JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

West Lothian Partnership September 2022

Contents

Map showing divisional concern hubs

Joint inspection of adult support and protection in the West Lothian 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 local partnership[1] 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 Lothian partnership area were safe, protected and supported.

The joint inspection of the West Lothian partnership took place between May and July 2022. We scrutinised the records of adults at risk of harm for a two-year period, April 2020 – April 2022.

The West Lothian partnership and all others across Scotland faced the unprecedented and ongoing challenges of recovery and remobilisation as a result of the Covid-19 pandemic. We appreciate the West Lothian partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

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

[1] https://www.careinspectorate.com/images/Adult_Support_and_Protection/1.__Definition_of_adult_protection_partnership.pdf

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

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.

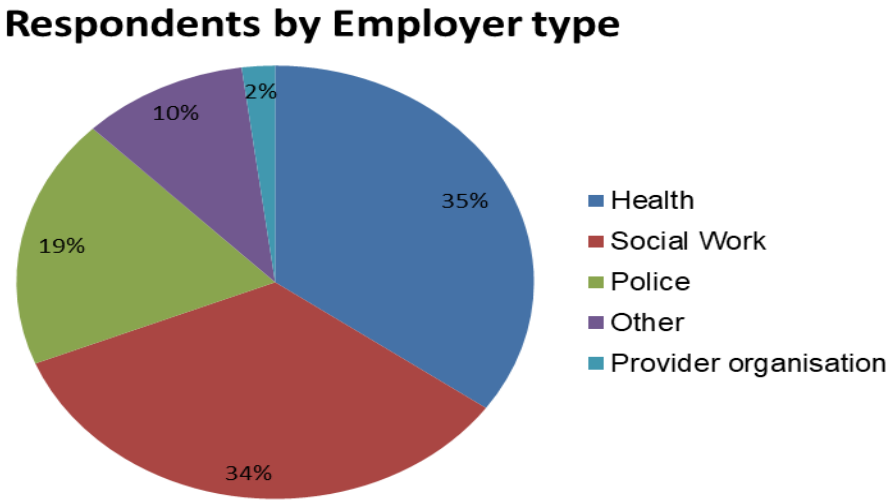
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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 forty-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.

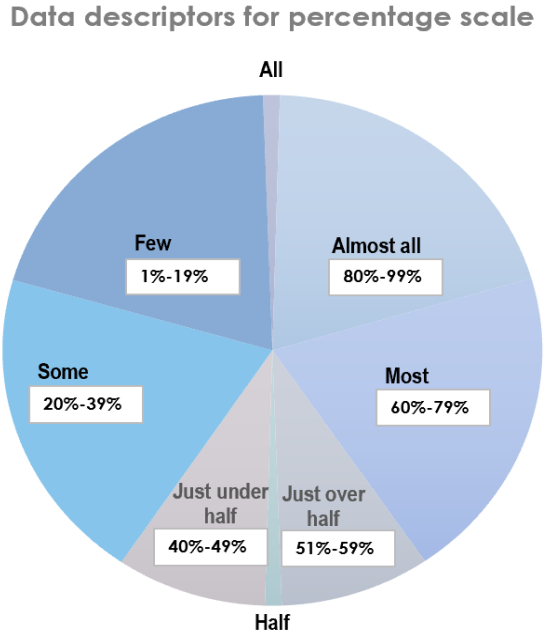


The scrutiny of social work records of adults at risk of harm. This involved the records of 36 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 50 adults at risk of harm where their adult protection journey progressed to at least the investigation stage.

Staff focus groups. We carried out two focus groups and met with twenty-two members of staff from across the partnership to discuss adult support and protection practice 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



Summary – strengths and priority areas for improvement

Strengths

- Partnership staff collaborated well, and shared information effectively to support adults at risk of harm.
- Frontline police officers and divisional concern hub staff worked diligently to help adults at risk of harm. They co-operated well with other partners.
- Partnership strategic leaders effectively managed adult support and protection during the Covid-19 pandemic. They maintained business continuity for adult support and protection.
- Partnership leaders instigated a comprehensive rolling quality assurance programme for adult support and protection. If methodology issues were resolved, the programme would support broader improvement.

