

A large, abstract graphic composed of numerous overlapping, diagonal, rectangular and triangular shapes in various shades of blue and purple, creating a sense of movement and depth.

# JOINT INSPECTION OF **ADULT SUPPORT** AND **PROTECTION**

Glasgow City Partnership October 2022

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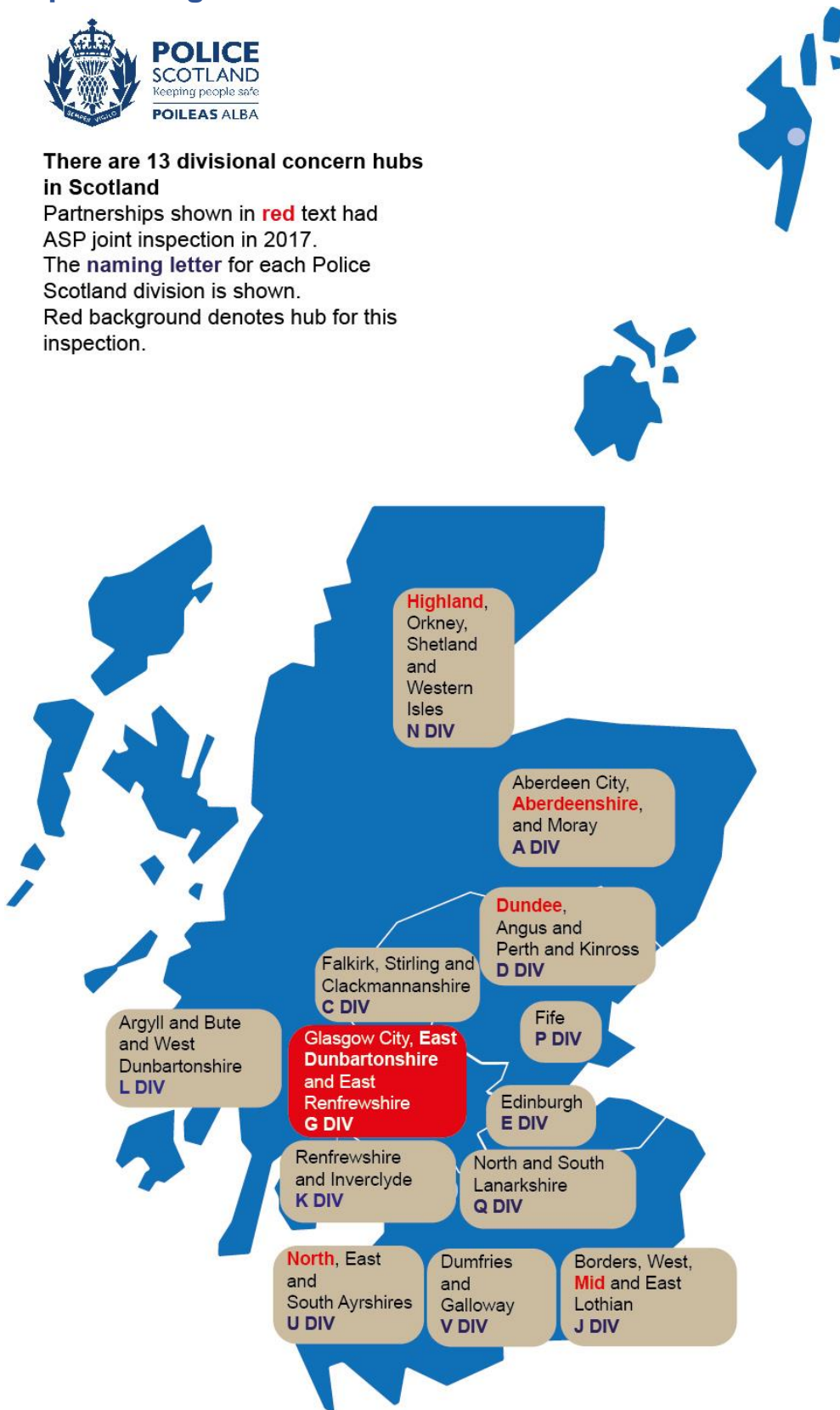
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## Map showing divisional concern hubs



### There are 13 divisional concern hubs in Scotland

Partnerships shown in **red** text had ASP joint inspection in 2017. The **naming letter** for each Police Scotland division is shown. Red background denotes hub for this inspection.



## Joint inspection of adult support and protection in the Glasgow City 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<sup>1</sup> 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 Glasgow City partnership area were safe, protected and supported.

The joint inspection of the Glasgow City partnership took place between June and August 2022. We scrutinised the records of adults at risk of harm for a two-year period, May 2020 – May 2022.

The Glasgow City 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 Glasgow City partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

### Quality indicators

Our quality indicators<sup>2</sup> for these joint inspections are on the Care Inspectorate's website.

