Learning from Dundee – taking a whole system approach to enable us to care for older people where they need it

Dundee City HSCP has undertaken a wide range of improvement and change programmes to enable them to provide effective care for older people where they need it – which, amongst other outcomes, has resulted in more timely discharge from hospital. This note summarises

1. The various initiatives undertaken to support older people.
2. The impact on Delayed Discharge numbers.
3. Why they might have been successful – exploring the model that Dundee attributes to their success.
4. What Dundee learned throughout the design and implementation of changes.

It is important to note

- This is not an independent evaluation of the effectiveness of the various initiatives undertaken in Dundee. It is an articulation of the changes they made and the impact that Dundee has attributed to these changes.
- Dundee's experience cannot be shifted and rolled out in different locations in Scotland. Instead, each area needs to design its local solutions, driven by its local context, assets, and challenges.

The key finding from the Dundee experience is that they moved as a system to prevent shifting the bottleneck somewhere else. They took action across

- Tayside – reducing local variation in process, policy, and outcomes for people,
- Inpatient and community settings across professions including doctors, nurses, AHPs, social care professionals, social workers, support workers, and
- Public, third, and independent sector organisations whom all provide critical pieces of the whole system puzzle.

This helped to ensure that by fixing a challenge in one area they didn't make it someone else's challenge or create new challenges.

Taking components of the changes described in this case study in isolation may not yield similar results, it may shift challenges to other parts of the system, rather than seek to address them, unless done as part of a whole system approach. We are unable to disentangle the initiatives from each other, to articulate which initiative is responsible for what impact. Instead, we can observe the impact that each of these initiatives contributes towards.

1. What did Dundee do?

The activity in Dundee is made up of several separate but inter-related initiatives all designed to improve the way that they identify, assess, move, and provide care for, people in a way that maximises the way they use the available community, primary, and acute resources across the public, third and independent sectors. There are a few features of the way that Dundee City HSCP is set up that is useful to note when reading about their initiatives.

- The main hospital supporting older people and those with frailty is in Dundee. Dundee City HSCP works closely with Perth and Kinross HSCP and Angus HSCP's community-based services to facilitate discharge into localities outside of a Dundee postcode.
- Dundee City HSCP has a number of delegated functions under their model of integration on behalf of NHS Tayside and the other HSCPs. This includes the Medine for the Elderly (MfE) doctors reporting into the senior manager who holds responsibility for health and social care in the community. Those MfE doctors work across both acute and community settings in NHS Tayside. They do not report directly into the ward that they work on within the hospital. All Occupational Therapy and Physiotherapy working in inpatient settings are also delegated to the Dundee City HSCP. This senior manager is also working closely with the manager responsible for healthcare provided by community teams, social care provided in the community, the Resource Matching Unit that links up community care provision with packages of need, and the social work teams that work within acute settings as part of working together on urgent and unscheduled care.

1.1 Care at Home commissioning – ad hoc availability and fair work principles pilot

Care at Home capacity is closely linked with the ability to prevent discharges with a delay. Social care workforce shortages exist across Scotland. The working conditions - including rates of pay and stability around the hours and income they can expect each week - play a large role in social care being an attractive career for people.

Dundee City HSCP's initiative around Care at Home sought to improve the working conditions for staff to increase capacity and enable the sustainability of provider organisations. They ran a test of change between October 2022 and March 2023 called "Care at Home – Ad hoc Availability and Fair Work Principles". This model was fully embedded following the test of change. It introduced a new model that

- Required Care at Home staff to be paid from the start to the end of shifts – which required the Dundee City HSCP to fund full shifts. Until this pilot, 50% of providers paid from start to end of shifts, with the rest paying staff for contact time only. Paying only for contact time doesn't consider the time spent by staff travelling between clients and can lead to a large variation in the hours available for staff if clients they support are admitted to hospital unexpectedly.
- Reduced significant periods of downtime within shifts by having staff provide 'ad hoc visits' to other clients to enable them to achieve better outcomes for people and increase their chance of staying at home and avoiding potential future admissions.

Key results from the pilot were

- Greater security and satisfaction for staff – 82% of staff said that it encourages them to stay with their current care employer, 82% said it gives them financial security, 69% felt more valued when being paid

for their full shift, 61% felt less anxious, and 90% said that having a variety of additional tasks (not just personal care) would contribute to greater job satisfaction.

> *"It can be financially crushing if too many clients cancel or there is massive gaps" (about not being paid for a full shift)*

> *"Being paid full shift I feel a lot more secure in my job"*

- Improved recruitment and retention for providers – 89% of care at home providers said it had supported improved recruitment and retention.
- Better care and reduced risk of admission – 95% of care at home providers felt that it helped prevent hospital admissions and maintained continuity of care and support.
- Fewer bed days lost due to Delayed Discharge (see section 2).
- Lower rates of interim placements as people can get home sooner, needing interim placements less.

1.2 Discharge to Assess Team – British Red Cross

Dundee City HSCP commissioned the British Red Cross to provide a Discharge to Assess service. It was developed to discharge people with interim care while they awaited their assessment. The service conducts the assessment and provides the required care while their ongoing care package is put in place. The underpinning logic for a Discharge to Assess intervention is that you can get a better sense of someone's ongoing care needs during the assessment if they are in their own homes and back in their routine than if someone is in a hospital ward. Their experience of assessments conducted in hospital settings is that they can often 'overprescribe' the level of care required once someone is settled back into their own home.
It was originally commissioned due to long wait times for care which delayed people's discharge. They reflect that now that they have increased their care at home provision through the ad hoc availability and fair work principles, the changes for wait times for ongoing care is less, so the scale of the resource required from the British Red Cross has reduced.

Originally, they required the discharge team to make a referral to the British Red Cross who would pick this up. Now, the British Red Cross team sits within the multi-disciplinary team (MDT) meetings to make decisions about providing care for people to enable discharge. The Discharge to Assess Team has a high degree of autonomy in how they utilise the resources available. They work predominately with the MDT in the hospital frailty unit to inform a decision about how intensive the interim care they provide is. Once someone is home, they are able to scale this up or down as they see fit, without requiring an assessment from the hospital or locality social workers. This enables them to maximise the impact they can have with their resource as there is no lag time between the need changing and the care provided changing to match.

Examples of two patient journeys as a result of Phase 1 of the Discharge to Assess programme are included in Appendix 3.

1.3 Integrated Discharge Team – integrated across Tayside

An Integrated Discharge Team was established to actively plan the discharge of patients across Tayside. It supports patients over 18, with the vast majority are over 65. It started as a Dundee only team – supporting discharge for patients with a Dundee postcode – which brought together social workers, discharge coordinators (who are usually nurses), and support workers into one team to plan discharge in a

more integrated way. This enabled more integrated decision making as social workers were embedded in the discharge planning process, working closely with discharge coordinators, medical staff, and allied health professionals with a regular link to the patient and family as relevant. Social workers within this service are clear on the importance of facilitating discharge as a way to avoid the impact that hospital stays can have on people (see Appendix 2 for the effects of bedrest) and they are able to work closely with their social work colleagues in the community – acting as a bridge between acute staff and locality social work teams.

The Integrated Discharge Team then did a test of change where it supported the surgical wards with the discharge of frail patients. Prior to this, surgical wards were expected to facilitate the discharge of patients which were in the majority of older and frail people, but without access to specialist skills in frailty (e.g. bought by a Geriatrician). When the Integrated Discharge Team took on this responsibility it created capacity within surgical wards and reduced the number of beds surgical wards required. This additional resource was reinvested into the Integrated Discharge Team to continue it as part of a Surgical Frailty Team beyond the test of change.

A second test of change was funded to enable the Integrated Discharge Team to roll coordinated social work resource involved in discharge planning out to Perth and Kinross HSCP and Angus HSCP areas so that they could work with all inpatients, and not just inpatients with a Dundee postcode. This further reduced the discharge planning burden on the various wards, and the three HSCPs decided to fund this beyond the test of change.

