that they will be up and running by the end of September. Nicky noted that there will be an outward reach for SLT with relevant business partners being included. With regards to the governance of the IJB once the Integration Scheme has been signed off the service will be able to move forward and it is anticipated that this would be by the end of September therefore the changes will be implemented through November/ December 2021. Cllr Dempsey noted the importance of Transformation and the ability to answer 4 questions, these being: Where are We? where are we going? how do we get there? and how do you know when you have arrived? He noted that he was looking forward to the 'how do we tell we have done it' point. He reminded all of the importance of not being scared of failing, because if you know you have failed then you have learnt something. Margaret Wells noted that she was pleased to see that the initial slide started with the people and the communities and reminded all the importance of starting with the people with whom the services are being provided for. And queried how do we get people into the services that they need, what is the route that we need to follow and understand, ensuring that it is user friendly for those accessing the service. Margaret noted when it comes to transformation the importance of harnessing ideas from the frontline staff as they know their service best and have excellent ideas of how it could be improved. Cllr Ross agreed with Cllr Dempsey and Margret Wells and noted his concern was how the Partnership was going to ensure that it doesn't get bogged down in bureaucracy and is going to be able to work at a speed that is going to make change happen. Also is the system that is being set up going to be able to handle public opposition and the IJB advising that they do not like what is being proposed? Audrey Valente thanked everyone for their comments noting that they were welcome as the service is on a journey and participation and engagement is key to it and is part of the business case. The business case will be	

	outlining the benefits, milestones and the deliverables which are important. Getting the balance right around what staff can just get on and do without escalating through the governance routes to empower staff. Nicky Connor noted that before 2022 the strategic plan is to be reviewed and she plans to have transformation significantly outlined in the new strategic plan. But to do all of this will require cognisance of the Health and Wellbeing Strategy of NHS Fife and the Plan for Fife as we are all in it together for the people of Fife. Nicky noted that Audrey's team is currently undertaking a map of what is going on and what will be focussed on to ensure that we are not working in isolation and the pieces of work will include Primary Care and Urgent Care interface with acute services and the expectation will be that we are actively listening to voices to shape the transformation that is being brought forward. Nicky noted that currently one of the areas that has commenced is Home First Strategy where there are colleagues from acute, third sector, independent sector and business partners. Eugene Clarke thanked Audrey for the presentation and all for the preceding discussions and agreed that the item should remain a standing item on the agenda.	
6	**IJB STRATEGIC RISK REGISTER**	
	Avril Sweeney noted that there had not been substantial change to the Risk Register since the last meeting as most review dates are August 2021. She noted that the risks are presented in order of residual risk score, there are currently 5 scoring High and they are shown in summary format in the SBAR and Column 9 in Appendix 1. Avril advised that the Drop In Sessions where questions can be raised have been organised and diary invites have been issued. Cllr Dempsey queried on pg. 56 on the summary of serious risk, risk 13 relating to delayed discharge has been reduced by 40 and would like some perspective on this number. Cllr Dempsey noted there is a reference in the action log to adding in a new box within the risk register, but he could not see it, he did note that another box could confuse further and text highlighted in red was more helpful. Avril Sweeney noted with regards the delayed discharges risk that the risk owner would be able to provide more detail on the perspective of the 40 that has been reduced. With regards the action log she hadn't appreciated that it was anticipated a further box would be placed in the risk register and had highlighted the changes within the SBAR noting that the Drop In Sessions will allow for the opportunity to review how the risks are presented and the best way forward. Nicky Connor confirmed with regards the delayed discharge, the position was reviewed in February 2021 where the delay position had significantly improved given the pressures that the service was experiencing, but the position has changed over the last month and she would like to investigate	**NC/AS**

	how to ensure that when there is significant change between review periods that there is a mechanism in place to flag this and bring forward review dates to ensure that the risk register is as current as possible. Margaret Wells noted Risk 23 (pg. 60) relating to Primary Care Prescribing Overspend where it mentions 2 specific medicines, sertraline and paracetamol. It appears sertraline is prescribed for mental health therefore it is not unexpected that there is an increase in demand for this medication, but the costs of prescribing paracetamol are extremely high when they can be bought for a fraction of the price of a prescription over the counter. Nicky noted that this is a point well made and discussion is required. Eugene Clarke confirmed that the Risk Register had been discussed and all were content with the update.	
7	**AUDIT & RISK COMMITTEE INTERIM ARRANGEMENTS**	
	Nicky Connor advised that NHS Fife is currently recruiting but the new members will not be in post until September 2021. In the interim to ensure that the committee is quorate current members of the IJB Committee from NHS Fife will be asked if they are able to provide support for the September Committee Meeting.	
8	**ITEMS FOR ESCALATION**	
	The Committee agreed there were no items requiring escalation.	
9	**AOCB**	
	Everyone wished to thank both Eugene Clarke and Margaret Wells for their support and contribution to the Partnership over the last few years. Both Eugene Clarke and Margaret Wells thanked the committee for their kind words and noted how much they had enjoyed working with the committee and seeing how the Partnership has evolved.	
14	**DATE OF NEXT MEETING**	
	Wednesday 15th September 2021 at 10.00 am	