Priority areas for improvement

- Social work should improve its initial inquiry process. Staff should always record the application of the three-point test. A newly introduced template should support better management oversight.
- Management of risk for adults at risk of harm needed improvement. All who require a chronology, a risk assessment, and a risk management plan should have them. The partnership should use a standard template for adult protection risk assessments.
- The partnership should revise its processes for adult protection investigations. It should make sure investigations are carried out in line with legislation. Council officers carrying out investigations should routinely interview adults at risk of harm.
- The partnership should strengthen its operational management oversight and improve strategic governance of social work adult protection practice. This will ensure strategic leaders are better informed about key process weaknesses.
- The lived experiences of adults at risk of harm and their unpaid carers were not represented at the adult protection committee. It should make sure they are involved.

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

Key messages

- Partnership staff worked collaboratively to keep adults at risk of harm safe, protected, and supported. They shared information about adults at risk of harm effectively.

- Police Scotland made a strong contribution to adult support and protection. Frontline officers and divisional concern hub staff identified when adults were at risk of harm and supported them.

- Social work's handling of initial inquiries into the circumstances of adults at risk of harm required improvement. Management oversight and recording of application of the three-point test were mostly missing. Some initial inquiries stopped the adult protection process too early, so the risk to the adult was not assessed.

- All three areas for the management of risk for adults at risk of harm required improvement – chronologies, risk assessments, and risk management plans.

- The partnership's approach of linking interagency referral discussions and adult protection investigations was ineffective. Adults at risk of harm and other relevant parties were not interviewed when they should have been.

- Adult protection case conferences showed room for improvement. Some were not convened when they should have been, and some were delayed. The partnership needed to do more to encourage and support adults at risk of harm to attend their case conference.

- Health staff played a key supporting role in adult protection work but were not consistently recording this in their records. Increased oversight should be introduced to ensure the necessary change.

We concluded the partnership's key processes for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

The partnership's adult social care inquiry team screened all adult protection referrals. The partnership stated it did this by applying the three-point test and a manager oversaw the screening of all adult protection referrals. Recorded application of the three-point test and evidence of management oversight of screened referrals was mostly absent. This was despite the partnership's earlier audit of adult protection referral screening. Screening of adult protection referrals called for improvement.

Initial inquiries into concerns about adults at risk of harm

Competent, prompt initial inquiries into concerns about adults at risk of harm are crucial to keeping them safe, supported and protected. Ineffective initial inquiries, lacking in managerial oversight resulted in missed opportunities to protect adults at risk of harm. This partnership did not carry out initial inquiries effectively and improvement was needed.

Almost all initial inquiries were prompt, but a significant few were delayed. Most initial inquiries did not record the application of the three-point test. Most had no managerial oversight. Only some were of good quality or better. Significantly, some initial inquiries halted the adult protection process prematurely. Consequentially, some individuals' risks were not properly assessed.

As a result of audit work, the partnership recently introduced a template, including a mandatory field for managerial sign off to record initial inquiries. It was too early to determine the impact of this measure. Initial inquiry deficits occurred despite the partnership's audits of this area. They needed to drive improvement more rigorously.

Positively, almost all initial inquiries were done in line with the principles of the Adult Support and Protection (Scotland) Act 2007. Partners collaborated well. The divisional concern hub passed on all adult protection concerns quickly, and almost all its reports were comprehensive.

Investigation and risk management

Chronologies

Chronologies for adults at risk of harm are an essential element of risk assessment and risk management. Just over half of adults at risk of harm, who needed one, had a chronology. But just under half did not, which impaired the assessment of their risks. Quality of chronologies was poor, with just over half weak or unsatisfactory. Some chronologies were good or better.

Following an audit of chronologies in 2021, the partnership recognised the need for improvement and introduced a template for chronology preparation. Problems with chronologies included, sparse detail, not up to date, no analysis of risk and patterns of adverse occurrences, and only recording adult support and protection actions. Competent chronologies for adults at risk of harm was a key area for improvement. The partnership recognised this, but it was too early to assess the impact of the new template. The partnership introduced chronology training for staff. It should progress this to drive improvements in chronology preparation.

Risk assessments

Most adults at risk of harm had a risk assessment. But some did not, which impacted adversely on their safety. Almost all risk assessments were timely and reflected partners' views.

