JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

West Dunbartonshire Partnership July 2021

Contents

Map showing divisional concern hubs

Joint inspection of adult support and protection in the West Dunbartonshire partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead these joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual [1]local partnership areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017- 2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the West Dunbartonshire area were safe, protected and supported.

The joint inspection of the West Dunbartonshire partnership took place between May and July 2021

1 https://www.careinspectorate.com/images/Adult_Support_and_Protection/1._Definition_of_adult_protection_partnership.pdf

Quality indicators

Our quality indicators[2] for these joint inspections are on the Care Inspectorate's website.

Progress statements

To provide Scottish Ministers with timely high-level information, this joint inspection report includes a statement about the partnership's progress in relation to our two key questions.

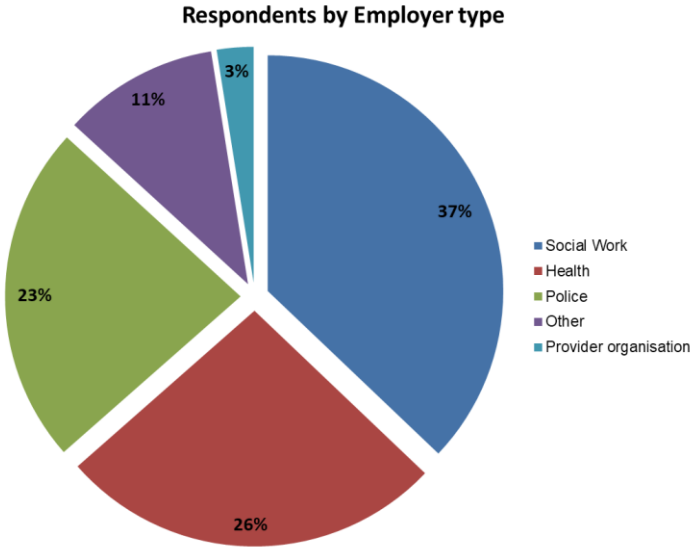
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

Joint inspection methodology

In line with the targeted nature of our inspection programme, the methodology for this inspection included four proportionate scrutiny activities.

The analysis of supporting documentary evidence and a position statement submitted by the partnership.

Staff survey. 159 staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The



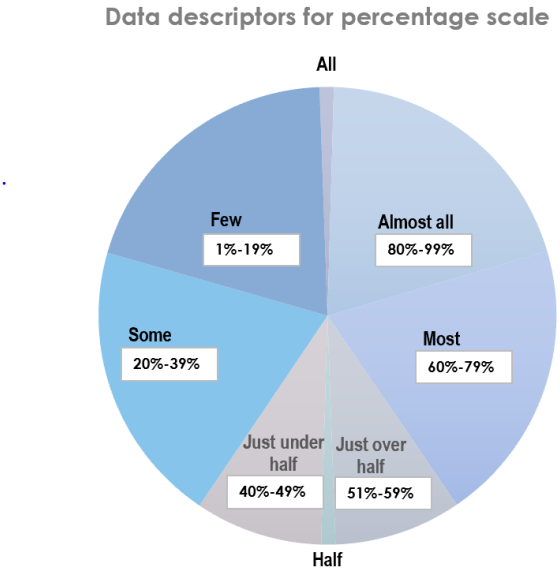
2 https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf

survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of fifty adults at risk of harm where their adult protection journey progressed to at least the investigation stage. It also involved the scrutiny of recordings[3] of thirty nine adult protection initial inquiry episodes where the partnership had taken no further action, in respect of further adult protection activity, beyond the duty to inquire stage.

Staff focus groups. We carried out two focus groups and met with twenty members of staff from across the partnership to discuss the impact of the Covid-19 pandemic on adult support and protection and adults at risk of harm. This also provided us with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Standard terms for percentage ranges



[3] We scrutinise the partnership's recording of the initial inquiry episode **not** the adult at risk of harm's records.

Summary – strengths and priority areas for improvement

Strengths

- The partnership made a sound decision to increase the capacity of their duty service at the beginning of the Covid-19 pandemic. As a result, screening and triage of adult support and protection referrals was accurate, timely, effective, and collaborative. Staff from across the partnership had a clear understanding of their roles and responsibilities in relation to adult support and protection.

- Adult support and protection investigations were routinely undertaken and effectively determined if the adult was at risk of harm.

- Partnership leaders responded well to the unprecedented strategic and operational demands of the Covid-19 pandemic. They ensured support was available to staff and provided good oversight of protection risks and recovery planning.

Priority areas for improvement

- The partnership should ensure that where criminality may have occurred inquiry and investigation activities are more joined up and robust.

- The quality of chronologies and risk assessments was inconsistent. The partnership should ensure there is training for staff aligned to the recently updated guidance.

- Some cases had no risk management/protection plan and/or did not progress to the initial adult protection case conference stage when they should have. The partnership should address these factors to ensure no adults are left at unnecessary risk.

