JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

East Dunbartonshire Partnership March 2024

Contents

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

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

Phase two

This programme follows our phase one inspections. We published an overview report which summarised the findings and key themes identified. Phase two is closely linked to the Scottish Government's improvement plan for adult support and protection, and the national implementation groups which support it.

The joint inspection focus

Phase two joint inspections aim to provide national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. We also offer a summary of the partnerships' progress since their inspection in 2017.

Updated codes of practice were published in July 2022. In recognition that adult protection partnerships were at different stages of embedding these, we issued a single question survey to all partnerships in Scotland. This asked respondents to describe their approach to inquiry and investigation work and outline the role of council officers. Twenty-two partnerships responded, and findings showed that practice and adoption across Scotland is variable, with most areas having work to do in this respect. The East Dunbartonshire partnership had fully adopted the codes of practice.

The focus of this inspection was on whether adults at risk of harm in the East Dunbartonshire partnership area were safe, protected and supported.

The joint inspection of the East Dunbartonshire partnership took place between October 2023 and February 2024. We scrutinised the records of adults at risk of harm for the preceding two-year period from October 2021 to October 2023.

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.

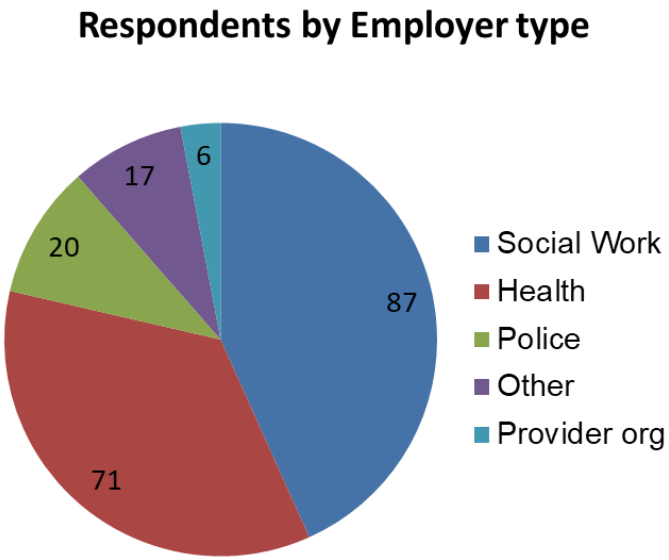
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

Joint inspection methodology

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

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

Staff survey. Two hundred and one 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 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.

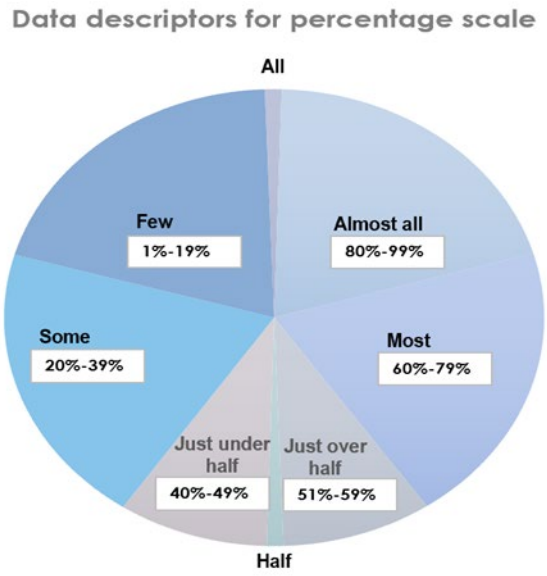


The scrutiny of social work records of adults at risk of harm. This involved the records of forty adults at risk of harm who did not require any further adult support and protection intervention beyond the initial inquiry stage.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of forty-two adults at risk of harm for whom inquiries have used investigative powers under sections 7-10 of the 2007 Act. This included cases where adult support and protection activity proceeded beyond the inquiry with investigative powers stage.

Staff focus groups. We carried out three focus groups and met with 36 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm.

Standard terms for percentage ranges



Summary – strengths and priority areas for improvement

Strengths

- Adult support and protection inquiries were undertaken in line with the revised code of practice. They were comprehensive, collaborative, and effectively determined whether the three-point criteria was met.

- The quality of completed chronologies was a clear strength. Strong collaboration and promotion of a trauma informed approach supported effective decision making and protective actions.

