The joint inspection of adult support and protection interim overview report –

Emerging key messages

Contents

1. Introduction

The joint inspection of adult support and protection overview report

The joint inspections are one aspect of the Scottish Government's improvement plan for adult support and protection in Scotland. The plan builds on the thematic inspections of adult support and protection that were undertaken in 2017-18. Scrutiny of practice is essential for robust public assurance of practice standards, for identifying national themes and priorities, and for enriching and complementing the learning that takes places locally.

Key areas of focus are emerging, and in the spirit of continuous improvement, it is prudent to share these at an early juncture. We trust that adult protection partnerships will consider this overview report and review practice in accordance with the emerging findings.

Joint inspection partners

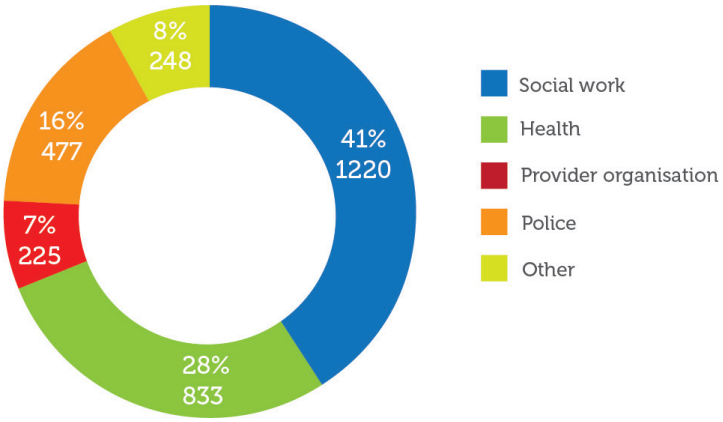
Scottish Ministers requested that the Care Inspectorate lead joint inspections of adult support and protection, in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland. To date we have undertaken 11 inspections and published 10 partnership reports.

Joint inspection methodology

The methodology for the inspections comprises four proportionate scrutiny activities as follows.

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

Staff survey. We are pleased to note that 3,003 staff from across the local partnership areas inspected to date have responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and 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 the health, police, and social work records of adults of risk of harm. We have read the records of 523 adults at risk of harm where their adult protection journey progressed to at least the investigation stage. We have also scrutinised recordings of 396 adult protection initial inquiry episodes where partnerships had taken no further action, in respect of further adult protection activity beyond the duty-to-inquire stage.

Staff focus groups. We have also met with 218 members of staff from across local partnership areas 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 partnerships supported staff and implemented the Covid-19 national adult support and protection guidance.

Covid-19

In the face of the emerging coronavirus (Covid-19) public health emergency, joint inspection partners took the decision on 17 March 2020 to temporarily suspend the adult support and protection inspection programme. In recognition of the continued significance of this work, the joint inspection team explored ways to resume the inspection programme that took account of the ongoing pandemic. During the suspension, we developed the joint digital arrangements, which allowed us to resume the programme remotely. The joint inspection programme recommenced on 25 November 2020 and has continued to develop its digital approach.

Quality indicators

Our quality indicators for the joint inspections are on the Care Inspectorate website.

Progress statements

To provide Scottish Ministers with timely high-level information, the joint inspection reports include statements about partnerships' 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?

In nine partnerships, key processes for adult support and protection were effective with areas for improvement. One had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm.

In eight partnerships, strategic leadership for adult support and protection was effective with areas for improvement. One was very positive and demonstrated major strengths, with another having important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. In our individual inspection reports we have applied standard terms for percentage ranges. These help us determine the progress being made.

2. Adult support and protection key processes

We considered the extent to which partnership areas effectively screened, triaged and handled adult protection concerns at the initial response stage. This determined if they ensured the immediate safety of adults at risk of harm. We explored the quality of adult support and protection inquiry, investigation and case conference work to establish if partnership areas effectively determined and supported adults at risk of harm. We took account of how effectively partnership areas collaborated to secure the safety, protection and support for adults at risk of harm.

Emerging key messages

Nearly all adults at risk of harm experienced improvements to their safety, health, and wellbeing. This was mainly due to the collaborative efforts of social work, health, Police Scotland and provider organisations involved.

Keeping adults at risk of harm safe and protected is the primary aim of adult (or public) protection committees. In every partnership most adults at risk of harm were safer and had experienced improvement in their life because of multi-agency working. There were also good examples of effective support provided to adults at risk by frontline practitioners in every partnership. Many staff surpassed what was expected of them. This was making a positive difference to people's lives.