Fife Health & Social Care Partnership
Supporting the people of Fife together

HEALTH AND SOCIAL CARE LOCAL PARTNERSHIP FORUM

WEDNESDAY 9 JUNE 2021 AT 9.00 AM VIA TEAMS (VIRTUAL MEETING)

PRESENT: Nicky Connor, Director of Health & Social Care (Chair)
Eleanor Haggett, Staff Side Representative
Debbie Thompson, Joint Trades Union Secretary
Alison Nicoll, RCN
Andrea Smith, Lead Pharmacist, NHS Fife
Audrey Valente, Chief Finance Officer, H&SC
Bryan Davies, Head of Primary & Preventative Care Services
Craig Webster, NHS Fife Health & Safety Manager
Dr Chuchin Lim, Consultant Obstetrics & Gynaecology
Elaine Jordan, HR Business Partner, Fife Council
Fiona McKay (FM), Head of Strategic Planning, Performance & Commissioning
Hazel Williamson, Communications Officer
Jim Crichton, Interim Divisional General Manager
Kenny Grieve, Fife Council Health & Safety Lead Officer
Kenny McCallum, UNISON
Lynn Garvey, Head of Community Care Services
Lynne Parsons, Society of Chiropodists and Podiatrists
Rona Laskowski, Head of Complex & Critical Care Services
Susan Young, Human Resources, NHS Fife
Valerie Davis, RCN Representative
Wendy Anderson, H&SC Co-ordinator (Minute Taker)
Wendy McConville, UNISON Fife Health Branch

APOLOGIES: Helen Hellewell, Associate Medical Director, H&SC
Mary Whyte, RCN
Simon Fevre, Staff Side Representative
Wilma Brown, Employee Director, NHS Fife

NO	HEADING	ACTION

As Eleanor Haggett was experiencing technical problems, Nicky Connor chaired the meeting on her behalf.

Nicky began the meeting by welcoming Bryan Davies and Rona Laskowski to their first Local Partnership Forum (LPF) meeting.

Bryan, Head of Primary & Preventative Care Services and Rona, Head of Complex & Critical Care Services, who took up post on Monday 7 June 2021, introduced themselves to the LPF members and both look forward to meeting colleagues in the coming weeks.

1 APOLOGIES

As above.

NO	HEADING	ACTION

2 PREVIOUS MINUTES

2.1 Minute from 12 May 2021

The Minute from the meeting held on 12 May 2021 was approved.

2.2 Action Log from 12 May 2021

The Action Log from the meeting held 12 May 2021 was approved.

3 JOINT CHAIRS UPDATE

Nicky Connor thanked Jim Crichton, who was attending his final LPF meeting, for his contribution to the work of the partnership over the past year.

All other items to be updated on were contained within the agenda for the meeting.

4 WORKFORCE UPDATE

The Interim Workforce Plan had been circulated with the papers for the meeting. Workforce Strategy requires to be refreshed in 2022 and LPF members will be key stakeholders in this work going forward.

Debbie Thompson praised the comprehensive paper and raised the question of future recruitment of staff to fill potential gaps.

Nicky Connor advised that she had recently spent an afternoon with modern apprentices – both new and those part of the way through their training – and was heartened by the inspirational stories which had been shared. There is work ongoing both nationally and locally to look at ways of increasing the number of younger people who see care as a potential career path.

Elaine Jordan advised that within Fife Council funding has been made available through the Workforce Youth Initiative and Directorates are being asked to apply.

Fiona McKay updated on a potential extension to the apprentice scheme which will hopefully provide continuing support and funding.

Within the NHS, Susan Young advised that youth employment is being given a greater focus with the introduction of a new role to support this.

Nicky Connor met recently with staff from Fife College to discuss ways of encouraging men into careers in care. A focus group is to be set up to look at this.

The Integrated Workforce Group is to be restarted and one of the objectives will be future recruitment of staff to care roles.

It was agreed that Elaine and Susan would collate information on youth employment from both parent organisations and share this with LPF members. Hazel Williamson will look at ways of promoting job opportunities within the partnership to younger residents of Fife. More at next meeting. **EJ/SY** **HW**

NO	HEADING	ACTION

5 WINTER / SYSTEM CHALLENGES & PRESSURES

Lynne Garvey outlined the content of the paper which had been circulated prior to the meeting. This gave an update on the delivery of the Winter Plan. Key highlights included the level of delayed discharges which had been kept below 25 for most of the winter and an average of over 100% of placements fulfilled.

Most of the Winter Plan actions are complete or on track. The following actions are ongoing, with slippage, but due to be completed prior to next winter:

- Implement Home First Model - more timely discharges & realistic home-based assessments
- Restructure of medical assessment and admissions.