- Adult support and protection investigations were competent and comprehensive. A significant number of health professionals were trained as second workers. This ensured that adults at risk of harm benefitted from a collaborative and multi-agency approach.

- Strategic leaders effectively communicated the joint vision for adult support and protection. This was well understood by staff at all levels.

Priority areas for improvement

- The partnership should promote more consistent use of chronologies to inform analysis and better reflect the impact of life events on the adult at risk of harm.

- The partnership should ensure that risk assessments are undertaken, and case conferences held for all adults at risk of harm when necessary. These are key components of protection and support for adults and will improve how protection risks are identified and mitigated.

- The partnership's self-evaluation framework should be assessed and refined to ensure it can identify all areas for improvement. This will strengthen leadership and governance of adult support and protection practice across the partnership.

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

Key messages

- Initial inquiries effectively determined whether adults were at risk of harm. All initial inquiries that involved investigatory powers were undertaken by a council officer, in keeping with the adult support and protection code of practice.

- Comprehensive and timely investigations were conducted for adults who required them. Health professionals were effectively deployed as second workers when necessary.

- Completed chronologies were of a high standard. The well-designed format was co-designed with staff and supported trauma informed practice. However, chronologies were not completed for some adults at risk of harm who needed one.

- Case conferences effectively determined what was needed to keep an adult at risk of harm safe. Police and health always attended when invited. The reasons why adults did not attend needed to be more accurately recorded in the minutes of meetings.

- Half of adults at risk of harm did not have a risk assessment and some adults did not have a case conference when they should have done. Although the quality of those completed was high, protection planning was inconsistent.

- The application of local guidance linking the risk assessment and management procedure (RAMP) was inconsistent. Some adults at risk of harm subject to RAMP were therefore denied access to the safeguards adult support and protection legislation offered.

- Referrals to independent advocacy were not consistently made limiting the adult at risk of harm's ability to express their views and wishes.

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.

Screening and triaging of adult protection concerns

All adult support and protection referrals and adult concern reports were recorded on the social work IT system upon receipt. This was overseen by the shared services business support team. Referrals were then forwarded on to the relevant specialist or locality team where social work team managers or deputising senior practitioners screened all referrals and concern reports within one working day.

All adult protection referrals automatically triggered a duty to inquire under the Adult Support and Protection (Scotland) Act 2007 unless there was already an ongoing inquiry. Adult concern reports sent by the police were also escalated to an adult protection inquiry where warranted.

Decisions to progress to an adult support and protection inquiry, were accurately recorded as an outcome of the screening process.

Repeat adult support and protection referrals or adult concern reports received within a six-month period were escalated to service manager level for a review of the circumstances. Multi-agency meetings were frequently used options to share information and agree a pathway for intervention if necessary.

Initial inquiries into concerns about adults at risk of harm

The partnership was an early adopter of the Scottish Government's revised code of practice for adult support and protection. It took positive steps to align social work capacity and resources to ensure requirements were met. These measures contributed to significant improvement in the quality of practice since the 2017 inspection.

Commendably, every initial inquiry where investigative powers were enacted was carried out by a council officer in a timely manner. The quality of almost all inquiries were good or better and completed in keeping with the principles of the act. The three-point criteria was almost always correctly applied. Communication between multi-agency partners at this early stage was effective. Strong management oversight also complemented this effective area of practice. This level of collaboration supported effective decision making and consequently every episode reached the right stage of the adult support and protection process. In just over half of initial inquires, the adult at risk of harm was informed of their rights and that they were subject to adult support and protection activity.

Interagency referral discussions

Following a pilot in 2018, interagency referral discussions (IRDs) were included in East Dunbartonshire partnership's local adult support and protection procedures. They were managed under a joint protocol agreed by social work, Police Scotland, and health and could be initiated by any partner.

While this was a very positive step taken by the partnership, IRDs were under-utilised. This limited the potential benefits for considering and mitigating against risk of harm. A more consistent approach would strengthen practice.

Inquiries including the use of investigatory powers

Chronologies

Where chronologies were completed, the quality was good or better in almost all cases reflecting a significant strength in this area of practice. This was aided by a well-designed tool available for and used by both child and adult protection services. Strengths included the concise level of detail recorded and clear layout of key events. This supported a trauma-informed approach that enabled staff to recognise and take account of past and present complex life events.