Quality of risk assessments was poor. While some were good or better, half were weak or unsatisfactory. There was a field for risk assessment in the partnership's interagency referral discussion electronic template. It was often sparsely populated, lacked cogent analysis of risks, and the likelihood of risk occurrence. It did not analyse the impact of the risks on the individual or take full account of protective factors. Creation and implementation of a standard template for assessing risk for adults at risk of harm would support necessary improvements.

Full investigations

The investigation and how it was recorded was linked to an interagency referral discussion process. The eIRD process was sound, but the eIRD recording template did not reference investigations. This made it difficult for staff to carry out and record investigations effectively. Adults at risk of harm at the centre of the investigation and others were not interviewed when they should have been. For some investigations, the partnership did not meet its statutory duty to investigate the circumstances of the adult at risk of harm. These problems with investigation practice continued despite the partnership's adult protection procedural update emphasising the requirement to interview the adult at risk of harm during an investigation.

Overall, some investigations were good or better for quality. The investigations for some adults at risk of harm were weak. Significantly, for a few adults at risk of harm, there was no investigation when there should have been. While most investigations were timely, some were delayed, with a few lengthy delays of over a month or over three months.

There were positives for investigations; almost all were collaborative, and effectively determined the risks for the adult at risk of harm.

The partnership needed to improve investigation practice. This would ensure investigations were competent and engaged with the adult at risk of harm and other relevant parties. A necessary step would be the creation of a standard template for recording investigations which is separate from the interagency referral discussion recording template.

Adult protection case conferences

Most adults at risk of harm who needed an adult protection case conference got one. But significantly, some did not benefit from a case conference when they should have. Most case conferences were timely, but some were delayed. This was an improvement on the partnership's case conference audit figure of just under half delayed.

Almost all case conferences effectively determined actions to ensure the adult at risk of harm was safe and supported.

Professionals' attendance at case conferences was mixed. Commendably, the police attended all when invited. Health staff attended most when invited but did not attend some. Health staff made some very good contributions to case conferences when they attended. This showed the importance of health staff attending adult protection case conferences.

Only some adults at risk of harm invited to their case conference attended. Staff supported them to take part meaningfully. The partnership should ensure it is doing everything possible to encourage and support adults at risk of harm to attend their case conference. Positively, all unpaid carers invited to case conferences attended.

Just over half of adult protection case conferences were good or better for quality. This showed there was room for improvement for adult protection case conferences.

Adult protection plans / risk management plans

Unlike risk assessments, there was a standard template for risk management plans. Population of this template was inconsistent. Most adults at risk of harm who needed a risk management plan had one. Significantly, some did not; therefore, they had no plan to reduce and manage their risks. Almost all risk management plans were up to date and reflected partners' opinions.

Quality of risk management plans needed improvement. Only some were good or better. Problems with risk management plans included, lack of detail, not saying who should carry out actions, and not specifying timescales for completing actions.

Adult protection review case conferences

The partnership promptly convened an adult protection review case conference on almost all occasions when needed. All of them effectively decided upon the actions needed to keep the adult at risk of harm safe.

Implementation / effectiveness of adult protection plans

Adults at risk of harm with protection plans (risk management plans) had improved safety and wellbeing outcomes. Partnership staff collaborated effectively for the implementation of protection plans. Staff persevered with adults at risk of harm who did not readily engage with efforts to protect and support them.

Large-scale investigations

The partnership carried out recent large-scale investigations appropriately and proficiently, and in line with national guidance. The Care Inspectorate was purposefully involved in large-scale investigations. The partnership's multi-agency care home support team supported large-scale investigations, and the dissemination and implementation of the learning from them. Residents of care homes, subject to a large-scale investigation, were safer as a result.

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

Overall effectiveness of collaborative working

Partnership staff collaborated well to deliver improved safety, health and wellbeing for adults at risk of harm. Almost all staff surveyed thought leaders supported them to work collaboratively.

The partnership's interagency referral discussion process was its main vehicle for collaboration among the core adult protection partners, social work, health, and the police. At the start of an adult protection investigation, an interagency referral discussion was opened. Any of the core partners could initiate an interagency referral discussion. Partners' contributions about the risk to adults at risk of harm were recorded sequentially in the interagency referral discussion record. A multi-agency group took the decision to close this record. The interagency referral discussions process worked well as a tool to promote collaboration among partners.