There are agreements in place between the three HSCPs that enable staff within the Integrated Discharge Team to conduct assessments and make direct referrals to the relevant local services (e.g. Care Homes, Care at Home, Rehabilitation etc) across all three HSCP areas without requiring sign off by a locality social worker in that HSCP. Before this, patients could be delayed in hospital waiting on a social worker from Angus or Perth and Kinross to travel to the hospital to conduct the assessment. This change enabled assessments to happen more quickly, thereby reducing delays.

The Integrated Discharge Team is organised to align its workforce to the clinical pathways used within NHS Tayside – for example surgery, stroke/neuro, medicine for the elderly, medicine, and orthopaedics. This alignment makes integrated action between the team and wards more efficient with stronger relationships formed.

1.4 Establishing a Dundee Enhanced Care at Home Team (DECAHT)

The Dundee Enhanced Care at Home Team was established to bring together nurses, Advanced Nurse Practitioners, and Consultant Geriatricians (consultant Geriatricians also work in inpatient settings). They provide health care in the community for people during an acute episode to prevent unnecessary hospital admission and enable earlier discharges. It provides care to patients in their own homes and in care homes in Dundee.

The patient care is led by the Advanced Nurse Practitioners who can draw on support from Geriatricians either by providing telephone advice to ANPs or by conducting in-person home visits as needed. Geriatricians also attend GP cluster meetings to provide advice and guidance on patients. GPs are also able to contact the Geriatricians allocated to their GP cluster by phone for advice on patients.

The team works in four clusters aligned to GP practices to enable the staff to work together on smaller groups of patients that they get to know. This enables them to be more confident in providing medical care

within the community and enabling them to more rapidly put in place the appropriate care. Both of these things contribute to fewer admissions and earlier discharges.

The consultant Geriatricians work across both the DECAHT and within the inpatient Frailty Unit, so they support the same group of patients when they are at home or in hospital. The team has a supported worker from the Hospital Discharge Team embedded within DECAHT to identify those in the Frailty Unit who may benefit from support from DECAHT to enable discharge.

This service currently only works with older people linked to the Frailty Unit but is exploring how they expand the current model to include other clinical specialisms (e.g. respiratory) and to widen the age of patients supported. They are also working to include the Scottish Ambulance Service so that paramedics attending community settings will be able to directly contact the relevant staff in the DECAHT to receive advice and access community health care as an alternative to taking someone to hospital.

Hospital at Home sits within the responsibility of DECAHT, but they note that they use this model less as their DECAHT approach more generally takes its place.

1.5 Independent Living Review Team

The Independent Living Review (ILRT) is a rehabilitation team made up of occupational therapists, physiotherapists and support workers. They focus on providing rehabilitation support to individuals immediately upon discharge from hospital to help build their functionality and ability to live independently. This ensures that people achieve the best possible health and wellbeing outcome, while reducing the overall level of care they would need to live independently. This reduces their demand for social care to live well at home – such as Care at Home and Care Homes.

- 33% of those reviewed by the ILRT (170 individuals between Oct 2022 and March 2023) could be removed from the waiting list due to improved function.
- In total the ILRT supported a cost saving of £518,851.84.

The next stage is for the ILRT to work with external providers to support ongoing reassessment and to support and train providers to use the enablement approach to manage the level of need each person has through reablement.

1.6 The Enablement Support Worker

Locality social work teams didn't have the capacity to regularly conduct reviews of people's care packages to identify where these needed to be increased or decreased. This resulted in a large number of individuals with care packages that were no longer needed with the same intensity. This could be due to rehabilitation increasing functionality or because the original assessment was higher than wasneeded. This placed strain on the care at home resource which was struggling to keep up the existing packages of care while meeting the needs of new patients returning home from hospital.

The responsibility for social care reviews was transferred to a new service headed up by an Enablement Support Worker – who isn't a qualified Social Worker. The service is now two whole time equivalent Enablement Support Workers. They provide support to individuals in the community to support their independent living. This includes assessing needs, goal setting and supporting self management, and referrals to third sector services (eg befriending) and HSCP services (eg moving and handling, community alarms, and Occupational Therapy).

Critical to this service is that the Enablement Support Worker reviews care packages within a few weeks of someone's initial assessment. This picks up rapid improvements in functionality or where the need was overestimated when the person was assessed in hospital. This means that people and their families are advised that their initial assessment is a short term level of support until a follow up assessment can be completed – enabling people and their families expectations to be better aligned with the required level of care.

The result of the reviews and enablement support was

- 27% of those reviewed by the Enablement Support Worker could be removed from the waiting list as they no longer needed support due to the impact of the enablement support provided.
- 50% of those reviewed by the Enablement Support Worker had their support hours reduced as they didn't need as many hours due to the impact of the enablement support provided.
- A number of others were removed from waiting who were deceased or had moved into long-term care which made the figures more accurate.
- In total the ESW supported a cost saving of £789,244.56.

1.7 Frailty Unit – Ninewells

Dundee HSCP (along with Angus HSCP) support a 24 bedded Acute Frailty Unit within Ninewells Hospital. They are in the early stages of increasing this capacity in Ninewells further to widen further access for the frail Dundee and Angus population. It is worth noting that Perth Royal Infirmary also have an Acute Frailty Unit, supported by the Perth and Kinross HSCP.

Winter funding in 2017/18 was utilised to create an Acute Frailty Team who were based in the Medical Assessment Unit which manages acute medical admissions to Ninewells hospital. The service operated 7 days and enabled frailty expertise to be used to assess and plan for people who were attending the Emergency Department with frailty related need, but mainly people admitted to Medical Assessment Unit. This service made an impact on care of people living with frailty and length of stay for frailty related admissions was reduced by an average of 1 day. The funding for this team was mainstreamed April 2018 based on positive evaluation.

In 2018/19 the winter surge funding was used to create and test a 12 bedded Acute Frailty Unit. The Unit's capacity was increased to 24 beds using the 2019/20 winter surge funding. This ward was situated adjacent to the Medical Assessment Unit and staffed by nurses with an interest and passion for caring for people living with frailty. The ward was quiet, well-lit and had an ethos of minimising hospital induced dependency, and Home First approach. It had optimal therapy, nursing and health care staffing to meet patient demand. This unit has robust integrated discharge team support who had priority access to downstream rehabilitation beds, to Red Cross home care for discharge to assess and aligned to the Dundee DECAT team for more clinical support to enable early discharge into the community. The impact of improved care and pathways for people living with frailty resulted in a further average 3-4 day reduction in length of stay to all frailty related admissions to Ninewells Medicine.

From April 2020, as a consequence of improved flow of people living with frailty and reduced impact of hospital induced dependency to Dundee (and also Angus population), the funding for the 24 bedded ward was mainstreamed by transferring resource and staff from down stream Medicine for the Elderly wards that had been closed as consequence of improved front door flow of people living with frailty. Despite

downstream bed closures to fund the Frailty Unit, the impact of the Unit also allowed Medicine Division to deliver hospital-based care at 90% occupancy, compared to >95% before the model change.

To access the Acute Frailty Unit, the Frailty Team assess people in mainly Medical Assessment unit but also Emergency Department who are identified as living with frailty via standard screening tools. The Frailty Unit is a closed unit, so admissions to it must be approved by the Frailty Team 24/7. There is an overnight on-call service to take admissions through the night. Following acceptance from the Frailty Team, the team aims to admit people to the Acute Frailty Unit within 4 hours, to limit hospital induced dependency and harm.

The Acute Frailty Unit accepts people who need to be admitted to hospital due to a frailty related need – for example a fall (not requiring surgery), delirium, mobility, dehydration, or infection – and who do not require treatment from another specialist area – for example stroke or cardiology. .