A Winter Review Event was held on 12 April 2021 through MS Teams, with over 70 participants. The event included 2 group work sessions;

- What worked well and not so well last winter
- What key learning and actions could be taken forward for 2021/22

Feedback will be used to plan and implement next winter's plan at the Winter Planning Event in August although it has been agreed that planning for capacity and flow of the whole health and social care system will continue over the summer months. A further update will be provided following this event.

Fiona McKay updated on a spike in A&E presentations which has a knock on effect within Social Care as people are discharged. The discharge target with NHS Fife has been exceeded over the last four weeks, but this can also build pressure on finance and resources.

As other services remobilise this may lead to more gaps in staffing and work is ongoing to encourage recruitment. A group has been set up to look at reviewing Community support services.

Lynne Garvey, Fiona McKay and Jim Crichton has undertaken a series of lunchtime sessions to allow them to engage with staff and hear their concerns. These will continue with feedback being provided once available.

Discussion took place around the Mental Welfare Commission's (MWC) report into discharges, during Covid-19, of people who may have lacked capacity. Fiona McKay advised that the MWC looked at a sample of cases in Fife whilst she undertook a full review of all cases. All were moved correctly and within the legal framework.

Granting of Guardianship has been identified as an issue which contributes to delayed discharge figures and Circles Network have been provided with funding to employ a staff member to support families through the initial stages of their application.

6 HEALTH AND SAFETY UPDATE

Craig Webster advised that the most commonly used face masks are now both back in stock at NHS Fife.

NO	HEADING	ACTION

6 HEALTH AND SAFETY UPDATE (Cont)

Alpha Solway have produced a see-through mask and it is expected that this will be available to NHS staff in the coming weeks.

Notices of Constraint which had been issued to NHS Fife have now been signed off. As more staff remobilise there may be more issues with non-compliance eg wearing masks, social distancing and there will be a focus on this from Health & Safety and Infection Control.

The NHS Health & Safety team are currently facing some workforce issues in relation to vacancies/long term sick leave and this has impacted on the ability to provide manual handling training but has given the opportunity to look at the team structure to ensure it is fit for purpose.

Demand for fit testing is low at present, there are opportunities for staff to be fit tested or indeed to be trained a local fit testers. Craig is the contact for both of these.

Kenny Grieve advised that the Fife Council Health & Safety Team continues to work with Services within the partnership. The Quarter 4 and monthly health and safety reports have recently been issued.

Checks have been carried out as staff begin to return to Council buildings to ensure compliance with covid guidance eg wearing masks, social distancing.

An introductory meeting has been arranged between the new Heads of Service and both Health & Safety representatives.

7 COVID-19 POSITION

Current Position

Fife is now in Level 1 and Lynne Garvey advised that there are currently no Covid-19 patients on any of our wards.

Staff Testing

Fiona McKay advised that there are currently no Fife Council staff who have tested positive for Covid-19, staff uptake of the vaccine has been good and staff in Care Homes are taking and recording tests on a regular basis. Staff in other areas are testing but not always recording results.

Lynne Garvey confirmed that the positivity rate within health staff is currently low. Work is ongoing to increase the uptake of LFT testing and reporting among staff.

Regular meetings are held with Scottish Government and information on changes to staff testing regimes will be shared as they become available.

8 HEALTH & WELLBEING

Attendance Information

Susan Young had shared information on H&SC sickness absence from April 2021 which has shown an increase from March 2021, although it is still lower than NHS absence overall from this year and last year.

Elaine Jordan advised that high level statistics were still not available from Oracle, although Service Managers can access information on their own teams and are having regular attendance panels in conjunction with HR staff.

Elizabeth Crichton who currently works in Fife Council's HR will be seconded to the partnership for 2 years with effect from 5 July 2021. This will be a Project Manager role, working with managers regarding attendance. A preventative approach will be taken and this work will start with staff stress surveys.

Discussion took place around when Oracle might be able to provide monthly, high-level statistics. Reports are in development but there is not a defined timescale for these being produced.

Staff Health & Wellbeing

Fiona Mckay advised that an app which provides Social Work Professional Support has been launched this week and information will be circulated to LPF members. **FM**

A Cycle to Work Scheme has been launched for NHS staff.

Discussion took place around getting staff together to provide peer support, which has not been able during the Covid-19 pandemic. Public Health advice would need to be adhered to. Fiona McKay and Lynne Garvey to explore what could be done safely around this. **FM/LG**

9 ITEMS FOR BRIEFING STAFF

Via Directors Brief and Staff Meetings

Recruitment of apprentices / younger people into caring careers.

Importance of booking annual leave and taking time off.

Information linking health and wellbeing resources, supporting staff teams to get back to meeting face to face as we move out of the pandemic.

10 AOCB

Nicky Connor advised that as there had only been a small number of enquiries about the Principle Social Work Officer role the closing date has been extended and interim support for professional supervision will be put in place.

11 DATE OF NEXT MEETING

Wednesday 11 August 2021 at 9.00 am