- Partnership leaders need to strengthen their vision and direction for adult support and protection. This should include the long-term plan for the deployment of their temporary public protection and adult support and protection lead officer posts.

- Partnership leaders need to ensure staff are meaningfully engaged in self-evaluation and improvement activity.

- Police Scotland L division require to strengthen their recordings of inter-agency discussions and implement more robust audit, compliance, and governance regime. This should be at both single and multi-agency levels.

How good were the partnership's key processes to keep adults at risk of harm safe, protected and supported?

Key messages

- Screening and triage practice was timely and effective, with a well-resourced duty team using established referral processes. Good communication supported accurate decision making at the screening stage.
- All adults at risk of harm who needed additional support received it and most experienced an improvement in their life as a result of adult support and protection interventions.
- Council officers played key roles in adult protection investigations and were supported by second workers. Together they effectively determined if the adult was at risk of harm.
- Police Scotland and health were not routinely involved in adult protection inquiry and investigations where criminality may have occurred.
- The quality of risk assessments and chronologies was inconsistent. Business systems needed to be easier to work with. Further training for social work staff was needed to support improvement in this area.
- Risk management/protection plans were not consistently undertaken, and not all adults progressed to initial adult protection case conference when they should have. This meant some adults were not as well protected as they could have been.

We concluded the partnership's key processes for adult support and protection were effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

Adult social work services in West Dunbartonshire had a generic duty team that provided a single point of contact for all adult support and protection concerns and referrals. This team had a dedicated senior social worker rota responsible for overseeing screening and triaging all referrals where the person met the three-point test.[4] Onward referral pathways were well established. There was confidence in this system and staff were encouraged to make referrals through this process.

The duty team was well resourced. It had a range of social workers and social work assistants and was augmented with an additional back up council officer dedicated to adult protection activity, introduced during the Covid-19 pandemic. The additional council officer resource aided the partnership to effectively triage adult protection duty activities. Business support systems effectively supported senior social workers to make decisions. Communication amongst staff and agencies at this stage was good and assisted appropriate decision making with episodes reaching the correct stage nearly every time. Adult support and protection principles were adhered to and decisions around the three-point test were accurately made within timescale on almost every occasion.

The partnership also had an established vulnerable adult's multi-agency forum (MAF). This was a two weekly meeting which reviewed the circumstances of adults who generated repeat referrals and allowed for jointly agreed actions. Overall, the quality of work undertaken by social work staff at the screening and triage stage was strong.

Initial inquiries into concerns about adults at risk of harm

Records indicated that adult support and protection inquiries were appropriately carried on every occasion. Nearly all were completed in a timescale in keeping with the needs of the adults at risk of harm.

Nine of the 39 records read identified the need for a medical examination at the inquiry stage but importantly just under half of these were undertaken. Potential harm that may involve criminality must always be urgently addressed and the involvement of police and appropriate medical practitioners is vital to this process. The partnership had updated multi-agency guidance in May 2021 which explicitly stated that where sexual or physical harm had been alleged the police and appropriate medical assistance must be sought immediately. This was not always the case in

[4] The Adult Support and Protection (Scotland) Act 2007 defines adults at risk as individuals aged 16 years or over, who: 1) are unable to safeguard themselves, their property, rights or other interests; 2) are at risk of harm; and 3) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others not so affected.

the records we read. Despite good evidence of senior manager oversight across social work services, a few records indicated uncertainty and hesitancy around capacity, consent, and the principle of the least restrictive option at the initial inquiry stage.

Investigation and risk management

Chronologies

Staff recognised the importance of chronologies in adult protection work. While chronologies were available in most records, almost half were evaluated as weak or unsatisfactory. Additionally, a few (18%) of the records that should have had a chronology did not have one. Staff described this area of practice as 'work in progress'. The partnership had recently updated inter-agency adult support and protection chronology guidance which will be central to addressing the required improvement work. Staff were unclear about the best way to utilise the business support system to extract chronologies . The process was complex as there were a few ways to generate them. Resultantly, consistency was an issue. This also made it difficult to determine if chronologies had informed the council officer and senior social worker's decisions about ending or progressing adult protection activity. The partnership would benefit from finding ways of accurately recording and retrieving the version of each chronology used at the investigation stage for quality assurance purposes.

Risk assessments

There was an up-to-date risk assessment in almost all adult support and protection records. Almost all of these were timely and most were appropriately informed by other agencies. While those completed well had a good level of risk analysis the overall quality of risk assessments was variable. We evaluated just under half (45%) as good or better. Twenty-six percent were weak.

There was a lack of a consistency around how risk was being recorded on adult protection templates. Critically, in complex work the views of other key agencies were not sought on every occasion. Risk assessments should have evidenced closer joint working between the police and GP's where sexual, physical, and financial harm was identified. While the number of cases were comparatively small the issues were significant and had an impact on the outcomes for those adults involved.