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1

[https://www.careinspectorate.com/images/Adult\\_Support\\_and\\_Protection/1. Definition\\_of\\_adult\\_protection\\_partnership.pdf](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?

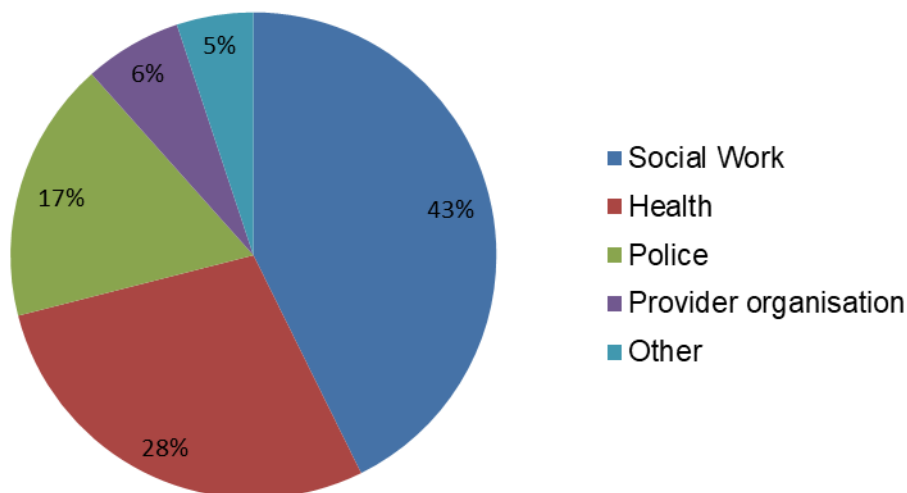
## Joint inspection methodology

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.** Four hundred and thirty-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.

### Respondents by Employer type



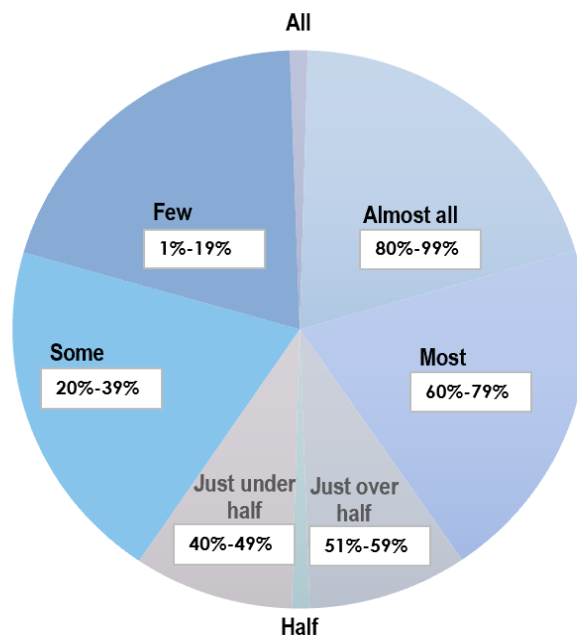
**The scrutiny of social work records of adults at risk of harm.** This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

**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 four focus groups and met with 47 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**

Data descriptors for percentage scale



## Summary – strengths and priority areas for improvement

### Strengths

- The partnership had implemented robust procedures to manage the very high volume of adult protection referrals. It had committed considerable resources and was transforming this area of practice to ensure further improvement.
- Access arrangements into adult support and protection processes were clear and the quality of inquiry work was completed to a high standard.
- Collaborative and robust risk assessments helped to ensure that almost all adults experienced improvements in their circumstances.
- The health and social care partnership had a clear and well understood vision for adult support and protection. This was threaded through adult support and protection strategies. A strong commitment to trauma informed practice underpinned this.
- Audit activity was driving change and improvement across the partnership. There were cohesive governance arrangements that supported this.
- There was engagement of adults at risk of harm in outcome focussed and strategic planning activity. Strong foundations were in place to take this work forward. Stronger collaboration between the Service User Representative Group and the Adult Support and Protection Committee was needed..
- Health were strong strategic partners. Almost all the records we read evidenced health involvement most of which recorded adult support and protection matters.
- Most areas of adult support and protection work was completed to a high standard with evidence of effective management oversight.

### Priority areas for improvement

- The quality of chronologies needed improved as did the consistency of decision making around progressing investigations to initial case conference.
- Aspects of case conferences needed improved. Stakeholder invites and attendance, accurate recording of attendees and the reasons why adults at risk of harm did not attend were areas for improvement.