The Frailty Unit has operated at 91% occupancy over the past 12 months (up until November 2024) and generally admits 6 new people per day. The aim, as per entire Ninewells Hospital, is to operate at 90% occupancy to deliver safest, most efficient healthcare, but also enable the Unit to accept frailty related admissions without delay.

Dundee HSCP found that the assessment and planning provided by the Frailty Team when it was introduced reduced the average length of stay for frailty related admissions by 1 day per admission. When they then established the Frailty Unit, they found that the combination of frailty specialist care within a frailty specialist physical ward environment and frailty specific discharge planning enabled them to reduce the average length of stay for a frailty related admission by a further 3-4 days (in addition to the 1-day reduction from the Frailty Team). This impact was attributed to the following features of the model

- Providing frailty specialist care within a frailty specialist environment enabled them to reduce the level of hospital induced dependency. Outcomes for people living with frailty improved, and improved more quickly because specialist staff were able to carefully tailor treatment and care to maintain (and/or increase) mobility and cognitive ability within the hospital setting – meaning people required less care at home upon discharge – making it easier to discharge them home quickly, but when people needed temporary increase in pre-admission home care, this was readily accessible within 24 hours and without delay. People required less step-down community hospital or intermediate care rehabilitation– reducing the demand for intermediate care beds and enabling Dundee HSCP to close a 28 intermediate care unit and reinvest that funding in community services, to progress early intervention DECAT services but also support ongoing Discharge without Delay via processes described above.
- People were less likely to deteriorate physically and cognitively in a way that led to further lengthy stays in hospital
- Bringing people living with frailty together in a single Unit enabled discharge planning and community care initiatives to cluster around the Frailty Unit instead of trying to respond to people living with frailty scattered around other specialist or general acute wards. This improved operational efficiency of the discharge planning and enabled the teams to build stronger relationships (because they were able to spend more time together and there were fewer people to build relationships with) between hospital staff, discharge staff, and community settings – which resulted in more shared planning and problem solving to support discharge and care.

1.8 NHS Tayside Medicine for the Elderly Care Older Peoples Standards

NHS Tayside developed a set of standards to be adopted across all NHS Tayside Medicine of the Elderly wards. They are designed to support collaborative practice and reduce variation and inequalities in care. The full standards across the three priority areas (patient-centred care, access to appropriate services and care settings, and quality assurance/care and clinical governance) can be found in Appendix 1. They are written to align with national standards and requirements. They are deliberately concise to enable an accessible and action focused set of expectations.

These standards were developed collaboratively between the four partnerships (the three HSCPs and NHS Tayside) and act as the agreement between them on what is expected. It enables staff to collaboratively and proactively plan together as there are clear and shared expectations of each other. It provides a useful reference point for discussions or disagreements between staff.

The standards are also public facing and provide details about the expectations around how patients and families are to be involved in care and decision making. This enables patients and families a reference point to set their expectations and hold staff accountable for meeting these.

1.9 Adults with Incapacity

Dundee City HSCP undertook changes to the way it managed its Adults with Incapacity processes. For patients who lack capacity to make some or all decisions for themselves about their care, there is a requirement to have the appropriate legal authority in place for someone to make those decisions on their behalf. These decisions must benefit the person, consider their wishes and feelings (including their previously expressed wishes), take into account the views of the relatives/carers, and restrict the person's freedom as little as possible while achieving the benefit desired.[1] Legal Authority can come from a number of sources – a Power of Attorney, interim powers under the Adults with Incapacity legislation, or a private or local authority held Guardianship. Where appropriate, 13ZA of the Social Work (Scotland) Act 1968 can be used as a mechanism to support discharge.[2]

Lengthy delays in discharge are common for patients who need care from a residential setting like a Care Home, lack capacity to make that decision and do not already have legal authority in place for someone to make that decision on their behalf. In these situations, 13ZA can be used, or guardianship or interim powers can be sought.

Dundee City HSCP were concerned that the delays associated with obtaining the appropriate legal authority to support discharge seemed to be longer than needed to adhere to the legal framework and required processes. They conducted an exploration of the challenges and identified that

- The AWI processes require contributions from social workers, mental health officers, flow coordinators, families, private solicitors and/or local authority legal teams, and clinicians. They identified that drift in timeframes was occurring because while different people would contribute their part of the process, no one was actively managing it to anticipate and line up the next step, follow up actions, and troubleshoot issues as they arose.
- There was a view amongst private solicitors that there was no urgency required on their work on private guardianships as delays within health and social care services (particularly a perception that

[1] https://www.scot.nhs.uk/sehd/mels/HDL2003_34AWIpt4.pdf
[2] Adults who lack capacity - discharge process: key actions - gov.scot

there were waitlists to get allocated a Mental Health Officer) were holding up progress and not the private solicitors' parts of the process.

In response to these challenges, Dundee City HSCP put in place the following

- A Mental Health Officer was reallocated from the Mental Health Officer team to the hospital discharge. They actively manage all the adults with incapacity processes for people in inpatient settings, coordinating activity and engaging directly with solicitors. They also coordinate with social workers to ensure that care placements are lined up to time with the legal authority being obtained. They are also responsible for upskilling staff in acute settings on AWI processes. The Mental Health Officer receives administrative support from the hospital discharge team and professional supervision from the manager of the Mental Health Officer team. They noted that to make it easier to retain staff in this role the Mental Health Officer participates in the Mental Health Officer team's duty team rota to provide greater job variety and enable them to maintain their skills in other parts of the Mental Health Officer role – like mental health legislative requirements.
- Families and carers who wish to pursue a private guardianship application are given a list of local solicitors, a letter that outlines that they have 7 days to identify a solicitor and to contact the Mental Health Officer with the solicitor's details. The Mental Health Officer will follow up with the family, and if progress isn't made within 7 days, then they switch to a local authority guardianship process.
- The Mental Health Officer engages regularly with the private solicitor to demonstrate action at the health and social care end and proactively provide the required reports for the solicitor.
- All guardianship applications for people in hospital include a request for interim powers to support discharge – citing the need to discharge the person from hospital as the urgency that justifies the interim powers request.
- Maximise the appropriate use of 13ZA to reduce the number of new guardianship orders required to support discharge. The Mental Health Officer convenes a decision-making meeting that explores whether 13ZA is an appropriate mechanism for the individual case. They are well attended by the relevant consultants, charge nurses, allied health professionals, families, discharge coordinators, and social work staff to discuss and agree together whether to use 13ZA for the individual. The meeting must utilise a template (see Appendix 4) to demonstrate that consideration has been given to the five principles under the human rights legislation and that all relevant parties have been consulted and agree with the approach decided in the meeting.[3]

In addition, Dundee City HSCP says that by investing well in rehabilitation and enablement they can have more people going home instead of into care homes which reduces the need for new guardianship orders.

[3] Consideration of Article 5 European Court of Human Rights (e.g. access to support, limitations of contact, freedom of movement, external environment, restraints, staffing)

2. The impact on Delayed Discharge numbers

The larger the number of hours of care yet to be provided for assessed individuals in hospital, the higher the number of delayed discharge bed days. Dundee has seen a consistent and sustained reduction in the number of occupied bed days lost to acute reportable delays since March 2024 (results show up until June 2024), see fig 1.