The partnership's multi-agency adult support and protection procedures were accessible to staff. A review of procedures was in progress. The procedures referenced the national health and social care standards. The partnership recently issued written reminder guidance for staff about initial inquiry episodes and interagency referral discussions. The original procedures were not clear enough about the requirement to interview the adult at risk of harm for investigations. This caused confusion for staff carrying out investigations and had a negative impact on adults at risk of harm.

Health involvement in adult support and protection

Health staff raised the adult protection concern in a few duty to inquire episodes, and adults at risk of harm whose journey went to the investigation stage or beyond.

The health response was good or better for almost all adults at risk of harm with repeated emergency admissions and emergency department presentations.

A universal electronic patient management system was used across all of NHS Lothian to record health information. The quality of recording was good or better in just over half of health records. But for just under half of adults at risk of harm there was no adult support and protection material in their health records when there should have been. There was no consistent place to record adult support and protection concerns within health records.

Health staff's contribution to the outcomes for most adults at risk of harm was good or better. Health staff delivered invaluable ongoing support to most adults at risk of harm who needed it. Record keeping within health records was an area for improvement.

Capacity and assessment of capacity

The partnership's handling of capacity issues for adults at risk of harm was proficient. In most cases social work requested a capacity assessment from health when necessary. Health professionals carried out capacity assessments for adults at risk of harm promptly almost all the time. There were isolated examples when social work should have sought an assessment of the adult at risk of harm's capacity from health and they did not. This had the potential to detrimentally affect the individual's safety, health, and wellbeing.

Police involvement in adult support and protection

Police officers and staff almost always effectively assessed contacts about adults at risk of harm. They competently assessed for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). Officers recorded an accurate STORM disposal code (record of incident type) most of the time.

In almost all cases, initial attending officers' actions were good or better for quality. Their practice was effective, and officers contributed meaningfully to the multi-agency response. Officers' assessments of risk of harm, vulnerability and wellbeing were accurate and informative almost all the time. They almost always considered and recorded the wishes and feelings of the adult at risk of harm.

Officers, who referred adult protection concerns, did so efficiently and promptly on all occasions, using the interim vulnerable persons database (iVPD).

Frontline supervisory input was almost always evident, and this was good or better most of the time. In a few instances, supervision was particularly strong. Supervisors exercised supportive, visible leadership for officers dealing with challenging adult protection incidents.

Divisional concern hub staff's actions were good or better in all cases. They always recorded a resilience matrix and a relevant account of police concerns. They carried out assessments diligently and shared them with social work quickly.

When divisional concern hub staff initiated the escalation protocol (following repeat police involvement) it proved effective. However, there were opportunities to further develop existing local practice. These included securing strategic input from the local area command. This would inform the response to high-volume repeat police activity to support adults at risk of harm.

Interagency referral discussions were common for adults at risk of harm when the police were involved. This approach supported open and prompt communication among professionals. Police involvement was good or better in most instances. The electronic interagency referral discussion template supported partner communication. But it blurred police, social work, and health roles and responsibilities for adult support and protection investigations.

Third sector and independent sector provider involvement

Third and independent sector organisations, such as care homes, raised adult protection concerns with social work when appropriate. There were examples of diligent work by staff, who had concerns about an adult at risk of harm, to pass on their concerns to social work quickly and efficiently.

These bodies adeptly supported adults at risk of harm to realise improvements to their safety, health, wellbeing, and inclusion. The partnership recognised these bodies invaluable contribution to adult support and protection. Encouragingly, there was a delegate from these bodies on the partnership's adult protection committee.

Key adult support and protection practices

Information sharing

Partners shared adult protection information promptly and efficiently for all adults at risk of harm. There were clear protocols for information sharing among partners.

Several staff survey respondents commented that they did not get feedback about what happened, after they made an adult protection referral to social work. The partnership acknowledged this was an issue. There was a small-scale initiative to improve feedback to the Scottish Fire and Rescue Service after it raised an adult protection concern with social work.