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

### Key messages

- Screening, triage, and inquiry work was underpinned by sound guidance and procedures. Management oversight was strong, and the quality of work done was robust.
- Collaboration and information sharing across the partnership helped to ensure that nearly every adult experienced improvement in their circumstances.
- Risk assessments were collaborative, well recorded and completed to a high standard. This was a real strength of the partnership's adult support and protection work.
- Requests to health colleagues for capacity assessments were being made and acted upon. Almost all assessments were timely and in keeping with the needs of the adult at risk of harm.
- Adult protection partners took account of the adult at risk of harm's views directly, or through appropriate, identified representatives. We saw this in almost all inquiries, investigations, and protection planning.
- Overall, investigation work was robust but there needs to be exploration around the rationale for not progressing a few adults at risk of harm to initial case conference where required.
- The police were not routinely invited to initial case conferences in matters relating to criminality.
- The reasons why adults at risk of harm were not present at case conferences were not clearly recorded.

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



## Initial inquiries into concerns about an adult at risk of harm

### Screening and triaging of adult protection concerns.

Glasgow City Council had a clear system for screening and triaging the rapidly increasing number of adult support and protection concerns/referrals intimated to it. All external referrals were submitted to the Social Care Direct (SCD) service which provided a single point of contact for screening and triaging. SCD staff were guided in their role by detailed and well understood procedures and referral processes. A duty to inquire episode was opened for every referral, and well-designed forms helped to prompt robust recordings and clear management oversight. Social care advisors made initial checks, and authorised referral outcomes. These arrangements were well embedded and effectively overseen by social work team leaders. Staff were encouraged to make referrals and had confidence in the handling process. Three locality duty hubs based in the north east, north west and south of the city received onward referrals where further inquiry work was needed about adults at risk of harm.

### Initial inquiries into concerns about adults at risk of harm

Initial inquiry processes were undertaken efficiently and in keeping with the principles of the Adult Support and Protection (Scotland) Act 2007. Almost all episodes' showed referrals were progressed within appropriate timescales. This was a clear strength but the recording of the three-point criteria needed to be more consistently applied. Communication was evident and effective, and enabled referral outcomes to be accurately determined. Management oversight was robust, and this had helped to maintain the quality of inquiry work. Almost all episodes were good or better.

The health and social care partnership (HSCP) was embarking on a significant transformational change programme to establish a new integrated single point of access service. It was intended to bring the various care group duty arrangements together to further strengthen early adult support and protection work.

## Investigation and risk management

### Chronologies

Chronologies for adults at risk of harm are an important element of risk assessment and risk management. The partnership had appropriately embedded them into the adult support and protection investigation template, and they were routinely evident. Almost all records included a chronology. While this was positive, the quality of chronologies needed to significantly improve with just under half weak or unsatisfactory. The partnership had made similar findings through their own internal audit work and had implemented a chronology improvement plan. Work was

undertaken to strengthen the training programme and a subgroup of staff were providing input into the design of a new client information system. These initiatives should enhance the quality of chronologies.

### **Risk assessments**

Almost all records of adults at risk of harm contained a timely risk assessment and reflected the input of multi-agency partners. This was a positive feature of adult support and protection investigation work. Most risk assessments were good or better with emphasis on detail of recording, level of analysis and achieving a good balance between protective and risk factors. There was clear evidence this area of practice was strong and effective.

### **Full investigations**

Adult support and protection investigations were completed in a timescale that met the needs of the adult at risk of harm almost every time. The involvement of other agencies was consistently sought and evidenced in council officers case records. Second workers are critical to adult support and protection work and were deployed in every case where they should have been. Health staff in the partnership undertook this role on most occasions where it was appropriate to do so. The strong collaboration evident in this work helped to ensure that investigations effectively determined if the adult was at risk of harm.

While the quality of investigation work overall was very good, some cases that should have progressed to initial case conference did not. Often these were complex cases where adult support and protection investigations were concluded without a clear justification evident in the records. Staff described the struggles they had managing increasing adult support and protection workloads. There were clear capacity issues, and some staff suggested this may be a factor in some investigations not progressing when they should. Particularly if it was deemed by those involved that risks were being adequately managed. The partnership recognised the pressure in the system and had enacted a test of change in the south duty hub.

### **Adult protection case conferences**

Adult support and protection initial case conferences were convened when they should have been most of the time. This meant some adults at risk of harm did not access a case conference and the protection planning this meeting affords. When they were convened almost all were timely, and most were conducted to a high standard. A twenty-four-hour decision letter was consistently sent to attendees following initial case conferences to ensure clarity around decisions and outcomes. Initial case conferences effectively determined what needed to be done to keep the adult at risk safe from harm. This decision letter reflected good practice and helped to strengthen this area of practice.

Not all relevant parties were invited to initial case conferences when they should have been. Police Scotland should have been invited more frequently in cases involving potential criminality. This limited their attendance and potential impact on protection planning outcomes. The recently implemented adult support and protection police team should help to address this issue. Health professionals were routinely invited and attended. Recording of attendees at case conferences needed to be clearer. This should be addressed to ensure greater accountability around decision making at case conferences.