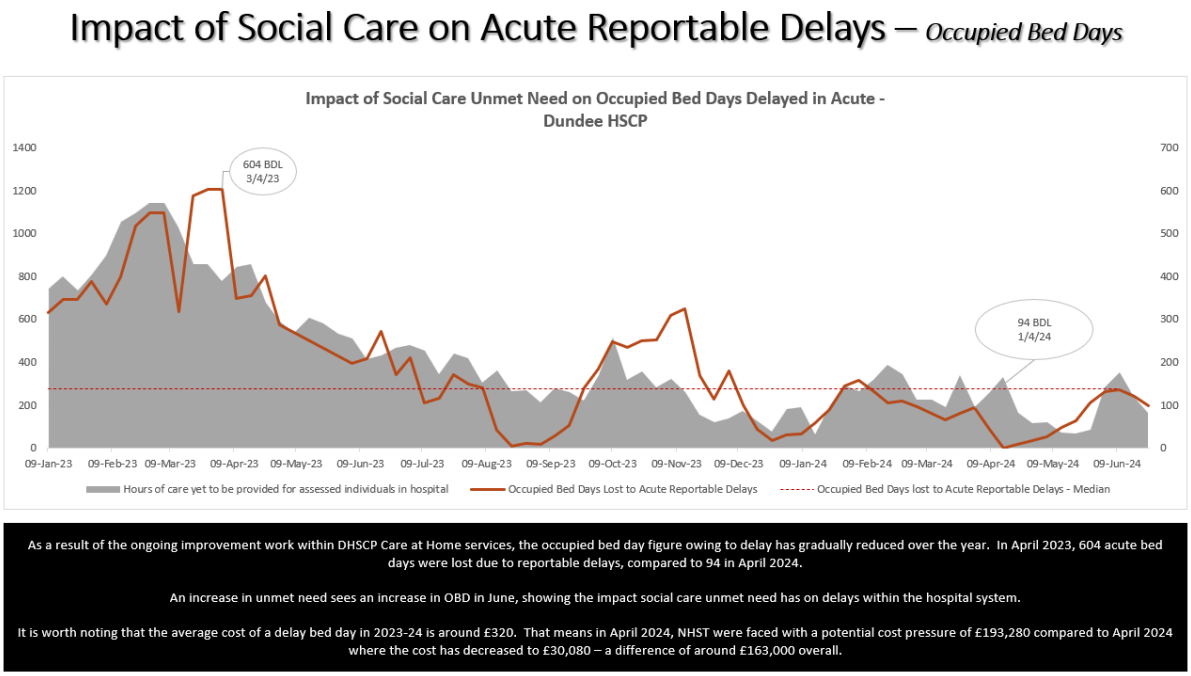


Figure 1

They attribute this reduction to the increase in provision of Care at Home capacity, the ability to put in place bridging care that allows time for longer-term care to be planned, and the ability to more rapidly assess and put in place the appropriate care without people needing to be in a hospital bed to do this.

3. Why might Dundee have been successful?

This section explores the features of the model that Dundee attribute to their success.

3.1 Discharge without delay and Home First were the underpinning drivers for all activity

The overarching values that drive what they do are

- That time inactive in a hospital bed is not good for older people so people should be discharged without delay as soon as medically fit, and to their home if possible. **Decisions to delay discharge come with an impact on the health and wellbeing of the patient and other patients** that need to be considered when considering decisions that keep people in hospital longer than medically necessary.
- That going **home is the first option** considered, with various **support in place to enable this to happen** including Discharge to Assess to rapidly put in place the right support to help someone home and the investment in enablement and independent living to enable rehabilitation to reduce the intensity of care they need making them more likely to be safe to go home instead of a Care Home.

When reflecting on their approach, they describe three principles that helped them to drive the 'discharge without delay' and 'home first' values

- **Narrative** – articulating a clear narrative that explains the rationale and evidence base behind the 'discharge without delay' ethos and provides the basis for discussions with stakeholders with conflicting views.
- **Culture** – building the culture required to arrive at a shared view on the driver of the work and create the relationships required to deliver effective system-wide activity.
- **Honesty** – creating an environment for open communication where people can provide challenges and raise concerns with each other – which may include honest conversations between staff and with patients and families.

3.2 The model is a combination of changes acting as a whole system response.

Overall, the key features of their approach that may have led to the impact in Dundee are

1. Targeted additional care at home for people still in the community for short periods of time when they appeared to need this, to reduce the need for them to present to unscheduled care as they had care needs better met and sought to prevent an escalation in the person's need. ***(Discharge to Assess and Dundee Enhanced Care at Home Team)***
2. Targeted care at home for people who did present to unscheduled care as a mechanism to avoid admission. ***(Discharge to Assess and Dundee Enhanced Care at Home Team)***
3. Putting in place interim care arrangements to enable people to be discharged home while they waited for their long-term Care at Home package to be put in place (only for those not needing Care Home placements). ***(Discharge to Assess)***
4. Creating capacity to provide greater levels of health care in the community to prevent admission and facilitate earlier discharge ***(Dundee Enhanced Care at Home Team)***
5. Bridging community and hospital provided healthcare by having the same consultants supporting people making it easier to put in place community-based health care ***(Dundee Enhanced Care at Home Team)***
6. Maximised how far Care at Home capacity will go by
    - Investing in rehabilitation immediately following discharge to enable individuals and reduce the package of care they need longer term **(*Independent Living Review Team)***
    - Reviewing packages of care within a few weeks of someone's initial assessment to ensure they are appropriate for the individual's need and reduce the risk of over-prescribed packages ***(Enablement Support Workers)***
7. Increased the supply of Care at Home through better working conditions to attract more staff, and improve the sustainability of provider organisations ***(Care at Home Ad Hoc Availability and Fair Work)***
8. Aligned social care, AHP, and social work processes with the specialist pathways of acute settings so that it was 'wrapped around' inpatient care in a way that proactively supported discharge. ***(British Red Cross Discharge to Assess participating in Frailty Unit MDTs, DECAHT wrapped around Frailty Unit with plans to wrap around other clinical specialisms, Integrated Discharge Team aligned to clinical pathways)***
9. Increased the consistency of people involved in decision-making for each patient so that the same clinician, nursing, social worker, and AHPs are involved in managing an individual between community and inpatient settings ***(DECAHT aligning geographically to create smaller virtual teams working with each other more closely)***

3.3 Impact would have been significantly limited without the work to maximise the availability of Care at Home

Maximising the availability of Care at Home (interventions 6 and 7 above) enabled long-term packages to be put into place quickly. This was vital as it ensured that people were only receiving care from interventions 1 – 3 for a short period, enabling the staff resource in these interventions to be continually freed up to support new people. Dundee noted that creating this flow-through was challenging, with care provided by interventions 1 – 3 for longer than originally intended. Without effective 'pull through' from Care at Home, interventions aimed at bridging care become a bottleneck like long-term care services do.

3.4 Utilising frailty specific skills and environments (within a Frailty Unit) reduced demand for services across the system

Creating a Frailty Unit (at the 'front door') enabled Dundee HSCP to achieve significant reductions in the demand for acute beds, intermediate rehabilitation beds, and care at home services. Dundee didn't anticipate the nature or extent of this impact when they first started. Establishing a Frailty Unit 'at the front door' enabled them to create a combination of frailty specialist

- Knowledge on the ward to enable better tailored treatment and care,
- Ward environment more conducive to meeting the needs of people with frailty and minimising their deterioration, and
- Discharge planning tailored to the needs of someone with frailty.

This helped patients maintain their physical mobility and cognitive functioning – thereby reducing hospital induced dependency. This meant that

- People required less care at home upon discharge – making it easier to discharge them home quickly.
- People were less likely to deteriorate physically and cognitively in a way that led to further lengthy stays in hospital.
- People required less intermediate care rehabilitation prior to going home – reducing the demand for intermediate care beds.

3.5 Principles aligned with Ethical Commissioning enabled effective working relationships

These initiatives required effective joint working and commissioning between the Dundee City HSCP and third and independent sector providers. In particular

- The relationship between Dundee City HSCP and the British Red Cross was strong, enabling them to commission the British Red Cross to test out new approaches which were passed to others to continue delivery once the concept was proven and the model refined. Critical to this relationship was a high level of trust. This gave the British Red Cross a certain level of autonomous decision making, which made the service far more flexible.
- Dundee City HSCP worked closely with independent and third sector Care at Home providers to commission in a way that enabled the provision of fair working conditions. This collaborative approach to considering sustainability and workforce challenges meant that Dundee City HSCP was able to identify and implement an effective commissioning arrangement.