Management oversight and governance

Sound management oversight and governance of adult support and protection is critically important. The police exercised sound oversight and governance of their adult protection records, with almost all showing this. Our findings about police adult protection records were consistently positive.

Management oversight and governance for social work records warranted improvement. Some social work records showed no evidence of governance. Line managers had not verified they read some social work records for adults at risk of harm. Supervision discussions and decisions were not recorded in some social work case notes for adults at risk of harm. There was a link between lack of oversight and governance of social work records and weaknesses in key processes for adult support and protection.

Some health records had evidence of governance. Evidence of exercise of governance was less apparent in health records. This was not necessarily a deficit due to the types of health records scrutinised.

Involvement and support for adults at risk of harm

Most adults at risk of harm had support throughout their adult protection journey, with most supports rated good or better. Almost all staff surveyed thought adults at risk of harm were supported to participate meaningfully in adult support and protection decisions that affected their lives.

Independent advocacy

The partnership offered independent advocacy to just over half of adults at risk of harm who needed it. But it did not offer advocacy to just under half who needed it. Those adults at risk of harm who wanted an independent advocate got one promptly. They benefitted greatly from the efforts of independent advocates to articulate their views and help them understand the complexities of the adult protection process. Independent advocates skilfully represented adults at risk of harm at case conferences.

Financial harm and alleged perpetrators of all types of harm

Some adults at risk of harm were financially harmed. In most cases, partners' joint actions to stop it were successful, and good or better for quality.

Just under half of the partnership's actions against known perpetrators were good or better.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced some improvement to their safety because of the partnership's adult support and protection efforts. There were examples of staff working collaboratively and diligently to deliver positive safety, health, and wellbeing outcomes for adults at risk of harm.

Adult support and protection training

The partnership had a comprehensive joint training plan. It delivered training in several important key process areas, such as preparation of chronologies and risk assessments. Our findings' showed improvements were required in these areas. The partnership needed to measure the impact of its adult protection training and initiate any necessary improvements.

While most staff surveyed were satisfied with mandatory adult protection training, some felt this could be better. Almost all council officers were confident their adult protection training equipped them for their role.

The partnership successfully maintained adult protection training online during the pandemic. While staff surveyed appreciated this, many favoured a return to face-to-face adult protection training.

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

Key messages

- Partnership leaders supported operational and strategic collaborative working for adult support and protection.
- The partnership successfully maintained business continuity for adult support and protection during the Covid-19 pandemic.
- The partnership had a comprehensive rolling quality assurance programme for adult support and protection. If methodology issues were resolved, the programme would support broader improvement.
- There was ineffective operational management oversight and strategic governance of social work adult protection practice. Therefore, strategic leaders were not fully informed about critical key process weaknesses.
- The partnership's adult protection committee did not have an independent convener. This was not in line with the Scottish Government's code of practice for adult protection committees (2021).
- The partnership's strategic decision making was not informed and enhanced by the lived experiences of adults at risk of harm and their unpaid carers.

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 suitable vision statement for adult support and protection. It communicated this effectively to partners, staff, and the public through the West Lothian public protection website. Most partnership staff surveyed thought this vision was clear.

The partnership had a comprehensive improvement plan for adult support and protection, dated 2020-2022. It noted that improvement work was completed for recording of the three-point test and management oversight of screening of adult protection referrals. We found most initial inquiries did not record the three-point test and lacked management oversight. Despite improvement activities for management of risk for adults at risk of harm, we found weaknesses in this critical area.

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

Leaders had a sound rationale for the change from a public protection committee back to an adult protection committee in 2019. This provided an enhanced strategic framework for adult support and protection.

Leaders were content that they did not have an independent convener of the adult protection committee. The appointment of an independent convener would ensure compliance with the Scottish Government's code of practice.

The chief officers' group and the adult protection committee ran efficiently. Delegates attended both regularly and contributed purposefully. The adult protection committee scrutinised adult protection activity performance data and compared it with published national data. It instigated relevant quality assurance by frequent audits and self-evaluation exercises. It had a constructive protocol for distribution of information across the partnership.

The partnership purposefully set up a multi-agency critical review team and had a protocol for escalation to this team. It reviewed complex, high-risk cases, and supported staff who worked on them. It reported to the adult protection committee.