Almost all staff were confident adults at risk of harm were supported to participate meaningfully in decisions affecting their lives. However, just under half of the adults at risk of harm were invited to initial case conferences. Reasons for adults at risk of harm not attending were not recorded in just over half of the case conference minutes. More work was needed to address this. Where adults were invited and did attend their case conference, they were supported to meaningfully participate. Unpaid carers were invited and attended most of the time.

### **Adult protection plans / risk management plans**

There was a protection plan in most records where required. Almost all were up to date and identified the contributions of other agencies. This reflected strong collaboration in a critical area of practice. The quality of this work was mostly good or better. The investigation template elicited a detailed response from council officers, and this helped to mitigate risks prior to case conference. In some instances, plans were not SMART (specific, measurable, achievable, relevant and time bound). There were some adults at risk of harm for whom a protection plan should have been undertaken but were not. The partnership should do more to ensure protection type risks are adequately recorded for this significant minority.

Case conference protection plans effectively captured what needed to be done to protect adults at risk of harm. They were collaborative, well formulated and quickly cascaded in summary format to attendees through the decision letter. Initial referral discussion (IRD's) protocols were in place, but case discussions between partner agencies were the preferred option. Both options provided good opportunities for early risk planning and management strategies to be put in place. There were close similarities between the two processes. The partnership identified this was an area of overlap that required to be addressed.

## Adult protection review case conferences

Almost all adult support and protection review case conferences were timely and in keeping with the needs of the adult at risk of harm. They effectively determined what needed to be done to keep the adult safe from harm.

## Implementation / effectiveness of adult protection plans

With some exceptions protection planning and management was effective. Both in activity leading up to and including case conferences. Guidance was clear and audit activity had led to improvements which had strengthened the quality of work and management oversight. Sound investigation tools contained risk assessment and protection plans. Accurate recording supported consistent practice in these areas.

A pool of assistant service managers provided an independent chairing role to both adult protection and adults with incapacity meetings. This helped adult protection case conferences to effectively determine what needed to be done to keep adults at risk safe from harm. Protection plans reflected a multi-agency approach to managing risk. Regular review case conferences were convened to monitor the effectiveness of protection plans. Quick circulation of summary outcomes following case conference provided immediate clarity for those agencies playing critical supporting roles.

## Large-scale investigations

The partnership had two large scale investigations (LSIs) in the last two years. They were collaborative and included a range of multi-agency partners and joint improvement plans. Appropriate agencies were involved including the Care Inspectorate. A well governed and structured approach in keeping with the partnership's guidance was evident, although operating procedures remained in draft form. The partnership was addressing this through a working group. Both LSIs had recently come to an end. The period between one commencing and completing was lengthy.

Work was ongoing to compile overview reports to highlight key learning through the quality assurance subgroup and related governance arrangements. The partnership had anticipated the newly published adult support and protection codes of practice. Resultingly, it had plans to make any necessary updates to procedures including the development of good practice guidance for care homes. LSI activity featured in the partnership's training content and was being considered for the new social work client information system due to already recognised recording challenges. Both the care home nursing team and multi-agency huddle arrangements had played key roles in supporting recent LSI work.

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

### **Overall effectiveness of collaborative working**

Almost all staff were encouraged to work collaboratively, and this was a positive feature of the partnership's work. The West of Scotland Inter-Agency Adult Support and Protection guidance and local operating procedures supported this approach. Every agency shared information effectively across adult support and protection activity. The partnership had developed cohesive working relationships evident in screening, early inquiry, case discussions and investigation work. The health and social care partnership's adult support and protection team led on regular liaison meetings with partner agencies including Social Care Direct, advocacy, police, Care Inspectorate and Scottish Fire and Rescue Service to help promote improvement and effective joint working.

### **Health involvement in adult support and protection**

Health services were the referral source in just under half of the records we read. This was positive and reflects the partnership's 2022 reporting data which reflects a significant year on year increase of adult support and protection referrals from a range of health colleagues. There was clearly a growing awareness about adult support and protection processes. Health staff were confident in their understanding of adult support and protection work and felt the positive impact from the training provided. NHS Greater Glasgow and Clyde had implemented a range of e-learning opportunities on protection issues including financial harm and chronologies.

Almost every case we read evidenced health involvement. Adult support and protection concerns were recorded in most of the associated health records. A few adults presented at accident and emergency departments, some of whom required emergency hospital admissions. Interventions from acute services to help keep these adults safe and protected were mostly good or better. Some adults at risk of harm had repeat referrals to community health services. Again, interventions from community services to help keep them safe and protected were mostly good or better. The support provided across these health settings was largely positive. However, there was a small number of adults at risk of harm attending hospital settings who had a less positive experience. This was an area for improvement.