3.6 Dundee created virtual teams that worked across different management structures that gain the benefit of joint working, without creating silos from operational separation

A notable feature of the work undertaken is the creation of a range of virtual teams to create alignment and joint working, rather than creating geographically or population-based teams with separate management structures. Staff within DECAHT, work aligned to GP practices which means the same community nurse, AHP, social worker, and consultant work together to support patients in each geography (with the consultant remaining the same both when someone is in the community and when they are in hospital for an inpatient stay or visit to unscheduled care). However the different geographies are still under the same management structure as each other across the services. The DECAHT staff across different disciplines are managed within the same structure – including the Consultant Geriatricians who treat people both in the hospitals and community.

In addition, the person with responsibility for the Resource Matching Unit also holds responsibility for the management of the Care at Home contracts, and the in-house care including Care at Home, Enablement Service, and the ILRT.

The range of virtual geographical teaming and virtual alignment to clinical specialisms means that they have

- Created strong relationships between a consistent set of staff who get to know each other and know more about their patients.
- Minimised geographical variations in processes and approaches that come with having teams that operate separately with separate governance structures and reporting lines.

3.7 Community care is wrapped around acute and clinical structures to provide effective coordination

When designing initiatives, a particular effort was created to wrap social care around the established acute and clinical structures available. For example,

- The British Red Cross Discharge to Assess programme staff, are working directly with the Frailty Unit within the hospital. They attend the MDT meetings and are flexible in how they support the patients in the Frailty Unit to be discharged.
- The Dundee Enhanced Care at Home Team (DECAHT) is aligned with the Medicine for the Elderly consultants and designed around the clinical pathways associated with frailty and older people. As Dundee looks to expand the team by taking on additional clinical specialisms one-by-one to effectively build care around clinical structures.

The purpose of this alignment is to make it easier for acute settings to line up the appropriate community care more easily. It also creates an environment where community and social care staff are able to proactively plan for patients' discharge thereby building trust and buy-in from the relevant staff in acute settings that helps with communication and joint decision-making required to discharge without delay.

4. What Dundee learned throughout the design and delivery of changes

Dundee is a story of incremental improvement and learning, with many of the features of their experience being the culmination of 20 years of change. They didn't start out to take a system-wide approach. Instead, they started to change and then proactively sought to understand the impact that it had on other parts of the system – starting by observing the impact, then understanding the impact, and eventually being able to predict the impact. This curiosity about how other parts of the system felt the changes they made, resulted in a system-wide view being adopted organically over time. When reflecting on how to articulate this to other areas exploring change, they recognise that the combination of activities across the system in Tayside would have been difficult to achieve by overlaying the current model over the context they had in one go. Creating the space for open and organic learning guiding progress feels critical to the Dundee story.

The following sections explore the key areas of learning from Dundee in more detail.

4.1 Framing change to build buy-in and prevent siloed 'patches' of good practice

As with many stories of successful change, Dundee represents a situation of one or two people with the passion, skill, and knowledge to approach systemic challenges differently. As the work and views of these individuals achieve more success and gain a higher profile, you see the organisation provide them with additional resources, teams, and services to increase the scale of their work and impact.

This leads to a patch of good practice. We see patches of good practice in health and social care across Scotland and are all familiar with the frequently used description "there are patches of good practice, and we have the desire to see this applied more consistently across Scotland".

The Dundee example isn't one service, hospital, or team implementing valuable change in an isolated patch of improvement. Instead, it represents a wide range of initiatives that span geographies, services, professions, organisations, and sectors across the three HSCPs and the NHS Board[4]. The learning from Dundee of how they turned what could have become an isolated example of practice into a more connected and fuller system change is around how they reach out and proactively link their work with the rest of the system and wrap it around the other parts to best meet the needs of the wider system.

They didn't just work with the willing. They reached out beyond the early adopters and were easy to convince, and into the wider range of stakeholders that were more likely to be resistant to their work. The importance of how to shape their messaging was identified in Dundee as a key learning. Turning something that was seen as 'one person's soap box' into 'everyone's driving rationale' required well-constructed messaging that they consistently invested in to bring the whole system along with them as they sought to design and implement change.

They carefully shaped the message to better align stakeholders around a single driving ethos. The driving ethos behind this work was that time inactive in a hospital bed is not good for older people so people should be discharged without delay as soon as medically fit. This was not widely accepted across the various health and social care professions in Dundee – for example, social workers who wanted a client to stay in hospital while awaiting their preferred care home rather than move them temporarily into the care

[4] Public, third and independent sector organisations

home available at the time, or who preferred not to use Section 13ZA in the Social Work Scotland Act, instead favouring the more lengthy guardianship process to enable discharge.[5] Core to doing this was the use of evidence on the impact on someone from time inactive in a hospital bed (see Appendix 2 for more detail) to help provide a more well-rounded set of evidence being used to inform discharge and ongoing care decisions by different professional groups, proactively countering the view that acute settings are only trying to move people to reduce operational pressure and not for the wellbeing of the patient.

Continually working to influence and build buy into the single ethos helped

- The wide range of stakeholders to gather activity under a common guiding principle.
- All parts of the system to see that they all play an active role in achieving success – that delayed discharges aren't the 'problem' of one part of the system, one service, or one profession.

4.2 Moving as a system is vital to prevent just shifting the bottleneck to somewhere else

Dundee describes their approach as a system-wide approach. By doing this they mean that they looked at how they needed to make changes across inpatient and community settings, across clinical, social work, social care, AHP, and other services to ensure that by fixing a challenge in one area they didn't just make it someone else's challenge or create new challenges for someone else.

From their learning, they caution picking up parts of the Dundee approach and implementing it in isolation. These initiatives work because they work together to create a smooth flow across the full system. For example,

- Without increasing and maximising the supply of social care any service that seeks to provide interim support for people in their homes until longer-term care is ready is going to become overwhelmed with a caseload of people receiving 'interim' care for far longer than intended, which means they won't be able to take on new patients coming from hospital.
- Initiatives to reduce the number of patients admitted to hospital in the first place carry too much risk unless there is effective care in the community that makes people more confident to manage higher needs in community settings.
- Implementing efficient assessment and discharge processes for people living in Dundee is unlikely to make a large impact on bed days if hospital-based social workers aren't also able to assess who lives in Perth and Kinross and Angus and directly request resources from their local community-based health and social care teams.

4.3 Trust leads to flexibility and tailored support required to get people home

A feature of the British Red Cross partnership with Dundee City HSCP was trust. The Discharge to Assess team delivered by the British Red Cross is wrapped around the inpatient frailty unit. The British Red Cross team attends the ward MDT meetings to identify patients that it can proactively support the discharge of by bringing them into the Discharge to Assess service.

Dundee City HSCP relies on the **British Red Cross to implement a high degree of independent decision-making around how they deploy the Discharge to Assess team resources** including how many patients they provide, how many hours and for how long. This autonomy is underpinned by trust developed from

[5] More information on 13ZA can be found here: Adults who lack capacity - discharge process: key actions - gov.scot (www.gov.scot)

long-term working relationships, open and honest communication and discussion, a view to approach challenges together rather than blame or leave each other to solve them on their own, and clarity that they have the same understanding of the purpose and focus of the service. In addition, the fee paid to the British Red Cross ensures that they can appropriately pay for the skill and experience level staff are required to be able to make these kinds of decisions on a day-to-day basis in partnership with the MDTs in the hospital.

This independent decision-making enables the service to respond flexibly to needs without being unduly restricted by fixed processes or contractual obligations.

4.4 Strong leadership is needed with knowledge, influence, and persistence

As with most examples of good practice in health and social care, the role that strong, skilled, and persistent leadership plays is evident in Dundee's ability to gain and sustain traction on change that spreads across the system. This includes

- Working knowledge around social work, acute settings, social care, and the relevant legal frameworks underpinning these areas.
- The ability to articulate and defend the rationale behind your decisions but be open to change when alternative courses of action hold weight.
- Constructively able to challenge views held by staff and families by understanding their priorities, values, and concerns.
- Able to foster and harness the appetite for change in others to build momentum for change across the wider system.