More positively, the mental health and addiction services had developed and implemented a useful red, amber, green (RAG) system to accurately assess risk and determine the level of contact adults received during the Covid-19 pandemic. We agreed with strategic leaders about the benefits of this approach, and that it could be more widely developed and deployed across all adult services.

Full investigations

Adult support and protection investigations were appropriately completed in every record we read with council officers playing a key role in leading this work. Effective deployment of second workers was also a strength of the investigation process. On some occasions this role was appropriately undertaken by a health colleague although there was room for improvement in this area. On nearly every occasion, investigations were timely and effectively determined if the adult was at risk of harm and most were evaluated as good or better.

A significant number (26%) of investigations did not involve all the parties that should have been consulted. As with inquiry and risk assessment work, this mainly excluded the police and health partners. Good adult protection investigation work relies on close collaboration between partner agencies, and this was clearly an area the partnership needed to strengthen.

The partnership did not always progress from investigation to initial case conference where this would have been appropriate. Only sixty-five percent of adults at risk whose circumstances should have been progressed to an initial case conference from the investigation stage did so. These statutory meetings are critical in terms of the partnership's ability to fully understand the risks, formulate support and make jointly accountable decisions about intervention. Staff suggested two main reasons for this. Firstly, that inquiry and early intervention work effectively negated the need for onward protection activity and secondly, that there was a propensity amongst managers to put complex work back to social workers to manage the identified risks though ongoing casework/care management. We saw evidence of the latter being implemented even in cases where the three-point test, significant risks and need for ongoing complex protection planning arrangements were established during the investigation stage.

Adult protection case conferences

On nearly every occasion where required the partnership convened the initial case conference in a timely manner in keeping with the needs of the person. Case conferences effectively determined what needed to be done to protect the adult and in most instances the quality of the initial case conference was evaluated as good or better. Adults at risk of harm were well supported to attend initial case conferences. The partnership encouraged case conference chairs to undertake helpful preparatory work with adults and unpaid carers[5]. Adults in attendance at initial case conferences were also well supported to understand proceedings during these meetings.

[5] Unpaid carers provide care and support to family members, friends or neighbours. A carer does not need to be living with someone.

While those adults who attended were well supported at the initial case conference, just under half of those who should have been invited were not. The reasons for these omissions were not consistently recorded in the records or case conference minutes making it difficult to understand the rationale for their exclusion. Relevant professionals were invited to initial case conferences most of the time but actual attendance was variable.

Adult protection review case conferences

Review case conferences were appropriately convened. On every occasion they were timely and effective in determining what needed to be done to protect the adult and this was a strongly held view that staff also shared.

Implementation / effectiveness of adult protection plans

Significantly, there were only risk management plans in some records. Those that were in place were up to date and evidenced good collaboration with other agencies. The quality of most were evaluated good or better. Most of those completed evidenced that protection risks had been dealt with adequately. There was room for improvement in the consistency of recording and how SMART[6] these plans were.

The records of adults at risk of harm who did not have a protection plan, but should have, highlighted significant areas for improvement. Too often, protection planning fell to front line social work teams to follow up on and practice was disjointed. Some of these adults at risk of harm would have clearly benefited from an initial case conference and more formal protection approach. Thresholds were not consistently applied, and this had a significant impact on the outcomes for a few adults at risk of harm in West Dunbartonshire. The lack of protection planning allied to the lack of collaboration between social work, police and health in a few critical cases meant adults continued to be at risk of harm after the investigation had concluded and needed to be addressed by the partnership.

Where case conferences were undertaken there was a demonstrable difference to the overall quality of protection planning with almost all evaluated as effectively determining what needed to be done to protect the adult at risk of harm. Even so protection plans could still be SMARTER and more consistently formulated by chairs. Too often, chairs that had overseen the adult support and protection process from the beginning hosted case conferences. There was a risk was that this approach lacked objectivity and needed to be reviewed.

Large Scale Investigations

[6] SMART; Specific, Measurable, Achievable, Realistic and anchored in a Timeframe.

There was one Large Scale Investigation (LSI) within a local care home. This was thorough with a carefully planned person-centred approach. This large-scale investigation commenced Feb 2019 and concluded appropriately with a multi-agency outcome meeting in March. This was undertaken in accordance with the West of Scotland Interagency Guidance and West Dunbartonshire Large scale investigation procedures. These procedures were updated following the learning and improvement from this event. The large-scale investigation appropriately involved the council officers and all the other agencies including the Care Inspectorate, health, the provider, adults, families, and independent advocacy. A temporary moratorium was also put in place as an additional protection measure.

Collaborative working to keep adults at risk of harm safe, protected and supported.