Some adults had very complex needs and remained at risk despite the best efforts of support services. A small but significant number of adults were adversely affected by a lack of adequate risk management or protection planning. Others did not progress to case conference when they should have. These missed opportunities contributed to a few adults experiencing poor outcomes.

Police Scotland officers consistently recognised and responded positively to adult support and protection concerns during initial call attendance, seeking support from health and social work colleagues where appropriate. Ongoing protection work was almost always of a high standard, person-centred and valuable in keeping people safe.

NHS staff across partnerships contributed to the delivery of improved safety and protection outcomes for adults at risk of harm. Services responded promptly and collaboratively to adult protection requests, although these interventions needed to be better recorded in the individual's records. Adults at risk who were repeatedly admitted to acute hospital wards and those who were supported by community health services received good adult protection support. The outcomes for those supported at emergency departments but not subsequently admitted were less positive.

Partnerships had strong adult concern screening and triage arrangements in place.

Partnerships typically had a dedicated social work single point of access that received all adult protection referrals. These arrangements were well supported by good onward referral pathways underpinned by effective processes and procedures. Staff had a high level of confidence in these arrangements. A few partnerships had developed multi-agency hubs, or similar joint arrangements, that screened adult concerns referrals and provided safeguarding through rapid interventions. Adult support and protection referrals were subsequently passed on to social work duty systems. Those who did not meet the three-point test were signposted on to other support service pathways. These arrangements not only helped to effectively triage the high volume of referrals but provided good opportunities for alternative early intervention and prevention work with adults presenting with high levels of risk and complex needs.

Police area control rooms effectively managed inquiries from the public using a well-established model of risk and needs assessment. This helped them to accurately determine how they prioritised their responses. Adult support and protection initial call attendance responses were collaborative and positive. Police Scotland divisional concern hubs formed an integral part of public protection screening and triage arrangements. Decisions and onward referrals to partnership duty systems were almost always effectively made.

In a few partnerships, NHS boards had introduced better ways to share adult support and protection referral information. One board had dedicated staff in a multi-agency hub and some others had firm plans to develop and host an electronic initial referral discussion template to ensure greater consistency. Good work was undertaken with partnership agencies in relation to referral pathways and preventing harm in care homes during the Covid-19 pandemic. NHS boards were actively involved in service-redesign work. This was being supported in most partnerships by NHS public protection teams and lead officers. There was evidence of progress in the strategic involvement of health that we saw developing in our 2017-2018 inspection.

Duty-to-inquire work was collaborative, of a high standard and underpinned by the principles of the Act. The three-point test was being clearly recorded by nearly every local partnership area. Multi-agency screening hubs and initial/interagency referral discussion (IRD) arrangements helped to mitigate the risks and enhanced early adult protection processes. In some partnerships, it was difficult to determine where inquiries started and ended.

The three-point test was accurately determined in nearly all the duty-to-inquire episodes we inspected in every partnership. The majority clearly recorded the outcome in the case records. However, we did not see this consistently applied and some partnerships should improve how this critical decision is recorded in their social work records. Duty-to-inquire work was

person-centred, collaborative and completed to a good standard. Information was being shared effectively and management oversight was strong. A few partnerships had work to do to ensure more timely completion of inquiry work. Others needed to achieve greater consistency of Police Scotland involvement at this stage, where there was evidence of criminality.

In some partnerships, it was difficult to determine where inquiry work started and ended. Client information systems were often difficult for staff to navigate and did not offer distinction between the different parts of the process. Also, staff did not always use the dedicated forms laid out in multi-agency adult support and protection guidance. Resultantly, variations in practice evolved. This was a critical issue that partnerships needed to address to ensure more clearly defined adult support and protection stages.

Some partnerships undertook initial/inter-agency referral discussions (IRDs). This approach provided a multi-agency framework to consider the circumstances, immediate risk management planning issues, and coordinating interventions. Some improvements still needed to be made to fully benefit from these arrangements. These included applying recording tools and templates more consistently. Finding the capacity and resources for the meetings was also a common challenge. Some were not held in a timely manner, meaning they were convened at different stages of the adult protection process, including at the investigation stage. On these occasions, opportunities to better oversee and govern the risks to adults from an early stage were missed. Partnerships that had implemented IRD processes continued to develop their approach.

Almost all local partnership areas undertook timely investigations that effectively determined if adults were at risk of harm. Work was required to involve health staff as second workers. Multi-agency guidance was not always clearly laid out or followed and this impacted significantly on the overall quality and consistency of the investigation recording.