4.5 Increasing long-term planning within the context of successful incremental change to create manageable and sustained momentum

Their mix of services, staff, and processes has evolved incrementally over time. They explored challenges and put in place changes, subsequently identifying ripple effects or further opportunities arising, and then moving on to understanding and addressing these before identifying and addressing the next thing. Incremental change – which embraces both planned and organic improvement holds many strengths in enabling a flexible, adaptive, and manageable approach to change that allows people to embed and understand change before being expected to embrace the next wave of change.

Sophisticated approaches to change can integrate effective longer-term planning into adaptive incremental change and there is strong evidence of the growth in long-term planning within the Dundee experience. An example of this is the Dundee Enhanced Care at Home Team are focused on frailty. There are now plans for this service model to create the structures required to support adults of all ages, and different clinical specialisms (eg respiratory) – by adding in new clinical specialisms one at a time opening up the age range as needed.

The benefit of increasing the role of long-term planning within these change programmes is the ability to keep the work manageable. Nearly always led by passionate people driven by the need to help people – the scale of activity can easily become unmanageable by the tendency to say yes as other people and areas become interested in having their service or area included within the improvement work.

- An example of this learning in action in Dundee is the high level of interest from inpatient teams when the British Red Cross was first brought in to deliver Discharge to Assess. Dundee describes how this

resulted in the service being stretched and adapted beyond its original intention and required Dundee City HSCP and British Red Cross to pause and redesign its offer.

Creating a plan that allows the interest and willingness of others to be harnessed and included as part of a phased and planned approach has helped Dundee to maintain interest and buy-in from others while maintaining momentum through focused action that doesn't spread their resource too thin.

4.6 Having the right stakeholders in the room helps to plan for ripple effects across the system in advance

Dundee widened the stakeholders they engaged with organically over time. They reflected that this was often by realising that their work was having an impact (both positive and negative) on other people, teams, or services – so they began to engage with them to explore these impacts and work together. Their learning was that if they had bought many of these stakeholders in earlier, they would have been able to appropriately plan for the impact on others and find solutions to these issues in advance.

Appendix 1: NHS Tayside Standards for Medicine of the Elderly care

Priority 1: Patient-centred Care

- Standard 1: There will be appropriate documentation regarding the older person's decisions, which can include views on resuscitation and future care. When it is appropriate assessments of capacity should also be documented.
- Standard 2: Older adults who are vulnerable and/or cognitively impaired should have their needs identified and met by staff working in acute inpatient units. This includes management of stress and distress, assessment of capacity, and safe and responsible discharge planning. When appropriate other relevant agencies must be consulted during discharge planning, to ensure that safeguarding and protection is maintained.
- Standard 3: Every frail older person within inpatient care will have a Planned Date of Discharge set and will be involved in the MDT approach used to work towards delivering this.
- Standard 4: Frail older people should be proactively managed by the MDT to ensure they are on the best pathway available, with care being delivered in the least acute setting, ideally as close to home as possible. Delays in the provision of care should be minimised, and ideally, all patients discharged from the acute setting should be offered short-term assessment and enablement at home.
- Standard 5: All older people being discharged from hospital to a long-term care setting should have an Anticipatory Care Plan developed prior to their discharge. This should include a decision about resuscitation and a treatment escalation plan. A level III Medication Review should also be undertaken. Where appropriate the opportunity to develop an ACP should be offered to all older people leaving hospital, irrespective of their discharge destination.
- Standard 6: The ACP process must involve clear written electronic communication to the primary care team and a paper copy should be sent to staff in any long-term care setting. Details of the involvement of the patient and their carers in developing the ACP should be included.
- Standard 7: All people moving into long-term care should undergo an assessment by their care manager after 6 weeks, to ensure that their needs are being met. Their ACP and medical issues should also be reviewed, with input from MFE or their GP as appropriate.

Priority 2: Access to appropriate Services and care settings

- Standard 8: People who are medically fit but require more than 7-9 days of assessment or rehabilitation prior to discharge should have access to a local step-down facility. People admitted from home should be discharged for assessment at home prior to admission to long-term care. Where this is not possible, they should be transferred to a local step-down facility for ongoing assessment, rehabilitation, and discharge planning. They should not be discharged directly to long-term care from an acute ward
- Standard 9: Older people in the community who would benefit from Comprehensive Geriatric Assessment (CGA) will be identified through Enhanced Community Support (ECS) or Locality Integrated Care (LInC). All MFE services in Tayside will ensure the development of locality-aligned geriatricians.

- Standard 10: Older people admitted to hospital, who are identified by functional screening or MDT assessment as needing CGA, should have this commenced within 24 hours of admission, in the least acute setting and as close to home as possible.
- Standard 11: Waiting times for new MFE outpatient reviews should not exceed 4 weeks, recognising that the ECS/LInC MDT can often negate the need for an outpatient clinic review.

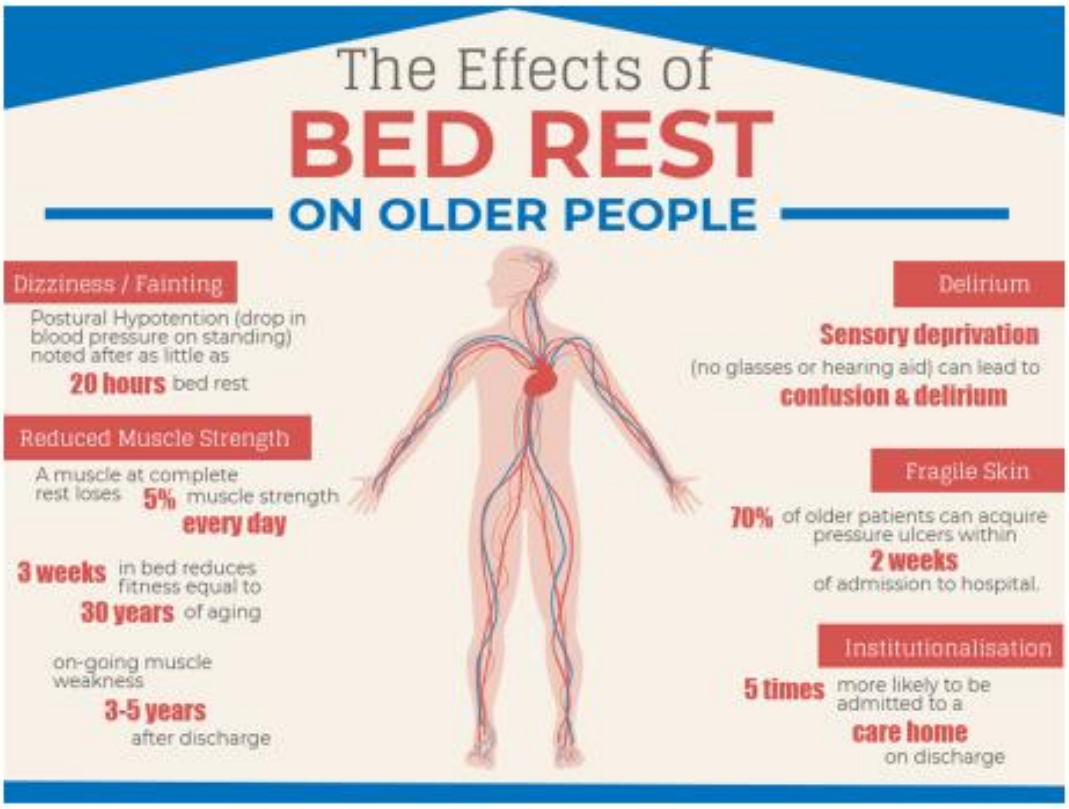
Priority 3: Quality Assurance/Care and Clinical Governance

To ensure that the standards agreed in this document are implemented and monitored, the following outcome indicators should be used in each of the Care, Clinical, and Professional Governance structures within the three Health and Social Care Partnerships (HSCPs) and the Operational Unit in Tayside, to populate the reports used in the care of frail older people.