Overall effectiveness of collaborative working

There was a strong and very positive view amongst nearly all (87%) staff in the partnership that they were encouraged to work collaboratively. During the pandemic this was more challenging for staff but there was a confidence amongst most of them that this had been maintained. This was supported by our analysis which determined that most records indicated a good or better level of joint working and information sharing. While this was the case overall, some areas for improvement were required particularly around inquiry, investigation, and protection management work.

The introduction of the adult protection single point of contact within the Police Scotland concern hub should have helped to focus on individual adult at risk concerns. While good discussions were happening between agencies the outcome of these were not always being consistently recorded. This made decision-making governance and accountability of this key decision-making arrangement difficult to determine. A more formal initial referral discussion arrangement would help to realise the benefits of this positive initiative.

Health involvement in adult support and protection

The staff survey indicated a strong level of confidence and positivity from health staff in relation to adult support and protection work and this was also reflected in our focus group. This included what to do and who to speak to should a concern arise about an adult at risk. Thirty-six health records were included in our file reading sample of fifty. In almost every case (92%) matters relating to adult support and protection were appropriately referenced. Where adults were repeatedly admitted to hospital there was evidence that good recording was taking place for health concerns that could have related to adult protection concerns. The interventions for those attending hospital were mostly positive including the small cohort attending accident and emergency departments. The quality of community health service interventions was more mixed.

While health services were raising some adult protection concerns with appropriate agencies, they did not always get feedback about the outcome. On most occasions health staff collaborated well with colleagues and other agencies and recorded this well in their case records. There were some records where matters relating to adult support and protection were not as clearly set out as they could have been and more collaboration at inquiry, investigation and case conference stages was required.

Police involvement in adult support and protection

Almost all contacts and enquiries to Police Scotland relating to adults at risk of harm were effectively assessed by service advisors who applied THRIVE.[7] In almost all instances the STORM Disposal Code (record of incident type), were accurately determined.

In most records the initial enquiry officers' actions were evaluated as good or better, and assessments of risk of harm, vulnerability and wellbeing were accurate and informative. Some police records would have benefited more from a greater focus on the adult at risk of harm. This would have added value to information shared with other agencies. In just over a half of cases the quality of initial inquiry supervisor oversight was viewed as being good or better indicating room for improvement in this area.

The existence of a direct lines of communication between partners and the Divisional Concern Hub was positive with regards to the sharing of information on adult protection concerns. However, there was limited evidence in police records that these discussions were being formally recorded. Consequently, there was no detail to reflect subsequent police action, and why, or to support and inform future decision making. On occasions this inhibited the adult support and protection process, including cases where potential criminality was involved leading to significant delays in investigations being initiated in some instances. This lack of recording was an important aspect of practice that needed strengthened as it had an impact on the outcomes for a few adults at risk of harm.

The divisional concern hub in most cases referenced their triage process to assess and determine risk prioritisation. This was helpful but in some cases there was evidence of undue delay in referrals being shared with the partnership. In a significant minority of cases adult protection referrals were not shared due to "the passage of time". Robust analysis and more intrusive governance would have improved information sharing time intervals. Better interrogation of SCOMIS would support enhanced governance arrangements.

It was noted that resilience matrix assessments were not shared with partners. This practice is out of step with national police guidance. A review of information sharing practices is required to ensure all measures are taken to improve outcomes for adults at risk.

Evidence of limited use of the Force Escalation Protocol appeared to be at odds with national guidance. Consequently, the divisional concern hub was dependent on the partnership to coordinate multiple referrals and escalating risks. The protocol, initiated through the hub, could have

[7] A proportionate assessment of threat, potential harm, risk, investigative opportunity and vulnerability when determining the engagement (THRIVE) required to resolve the reported concern.

generated supportive interventions in a coordinated way following repeat calls or escalating concerns.

Third sector and independent sector provider involvement

In the main the responses to our survey were positive and the third and independent sector made a strong contribution to adult support and protection. Access to regular training and responses to strategic leadership questions highlighted areas the partnership should explore further.

Provider organisations were at the centre of adult support and protection in West Dunbartonshire and supported some of the most complex and high-risk adults. Overall, our analysis showed they undertook this work to a high standard and in collaboration with other agencies. They attended key meetings and discussions, were responsive, flexible and supportive partners and this was shown in a number of records we read and also in the large-scale investigation work undertaken by the partnership in 2019. In our focus group with strategic leaders, it was highlighted that care home providers have been under enormous pressure during the pandemic. The partnership had to work hard to maintain the balance between support and oversight. Their care home assurance and governance framework supported this.

More work needed to be done to address some gaps in knowledge about what to do when confronted with an adult protection concern. We highlighted examples of this to the partnership for further consideration. Both threshold and revised multi-agency guidance had recently been introduced which should help to strengthen practice in this area.

Key adult support and protection practices

Information sharing

Referrals that required no further action and those that progressed to investigation or beyond were made from a wide range of organisations. In duty to inquire work these were shared in a timely manner. The subsequent communication between protection partners was good and fostered an effective and efficient decision-making framework.