Adult support and protection investigations were largely inclusive, completed timeously and accurately determined if the adult was at risk of harm. While these were clear strengths, the quality of the investigation work was mixed with room for improvement in most partnership areas. Almost all partnerships were appropriately deploying council officers to lead adult support and protection investigations. Second workers were effectively supporting this work where required in most cases. Some partnerships needed to do more to involve health colleagues in the second worker role. Having a holistic understanding of the needs of the adult at risk of harm is a crucial element of protection work.

Some areas for improvement we saw in 2017-2018 remained. In a small number of partnerships, there was a mixture of ineffective or poorly organised client information systems and unclear or unheeded guidance. Custom and practice had developed over time in health and social care partnerships, which did not always support the consistent delivery of the council officer's investigation processes.

Following the completion of investigations a few partnerships did not convene initial adult protection case conferences when they should have. And some were not convened quickly enough. These scenarios were uncommon but when they occurred the outcomes for individuals were negatively affected. Staff working with case management responsibilities would regularly pick up this work upon completion of the adult support and protection investigation. This left them to manage very complex, high-risk cases out with the support of multi-agency adult protection process safeguards. Management oversight of key decisions required to be strengthened in a few partnership areas to ensure a greater consistency of decision making for those requiring the full consideration of an initial case conference.

Chronologies, risk assessments and risk management/protection plans needed to be more consistently applied in every partnership. Where they were in place, the quality was mixed and partnerships had significant work to do in these critical areas of practice. Management oversight of these key areas needed to be stronger and more visible in the records.

There has been little progress since our 2017-2018 inspection with respect to adult support and protection chronologies, risk assessments and protection plans. There remains much improvement work to be done to ensure these are completed and in the records of every adult subject to adult support and protection. Chronologies are a critical element of adult support and protection investigation work, however they were absent from a significant number of records we read. Where they were completed, the quality was mixed. A high proportion were evaluated as weak, with all partnerships having significant improvements to make. Too often, it was not possible to determine how chronologies informed decisions to proceed from investigation to case conference. The lack of chronologies also compromised decisions made at case conferences significantly weakening the strength of accountable decision making. Across the inspections, the practice of completing comprehensive chronologies was poor, with significant areas for improvement.

Risk assessments are core components of adult support and protection investigations and most partnerships had established processes to clearly embed these in the council officer records. A few partnerships had a significant number of records that did not contain a risk assessment when they should have. These partnerships had work to do to develop and implement risk assessment tools, frameworks and procedures. Business support systems needed to be updated to support this, and staff needed to be provided with relevant training.

In the main, risk assessments that were in place were undertaken collaboratively and in a timely manner, but the quality was mixed. Some partnerships applied discretional thresholds for staff to decide when to complete adult protection risk assessments. It is our view that all adults subject to an adult support and protection investigation are afforded the same degree of risk analysis and consideration. This is the foundation for good protection planning and decision-making practice.

Protection planning forms an important element of adult support and protection investigation and case conference work. Nearly every partnership had its own protection plan template or templates. Of those completed, areas of good practice included the quality, collaboration, timeliness and involvement of the adults themselves in developing their plans. While this was positive, most partnerships did not always have protection plans in place for adults who required them at the investigation stage, leaving some unnecessarily exposed to risk and poor outcomes. The inconsistent application of the Police Scotland escalation protocol further compounded the risks in this area of practice.

Most case conferences were convened in a timely manner and effectively determined what support needed to be in place to keep adults at risk safe. Invitations were consistently issued but more needed done to ensure Police Scotland, health partners and adults themselves attended.

Adult protection case conferences are crucial multi-agency meetings that consider how best to protect and support an adult at risk of harm and keep them safe. Some improvements were required to ensure that all those adults at risk who would benefit from a case conference, did so. Those who missed out were overlooked for the protection planning they required. During the Covid-19 pandemic, partnerships had successfully implemented digital solutions to continue hosting case conferences. Where case conferences took place, most were undertaken promptly and effectively determined what needed to be done to keep the adult at risk of harm safe. Some partnerships had offered training for the role of chair, and this had helped to support the high quality of case conference work seen across almost all partnerships.

While this was positive, the reasons why adults at risk of harm did not attend case conferences were not always clear in the records. This was important because seeking and recording the views of adults at risk of harm for a case conference was also an area for improvement in our 2017-2018 adult support and protection inspection. It is important that staff take the time to ensure the adults' views are sought prior to case conferences where appropriate. It is also important that chairs ensure these views are recorded in the minutes of case conferences whether the adult attends or not. Attendance from professionals was also not as positive as it could be, particularly among health and Police Scotland. Objectivity and independence of case conferences could be improved by ensuring that those chairing are not part of the service area supporting the adult at risk of harm. Review case conferences reflected similar issues.