The three HSCPs report to the Care Quality Forum and the Operational Unit through their Quality and Performance Reviews. The same reports will be shared at the Older People Clinical Board (OPCB) for the purpose of sharing and learning across the organisations

- Number of patients over 65 years admitted to care homes from acute, non-acute, and community.
- Bed days/emergency admissions / average length of stay in hospital as a ratio of population over 75 years.
- Readmission Rates at 28 days and 7 days in over 75's, per 1000 population.
- Bed days lost to delayed discharge in acute and non-acute wards (over 75 years).
- Proportion of last 6 months of life spent at home.
- Admission numbers to Acute hospital from Care Homes.
- Patient and staff experience.
- Robust documentation and evidence of CGA and DNACPR decisions and communication to inpatients and carers.
- Number of people being discharged on agreed Planned Date of Discharge (PDD).
- Number of people in locality care homes with ACPs and Level III medication reviews within the last year.
- Proportion of people admitted to acute hospital settings who undergo functional screening for frailty within the first 24 hours of admission.

Appendix 2: Effects of bedrest poster

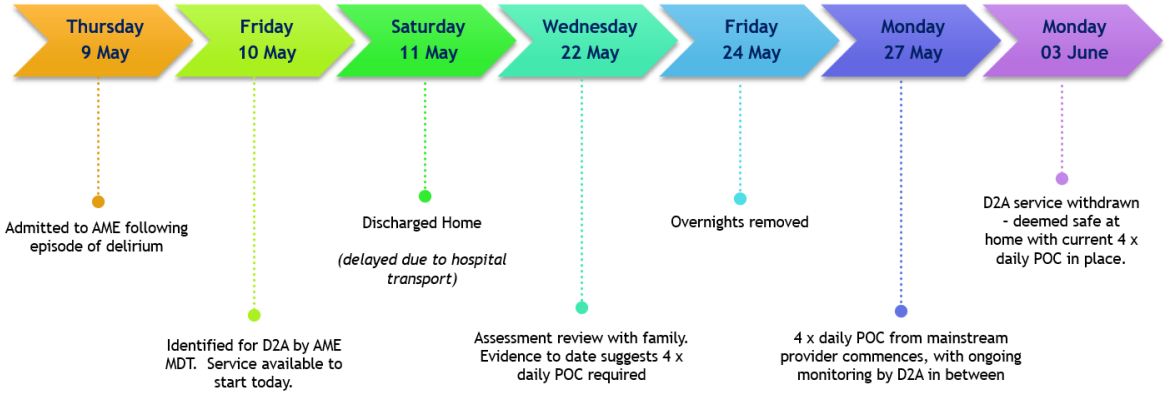


Scottish Government
Riaghaltas na h-Alba
gov.scot

Appendix 3: Example patient journeys from Discharge to Assess service

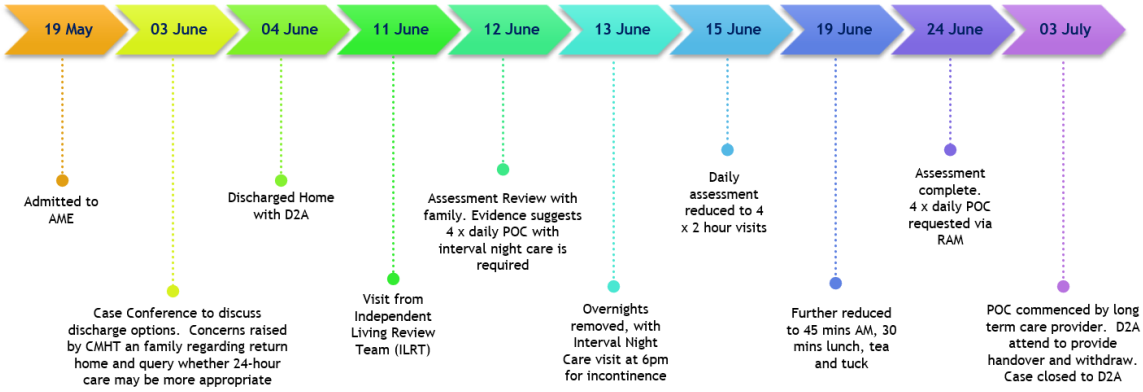
PATIENT A

Presentation	• Delirious/confused in the last few days and wandering. • Son was struggling to manage at home. • Diagnosed with a lower respiratory tract infection and commenced on oral antibiotics for this. • Mobilising independent. • Ongoing issues with confusion likely to be caused by infection and environmental changes. • Awaiting Psychiatry of Old Age (POA) review in the community.
Length of time on Service	24 days
Outcome of Assessment	Remain home with POC

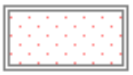


PATIENT B

Presentation	• Admitted following fall at home 3 days prior which resulted in increasing pain and reduced mobility. • Has input with the community mental health team including a support worker, social worker and CPN. • Befriending service in place who visit on a Tuesday, Thursday and Sunday for an hour. • Significant overnight needs due to incontinence. • District nurses to continue medication administration AM and PM - has a venalink and locked box.
Length of time on Service	30 days
Outcome of Assessment	Remain home with 4 x daily POC and interval night care



Appendix 4 13ZA Operating Procedures



Dundee CHANGING FOR THE FUTURE

Approved / Reviewed:
Next Review Date:

Adults with Incapacity Decision Making Guidance

MAIN RESPONSIBILITY :

LEGISLATION : Social Work (Scotland) Act 1968(the 1968 Act)
Adult Support and Protection (Scotland) Act 2007 (ASPA)
Adults with Incapacity (Scotland) Act 2000 (AWIA)
Equalities and Human Rights Act 2010

POLICIES: **Code of Practice for Local Authorities Exercising Functions under the 2000 Act**
http://www.scotland.gov.uk/Resource/Doc/216923/0058136.pdf
Circular CCDS/2007 Guidance for local authorities: provision of community care services to adults with incapacity
http://www.show.scot.nhs.uk/sehd/publications/CC2007_05.pdf

1. PURPOSE

1.1 To provide guidance on the use of powers under s13za of the Social Work (Scotland) Act 1968 (the 1968 Act) or the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) when making and recording actions and decisions about the discharge from hospital of adults who lack capacity to act or make decisions for themselves.

2 BACKGROUND

The background to this guidance is an issue which arose about local authorities' use of their powers under part 6 of the 2000 Act. Local authorities have duties under the 2000 Act to apply for a guardianship or intervention order where that is necessary to protect the welfare (or financial affairs) of an adult with incapacity and no-one else is available or willing to apply.

In some areas a practice had developed of the Local Authority requiring an order to be obtained in all cases where an adult with incapacity was to be moved to residential accommodation, even where the adult was compliant and there was no disagreement as to the appropriateness of the service to be provided. This resulted in unnecessary delays in discharging patients from NHS hospital care when they were clinically fit. This directly conflicts with the Scottish Government's aim of ensuring that community care services are provided as quickly as possible following an assessment, and that such provision should be affected without recourse to the courts, unless that is necessary.

The Scottish Government's view was that local authorities implied powers under the 1968 Act were sufficient to allow them to move an adult with incapacity into residential care or provide them with community care services, depending on the circumstances of the case. To clarify the legal position in this area the Executive

consulted with relevant interest groups. The outcome was that Section 13ZA of the 1968 Act was inserted by amendment at Stage 3 of the Adults Support and Protection (Scotland) Act 2007. Section 13ZA makes it explicit that, where a local authority has, following an assessment of the adult's needs, concluded that the adult requires a community care service, but is not capable of making decisions about the service, they may take any steps which they consider necessary to help the adult benefit from that service. Local authorities must act compatibly with the European Convention on Human Rights (ECHR) and the power does not allow steps to be taken which would be incompatible with those rights, including depriving an adult of their liberty in terms of Article 5, ECHR.