Leaders ensured there was a comprehensive programme of adult support and protection training in place. This continued to run successfully online during the pandemic.

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

The lived experiences of adults at risk of harm and their unpaid carers did not inform the partnership's strategic decision making. The adult protection committee did not have an adult at risk of harm as a member. No adults at risk of harm took part in adult protection committee subgroups. Unpaid carers, who cared for an adult at risk of harm, were not represented at a strategic level within the partnership. There was a delegate from independent advocacy on the adult protection committee.

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

There were important weaknesses in the execution of key processes to keep adults at risk of harm safe, protected and supported. The partnership acknowledged our findings and that it needed to make improvements.

There was a marked contradiction between what the partnership's procedures said should happen – duty to inquire, interagency referral discussion, adult protection investigation – and our findings about what happened in operational practice.

Despite key process weaknesses, there was effective strategic and operational collaborative working for adult support and protection.

Police Scotland's contribution to adult support and protection was very good. Frontline officers and divisional concern hub staff supported adults at risk of harm empathetically and proficiently. Senior police officers' exercised sound leadership for adult support and protection.

A Scottish Fire and Rescue Service delegate was a member of the adult protection committee. When firefighters were concerned about an adult at risk of harm, they referred them to social work promptly. Housing services was represented on the adult protection committee.

The care home oversight group set up a multi-agency care home assurance team, which provided vital support to care homes during the Covid-19 pandemic. This team continued to effectively support care homes after the pandemic's restrictions ended.

The partnership managed adult support and protection well during the Covid-19 pandemic. It successfully maintained business continuity for adult support and protection despite the unprecedented challenges of the pandemic and its associated restrictions. It effectively supported its staff to carry out their duties and offered them support for their health and wellbeing. During the pandemic, it progressed strategic activities such as improvement planning and development of its large-scale investigation procedure. The partnership planned to embed learning from the pandemic

– remote working, digital solutions, purposeful partnership working during a crisis – in continuing adult support and protection practice.

Quality assurance, self-evaluation and improvement activity

The partnership had a comprehensive rolling programme of audits and self-evaluations of adult support and protection. The partnership's position statement and supporting evidence showed creditable activity levels in this area. One example of a progressive audit was a rolling survey of the views of professionals who attended adult protection case conferences. Leaders understood the importance of quality assurance of adult support and protection. They had made strenuous efforts to set up an extensive quality assurance programme

The many audits and self-evaluations of adult support and protection did not find some of the critical key process weaknesses that we later found. They examined a relatively small number of records, limiting the reliability and accuracy of key results. It was hard to interpret the results of the audits. These issues inhibited the audits' ability to effectively inform strategic leaders and improvement activity. The partnership did not seek the views of adults at risk of harm and their unpaid carers to inform strategic decision making.

The partnership would have strong capacity for improvement if it resolved the issues with its quality assurance programme. It could then use it to monitor and drive progress with the key improvements our inspection identified.

Initial case reviews and significant case reviews

The partnership had a thorough procedure for initial case reviews and significant case reviews, which was in line with national guidance. It planned to revise the procedure to take account of the national learning review on adult significant case reviews. It carried out one recent initial case review and no significant case reviews. It prepared an improvement plan to implement learning from the initial case review.

Summary

Partnership staff collaborated well, and shared information effectively to support adults at risk of harm.

Frontline police officers and divisional concern hub staff helped and supported adults at risk of harm. They co-operated well with other partners.

The partnership's key processes for adult support and protection needed considerable revision and improvement to ensure adults at risk of harm were safe, supported, protected, involved, and included. For this reason, we considered the partnership's key processes for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm

The partnership's initial inquiry process required improvement. Staff mostly did not record the application of the three-point test. Managers mostly did not consistently check initial inquiries and sign them off. Ineffective initial inquiries could lead to missed opportunities to protect adults at risk of harm.

All the partnership's processes for management of risk for adults at risk of harm called for improvement. The partnership should create a standard template for adult protection risk assessments.

The partnership's processes that linked interagency referral discussions and adult protection investigations needed revision. The partnership needed to carry out all adult protection investigations competently and in line with legislation.

Partnership strategic leaders efficiently managed adult support and protection during the Covid-19 pandemic. They maintained business continuity for adult support and protection.