Communication, collaboration and information sharing among practitioners was of a consistently good standard. Client information systems did not support this as well as they could have.

Collaboration and information sharing among key agencies was effective in nearly every partnership. There was strong evidence of this throughout duty-to-inquire and investigations. In a few partnerships, collaboration among agencies needed to be stronger where criminality was a factor.

There were a few examples of multi-agency hubs working well together to determine if adult concerns met the three-point test and what response was required. These also effectively signposted adults to early intervention and prevention pathways and services. Provider organisations played a key supporting role in every partnership area. There was good evidence of their important contribution to investigation work, case conferences and important early intervention and prevention work.

Adult support and protection work is often dependent on whether an adult has the capacity to make decisions for themselves. Health staff play an important role in determining this. On most occasions, they were undertaking capacity assessments where they should have done so. Of those undertaken, most were done so in a timely manner, but not every time. As with our 2017-2018 inspection, this was an area that needed to be more consistently delivered. Most partnerships needed to improve the provision and timing of capacity assessments for adults at risk of harm.

Independent advocacy continued to play a critical role in supporting adults to express their own views throughout adult support and protection processes. Every partnership made this service available. Where adults at risk of harm accepted the offer of advocacy, it impacted positively on their experience. In a few partnerships, this independent support was not offered to adults when it should have been, or the adult at risk of harm chose not to accept the help. The records did not always accurately indicate the reasons for this. During the height of the Covid-19 pandemic, nearly all independent advocacy services were maintained remotely. While the continuity was commendable, the lack of face-to-face work limited the benefits and positive impact that advocacy had for adults at risk of harm.

3. Adult support and protection strategic leadership

We explored if partnerships delivered robust, integrated and effective adult protection practices underpinned by inclusive audit and self-evaluation quality assurance frameworks

Emerging key messages

Nearly all partnerships had a clear adult support and protection vision. However, these were not always clearly understood by frontline staff and more needed to be done to address this.

Almost all the partnerships had a strong vision and strategy for adult support and protection, and these were well laid out in each partnership's strategic documents. Partnerships also took other steps to strengthen their vision among frontline staff including frequently circulated newsletters, opening strategic meetings to wider staff groups and the use of innovative digital communication solutions. Despite these clear efforts they all had more work to do. Too many staff were unsure or did not agree that strategic leaders provided a clear vision for adult support and protection.

Strategic governance and oversight of adult support and protection work was strong. Both adult and public protection committees were well aligned to assurance frameworks. The quality of reporting information and analysis was more mixed.

Effectiveness of strategic leadership and governance for adult support and protection across each partnership is critical. There was evidence that nearly all chief officer groups were showing good leadership. Effective strategic planning, delivery and governance structures were in place. Adult support and protection reporting processes were clearly outlined and took account of the need for local and national reporting demands. The quality of reporting was mixed, with some partnerships providing better analysis of the data than others. This limited their ability to capture and address all the improvement work required.

Both adult and public protection committee models functioned well and were well aligned to all strategic oversight groups including integration joint boards and clinical and care governance groups. Protection committee meetings were held with good attendance, and decision making was timely. Most partnerships were cognisant of the interests and concerns of adults and unpaid carers. Priorities were mostly set out in clear engagement strategies with commissioned organisations supporting the work and creating strong links between adults at risk of harm,

unpaid carers and adult protection committees. In some instances, there were dedicated engagement subgroups driving this work forward. Covid-19 presented partnerships with digital opportunities that a few actively planned to capitalise on. While these measures ensured the voice of adults at risk of harm and unpaid carers supported service improvements, some partnerships had more work to do.

The wider suite of adult and public protection committee subgroups was largely in place although work and progress had slowed down in some partnerships. Some partnerships had longstanding adult protection lead officer or coordinator vacancies and frequently appointed temporarily to these critical posts. Where this was the case, it was a barrier to the quality of reporting and improvement activity progress. Partnerships in this situation recognised and had plans in place to address this.

Delivery of competent, effective and collaborative adult support and protection practice is critical. Frontline managers were providing staff with good support but this oversight was not always detailed in the records. Adult support and protection practitioner guidance was in place in every partnership but this was not always up to date or consistently applied. There were a few key areas for improvement that repeatedly arose including chronologies, risk assessments and protection plans. The lack of improvement in these key areas was disappointing as these were identified in both our previous 2017-2018 inspection activity and in most partnerships' own, more recent, quality assurance activity. Oversight of these areas for improvement needs to strengthen considerably among strategic leaders.