2.1 **This guidance aims to:**

- Describe how the relevant duties and powers under the 1968 and 2000 Acts sit alongside each other;
- Promote and support good practice when major decisions require to be made on behalf of an adult who lacks capacity and;
- Ensure greater consistency in the way the legislation is implemented

2.2

This guidance applies to adults for whom decisions relating to care and support need to be made and who:

- Have complex and/or significant care needs; and
- May be incapable in relation to the decision/action in question; and
- There is no proxy or proxies with relevant powers in place or such an appointment is in process

3. Deciding how to proceed

The views of all parties must be sought including the adult, independent advocate (if they have one), GP, relevant family, carers, proxies (with powers other than those relevant here.)

S.13ZA cannot be used when:

- The adult has a guardian or welfare attorney with relevant powers[1]
- An intervention order has been granted relating to the proposed steps
- Application papers have been lodged in court for an intervention order/guardianship order relating to the proposed steps
- The adult has capacity to make his/her own decisions and give consent to care arrangements[2]
- All parties do not agree with the proposed care intervention

3.2 **Key elements to consider where the person lacks capacity to consent to the decision and/or action in hand and the local authority needs to act**

1 The involvement of any existing proxy with relevant decision making powers will be crucial. His/her consent will be necessary before the local authority is able to provide services to the adult.

2 If the adult has relevant capacity, then a decision by the adult to refuse services must be respected, even if no-one else agrees. NB The only exception would be in the rare circumstance that procedures under the Mental Health (Care and Treatment) Act 2003 could be appropriate e.g. where the person's refusal of treatment for mental disorder puts the person at risk to themselves or others.

on behalf of the adult to ensure the provision of services to meet assessed needs.

3.2.1 **Multi-disciplinary meeting/case conference**

Where the capacity to participate in discharge planning is in doubt, it will be necessary to convene a multi-disciplinary review/case conference to decide on

- How to take forward decisions on behalf of the adult and
- Address any ongoing concerns about the adult's need for safeguards to be put in place

The views of all relevant parties should be sought – including the adult, independent advocate (if they have one), GP, relevant family, carers, proxies (with powers other than those relevant here.)

3.2.2 **Preparatory meeting**

Prior to the case conference the care manager/social worker should consult with the adult, their independent advocate (if they have one), relevant family and their carer to discuss the steps that may be taken. The meeting should be used to provide info to the adult and their carer about how the decision making process works.

NB every effort should be made to maximise the capacity of the adult to make their own decision. Guidance on assessing capacity prepared by the Scottish Executive should be referred to: http://www.scotland.gov.uk/Publications/2008/02/01151101/0

3.2.3 **Initial Assessment of Capacity**

The care manager/social worker co-ordinating the review will have formed a preliminary view about the capacity of the adult to give consent to the proposed care plan. This will be based on direct contact with the adult, and from consultations with others as part of the assessment process eg nursing staff, SALT, etc. If there is a lack of clarity around the adult's capacity, and no consensus has been reached about the proposed care plan, then a formal assessment of the adult's capacity in relation to the area of decision making in question must be requested from a suitably qualified medical professional.

3.2.4 **The Multi-disciplinary meeting/case conference should take the following points into account:**

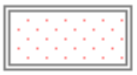
- The preferred outcomes and associated risks of the care plan under consideration
- The capacity of the adult must be assessed in relation to the decision in hand
- Where it is agreed the adult lacks capacity to make some/all of the decisions required, a consensus will have to be reached and a decision taken as to the appropriateness of powers under the 1968 Act.

4. In determining what course of action needs to be taken, the following key elements should be fully considered:

4.1 **Applying the principles** - The principles underpinning the 2000 Act must inform whatever steps are taken by the local authority http://www.mwcscot.org.uk/the-law/adults-with-incapacity-act/principles-of-the-act/

4.2 **Assessment of needs and risks**

Where the needs assessment gives rise to care and protection concerns, a specialist risk assessment may be needed. (refer to Tayside Multi-Agency Adult Support and Protection Protocol at; http://www.dundeeprotectsadults.co.uk/links.htm .) This will inform consideration as to whether an order is necessary in terms of the criteria set out in sections 53(3) and 57 (2) of the 2000 Act. This may include circumstances



where there is a severe family conflict about the future care of the adult, or where the adult themselves is resisting help.

4.3 **Deprivation of Liberty**

Consideration must be given as to whether the proposed care intervention would amount to a 'deprivation of liberty' under article 5, ECHR. Factors to consider in assessing whether a person is or is likely to be deprived of their liberty are set out in appendix 2.

4.4 **Assessment of financial management arrangements**

Welfare decisions often have financial implications therefore it will be necessary to assess whether the adult is also unable to manage his/her finances or deal with legal contracts (such as a tenancy agreement, or the sale of a house) in relation to the decision in hand. It will be essential to find out if anyone has relevant powers over the adult's property and finances. Where no arrangements are in place an assessment of the financial circumstances of the person will be needed in order to decide if any financial interventions will be appropriate. (see code of practice for local authorities, chapter 3 in the link.)

5. Recording decisions and informing interested parties

The minute of the case conference will provide the key record of decisions taken, including arrangements for future reviews. It is essential to record the decision about which power to use to provide service and the reasons for taking this decision (appendix 3 – AWI Decision Making Template). In addition to the record, a formal letter should be sent to the adult, his carer, relevant family, his/her primary carer, independent advocate and relevant professionals. The letter should:

- Inform them of the outcome of the case conference/review
- Confirm what care package and or actions were agreed; and
- State clearly whether or not an order under AWI Act is going to be sought, with reasons for the decision, and arrangements for the next review
- Information on their legal right to object

A copy of the letter should be place on the adult's file. (see letter template at appendix 4)

6. Monitoring and review

The decision will be reviewed in accordance with community care operational guidance and decisions made at the multi-disciplinary meeting.

It should be recognised that changes may occur for the individual and their relationship to the social and physical environment which could have implications for the power under which the local authority can act. Reviews should explicitly consider whether any such change affects previous decisions about whether the person is or is likely to be deprived of their liberty in terms of Article 5, ECHR.

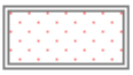
7. Quality Assurance

7.1 How decisions about 13ZA will be audited. A quality assurance case file audit will be undertaken annually to review decision making about 13ZA. A report and recommendations will be published.

8. EQUALITY IMPACT ASSESSMENT SCREENING: (low/medium/high)

Completed EQIA (template also available on SWIM) must accompany this procedure

9. Consultation:



10. Lead Officer for the Procedure:

a) Name:
b) Designation:
c) Telephone:

11. Procedure Approved by:

a) Name (Head of Service)
b) On (Date)

Appendices
1.When to use 13ZA
2. Deprivation of Liberty
3. Decision Making Template
4. Letter recording decision

AWI Decision-Making Template

Service User:	
URN:	
DOB:	
Date:	

Present:

Outcome of Assessment

Capacity Assessment (consider the specific ability to make decisions re- future care planning. Can the individual retain, understand, act and communicate)

Wishes of Service User (past and present wishes should be considered)

Wishes of Family/Carers

Views of Multidisciplinary Team

Consideration of Article 5 European Court of Human Rights (e.g. access to support, limitations of contact, freedom of movement, external environment, restraints, staffing)

Conclusion (consideration of least restrictive option)

Name

Designation

Date

CHECKLIST

	Please tick (✓) as appropriate Yes	No	Comments
Any existing proxy i.e. guardian, power of attorney			
Referral for advocacy			
Capacity assessment undertaken prior to meeting			
Is risk assessment required			
Deprivation of liberty considered (see Annex A, CCD5/2007)			
Financial management arrangements			
Minute of meeting to all relevant parties & in case file/medical notes			
Info provided re- right to object i.e. complaints procedure			