In cases that went to investigation and beyond the same principles generally applied although importantly, there were a small number of critical cases where improvement was needed. The lack of information sharing identified in these instances centred around core agencies including social work, health, police, and provider organisations. Stricter adherence to the partnerships revised guidance will be essential to drive the required change forward. These documents clearly set out the legal framework and practice requirements for staff to consider. The newly appointed adult support and

protection lead officer should be well placed to embed the required improvement.

Management oversight and governance

Oversight of adult support and protection screening and triage activity across adult social work services was very strong. Almost all referrals processed through the duty system had clear evidence of this. This was also a positive feature of subsequent social work protection activity where discussions between front line staff and managers were consistently recorded. Social work managers were actively reading and exercising governance over records. Improvement was required to ensure that partner agencies were involved in aspects of key processes, particularly where possible criminality arose. Oversight should also ensure that adults at risk of harm requiring an initial case conference received one.

Almost all Police records reflected management/supervisory input. However, police hub managers should further evaluate their local governance structures to ensure that all involved are best placed to bring appropriate levels of oversight to the relevant stages of the adult support and protection process. There was less evidence for management oversight for health records. It is recognised that management oversight in all health records is not typical in clinical practice.

Involvement and support for adults at risk of harm

There was good evidence that nearly all adults at risk of harm were involved in most aspects of adult support and protection activity including inquiry, investigation, and protection planning. There was room for improvement at the case conference stage.

Where adults at risk of harm and unpaid carers attended case conferences they were well prepared and supported to express their views. The use of an adult support and protection feedback questionnaire had the potential to augment the good practice in this area of work.

While this was positive there was several case conferences where the adult did not attend and the reasons for this were not clearly recorded in the minute of the case conference. While attendance is not always expected, necessary or beneficial for every adult at risk, it is critical that the reasons for are clearly noted to demonstrate their involvement in line with the principles of the legislation.

Independent advocacy

There was evidence that independent advocacy was offered in just over half of the cases we read. There were a few examples where it should have been offered but wasn't. Our analysis showed the reasons for this were

variable and often not clearly outlined in the records. Even where adults were offered this vital service only some took it up. Where they did the service was prompt and the impact was determined to be very positive.

Capacity and assessment of capacity

There was evidence of concerns about the adult's level of capacity in just under half of the records we read. In most of these instances, a formal request for a capacity assessment was made. Most of those requests made to the relevant medical practitioner were carried out in a timely manner. There were a few cases where adults did not receive or waited too long for the assessment they required. The partnership should strive to build on the foundations of this joint work to ensure that further improvement in this critical area of practice is made.

Financial harm and perpetrators of all types of harm

Financial harm was a prevalent cause of harm in the adult support and protection cases we read. Verbal coercion being the most common approach applied to access finances from the adults at risk of harm.

A few records indicated that significant amounts of money were involved. In almost every case the partnership worked collaboratively to stop the harm, and this was mostly achieved working alongside the appropriate financial institutions.

While the outcomes for adults at risk of harm were mostly positive there was evidence across the records that key processes were not as efficient as they could have been. Statutory powers were considered but there were a few missed opportunities for early intervention and protection work between agencies. Intelligence wasn't always shared between agencies and responses to concerns on a few occasions were not decisive enough leaving vulnerable adults exposed to further risk unnecessarily. A draft standard operating procedure was distributed at the beginning of 2021, and the adult protection committee were considering a financial harm sub-group. These measures should help to strengthen the partnerships approach to financial harm.

Safety outcomes for adults at risk of harm

All adults at risk of harm who needed additional support received it and most (74%) had experienced the improvement in their life that you would reasonably expect to see. This was primarily because of effective multi-agency working across the various adult support and protection partnership agencies in these situations. While this was positive some adults at risk did not experience this favourable outcome and for just over half of this cohort gaps in multi-agency working was the primary cause. The lack of a strong

collaborative approach to risk management and planning for some of those individuals who did not progress to adult protection initial case conferences was the main reason for this.

Adult support and protection training

Adult support and protection training was set out as a clear priority for the partnership, but progress had stalled. Between 2018-20 they had successfully grown the multi-agency training programme. This included a wide range of opportunities and was attended by just under seven hundred staff from all agencies playing key protection roles. Staff were confident the partnership provided the right amount of mandatory training.

Strategic leaders and front-line staff acknowledged recent challenges for the partnership with training. These included both the impact of Covid-19 and the impact of not having a dedicated adult support and protection lead officer in post. The latter was a point acknowledged by staff who also recognised and missed the past influence of that role in delivering training. Receiving this training was essential because where it took place it impacted on the staff protection role understanding, confidence and practice.