Nearly all multi-agency self-evaluation approaches had stalled but single-agency quality assurance was being consistently undertaken. This enabled partnerships to monitor the performance of core adult protection activity. Adult and public protection committees oversaw initial and significant case reviews, and large-scale investigation activity.

Comprehensive quality assurance, self-evaluation and improvement activity are essential components of an improvement-focused partnership. Most partnerships had well established multi-agency and single-agency frameworks in place. However, some had found it difficult to undertake this work as thoroughly as they should due to the lack of clear data-sharing arrangements and the pressures of Covid-19 on resources to complete this work. Most partnerships were therefore relying on single-agency audits or quality-assurance reporting processes alone to determine the strength of their adult protection processes. Performance reporting on audit activity was typically well aligned to the various reporting and improvement frameworks including the adult protection committees and chief officer groups. Adult and public protection committee subgroups continued to play a role in supporting this work. Most partnerships found it difficult to resource improvement work and the impact from recommendations were not always achieved or easily evidenced. Crucially, staff involvement in self-evaluation and improvement activity work was consistently overlooked and needed to be addressed.

Large-scale investigations (LSIs) were undertaken in almost all partnerships. They followed established guidance and were generally collaborative, inclusive and competently undertaken, with key agencies and individuals involved including the Care Inspectorate. There was good evidence that learning was being both identified and carried forward with effective governance, oversight and support arrangements in place. In a small number of partnerships, the relationship between LSIs and individual adult support and protection investigations required to be strengthened.

Business continuity had been maintained throughout the Covid-19 pandemic. Practical and welfare measures were supporting frontline staff. The early stages were difficult for frontline staff and leaders but morale and optimism had grown over time. Staff felt safe and well supported by frontline managers throughout Covid-19 but there was a strong perception that senior managers were less visible and accessible.

During the Covid-19 pandemic, every partnership had commendably prioritised the welfare of its staff and we saw a range of measures put in place to support staff. While flexible working arrangements were introduced to protect staff, adults at risk of harm remained at the centre of protection work. Frontline managers were flexible and supportive but there was a clear disconnect between frontline staff and strategic leaders, despite every partnership implementing a range of specific supportive measures.

Nearly all governance, oversight and assurance measure arrangements were effective. There was good collaboration amongst agencies despite the logistical challenges. Decision making and business continuity processes worked well. There were strong links to the third and independent sectors. Some areas undertook good early intervention and prevention work to ensure welfare checks on large numbers of vulnerable adults living across communities. Most partnerships had reviewed their 'front door' arrangements and made the necessary resourcing commitments to ensure adults-at-risk referrals were effectively managed.

