Agenda Item 11

Falkirk Adult Protection Committee Large Scale Investigation

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Falkirk IJB Clinical and Care Governance Committee

27 August 2021

Falkirk Adult Protection Committee Large Scale Investigation

For Consideration & Comment

1. Executive Summary

1.1 Falkirk Adult Protection Committee (APC) has a range of duties linked to what is happening locally to safeguard adults at risk of harm. These include reviewing adult protection practices, improving co-operation, improving skills and knowledge, providing information and advice and promoting good communication. APC would like to update CCGC on their recent review of adult support and protection (ASP) Large Scale Investigation (LSI) practice.

1.2 APC have responsibility for reviewing LSI practice, the Care Inspectorate have specific quality indicators for this area of ASP practice. This section of the Quality Indicator Framework can be found at Appendix 1. APC were assured following review that LSI's were taking place when necessary and that practice was good. They agreed a number of continuous improvement actions to maintain the development of ASP practice in this area. These will be taken forward by the subgroups of APC.

1.3 LSI activity has increased in this data reporting period reflecting that multiagency partners are applying our ASP procedures, planning and conducting LSI's when necessary and resourcing these. The Care Inspectorate and Commissioning Teams were involved in LSI's which involved regulated care services. The introduction of the Early Indicators of Concern Group and the procedures and framework they oversee have enabled the development of greater understanding and more insightful summaries and findings following investigations in regulated care settings. The EIOC framework can be found at Appendix 2. One of the LSI's in this reporting period did not relate to a regulated care service but to a common perpetrator of harm in a Falkirk community. The identification of this harm towards more than one adult living in this community was identified during our initial referral discussion process which highlights the strength in this tripartite information sharing practice.

2. Recommendations

The Clinical and Care Governance Committee is asked to:

2.1 consider and comment on the review of LSI practice both locally and nationally.

2.2 support the continuous improvement of LSI practice in operational teams including training, application of procedures and associated frameworks and

participation and resource towards LSI proceedings and actions upon findings.

3. Background

3.1 A large-scale investigation (LSI) is a multi-agency response to circumstances where a report is received about an adult at risk being harmed and there is potential that other adults are also experiencing harm or are at risk of harm. This is particularly relevant to adults in a registered care settings which may include care homes, day care, hospital or care at home provided by a care provider. A LSI can also be indicated where there is a common perpetrator of harm in a community setting. The Forth Valley LSI protocol is available here

3.2 The Adult Support and Protection (Scotland) Act 2007 makes no reference to large scale investigations (LSIs), but these have become increasingly prevalent across Scotland since the implementation of the Act. Many partnerships have their own procedures, sometimes across a number of partnerships (e.g. within one Health Board area, this being the case in Forth Valley). LSI's frequently involve other agencies including the Care Inspectorate, NHS and Police Scotland, but there are no nationally agreed definitions of what warrants an LSI, or guidance for conducting LSI's or for governance arrangements locally. However the refresh of the ASP codes of practice is now out for consultation here and does include a new chapter on assessing and managing risk including case reviews and large scale investigations.

3.3 The Scottish Government are also planning a scoping study with the overall aim being to collate and analyse data nationally (taking account of variation in local interpretation and processes) to establish the scale of LSI's and any correlated increase of such during the Covid–19 pandemic. Falkirk are not the only area reporting an increase this is widespread.

3.4 Since 2019, APC have been aware of and have been tracking the progress of a national LSI working group supported by Iriss who have taken on the work of establishing national training resources for LSI. These are soon to be finalised and shared for local trainers to use. This will be a priority area of work for the learning and development subgroup as due to their modest application it has been clear that knowledge and experience of undertaking LSI activity requires support locally.

3.5 APC welcome the focus on this area of ASP practice nationally and will participate in all national scoping and learning activity.