Some records that should have contained a chronology did not. The partnership's own audits showed more work was needed to ensure that all adults at risk of harm benefitted from this commendable approach.

Risk assessments

There was a risk assessment in half of the records we read. Where available, all were timely and nearly always informed by multi-agency partners' views. The quality of those completed was mostly good or better. Positive features of completed risk assessments included the comprehensive level of detail and analysis of risk.

While the overall quality of completed risk assessments was high, the partnership must address the significant number of adults at risk of harm with no risk assessment in their record. Risk assessments in cases not progressing to case conference should be an area of particular focus. Risk assessment is a critical area of practice that should be addressed to ensure all adults are safe from harm.

The partnership identified that risk assessment practice required improvement and targeted improvement actions were ongoing.

Investigations

Almost all records included a comprehensive investigation. Positively they were timely, and appropriate parties were involved every time including council officers. Where second workers were needed, they were almost always deployed including where health professionals were needed. The quality of most investigations was good or better and almost all effectively determined if the adult was at risk of harm. There was a combined inquiry and investigation template co-designed with staff that supported this work. This template contributed to effective work in this important area of practice in accordance with the code of practice.

Adult protection initial case conferences

Where case conferences took place, they effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported. The quality of case conferences was positive with almost all being good or better. Case conferences were almost always undertaken in a timely manner with most involving the relevant professional parties. Health and police attended every time they were invited.

Just under half of cases should have progressed to the initial case conference stage but did not. For those cases that failed to progress, this meant the adult missed the opportunity to benefit from careful protection analysis and planning. A common diversion for those who should have progressed was the use of various pre-planning meetings and the Risk Assessment and Management Procedures (RAMP). Senior staff were clear that the RAMP process was specifically for complex cases that did not meet the three-point criteria, but we found this varied. Both processes were coupled together with adults frequently passing between the two processes. There was inconsistency of practice in this area of work.

The adult's attendance at case conferences is important but sometimes not appropriate. Almost all records showed that adults were not invited to case conferences with the reasons evident just under half the time. The commitment to carer involvement was clearer. They were always invited where appropriate, were well supported and attended every time.

Adult protection plans / risk management plans

Protection plans were completed when an initial or review case conference decided that one was necessary to manage risk under adult support and protection or RAMP. Cases that did not progress to case conference did not benefit from a risk management plan. Some records did not have a protection plan when they should have. This was an area of practice needing some attention. All of those completed were up to date and almost all reflected the input of multi-agency partners. The quality of most was good or better.

Adult protection review case conferences

The picture for review case conferences mirrors the issues in the initial case conferences. They were timely, of good quality and effectively determined how to keep the adult safe when they took place. Just under half the time they did not take place when they should have.

Implementation / effectiveness of adult protection plans

The partnership used core group meetings where relevant, to review allocated actions of protection plans arising from adult support and protection case conferences. Where protection plans were in place, they were almost always collaborative and effectively determined what was needed to keep the adult at risk of harm safe. The quality of protection planning for adults who did not move on to case conference was mixed. Too often the records did not detail what needed to be done to keep adults safe from harm.

Large-scale investigations

The partnership recently updated its large-scale investigation guidance in 2023. No large-scale investigations had been conducted during the inspection timeframe.

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

Overall effectiveness of collaborative working

The partnership broadly followed the West of Scotland interagency adult support and protection practice guidance 2019. The partnership has diverged from the West of Scotland guidance for areas related to the Scottish Government's revised code of practice. Local operational adult support and protection procedures were updated in 2023 and took account of these changes. They were well embedded and supported confidence amongst staff.

The partnership recently implemented a public protection website with both public and staff facing pages. Although the adult protection pages still required some development, they allowed staff to access policies, procedures and other relevant documents more easily.

Staff felt they were well supported to work collaboratively. There was strong collaboration evident in key areas of practice including investigations and case conferences. Health and police attended all case conferences when invited and it was clear from case conference minutes that agencies collaborated to support and protect adults at risk.

Health involvement in adult support and protection

Community-based health services in the partnership area were well organised and effective. Key health staff at all levels were often co-located with social work colleagues which promoted effective networking and knowledge sharing. A dedicated joint team worked closely with care home providers. The integrated care home support team addressed care home related referrals in a timely manner and supported improvements in practice that reduced risks to adults living in these settings.