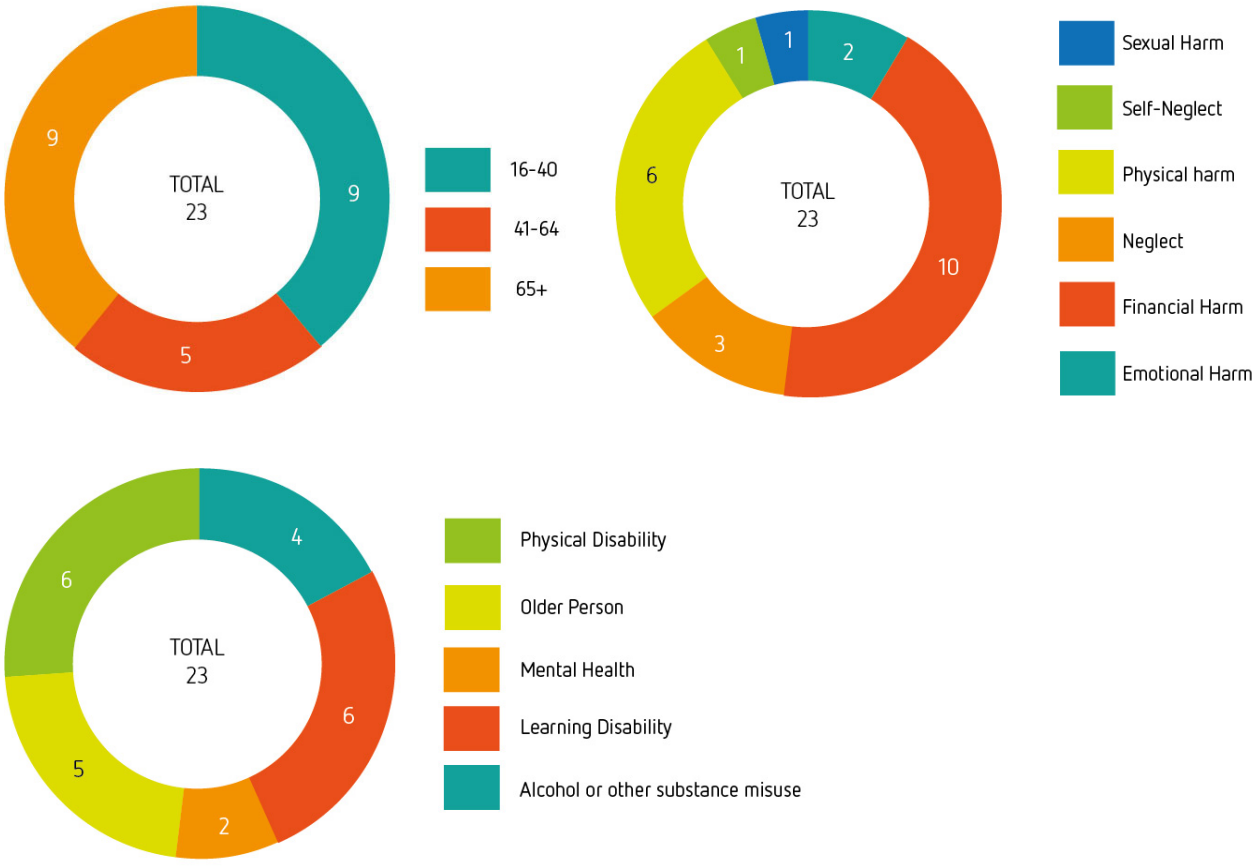
In the early stages of the pandemic, effective communication and collaboration with partner agencies was difficult. Staff in all roles found adjusting to the Covid-19 pandemic challenging. The move towards remote working supported by digital technology presented early challenges, but partnerships had largely overcome these. Staff developed confidence and familiarity with digital approaches. Crucially, staff continued to undertake face-to-face work with adults at risk of harm when required and they reflected a very strong view about this. A few expressed some concerns about the impact of remotely delivered independent advocacy services. They felt that it made it more difficult to effectively reflect the views of adults at risk of harm. In our 2017-2018 inspection, digital approaches to adult protection work, including information sharing, were at the early stages. The Covid-19 pandemic had clearly accelerated progress and effective communication and data-sharing arrangements were being widely deployed.

The provision of collaborative learning and development had been a considerable challenge for partnerships since the onset of the pandemic but remained a priority for leaders. Prior to the pandemic, most had comprehensive and up-to-date multi-agency frameworks that successfully included and upskilled large numbers of staff. The Covid-19 pandemic had slowed this, or in some areas led to work being paused except for some mandatory training. Where learning and development was taking place, staff from all agencies expressed confidence in how it strengthened their understanding of the role they undertook in protecting people. E-learning opportunities were gradually introduced but partnerships acknowledged future models should blend this with face-to-face approaches. Some partnerships did not have an identified lead person driving this work forward and were at various stages of addressing this. Police Scotland benefited from their corporate guidance and procedures, which supported consistency and an ability to share learning.

4. Practice themes from cases we escalated

During our inspection work, we sometimes formally escalated cases to partnerships. The primary and well-established purpose of escalations is to address and seek assurance from partnerships about issues pertaining to the safety of adults at risk of harm. This is an important arrangement that promotes evaluation and encourages learning and improvement activity. To date, we have read 523 records and escalated 23 cases to partnerships.

When initial responses to queries did not provide the necessary clarity, we asked each partnership's adult protection committees to share and implement the subsequent learning and improvement opportunities. Despite evidence in each partnership area of close joint working we saw a small but significant issue where the police were not routinely alerted to or involved matters of criminality. This included cases of physical, sexual and financial harm. Despite prevention being a national priority, only just over half of partnerships' actions to stop financial harm was good or better.



5. Next steps

The Care Inspectorate, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland are committed to completing the 26 adult support and protection inspections by July 2023. We will provide timely national assurance about partnerships' effective operation 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 final overview report to the Scottish Government. This will shape the development of the remit and scope of further scrutiny and improvement activity to be undertaken in phase two.

