



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

in these partnerships  
North Ayrshire, Highland, Dundee City, Aberdeenshire,  
East Dunbartonshire and Midlothian

July 2018

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# Foreword

The Care Inspectorate led this joint inspection of adult support and protection. Her Majesty's Inspectorate of Constabulary for Scotland was our main partner for this joint inspection. Healthcare Improvement Scotland assisted us to carry out this joint inspection.

It is ten years since the commencement of the Adult Support and Protection (Scotland) Act 2007. Scotland has been widely commended for the passing of this ground breaking legislation, which is unique within the United Kingdom.

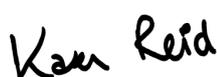
This is the first time there has been independent scrutiny of adult support and protection in Scotland. The main objective for our joint inspection of a sample of six representative partnerships across Scotland was to find out what adult protection partnerships were doing to make adults at risk of harm safe, supported, and protected and to ascertain the effectiveness of this activity. This report consists of two parts; we begin with an overview of what we found across the partnerships and what that tells us about adult support and protection in Scotland in general, followed by our findings for the partnerships individually.

We carried out proportionate scrutiny of adult support and protection in six partnerships, selected to reflect the geography and demography of Scotland. They were:

- North Ayrshire
- Highland
- Dundee
- Aberdeenshire
- East Dunbartonshire
- Midlothian

We would like to thank all of the partnerships for agreeing to be involved in our joint inspection. We would also like to thank all of the adults at risk of harm and their unpaid carers who kindly agreed to be involved in our joint inspection, as well as all of the partnerships' staff, whose co-operation and support was invaluable.

Our inspection has yielded important information about partnerships' efforts to implement the Adult Support and Protection (Scotland) Act 2007 and make adults at risk of harm safe, protected, and supported. Overall, the partnerships we inspected have made considerable progress with adult support and protection over the last 10 years. I commend this report to you and I am confident that it will make an important contribution to the development and improvement of adult support and protection in Scotland.



**Karen Reid**  
Chief Executive

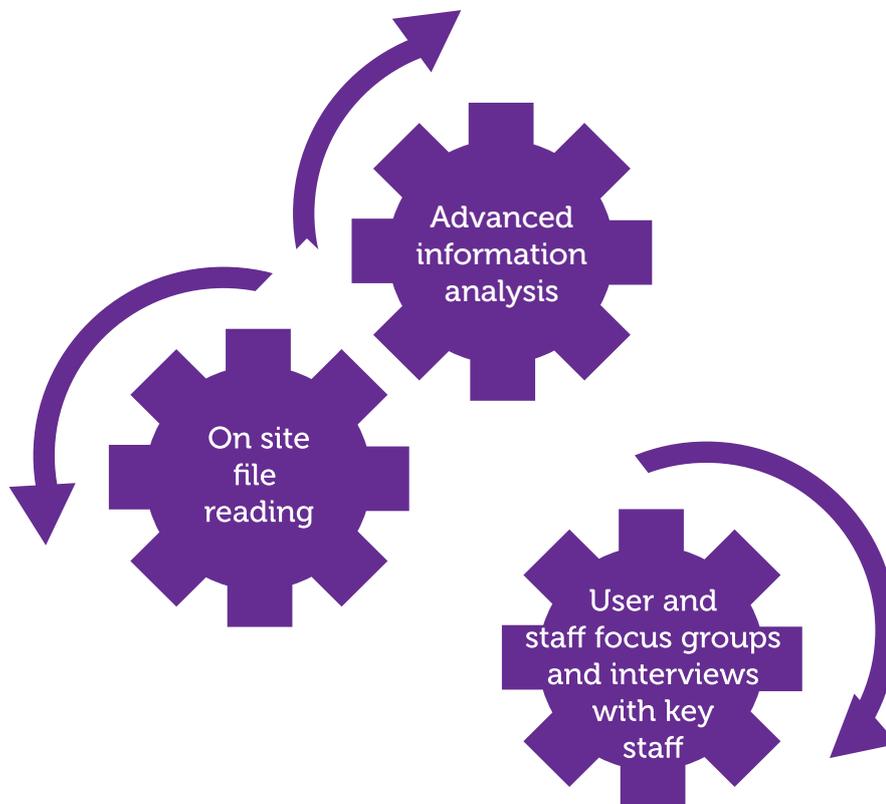
# Introduction

This joint inspection was constituted pursuant to section 115 of the Public Services Reform (Scotland) Act 2010

## Joint inspection partners



## Joint inspection methodology



The key precept that underpinned our methodology was: **need to do, not nice to do**. The minimum scrutiny activity undertaken for each partnership was the following.