NHS Greater Glasgow and Clyde provided acute hospital services. In line with the NHS public protection accountability and assurance framework, the NHS board recently developed a public protection strategy and service. The public protection leads attended the adult protection committee to ensure clear links and information sharing.

Health staff made referrals for adult support and protection in some of the cases. Timely feedback was provided to the referrer in most instances. Health staff fully understood their role and what to do when concerns about an adult at risk of harm arose. They were confident about appropriately escalating matters relating to adult support and protection and applying the three-point criteria.

The quality of community health services interventions was always good or better. The interventions provided following emergency readmissions were mostly good. Medical examinations were always carried out when required. Commendably, suitably qualified health professionals were always deployed as second workers when appropriate. This was a strong area of practice. Health colleagues always attended case conferences when invited however, in some cases the partnership did not invite health colleagues. This was an area for improvement.

Health staff shared information appropriately and effectively. Commendably, in most cases adult support and protection information was evident in and well recorded in health records.

Capacity and assessment of capacity

For some adults at risk of harm, an assessment of capacity was necessary. Staff sought these most of the time when required. A suitable health professional carried out capacity assessments promptly when requested on all occasions. Overall, this was a positive element of practice.

Police involvement in adult support and protection

Contacts made to the police about adults at risk were almost all effectively assessed for threat of harm, risk, investigative opportunity, vulnerability and engagement (THRIVE). Just over half of cases had an inaccurate STORM Disposal Code (record of incident type).

In almost all cases the initial attending officers' actions were evaluated as good or better. The assessment of risk of harm, vulnerability and wellbeing was accurate and informative in all cases. The wishes and feelings of the adult were always appropriately considered and recorded.

Where adult concerns were recorded, officers did so efficiently and promptly on all occasions, using the interim vulnerable persons database (iVPD).

In almost all instances, frontline supervisory input was evident. Supervisory oversight was found to be good or better on most occasions.

Divisional concern hub staff actions and records were good or better in almost all of the cases read, with a resilience matrix and relevant narrative of police concerns recorded in all instances. Almost all referrals were shared by the divisional concern hub timeously to partners.

The inspection team were encouraged by the commitment of Police Scotland in the creation of a dedicated adult, support and protection team. Officers were tasked to deal with any issues and work alongside statutory and third sector partners, to improve the wellbeing of individuals who placed the greatest demands on services. This resource commitment built on existing relationships and enhanced a collaborative approach to complex or protracted cases.

The initiation of an escalation protocol review (instances of repeat police involvement) appeared to be well embedded with almost all relevant cases following

the protocol. When the escalation protocol was adhered to, almost all action was rated good or better.

The Police attended case conferences on all occasions when invited. It was evident that the Police were invited to most case conferences.

Third sector and independent sector provider involvement

The third and independent sector made a few adult support and protection referrals. They provided additional support in some cases and were involved in delivering crucial services relating to protection plans. Almost all adults at risk of harm who needed additional support from services got it. For most adults, this support was comprehensive, effective, and met the adult's personal outcomes. All provider staff who responded to the survey were supported to work collaboratively and understood their role. They were positive about their opportunities to participate in multi-agency training and development opportunities.

Key adult support and protection practices

Information sharing

Information sharing between partners was timely and effective. Almost all staff agreed that they understood their role and knew what to do if they were concerned that an adult was at risk of harm. Local adult support and protection procedures encouraged agencies to make referrals where there were concerns. On most occasions, referrers were offered feedback in accordance with procedures.

Management oversight and governance

While most social work managers read adult support and protection records, discussions and decisions from supervision were evident just under half the time. Overall, most recording was in line with the needs of the adult at risk of harm. Governance of police records was almost always evident. Commendably, health records demonstrated management oversight most of the time.

Involvement and support for adults at risk of harm

The views of adults at risk of harm were almost always considered throughout their adult support and protection journey. Potential barriers to their involvement were effectively addressed, and effective support for the adult at risk of harm, was provided in almost all cases. Unpaid carers were also consulted, and their views consistently sought indicating a strong person-centred approach by staff.

Less positively, only a few adults at risk of harm were invited to case conferences. These were critical decision-making forums that had the potential to change adults' lives. More transparency in this important area of practice was needed.

Independent advocacy

Adults at risk of harm were not routinely offered advocacy. Reasons for not referring to advocacy were not always recorded. A referral was made in just over half of the cases where it was deemed appropriate. When the advocacy service was offered, it was always provided timeously and helped the adults at risk of harm's views to be articulated and heard. A more consistent approach would benefit adults at risk of harm to express their views.