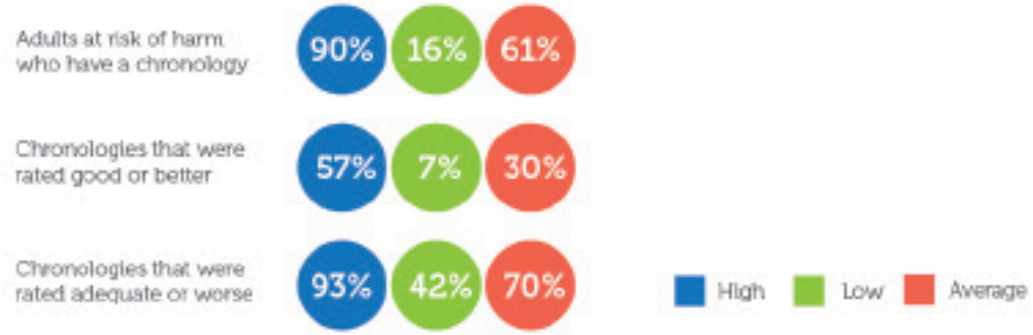
Appendix – core data set

So far, we have published 10 adult support and protection inspection reports on partnerships across Scotland. Each of the partnership reports we have published contains an appendix based on the question set below. For the purposes of this interim overview report, we have looked across the 10 inspection reports and highlighted both the lowest and highest response for each individual question. Then, taking the results from each of the 10 inspections into account, we have calculated the average (mean) for each individual question and shown this in the table below.

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

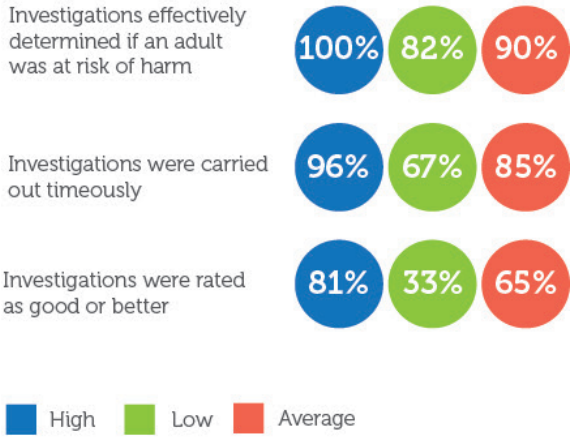
Information sharing among partners for initial inquiries

Chronologies:

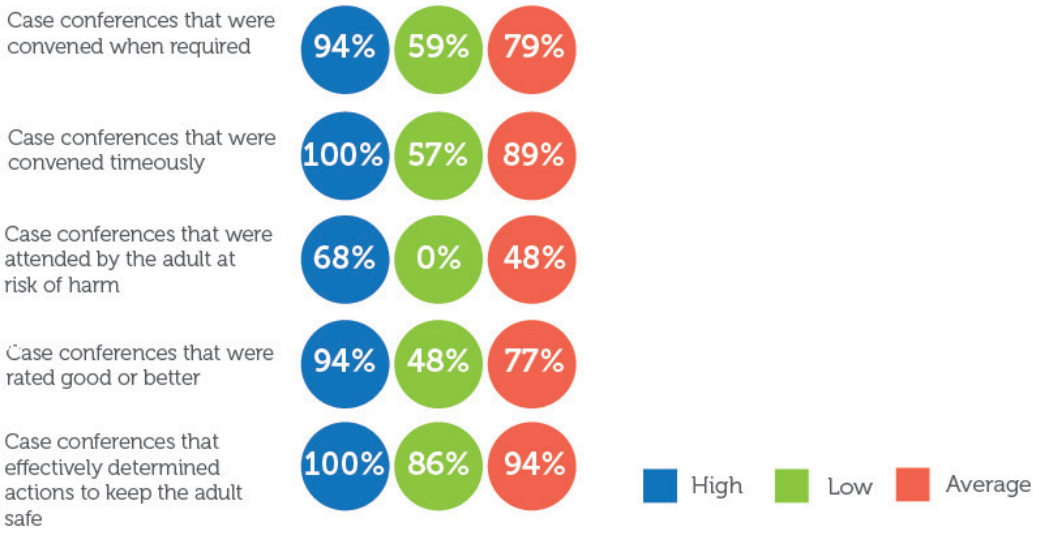


Risk assessment and adult protection plans:

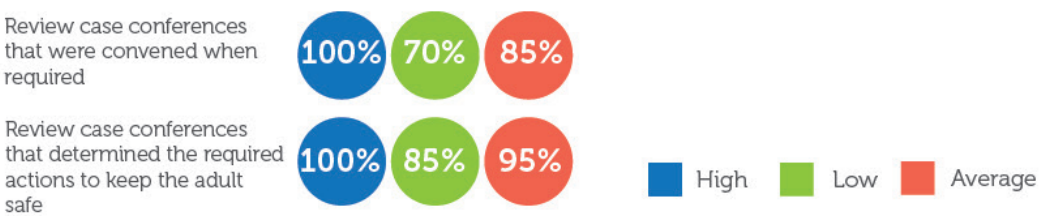
Full investigations:



Adult protection case conferences:

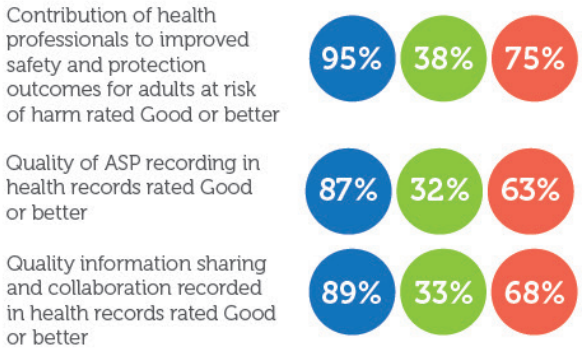


Adult protection review case conferences:

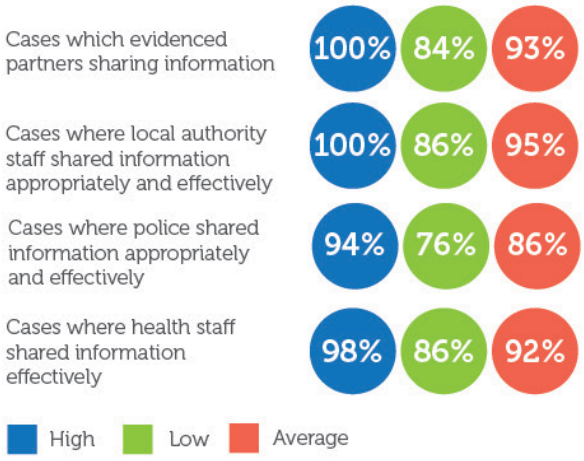


Police involvement in adult support and protection:

Health involvement in adult support and protection:



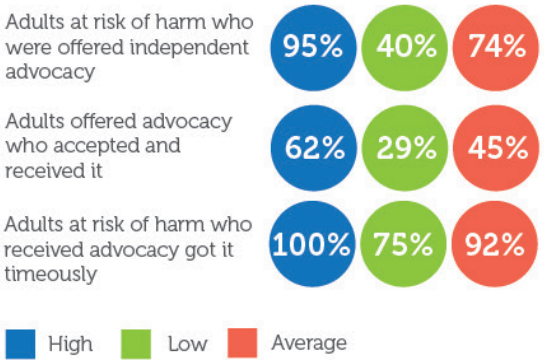
Information sharing:



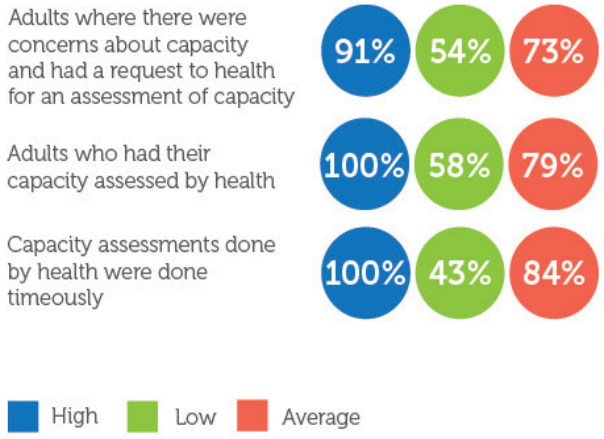
Management oversight and governance:

Involvement and support for adults at risk of harm:

Independence advocacy:

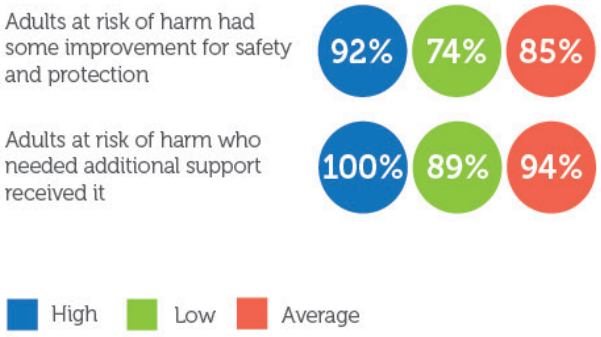


Capacity and assessments of capacity:



Financial harm and all perpetrators of harm:

Safety and additional support outcomes:



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