The partnership had very recently appointed someone in that crucial adult protection lead officer role on a temporary basis. They also had undertaken a helpful training survey and re-designed their 2021-22 training programme accordingly and these measures should combine to help accelerate progress. While these were early signs of this there was still work to do to re-establish this essential programme including the use of e-learning opportunities which was under used. Importantly, council officer and basic awareness training were delivered as core elements of the training programme during the restricted period. In addition to this health had commendably delivered their public protection training to almost all applicable health staff during the restricted period.

How good was the partnership's strategic leadership for adult support and protection?

Key messages

- The strategic leadership team, supported by the third sector, played a critical early intervention and prevention role in monitoring the wellbeing of vulnerable adults in during the Covid-19 pandemic.
- Partnership leaders responded well to overseeing the unprecedented strategic and operational demands of the Covid-19 pandemic.
- Partnership leaders shared a collaborative ethos but needed to strengthen this in critical areas of operational practice.
- Partnership leaders needed to strengthen their vision for adult support and protection both in strategic documents and in their commitment to appointing to permanent key strategic posts.
- Partnership leaders need to ensure staff are actively involved in continuous improvement activity including audit and self-evaluation activity.
- Police Scotland L division leaders should oversee the strengthening of some key communication and information sharing partnership arrangements. This includes recording of inter-agency discussions.

We concluded the partnership's leadership for adult support and protection was effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

Vision and strategy

The vision and strategy for adult support and protection in West Dunbartonshire was not articulated as clearly as it could have been in the strategic documents. Neither the biennial report nor supporting evidence provided a clear vision statement. The adult protection committee had an improvement plan for 2019-22 that was aligned to the West Dunbartonshire biennial report, but it was unclear how widely circulated, or well understood, this was across the partnership. Importantly, the need for a clearer vision was a view shared by staff and more needed to be done by partnership leaders to address this.

Effectiveness of strategic leadership and governance for adult support and protection across partnership

There was evidence of a collective approach to leadership across the partnership including the third sector. They played a key early intervention and prevention role during the Covid-19 pandemic by undertaking a high volume of frequent welfare calls to vulnerable adults across the community. Collaboration was also reflected in the adult protection committee which had strong representation from across the key partners.

Both the public protection chief officer's group (PPCOG) and clinical and care governance group provided the necessary oversight work for adult support and protection activity across the partnership. These groups, and other strategic groups such as the integration joint board, had responded well to the challenges of the Covid-19 pandemic and had appropriately escalated the frequency of their oversight meetings. This was instrumental in enabling them to keep a close, and effective watch on their risk register and key performance indicators, including those relating to adult support and protection work. This provided assurances around aspects of key processes.

The partnership had not had a permanently appointed adult support and protection lead officer since early 2020. Efforts to address had been made without success. Another temporary appointment had been made just prior to our inspection. The impact of this was evident in some critical areas of leadership and governance including the adult protection committee (APC) business continuity, adult protection training and development, self-evaluation, improvement activity and analysis of key adult protection performance information. In recognition of these gaps the partnership had recently agreed to appoint to a public protection learning and development, and audit/quality assurance post in addition to the lead officer post. While these were positive developments, these key roles were all temporary in nature further undermining certainty and continuity for staff. Just under half in our survey agreed local leadership of adult support and protection was effective and addressing this will help to improve the staff outlook.

The partnership would also further benefit from re-establishing adult protection committee sub-groups. These are typically the engine rooms that support the necessary quality assurance, audit, policy, and improvement activity.

Delivery of competent, effective, and collaborative adult support and protection practice

There was a positive collaborative ethos amongst strategic leaders in the partnership, but this was not always reflected in the practice we inspected. Partnership leaders were confident the Covid-19 pandemic had drawn the leadership team closer together and they had worked hard through the restricted period on adult protection matters. We saw evidence of this in key documents such as the Chief Social Work Officer situation reports, biennial report and both the APC minutes and improvement plan 2019-22. In addition, effective oversight of protection issues was increased and maintained during Covid 19 by the partnership with frequent key performance reports submitted for assurance purposes.

Leaders encouraged joint initiatives that were developing on the ground. Some positive examples included the vulnerable adult multi-agency forum (MAF), the adult support and protection single point of contact within the police concern hub and early joint work to address financial harm. The partnership was positively adopting the learning from the independent work they commissioned including the independent audit of adult support and protection completed in June 2021. Many of these measures were very recent meaning it was too early to determine their effectiveness and full impact.

The partnership need to progress their planned improvement activity to address key aspects of collaborative practice. Multi-agency guidance in critical cases was not always applied and the involvement of health and police in cases that included potential criminality should have been stronger. Closer joint working was also required to support those individuals without protection plans who should have progressed to case conference. The partnership leaders had an important role to play to ensure that staff across the partnership worked more closely together and in line with guidance to protect the most vulnerable adults in their communities.