Health were strong adult support and protection partners. They supported inquiries, investigations, LSIs, and capacity assessment activity. Health was also central to the planning and delivery of key joint initiatives including the complex needs service.

## Capacity and assessment of capacity

Some adults at risk of harm lacked capacity to make decisions for themselves. The partnership provided staff with good guidance and investigatory templates to identify and promote necessary responses.

On most occasions referrals for capacity assessments were made and an assessment carried out. Almost all assessments were timely and in keeping with the needs of the adult at risk of harm. This was a strength in health services which supported prompt decision making and protection planning. The partnership also recognised the benefits of social work mental health officers and had ensured they were well positioned to affect adult support and protection decision making.

## Police involvement in adult support and protection

Nearly all contacts made to the police about adults at risk were effectively assessed for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). STORM disposal codes (record of incident type) were almost always accurately recorded.

Initial attending officers' actions were evaluated as good or better almost every time, with evidence of effective practice and meaningful contribution to the multi-agency response. The assessment of risk of harm, vulnerability and wellbeing was accurate and informative. The wishes and feelings of the adult were almost always appropriately considered and properly recorded.

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

Frontline supervisory input was well evidenced. This contribution was good or better in most cases.

Divisional concern hub (DCH) staff actions/records were good or better in almost all cases, with a resilience matrix and relevant narrative of police concerns consistently recorded. Resilience matrix research and assessments were inconsistent. Standardisation of appropriate and relevant research may improve qualitative information sharing with partners. Referrals were shared timeously by the DCH to partners.

Police Scotland had a dedicated adult support and protection team tasked with ensuring a timely response to the needs and expectations of vulnerable adults. This commendable resource commitment was built on existing relationships and enhanced the collaborative approach to complex or protracted cases.

The initiation of an escalation protocol review (instances of repeat police involvement) was inconsistent. Practice improvement may assist in identifying instances of an emerging pattern of wellbeing concerns. This should include appropriate measures based on risk of harm, taken to improve the safety and wellbeing of vulnerable adults. Opportunities remained to further develop existing local practice by involving local area command in response or protection planning.

Police attended case conferences, on almost all occasions when invited. The contribution of officers was consistently good or better.

### **Third sector and independent sector provider involvement**

The third and independent sector in Glasgow City was significantly involved in supporting adults at risk of harm during key processes. This included housing and homelessness services. Providers supported some of the most complex individuals with dedicated care. They often went beyond the call of duty to maintain contact with adults who did not want any help. They supported investigations well and attended some case conferences to provide information and help with protection planning.

These sectors are well represented on the adult support and protection committee and other subgroups. They have an established voice and were key to several recently developed early intervention and prevention initiatives. While this was positive, they wished to be more involved in multi-agency training and development. Those who attended clearly benefitted. This is critical to the overall delivery of adult support and protection key processes.

## **Key adult support and protection practices**

### **Information sharing**

The partnership shared information effectively. Good guidance and operational procedures supported this. The divisional risk and concern hub shared almost all its concern reports to social work in a timely manner and regularly provided reports for case conferences. Increased referrals from health were a positive trend but accessibility of the referral form for health staff was an area for improvement, although this was being addressed. Most health records contained evidence of adult support and protection concerns which reflected sound sharing and recording practices.

Onward referral processes from screening and triage to locality duty hubs were robust. Inquiry and investigation work reflected a high volume of close working and information sharing across partners. This supported good decision making in keeping with the needs of the adult at risk of harm.

## Management oversight and governance

There was evidence of effective governance and manager oversight in almost all social work and police records. Exercise of governance was evident in just over half of health records. This was not necessarily a deficit due to the types of health records reviewed. The level of recording was almost always appropriate, including evidence of supervisory discussions. While most records showed managers had read the records, this could be improved. The partnership had plans to measure this in future audit activity.

## Involvement and support for adults at risk of harm

Adult protection partners took account of the adult at risk of harm's views directly or through an appropriate identified representative. This was evident in inquiries, investigations, case conferences and protection plans. Support was effectively provided to enable these interactions. Staff put great emphasis on this aspect of their work. Almost all support was good or better. Case conferences did not always capture these positive interventions including the work done to elicit the views of adults at risk of harm.

## Independent advocacy

Independent advocacy was offered in all but a few instances when it should have been. Where it was offered, it was accepted on just under half occasions. Almost all who accepted it received a timely service. During the height of the Covid-19 pandemic independent advocacy was restricted to a telephone-based approach. Staffing challenges during this difficult period impacted on response times.. However, the independent advocacy service was back to a full complement of staff and doing face-to-face visits. Frontline staff said adult support and protection timescales made it difficult to build relationships between adults at risk of harm and advocates. But despite the challenges adults who used the service were effectively helped to express their views.