Financial harm and alleged perpetrators of all types of harm

A few adults at risk of harm whose records we read experienced financial harm. The partnership took effective multi-agency action to stop this harm in all cases. The perpetrator was almost always known to the partnership, and it undertook the necessary supportive work with them most of the time. The quality of work with perpetrators was good or better in just over half of cases.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced some improvement to their safety due to the partnership's adult support and protection intervention. For most adults this was a result of multi-agency working. Almost all adults who required additional support received it.

Adult support and protection training

The partnership's adult support and protection learning strategy was reviewed annually. This supported a comprehensive and ambitious local multi-agency training programme including a bespoke approach for local community health teams. All social workers within adult services were expected to undertake council officer training when they met the requirements set out in the revised code of practice. This resulted in sufficient council officers to meet the demands of adult support and protection work within the partnership.

Training was viewed very positively by staff. All survey respondents agreed that the adult support and protection training that they received provided them with the skills, confidence, and knowledge to undertake their role and duties.

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

Key messages

- The vision for adult support and protection was well understood by staff at all levels across the partnership.
- Strategic leaders drove a high level of strategic collaboration that led to impressive innovations and improvements in some areas of practice.
- The partnership had well embedded leadership and governance frameworks that oversaw the quality of adult support and protection activity.
- The approach to self-evaluation should be assessed and refined to better highlight those key areas for improvement identified. A more comprehensive approach will strengthen the partnership's delivery of competent and effective practice.
- There was no involvement of adults with lived experience on the adult protection committee. The partnership was implementing a strategy to address this issue.

We concluded the partnership's strategic 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 partnership had a clear vision statement it intended to refresh and promote in the spring of 2024. Commendably, almost all staff agreed that local leaders provided them with a clear vision for their adult support and protection work. Strategic leaders and frontline staff worked in proximity and joint working practices promoted a culture of co-production with staff. A champions group supported such initiatives. The adult protection committee and lead officer played a key role in promoting the vision in their work. The lead officer often attended team meetings and partner agency forums to promote and embed adult support and protection priorities in practice.

The partnership's vision would benefit from being more clearly embedded in their strategic planning and delivery of core documents. This would provide a stronger and more visible golden thread for its vision.

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

The chief officers' group provided the high-level oversight for adult support and protection work. The group consisted of relevant agencies and meetings were planned at regular intervals. There was good evidence that this meeting connected well with the adult protection committee, public protection and wider health and social care strategic groups.

The chief officers' group received regular adult protection performance reports as well as briefings on the results of adult support and protection self-evaluation activity. They ensured necessary scrutiny and analysis. The independent convenor oversaw both child and adult protection committee activity which ensured a further layer of scrutiny. The convenor and lead officers shared dedicated administrative support that made effective use of their time.

Following the publication of the NHS Public Protection Accountability and Assurance Framework NHS Greater Glasgow and Clyde developed an NHS GGC public protection strategy. The public protection service was transitioning from a child protection unit to a public protection service. Adult support and protection work was well supported by the public protection leads and service team who attended the adult protection committee. This strengthened links across protection agendas.

The adult protection committee oversaw five sub-groups. Two operated jointly with the child protection committee. These arrangements provided opportunities for collaboration which the partnership took advantage of including the development of their effective chronology tool. Work across the sub-groups was collaborative and well supported by the chief officers' group. Improvement activities were co-produced and included representation across sectors and staff groups. For example, this was evident in their hoarding and self-neglect, integrated care home support team and large-scale investigation work. The partnership's efforts to promote this approach was evident amongst staff who shared a very high level of staff confidence in their strategic leadership team.

Effectiveness of leaders' engagement with adults at risk of harm and their unpaid carers

Adults and carers were not directly represented on the adult protection committee. The partnership recognised this and placed a high value on the voice of lived experience. There was previously a consultation sub-group that was deemed impactful, but its lifespan had ended. In response, the adult protection committee reviewed their approach and was actively developing a participation strategy. This built on the positive achievements of the previous sub-group and was engaging adults with lived experience to inform the partnership's priorities and adult protection committee business plan and improvement cycle.