Strategic leaders productively supported operational and strategic collaborative working among adult protection partners.

Adults at risk of harm and their unpaid carers were not represented at the adult protection committee. It should involve them.

Creditably, the partnership instigated a comprehensive rolling quality assurance programme for adult support and protection. Its audits and self-evaluations of adult support and protection were not rigorous enough. The reports of audits and self-evaluations did not convey key messages to strategic leaders. They did not flag up some of the key processes deficits that we later found.

Operational management oversight and strategic governance of social work needed to improve. This would ensure strategic leaders know about any key process weaknesses and can take prompt remedial action.

There would be strong capacity for improvement if leaders could quickly resolve the issues with quality assurance. An invigorated quality assurance programme could support the key improvements our inspection identified. On this basis, we considered that on balance strategic leadership for adult support and protection was effective.

Next steps

We asked the West Lothian partnership to prepare an improvement plan to address the priority areas for improvement (see prioityareasforimprovement 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 process 1

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

- 92% 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
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 33% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 78% of episodes where the three-point test was applied correctly by the HSCP
- 83% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 17% less than one week, 33% one to two weeks, 33% two weeks to one month, 17% one to three months
- 36% of episodes evidenced management oversight of decision making
- 39% of episodes were rated good or better.

Staff survey results on initial inquiries

- 89% concur they are aware of the three-point test and how it applies to adults at risk of harm, 6% did not concur, 5% didn't know
- 84% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 4% did not concur, 12% didn't know
- 77% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 10% did not concur, 13% didn't know

Information sharing among partners for initial inquiries

- 83% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm

Chronologies

- 56% of adults at risk of harm had a chronology
- 26% of chronologies were rated good or better, 76% adequate or worse

Risk assessment and adult protection plans

- 73% of adults at risk of harm had a risk assessment
- 25% of risk assessments were rated good or better
- 66% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 36% of protection plans were rated good or better, 64% were rated adequate or worse

Full investigations

- 93% of investigations effectively determined if an adult was at risk of harm
- 74% of investigations were carried out timeously
- 33% of investigations were rated good or better

Adult protection case conferences

- 76% were convened when required
- 79% were convened timeously
- 27% were attended by the adult at risk of harm (when invited)
- Police attended 100%, health 71% (when invited)
- 58% of case conferences were rated good or better for quality
- 84% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 80% 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
- 91% of inquiry officers' actions were rated good or better
- 100% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 82% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 54% good or better rating for the quality of ASP recording in health records
- 82% 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

- 100% of cases evidenced partners sharing information
- 96% of those cases local authority staff shared information appropriately and effectively
- 100% of those cases police shared information appropriately and effectively
- 92% of those cases health staff shared information appropriately and effectively

Management oversight and governance

- 66% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 70%, police 93%, health 25%

Involvement and support for adults at risk of harm

- 76% of adults at risk of harm had support throughout their adult protection journey
- 62% were rated good or better for overall quality of support to adult at risk of harm
- 85% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 5% did not concur, 10% didn't know

Independent advocacy

- 52% of adults at risk of harm were offered independent advocacy
- 69% of those offered, accepted and received advocacy
- 91% of adults at risk of harm who received advocacy got it timeously

Capacity and assessments of capacity

- 79% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 82% 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

- 22% of adults at risk of harm were subject to financial harm
- 72% of partners' actions to stop financial harm were rated good or better
- 25% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 84% of adults at risk of harm had some improvement for safety and protection
- 94% of adults at risk of harm who needed additional support received it
- 77% concur adults subject to ASP, experience safer quality of life from the support they receive, 7% did not concur, 17% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 66% concur local leaders provide staff with clear vision for their adult support and protection work. 15% did not concur, 19% didn't know

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

- 67% concur local leadership of ASP across partnership is effective, 12% did not concur, 20% didn't know
- 61% concur I feel confident there is effective leadership from adult protection committee, 13% did not concur, 26% didn't know
- 46% concur local leaders work effectively to raise public awareness of ASP, 18% did not concur, 36% didn't know

Quality assurance, self-evaluation, and improvement activity

- 56% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 12% did not concur, 31% didn't know
- 53% concur ASP changes and developments are integrated and well managed across partnership, 17% did not concur, 31% didn't know