## Financial harm and alleged perpetrators of all types of harm

Financial harm was evident in some cases. The partnership took appropriate actions to mitigate the harm almost every time and, on most occasions, this stopped both physical and verbal coercion from happening again. An appropriate range of agencies played key roles to support these interventions including the police and banks. Most interventions were good or better.



## Safety outcomes for adults at risk of harm

Staff were confident the partnership worked hard to deliver good outcomes for adults at risk of harm and there was evidence to support this. Almost all adults had experienced reasonable improvements in their safety and protection because of adult protection interventions. This was almost always due to effective multi-agency working. Only a few adults experienced poor outcomes due to lack of effective multi-agency work and/or where the adult was unwilling or unable to engage.

## Adult support and protection training

The health and social care partnership had an up-to-date training plan and dedicated training team. Strategic leaders saw training as the bedrock to good practice. The training team led on training for council officers, team leaders, second workers and student social workers. These courses were in-person and had quickly re-commenced following the pandemic. A blended approach to training with online multi-agency awareness raising and various bespoke training events supported service delivery in key areas. External agencies contributed to the delivery of joint training to staff, including the service users' representative group, independent advocacy, and police.

The adult support and protection committee (ASPC) had a multi-agency training strategy supported by a dedicated senior learning and development officer working across public protection. They in turn were supported in their role by a network of trainers who helped to embed this work. Together, they led the development of multi-agency training in conjunction with the learning and development subgroup. There was a clear focus on a partnership wide approach.

A plan was underway to develop an adult support and protection learning network and roll out training for trainers in adult protection in August 2022. Practitioner forums and staff briefings offered routes to share helpful learning packs. A suite of public protection training was also available with emphasis on trauma informed practice.

While these measures were positive, the views of staff were mixed. Some staff said awareness of what was available needed to improve. Others felt the pressure of work prohibited their ability to attend opportunities. Staff from provider organisations were the least positive about access to multi-agency training. Almost all staff who undertook training experienced increased confidence and understanding of adult protection risks.

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

### Key messages

- The health and social care partnership had a clear and well understood vision which underpinned their joint adult support and protection work.
- Strategic leaders were committed to developing a strong trauma informed approach to their public protection work including adult support and protection.
- Strategic leaders engaged adults at risk of harm in outcome focussed and strategic planning activity. Strong foundations were in place to take this work forward, but greater collaboration was needed to ensure continued progress.
- Strategic leaders were implementing a transformational change programme around their single point of contact arrangements. The views of staff should be central to developing future models of delivery.
- Social work audit activity was rigorous and drove collaborative change and improvement across the partnership. Plans for further multi-agency audits and self-evaluation work should augment the good work already being carried out.
- While change and improvement work was positive, our survey indicated that more needed done to strengthen the involvement and understanding of staff.

**We concluded the partnership's strategic leadership for adult support and protection was very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm.**

## Vision and strategy

The vision and priorities for adult protection were clearly laid out in the health and social care partnership's (HSCP) strategic plan. It was closely aligned to both the national health and wellbeing outcomes and threaded through a range of other key adult support and protection strategic documents. This included annual performance reports, the biennial report and publicly available information. Most staff understood the adult support and protection vision and strategic leaders were working to strengthen this. The HSCP had recently invited staff share their views about priority areas of work and to inform the next version of the strategic plan.

The partnership effectively oversaw the vision and was effectively linked into other key public protection strategies including the alcohol and drug partnership, domestic abuse, and child protection. There was evidence of close joint working across these areas of practice.

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

The public protection chief officers' group (COG) was chaired by Glasgow City council's chief executive. Representatives from a wide range of appropriate organisations were part of the COG. They oversaw public protection in the widest sense and connected the agendas effectively. There was a very strong emphasis towards support, as well as protecting adults at risk from harm. This was evident in their early intervention and prevention initiatives. The COG provided effective oversight and governance of the ASPC's work including its improvement plan and biennial reports. It met regularly and considered the necessary performance reports which provided them with accurate assurances about the quality of adult protection activity in Glasgow City.

There were strong links between the work of the ASPC and its subgroups with broader public protection work. The ASPC had an independent convener, who also chaired the child protection committee (CPC). This fostered good cross cutting work. Both the ASPC and its subgroups were well attended and supported by a dedicated team which provided a good network of support to the ASPC and convener. The quality assurance, learning review panel (joint with the child protection committee), service user representative group, financial harm, and learning and development subgroups reported regularly to the ASPC. Each subgroup had a workplan which evidenced close multi-agency involvement. The quality assurance group provided an important oversight role in terms of quality and improvement focus for the ASPC.

