AGENDA ITEM NO 6

REPORT NO IJB 88/21

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 24 FEBRUARY 2021

ADULT PROTECTION IMPROVEMENT WORK PROGRESS REPORT

REPORT BY GAIL SMITH, INTERIM CHIEF OFFICER

ABSTRACT

This report identifies work currently being undertaken within the AHSCP to address performance improvement in Adult Support and Protection. It provides a progress report against the planned work identified in previous reports, 26/08/20 IJB 61/20 and 28/10/20 IJB 70/20.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board: -

(i) notes the work being undertaken to address adult support and protection improvement issues within the AHSCP; and

(ii) notes that the thematic improvement plan will be progressed via the Angus Adult Protection Committee and noted within the Scrutiny and Audit Committee.

2. BACKGROUND

In the autumn and winter of 2019/2020, an independent review of Adults with Incapacity/Guardianship work in the AHSCP Community Mental Health Under 65's service was undertaken by a service manager from Aberdeenshire HSCP. The independent review concluded in February 2020 and made a series of recommendations for improvements, some of which were in response to concerns about adult protection. An implementation plan was developed and, following some delay caused by the COVID-19 pandemic, is being implemented. The Angus Chief Officer Group (COG) for public protection has received progress reports regarding implementation.

In the early summer of 2020, concerns were expressed about the decision-making of staff and managers in specific cases within the Community Mental Health Under 65's teams and in AIDARS. The COG was concerned that these cases may have had similar themes to those in the independent review. The NHS Tayside Lead for Adult Protection has reviewed the cases concerned. The Chief Officer was required to seek assurance from the Head of Mental Health regarding these cases in order that these could be reported to the COG, and more generally from the Heads of Service about the effectiveness of adult protection work within care management.

Under the auspices of the Angus Adult Protection Committee (AAPC), there are two Significant Case Reviews and one Initial Case Review active. Their findings will conclude with recommended improvement actions. These will be added to those of the large-scale audit to form an overall improvement plan.

The Angus HSCP was scheduled to receive a Care Inspectorate Adult Protection inspection in the autumn of 2020. Timescales have been deferred due to COVID-19. All of the work described above will contribute purposefully to the self-assessment that is required for the Care Inspectorate inspection.

3. CURRENT POSITION

SCR 018

This was published in August 2020 and an improvement plan has been progressed.

Large Scale Audit of Care Management activity in Adult Protection

In August 2020, the Head of Community Health and Care Services (South), with the agreement of the Chief Officer of the AHSCP, instructed that a large-scale audit of care management activity in adult protection be carried out following concerns arising in one specific service, as described above. Audit work was carried out in ninety-six cases between August and October 2020 and a full report submitted on 18-11-20.

The scope and key findings of this single agency audit of Adult Support and Protection (ASP) cases open between 2017 and November 2020 is described below. It is noted that the findings only relate to the specific files that were submitted for audit and that within this sample, the applicable data was at times limited because full ASP processes were not necessary in every individual case. However, the findings do provide a reliable picture of strengths and areas where improvements can be made in Adult Support and Protection practice in Angus.

Services in Scope:

a) Older People's Service and CMHT - over 65's
b) Learning Disabilities and Physical Disabilities
c) CMHT - under 65's
d) Angus Integrated Drug and Alcohol Recovery Services (AIDARS)

Cases in Scope:

1. New ASP referrals and investigations
2. Registered ASP cases
3. Large Scale Investigations.
4. Police Adult Concern reports.
5. ASP referrals from sources other than the police
6. ASP referrals allocated via the Early Screening Group
7. Review of new referral process introduced in December 2019

Key findings:

Findings have been linked to the quality indicators in the Adult Support and Protection Quality Indicator Framework (2020):

Key Strengths

- Adult protection processes were found to have reduced risk and improved the lives of service users in 87% of cases audited where this could reasonably be expected.
- There were many examples in the Adult Support and Protection paperwork of good, very good, and excellent inter-agency and inter-professional information sharing in every service area.
- The incoming referral system (introduced in December 2019) was found to have provided the majority of people with timely access to appropriate services.
- Overall, once a person was deemed to be an "adult at risk", it was clear that professionals worked more effectively together.
- Advocacy was offered in 80% of cases.

Key areas for development

- The systems supporting information sharing were fragmented and therefore did not support effective collaboration.

- Compliance with target timescales for duty to inquire, investigation, and ASP case conference were met in only around half of the applicable cases. Two thirds of core groups were held more than a month after conference.
- The use of chronologies was limited, and their timing, style and content was variable. Where present, chronologies were usually written as part of the ASP1.
- Sometimes IRDs or case conferences appeared to be triggered by the number of police concern reports received rather than a decision relating clearly to actual risk.
- 94% of case conferences were not attended by the relevant health professionals. (in 67% of cases, health professionals were found not to be involved in investigation where this would have benefitted the person at risk)
- The evidence available illustrating management oversight of cases was very limited.
- The rationale for decision making in ESG was not always evident and the coding system of recording was found to be inaccessible to workers. Action on some incoming referrals needed to be taken earlier.
- There was lack of reliable data for Adult Protection staff training records in the Partnership.
- There was a general need for an understanding across the partnership of outcome focussed planning to move away from systems-led practice and towards earlier intervention.

The audit concluded with a series of recommendations to improve ASP practise in Angus, specifically, but not exclusively, in social work care management. Four feedback sessions were held with care managers and team managers to discuss the audit findings and to seek feedback. This feedback was incorporated into the final report. Service Leaders are now progressing any “quick wins” or matters of urgency with their teams. The recommendations and improvement actions will be incorporated into a thematic improvement plan which will include recommendations from the independent report referred to above, any recent SCRs/ICRs, and one which is yet to be published.

The approach described will address the following themes: professional learning and training; systems and processes; information sharing; risk management; early intervention; case supervision and oversight; and working with service users, families and support networks

4. PROPOSALS

The IJB is asked to note the concerns that have emerged from one area of care management activity in adult support and protection and the further work which was undertaken to provide senior managers, the CSWO, the AAPC and the COG with assurance that adult protection work is of a good standard overall. Whilst an audit of the scale of the one described in this report will always identify improvement areas, one can conclude that adult protection work in Angus is of a good standard.

5. FINANCIAL IMPLICATIONS

There are no new financial implications, but it should be noted that the improvement work is resource-intensive in terms of planning and operational capacity.

6. OTHER IMPLICATIONS

RISK ASSESSMENT

It is essential to the public interest to ensure a high standard of practise in adult protection work and for senior professionals to ensure that this is maintained; not doing so would result in increased risk to vulnerable adults and to the organisations involved. The actions described are intended to provide mitigation in an area of professional intervention which, by its nature, contains strong elements of risk, and to offer assurance to senior managers about quality of practise.

It should be noted that the COVID-19 pandemic may interfere with timescales for the delivery of change.

7. DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in Section 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Angus Council and NHS Tayside.

Direction Required to Angus Council, NHS Tayside or Both	**Direction to:**	
	No Direction Required	X
	Angus Council	
	NHS Tayside	
	Angus Council and NHS Tayside	

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