This plan identified what needed to be done to further integrate the voices of those with lived experience in the partnership's improvement journey. The strategy aimed to ensure the views of adults with lived experience was routinely captured and that this influenced strategic change and improvement. These were cognisant with the principles of adult support and protection legislation.

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

The partnership had tools in place to ensure a very high level of adult support and protection work. Governance arrangements were long-standing and well embedded. Self-evaluation, audit, and improvement activity was collaborative and inclusive. However, despite these robust frameworks, there were several areas of key practice that required close attention. This included chronologies, risk assessments, protection plans, investigations, and case conferences.

While the quality of work done in these areas was sound, there were too many instances where more adult support and protection work should have been done to secure the safety of the adult. Adults who should have accessed these interventions risked missing out on protection planning and mitigation.

The risk assessment and management procedure (RAMP) process was well understood by social work managers and leaders. This level of confidence was not consistent across frontline social work services or other agencies including health and police. A few staff said the RAMP and adult protection key processes often converged. While we commend the complex case RAMP alternative to adult support and protection processes, there should be clearer delineation of those parallel processes.

Quality assurance, self-evaluation, and improvement activity

The partnership had a strong history of undertaking annual multi-agency self-evaluation activity that was thematic and took account of a small number of cases. Commendably, the third sector was well represented in this process led by the adult protection committee's continuous improvement sub-group. This was stood down during the Covid-19 pandemic but had re-started. Both the methodology and approach were mostly sound including benchmarking against other relevant national reports.

Action plans developed following this work were embedded in the adult protection committee's improvement plan and overseen by the adult protection committee and chief officers' group. Actions relating to wider health and social care issues were well connected to wider governance and reporting frameworks. Improvements were joint in nature and crossed partner agencies.

Routine social work audits took place, some of which related to protection or high-risk cases. Police Scotland G Division's adult protection team took on a quality assurance role in relation to the handling of adult concern reports and the adult protection committee was well sighted on the NHS public protection governance and accountability framework.

Overall, the deployment of multi-agency self-evaluation and audit was well embedded and collaborative. That said, refinement was needed to ensure it more accurately identified those areas for improvement noted in this inspection. Although we are assured the systems to govern and oversee improvement were in place, a more comprehensive approach was needed to impact more widely on areas for improvement.

Learning reviews

The partnership had not undertaken any learning reviews during the timeframe of the inspection. Learning points were addressed from an initial case review that was undertaken.

The partnership updated their learning review protocol. This was a helpful document that was aligned with the national guidance 2022 and provided a useful section on implementing recommendations.

Summary

Key processes

Overall, the partnership demonstrated resilience since 2017, including during the Covid-19 pandemic. During this period, it had maintained their approach to self-evaluation and audit and were early adopters of the code of practice.

The 2017 joint inspection of adult support and protection in East Dunbartonshire highlighted chronologies as an area for improvement. In response, the partnership implemented a chronology project in conjunction with staff from across children's and adult services. They effectively identified the barriers to creating, updating, and reviewing chronologies. The resulting improvement ensured a shared template with a focus on trauma and portability for young people transitioning from children's services. A prompt for managers to check for completion of chronologies was introduced to the reflective supervision tool in 2019 and staff were trained. Subsequent partnership audits found quality had improved but challenges remained with completion of chronologies. We found this remains the case. There was significant improvement in the quality of chronologies, but completion had only slightly progressed.

In 2017 just over half of initial inquiries were good or better. Improvement in this area was significant with all initial inquiries now good or better. Compliance with the code of practice was closely adhered to, with strong collaboration and oversight evident.

In 2017 almost all adults at risk of harm had a risk assessment completed, but this had since reduced to half. Protection plans had also declined from being present in almost all cases to just over half. Where completed, the quality of risk assessment had remained stable, with the quality of mostly good or better.

The quality of investigations in 2017 was a strength with almost all good or better. This had reduced, but as in 2017 almost all effectively determined if the adult was at risk of harm and all were completed timeously. A multi-agency approach was evident. Commendably, health staff were trained and acted as second workers when this was beneficial to the investigatory process.

Despite clear guidance the risk assessment and management procedure (RAMP) was used for some adults at risk of harm as an alternative to adult support and protection processes. This remains the case with convergence between the two processes impacting on the outcomes of a few adults at risk of harm. Adults meeting the three-point criteria should always access the protective safeguards afforded by adult support and protection legislation. In 2017 The chief officers' group were sighted on the need to monitor this delineation and oversight should continue as a priority.