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

The ASPC had a well-established communication and engagement strategy committed to inclusion. A carer representative attended each meeting. There was good practice guidance and a service user subgroup (SURG), including people with lived experience, which influenced the work of the ASPC. Representatives from SURG attended ASPC development events. This group's role was to hold the committee to account, make recommendations and influence policies. Examples included the design of information, newsletters, bulletins, and adult protection feedback questionnaires. Representatives of the SURG attended our strategic leadership focus group. It was clear more work needed done to build on the progress already made. The partnership engaged adults at risk of harm in self-evaluation activity, with mixed results. They were committed to finding ways to improve this.

The partnership also commissioned independent advocacy to support adults at risk of harm to have their voices heard during adult protection processes. Performance in this area of practice was closely monitored, with improvement work evident. Guidance and templates were updated following audits. Information was designed to accurately describe the support role independent advocates play in protection activity. Advocacy frequently represented the views of adults at risk of harm in formal training sessions for frontline staff.

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

The Glasgow City partnership recognised and responded well to the unique challenges it faced in terms of volume and complexity of adult protection concerns. It applied the West of Scotland Guidance but had its own local operating procedures to effectively govern the work. Social Care Direct was commissioned to provide a single point of contact for all referrals coming into social work services. This amounted to several thousand every year and the partnership handled this complex arrangement well. Close adherence to the guidance, well designed templates and adult support and protection team oversight had all ensured strong performance in this area of work. This recently established adult support and protection team was well resourced and positioned within the wider public protection structure. They enabled better governance, effective communication across agencies and shared learning.

This team had begun to support regular multi-agency city wide meetings and to consider emerging issues and learning opportunities arising from practice. It was also helping to establish a more consistent delivery of adult support and protection practice across the three locality areas in the Glasgow City HSCP area. A divisional adult support and protection Police Scotland team had also been established in November 2021, but the full

impact of its role had yet to be determined. Strategic engagement by health was also well evidenced. NHS Greater Glasgow and Clyde had a public protection service, the adult support and protection landing page was being refreshed, referrals generated by health were increasing, supporting roles were evident and they were closely involved in learning events. The third sector was well represented at the ASPC and the various subgroups and played a key role in service re-design.

Information sharing and collaboration was also evident in operational practice. Social work operated three locality hubs to receive onward referrals. Overall, these arrangements worked effectively but staff reflected considerable pressure on the duty systems capacity to manage. The partnership recognised this and was undertaking transformational change around first contact and onward referral arrangements.

Proactive initiatives included the care home quality assessment team, complex needs service, the mental health assessment units, the neglect toolkit, and domestic abuse strategy. These evidenced the partnership's commitment to support as well as protect people from the effects of the pandemic, poverty, and neglect. The partnership was establishing a strong foundation in trauma informed adult support and protection practice. Despite the positive nature of all this work just over half of staff agreed leadership across the partnership was effective. This suggested more needs done to engage them in change more meaningfully.

### **Quality assurance, self-evaluation, and improvement activity**

The partnership undertook multiple audits across adult support and protection planning. These were recent and had led to numerous change and improvement activities. There was a clear synergy between the quality assurance, learning and development subgroups and the ASPC driving this work forward with support from the lead officer. Audit activity was routinely reported to the ASPC as well as to the COG and other HSCP governance groups for scrutiny and assurance purposes.

Evidence of audit work was primarily around thematic aspects of social work practice. Most of these showed that the audits were repeated periodically which allowed for comparisons and trend information to be determined. Adult support and protection audit material was robust and focussed mainly on social work functions. Joint audit activity was evident in a few service areas including complex needs and domestic abuse services.

The last multi-agency self-evaluation the partnership undertook was in 2019. Plans to repeat this sooner were disrupted by the Covid-19 pandemic. A plan was in place to conduct this again in November 2022. Within the process, consistent adult at risk of harm feedback was difficult to get. Various engagement approaches were being applied in other service settings which the ASPC was closely monitoring. The views of frontline staff were not sought the last time and the partnership should address this.

Only some survey respondents agreed they had been involved in evaluating the impact of the adult support and protection work done which led to improvement activity.

The partnership had recently tested the multi-agency local management review approach in each of its three localities. Significant case review learning packs contained very good guidance. These measures enhanced the partnership's overall approach to audit and self-evaluation activity.

### **Initial case reviews and significant case reviews**

The partnership had published two significant case reviews (SCR's) in the previous two years: National guidance was adhered to with good evidence of learning, progress oversight and action plans resulting in service change and improvement across partnership agencies. Since 2016, Glasgow City has used lead reviewers drawn from partner agencies rather than commissioning external independent reviewers. This had resulted in a small but experienced group of reviewers and review team members. Work was underway to expand this approach.

More recently the ASPC operated a joint learning review panel and had a joint protocol in place. It had adopted the term 'learning review' to replace ICR/SCR. The panel had multi-agency representation and was chaired by the vice-chair of the ASPC. Work had been ongoing for the past two years to raise awareness of the learning review process.