4. Large Scale Investigation's

4.1 LSI activity has increased in Falkirk over 2020/21, with four LSI's undertaken.

4.2 A Covid-19 impact featured in some of the findings for 2 care homes for adults over the age of 65.

4.3 An overview of the systems findings from all LSI's is available at Appendix 3. These systemic findings are presented to the settings in a way that allows their own self evaluation and then development of improvement activity supported by multiagency partners. It is felt that this joint activity is likely to support the ownership of improvements by the regulated service and involve their full workforce in understanding these and committing to them collectively therefore diminishing the risk of future harm to adults supported in the setting.

4.4 In previous reporting years the number of LSI's commencing were 1 in 2018/19 and 0 in 2019/20.

4.5 All LSI planning meetings, investigative actions and supported improvement activity has been multiagency and the Care Inspectorate have been fully involved in those relating to care homes.

4.6 A good example of effective use of LSI procedures is when a common perpetrator is identified, this involves strong partnership working, development of multiagency chronologies and joint work with criminal justice and prison colleagues. The inquiry into the health and wellbeing of the common perpetrator of harm is also a great example of application of Safe and Together principles.

4.7 The Early Indicators of Concern Group and reporting into this group would trigger an over 65 care home LSI. The group would recognise the need for an LSI through accumulating reports of multiple concern from visiting professionals. This would allow for swift recognition, reporting and the support and protection of adults in this setting. EIOC guidance and procedures are available here.

4.8 Professionals applying our current LSI procedures have made recommendations for some further practitioners tools which could be included in the procedure refresh to assist those conducting and coordinating LSI's.

4.9 The impact of the LSI process and improvements resulting from LSI findings.
We have received feedback from a care home manager that the LSI process enabled them to take forward improvement activity and the ongoing partnership approach strengthened the impact of these. Internal improvement activity has taken place however partnership staff have also attended two care home team away days where the LSI findings were again reviewed and the care home staff teams carried out reflective activity and developed their improvement plans. We feel that this type of activity will result in more rapid improvement and sustained improvement as it has involved all frontline staff. Carers of residents have also reflected this to be the case and one carer/welfare guardian has worked with the ASP lead officer to develop a 25 minute training video for the care setting where an improvement in knowledge of adults with incapacity legislation was identified. This will provide an important lens from the perspective of a welfare guardian, when applied will

provide enhanced support and protection to adults with incapacity and can be used in induction for new team members.

4.10 As in all health and social care services improvements will be ongoing and continuous however other tangible impacts that link to the findings in Appendix 3 include recruitment of 2 new activity coordinators in care settings, new and clear key working roles and procedures, increased staff training, review and refresh of core procedures and more team meetings and forums for staff update and reflection being scheduled within settings.

5. Conclusions

5.1 This area of ASP practice is an important area for continued focus and commitment from multiagency partners. The local and national appetite for developing frameworks, better understanding of common causes aimed at prevention and ensuring all the ASP workforce are appropriately trained and supported to carry out investigatory activity is evidenced. The evidence for involving regulated services in embedding our early indicators of concern framework and adopting a collaborative approach to improvement planning is also demonstrating efficacy.

Resource Implications

The subgroups of APC will take forward work associated with the actions including refresh of LSI procedures and ongoing learning and development opportunities for multiagency partners.

Impact on IJB Outcomes and Priorities

Our shared commitment towards very good practice in this area will ensure that adults and their families are safe and protected and that their experience if involved in this type of investigative activity is positive and fair being supported by a workforce that are skilled, committed, motivated and valued.

Legal & Risk Implications

Police Scotland are involved in all LSI planning meetings.

Consultation

Falkirk HSCP Participation and Engagement Strategy sets out commitment to effective and meaningful engagement with service users, carers, communities, staff and partners. This commitment is mirrored by APC. The participation of any adults at risk of harm is central to ASP legislation and practice.