Quality assurance, self-evaluation, and improvement activity

Social work managers routinely audited adult support and protection activity across their teams each month they audited practice in line with the recently introduced case file audit framework. This framework included discussions in supervision (level 1 of the recently drafted case file audit framework) and use of an audit template to screen the quality of work in a small number of cases in each service on a rolling basis (level 2). The focus of the subsequent performance reports provided to the PPCOG were primarily

around level 2 audit activity and timescales in relation to key processes. We saw from recent performance and assurance framework reporting that these findings were scrutinised by the PPCOG and were generally positive.

Level 4 of this framework related to multi-agency case file audits. The partnership had not undertaken any recent level 4 (multi-agency case file audits) audit activity. This was primarily because of Covid-19 but also was affected by the lack of an adult support and protection lead officer to play the key coordinating, analysis, and improvement roles in this area of work. In recognition of this the partnership commissioned an independent review of their adult support and protection processes at the beginning of 2021 which highlighted a few strengths and areas for improvement. The partnership had responded and developed an improvement plan based around the findings of the June 2021 report.

There was recognition amongst the partnership leaders that the new lead officer posts recently agreed will need to work closely together to re-design and fully implement this critical aspect of quality assurance, self-evaluation, and strategic improvement work.

Most staff were not confident that strategic leads knew about the quality of work or evaluated the impact of the protection work. Staff were not consistently involved in evaluating the impact of the work they did to inform improvement activity. The new post holders would benefit from developing the role of staff in this area of work. It needs strengthened if front line staff involved are to fully recognise and understand the positive impact of self-evaluation and improvement work and for staff to support continuous improvement in adult support and protection practice.

Initial case reviews and significant case reviews

The partnership appropriately undertook and effectively managed all aspects of an initial case review in 2020. A review steering group was established and in February 2021 the lead for the practice review was identified and the work progressed with commissioning and information sharing arrangements completed and in place. This work was being concluded at the time of the inspection with a firm plan to report its findings back to the next adult protection committee for final consideration.

Both the PPCOG and clinical and care governance group had key oversight roles in establishing the terms of reference and monitoring the progress of the improvement action plan.

Impact of Covid-19

Overall, the partnership leadership team had responded well to the Covid-19 pandemic. Strategic planning and delivery groups revised their constitutions and appropriately increased the frequency of the key oversight meetings. Systems were put in place to support Scottish Government reporting requirements and the COG had effective oversight relevant performance reporting information and data throughout. Risk registers and recovery planning included a public protection focus.

Most staff felt supported and valued throughout the restricted period although Police Scotland staff were less so. Early challenges were highlighted by staff but there was a confidence that over the period these were positively addressed. The leadership recognised the importance of maintaining a robust duty system and augmented the service well with additional staff resources. Staff recognised the additional work at the 'front door' but felt it provided additional assurances for how they managed work involving adults at risk of harm. Critically, home visits to those at most risk were sustained as was the delivery of adult support and protection key processes.

Communication between staff and agencies was challenging. There were numerous systems to work across and they were not all compatible. Keeping in touch with colleagues or sharing information was understandably more difficult than before but was still being achieved. The partnership had made progress in the development of IT solutions and throughout the pandemic staff and front-line managers had developed more innovative ways to support each other. The leadership team had ensured they provided staff groups with access to the relevant support services in an effort to maintain staff wellbeing across services and agencies.

Overall, adult support and protection services were maintained. This was positive but the staff survey indicated a significant dip in the level of positivity amongst staff about the robustness of nearly every key process. This was understandable but the partnership should use the learning to strengthen the resilience of the work force against any similar future events.

Summary

Overall, the quality of adult support and protection services in West Dunbartonshire was mixed. The front door duty services had been appropriately augmented by the partnership leadership team and the benefits of this was positively reflected in the quality of this work. While adult support and protection screening and triage activity was undertaken very well there were critical aspects of key processes that needed the urgent attention and improvement. Staff and front-line managers needed to follow the guidance more closely, particularly where criminality was or may have been a factor. Communication and collaboration in these instances needed strengthened to ensure inquiry and investigation work was more joined up and outcome focussed.

The quality of chronologies, risk assessments and risk management/protection planning also need to be more consistent. The partnership should review investigation outcome thresholds to ensure that all the adults who should go to initial case conferences do so. It is an important protective planning measure, and where they do occur, it is important the reasons for any adult not attendance is more clearly recorded.

Since the beginning of 2020 the partnership had made attempts to permanently appoint to the adult support and protection lead officer. This had undoubtedly impeded the partnership's ability to consistently undertake analysis, audit, self-evaluation, learning and development and improvement activity. The partnership's leadership team had found it difficult to recruit to this position and the impact of this had caused gaps between adult protection operational delivery and strategy to develop. Communication between staff and leaders was not as strong as it could have been.

The partnership had recognised this and created new posts in key positions to address this, but they too were temporary in nature risking similar issues arising. Staff would benefit from a more stable adult protection leadership team and much work still needed to be done to consistently build on some of the good work we saw being undertaken. The partnership had responded appropriately to the independently commissioned report, and we saw evidence of some early improvement progress. This was at an early stage, and it was too early to determine the impact of this work. Both this, and our inspection have provided the partnership with the necessary baseline for future improvement work. There were critical issues raised with the partnership during file reading week that require further response from the joint leadership team.