Strategic leadership

The level of staff confidence in strategic leaders had improved since 2017 and was a positive feature of this inspection, reflected in our staff survey. This foundation forged close working relationships and confidence amongst staff across the partnership.

In 2017 the strategic leadership team had a clear vision that promoted productive and collaborative work for adult support and protection. There was effective oversight of multi-agency practice and the partnership used long established self-evaluation and audit activities to identify areas for improvement to good effect.

While this largely remained, the audit and self-evaluation approaches needed to be reviewed to ensure that key areas for improvement were identified and subsequently embedded in improvement plans. The competence and effectiveness of key areas of adult support and protection practice will improve as a result.

The strategic leadership continued to promote collaborative working. Close working relationships were evident at all levels, particularly between social work and health staff in adult support and protection work. They were strong operational and strategic partners. The integrated care home support team had reduced adult support and protection referrals from care homes and ensured that protection issues were dealt with consistently from a multi-agency perspective.

Next steps

We asked the East Dunbartonshire partnership to prepare an improvement plan to address the priority areas for improvement we identify. The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key process 1

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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 95% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 95% of episodes where the three-point criteria was applied correctly by the HSCP
- 98% of episodes were progressed timeously by the HSCP
- Of those that were delayed,100% were one to two weeks
- 85% of episodes evidenced management oversight of decision making
- 100% of episodes were rated good or better

Staff survey results on initial inquiries

- 96% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 2% did not concur, 1% didn't know
- 91% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 3% did not concur, 6% didn't know
- 90% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 3% did not concur, 7% didn't know

Information sharing among partners for initial inquiries

- 88% of episodes evidenced communication among partners

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

Chronologies

- 61% of adults at risk of harm had a chronology
- 95% of chronologies were rated good or better, 5% adequate or worse

Risk assessment and adult protection plans

- 50% of adults at risk of harm had a risk assessment
- 74% of risk assessments were rated good or better
- 58% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 73% of protection plans were rated good or better, 27% were rated adequate or worse

Full investigations

- 94% of investigations effectively determined if an adult was at risk of harm
- 100% of investigations were carried out timeously
- 72% of investigations were rated good or better

Adult protection case conferences

- 58% were convened when required
- 93% were convened timeously
- 100% were attended by the adult at risk of harm (when invited)
- Police attended 100%, health 100% (when invited)
- 93% of case conferences were rated good or better for quality
- 100% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 45% 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

- 100% of adult protection concerns were sent to the HSCP in a timely manner
- 93% of inquiry officers' actions were rated good or better
- 93% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 67% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 70% good or better rating for the quality of ASP recording in health records
- 74% 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

- 98% of cases evidenced partners sharing information
- 95% of those cases local authority staff shared information appropriately and effectively
- 95% of those cases police shared information appropriately and effectively
- 100% of those cases health staff shared information effectively

Management oversight and governance

- 69% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 76%, police 90%, health 61%

Involvement and support for adults at risk of harm

- 83% of adults at risk of harm had support throughout their adult protection journey
- 76% were rated good or better for overall quality of support to adult at risk of harm
- 90% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 2% did not concur, 8% didn't know

Independent advocacy

- 58% of adults at risk of harm were offered independent advocacy
- 100% of those offered, accepted and received advocacy
- 100% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 73% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 100% of these adults had their capacity assessed by health
- 100% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 17% of adults at risk of harm were subject to financial harm
- 100% of partners' actions to stop financial harm were rated good or better
- 20% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 88% of adults at risk of harm had some improvement for safety and protection
- 93% of adults at risk of harm who needed additional support received it
- 86% concur adults subject to ASP, experience safer quality of life from the support they receive, 3% did not concur, 11% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 82% concur local leaders provide staff with clear vision for their adult support and protection work. 5% did not concur, 13% didn't know

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

- 82% concur local leadership of ASP across partnership is effective, 2% did not concur, 15% didn't know
- 78% concur I feel confident there is effective leadership from adult protection committee, 3% did not concur, 18% didn't know
- 62% concur local leaders work effectively to raise public awareness of ASP, 10% did not concur, 28% didn't know

Quality assurance, self-evaluation, and improvement activity

- 69% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 4% did not concur, 26% didn't know
- 75% concur ASP changes and developments are integrated and well managed across partnership, 4% did not concur, 21% didn't know