6. Report Author

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7. List of Background Papers

n/a

8. Appendices

Appendix 1:	Care Inspectorate Quality Indicator Framework
Appendix 2:	Early Indicators of Concern Framework
Appendix 3	LSI Systems Findings

Appendix 1

No Illustration	Quality indicator	What very good looks like	What weak looks like
1.7	1.7 We conduct large-scale investigations (LSI) competently, commensurate with the national code of practice. These exercises ensure the adults currently at risk of harm are safe and protected and diminish the risk of future harm to individuals.	1.7.1 We carry out coherent, competent, multi-agency large-scale investigations (LSI) when this is called for. Our LSI are well resourced and carried out in line with the Scottish Government code of practice. Care Inspectorate staff are involved in LSI where there is an element that involves regulated services. Healthcare Improvement Scotland staff are involved if appropriate. Commissioning staff are effectively involved in LSI. We take robust, prompt action based on the findings of the LSI – if required - to ensure that adults at risk of harm are safe and protected. 1.7.2 We prepare competent, comprehensive, and insightful written reports of LSI, and disseminate them within our partnership. 1.7.3 We share the learning from LSI and use this to inform improvement activity.	1.7.1 We do not always carry out an LSI when this course of action is called for. When they are carried out, LSI lack the necessary multi-agency involvement, and might be inadequately resourced. In some instances, our partnership does not involve Care Inspectorate staff in LSI. Commissioning staff are not involved in LSI. Our actions after the completion of the LSI are insufficiently forceful and purposeful, with potentially harmful impact on some adults at risk of harm. 1.7.2 Our written reports of LSI lack detail and cogent analysis. 1.7.3 Learning from LSI is not shared appropriately. We do not bring about required improvement activity following LSI.

Appendix 2:

1. Concerns about Management, Leadership and Organisation	2. Concerns about Staff Skills, Knowledge and Practice
• There is a lack of leadership by managers, for example, managers do not make decisions, set priorities, or ensure staff are supported to complete their task successfully. • The service/home is not being managed in a planned way but reacts to problems or crises. • Managers appear unaware of serious problems in the service. • The manager is new and doesn't appear to understand what the service is set up to do. • A responsible manager is not apparent or available within the service. • There is a high turnover of staff or shortage of staff. • The manager does not inform Social Work that they are unable to meet the needs of specific individuals.	• Staff appear to lack the information, skills, and knowledge to support people with specific needs e.g. dementia, profound and multiple disabilities, mental health, etc. • Staff appear challenged by some individual's behaviour and do not know how to support them effectively. • Members of staff use negative or judgmental language when talking about individuals. • Record keeping by staff is poor. • Communication across the staff team is poor.
3. Behaviour, interaction, and well-being of Residents – One or more of the residents:	**4. Concerns about the service resisting the involvement of external people, isolating individuals and lack of open-ness**
• Show signs of injury through lack of care or attention. • Appear frightened or show signs of fear. • Behaviours have changed. • Moods or psychological presentations have changed. • Behaviours potentially put themselves or others at risk.	• Managers/staff do not respond to advice or guidance from practitioners and families who visit the service. • The service is not reporting concerns or serious incidents to families, external practitioners, or agencies. • Staff or managers appear defensive or hostile when questions or problems are raised by external professionals or families.
5. Concerns about the way services are planned and the delivery of commissioned support	**6. Concerns about the quality of basic care and the environment**
• There is a lack of clarity about the purpose and nature of the service. • The service is accepting individuals whose needs they appear unable to meet. • Individuals' needs as identified in assessments, care plans or risk assessments are not being met. • The layout of the building does not easily allow individuals to be supervised and adequately supported to socialise and engage safely with others. • Agreed staffing levels are not being provided. • Staff do not carry out actions recommended by external professionals. • The service is "unsuitable", but no better option is available. • The collective needs of individuals/service user group appear to be incompatible.	• The service is not providing a safe environment • There is a lack of activities or social opportunities for individuals. • Individuals do not have as much money as would be expected. • Equipment is not being used or is being used incorrectly. • The home is dirty and shows signs of poor hygiene. • There is a lack of care of personal possessions. • Support for the individuals to maintain personal hygiene is poor. • Essential records are not kept effectively. • Individuals' dignity is not being promoted and supported.

Appendix 3:

Systems Findings/Improvement Areas from LSI's