The leadership team should take this opportunity to refresh their vision and work collaboratively to better govern and oversee the necessary change

and improvement work. The effective involvement of front-line staff in this work going forward will be critical to its success.

Next steps

We ask the West Dunbartonshire partnership to prepare an improvement plan to address the priority areas for improvement (see priority areas for improvement we identify). The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and HMICS will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key processes

Initial inquiries into concerns about adults at risk of harm scrutiny recordings of initial inquiries

- 97% of initial inquiries were in line with the principles of the ASP Act
- 100% (2 cases) of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 0% delay (0 Cases) in the concern hub passing on concerns by less than one week, 0% (0 Cases) were delayed by one to two weeks
- 82% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 97% of episodes where the three-point test was applied correctly by the HSCP
- 95% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% (1 Case) less than one week, 0% one to two weeks, 50% (1 Case) two weeks to one month, 0% one to three months
- 87% of episodes evidenced management oversight of decision making
- 90% of episodes were rated good or better.

Staff survey results on initial inquiries

- 95% concur that the partnership accurately screens initial adult at risk of harm concerns, the remaining 5% didn't know
- 88% concur they are aware of the three-point test and how it applies to adults at risk of harm, 6% did not concur, 6% didn't know
- 75% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 6% did not concur, 19% didn't know
- 83% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 7% did not concur, 10% didn't know

Information sharing among partners for initial inquiries

- 87% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm, staff survey results (purple)

Chronologies

- 80% of adults at risk of harm had a chronology
- 24% of chronologies were rated good or better, 76% adequate or worse
- 80% concur chronologies form an important feature of ASP investigation reports, 9% did not concur, 11 didn't know

Risk assessment and adult protection plans

- 84% of adults at risk of harm had a risk assessment
- 45% of risk assessments were rated good or better
- 50% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 76% of protection plans were rated good or better, 24% were rated adequate or worse
- 77% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors the remaining 23% didn't know.

Full investigations

- 88% of investigations effectively determined if an adult was at risk of harm
- 90% of investigations were carried out timeously
- 76% of investigations were rated good or better

Adult protection case conferences

- 65% were convened when required
- 92% were convened timeously
- 57% (4 Cases) were attended by the adult at risk of harm (when invited)
- Police attended 67%, health 83% (when invited)
- 69% of case conferences were rated good or better for quality
- 92% effectively determined actions to keep the adult safe
- 85% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences the remaining 15% didn't know

Adult protection review case conferences

- 70% of review case conferences were convened when required
- 100% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 88% of adult protection concerns were sent to the HSCP in a timely manner
- 65% of inquiry officers' actions were rated good or better
- 36% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 75% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 69% good or better rating for the quality of ASP recording in health records
- 75% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 50 adults at risk of harm and staff survey results (purple)

Information sharing

- 90% of cases evidenced partners sharing information
- 96% of those cases local authority staff shared information appropriately and effectively
- 84% of those cases police shared information appropriately and effectively
- 91% of those cases health staff shared information effectively

Management oversight and governance

- 80% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 90%, police 91%, health 55%

Involvement and support for adults at risk of harm

- 89% of adults at risk of harm had support throughout their adult protection journey
- 91% were rated good or better for overall quality of support to adult at risk of harm
- 76% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 6% did not concur, 18% didn't know

Independent advocacy

- 78% of adults at risk of harm were offered independent advocacy
- 39% of those offered, accepted and received advocacy
- 91% of adults at risk of harm who received advocacy got it timeously.
- 83% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy, 11% did not concur, 6% didn't know

Capacity and assessments of capacity

- 79% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 68% of these adults had their capacity assessed by health
- 92% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 36% of adults at risk of harm were subject to financial harm
- 39% of partners' actions to stop financial harm were rated good or better
- 47% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 74% of adults at risk of harm had some improvement for safety and protection
- 100% of adults at risk of harm who needed additional support received it
- 69% concur adults subject to ASP, experience safer quality of life from the support they receive, 9% did not concur, 22% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 47% concur local leaders provide staff with clear vision for their adult support and protection work. 20% did not concur, 33% didn't know

Effectiveness of leadership and governance for adult support and protection across partnership

- 48% concur local leadership of ASP across partnership is effective, 15% did not concur, 37% didn't know
- 45% concur I feel confident there is effective leadership from adult protection committee, 16% did not concur, 39% didn't know
- 30% concur local leaders work effectively to raise public awareness of ASP, 23% did not concur, 47% didn't know

Quality assurance, self-evaluation, and improvement activity

- 38% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 13% did not concur, 49% didn't know
- 41% concur ASP changes and developments are integrated and well managed across partnership, 16% did not concur, 43% didn't know