### **Summary**

The increasing volume of complex adult support and protection work caused challenges for both the frontline staff and strategic leaders in the Glasgow City partnership. Leaders had responded well to support staff by introducing digital briefings and wellbeing surveys. These, and other measures, helped to ensure most staff felt valued and optimistic.

The partnership's vision was clear, and agencies collaborated effectively in most areas of work. They recognised and responded to the demands by developing new joint initiatives, models of working and oversight arrangements. Emphasis was put on trauma informed early intervention and prevention approach. Capacity and resources were being committed to identified pressure areas. Despite the challenges, there was evidence of good quality practice, innovation, change, and improvement driven by effective audit and self-evaluation activity. That said, the perception of strategic leadership was not as positive as it could be amongst staff. The partnership needed to improve how they engaged staff in their change and improvement journey.

The joint governance arrangements were appropriately structured with clear accountability and reporting structures in place. They were appropriately embedded and linked in to work across the other public protection areas. Shared chairing arrangements was helping to connect the various agendas. Stronger collaboration was needed between the SURG and ASPC.

Some case investigations should have progressed to initial case conference but did not and more needed done to ensure police were invited to initial case conferences where criminality was evident. However, overall, adult support and protection practice was sound. Access arrangements and risk assessments were both examples of strong practice.

### **Next steps**

We asked the Glasgow City 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 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

- 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
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 73% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 83% of episodes where the three-point criteria was applied correctly by the HSCP
- 93% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 33% less than one week, 33% two weeks to one month, 33% one to three months
- 93% of episodes evidenced management oversight of decision making
- 93% of episodes were rated good or better.

#### Staff survey results on initial inquiries

- 87% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 9% did not concur, 4% didn't know
- 77% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 9% did not concur, 13% didn't know
- 67% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 18% did not concur, 15% didn't know

#### Information sharing among partners for initial inquiries

- 85% of episodes evidenced communication among partners



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

### Chronologies

- 92% of adults at risk of harm had a chronology
- 24% of chronologies were rated good or better, 76% adequate or worse

### Risk assessment and adult protection plans

- 92% of adults at risk of harm had a risk assessment
- 71% of risk assessments were rated good or better
- 74% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 65% of protection plans were rated good or better, 34% were rated adequate or worse

### Full investigations

- 94% of investigations effectively determined if an adult was at risk of harm
- 83% of investigations were carried out timeously
- 74% of investigations were rated good or better

### Adult protection case conferences

- 79% were convened when required
- 87% were convened timeously
- 29% were attended by the adult at risk of harm (when invited)
- Police attended 83%, health 79% (when invited)
- 71% of case conferences were rated good or better for quality
- 87% effectively determined actions to keep the adult safe

### Adult protection review case conferences

- 72% of review case conferences were convened when required
- 92% of review case conferences determined the required actions to keep the adult safe

### **Police involvement in adult support and protection**

- 90% of adult protection concerns were sent to the HSCP in a timely manner
- 85% of inquiry officers' actions were rated good or better
- 80% 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
- 78% good or better rating for the quality of ASP recording in health records
- 81% 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
- 92% of those cases local authority staff shared information appropriately and effectively
- 69% of those cases police shared information appropriately and effectively
- 94% of those cases health staff shared information effectively

#### Management oversight and governance

- 62% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 86%, police 91%, health 57%

#### Involvement and support for adults at risk of harm

- 80% of adults at risk of harm had support throughout their adult protection journey
- 85% were rated good or better for overall quality of support to adult at risk of harm
- 81% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 10% did not concur, 10% didn't know

#### Independent advocacy

- 82% of adults at risk of harm were offered independent advocacy
- 45% of those offered, accepted and received advocacy
- 86% 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
- 79% of these adults had their capacity assessed by health
- 93% of capacity assessments done by health were done timeously

#### Financial harm and all perpetrators of harm

- 20% of adults at risk of harm were subject to financial harm
- 70% 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

- 82% of adults at risk of harm had some improvement for safety and protection
- 89% of adults at risk of harm who needed additional support received it
- 70% concur adults subject to ASP, experience safer quality of life from the support they receive, 14% did not concur, 16% didn't know

### Staff survey results about strategic leadership

#### Vision and strategy

- 60% concur local leaders provide staff with clear vision for their adult support and protection work. 18% did not concur, 22% didn't know

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

- 58% concur local leadership of ASP across partnership is effective, 15% did not concur, 27% didn't know
- 55% concur I feel confident there is effective leadership from adult protection committee, 16% did not concur, 29% didn't know
- 45% concur local leaders work effectively to raise public awareness of ASP, 22% did not concur, 34% didn't know

#### Quality assurance, self-evaluation, and improvement activity

- 49% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 15% did not concur, 35% didn't know
- 47% concur ASP changes and developments are integrated and well managed across partnership, 21% did not concur, 32% didn't know