*Need to do, not nice to do.*

1. **Advanced analysis of partnership data.** We asked each partnership to submit documents that evidenced how it met our quality indicators and a short position statement.
2. **Analysis of redacted adult protection referrals.** Information submitted by each partnership included a sample of 50 adult protection concern referrals, whereby the partnership had taken no further action in respect of further adult protection related intervention beyond the duty to inquire stage. We developed a bespoke Microsoft Excel audit tool for the analysis of these referrals by our inspection team. This was new methodological development, which might have wider application to future thematic scrutiny.

*Our off-site analysis of redacted adult protection referrals enabled us to analyse the initial stage of adults at risk of harms' adult protection journey.*

3. **Scrutiny and analysis of adults at risk of harms' social work and police records.** We scrutinised the social work and police records of individuals who were subject to each partnership's adult protection procedure. We read the police and social work records for 50 individuals.
4. **Specifying which adult protection records we would read.** We asked each partnership to provide us with records of all adults at risk of harm whose adult protection journey had progressed to at least the full investigation stage.

We asked each partnership for information in order to stratify our sample by:

- person characteristic – age, gender, ethnicity
- client group
- type of harm
- the stage the person had reached on their adult protection journey – investigation, case conference or post case conference implementation of protection plan.

We asked for the numbers of adults at risk of harm that met our criteria at some point over the last two years – September 2015 to September 2017.

Our sample of the records of 50<sup>1</sup> adults at risk of harm constituted a significant percentage of the total population of adults at risk of harm that met our sample criteria. The figures for each partnership are shown in table 1.

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<sup>1</sup> For three partnerships (Dundee, East Dunbartonshire and Midlothian ) we read the records for 49 individuals

Partnership	Population of adults at risk of harm	Our sample constitutes this percentage of the total population
North Ayrshire	130	38%
Highland	172	29%
Dundee	260	19%
Aberdeenshire	172	29%
East Dunbartonshire	82	60%
Midlothian	207	24%

**Table 1**

The average percentage by partnership of records read per total population was 33%. This figure gives us a good level of confidence that the results from our file reading were representative of the individuals' records in the population.

The percentages above are different for each partnership. This is because each partnership's population of adults at risk of harm is different.

The stratification of our statistically valid sample was determined by the characteristics of the adults at risk of harm population for each partnership. This differed significantly across the six partnerships. This results in a very important caveat for the results of our file reading for each partnership – they stand-alone. Our file reading results should not be compared across the six partnerships because the stratification is different for each partnership you would not be comparing like for like.

We carried out 12 on-site scrutiny sessions in each partnership in the same week as our on-site file reading.

5. **Focus groups and individual interviews with adults at risk of harm and unpaid carers.** We met with people who were subject to adult support and protection procedures and interventions. We also met with unpaid carers whose cared for person was an adult at risk of harm.
6. **Multi-disciplinary focus group.** We met with frontline social work, police and health staff who carried out adult protection investigations and on-going work to support and protect adults at risk of harm.
7. **Multi-disciplinary focus group** – We met with first-line social work, police and health team managers and leaders (or equivalent) who carried out the operational management of adult protection investigations and on-going work to support and protect individuals at risk of harm .
8. **Multi-agency focus group.** We held a focus group that included the range of adult support and protection partners:
  - social work
  - police
  - health (including GPs, consultants in emergency medicine, clinical leads, acute and primary care staff and allied health professions).

- fire and rescue
- independent advocacy
- third sector partners
- independent sector partners
- trading standards.

Healthcare Improvement Scotland joined us to lead the multi-agency focus groups.

9. We met with each partnership’s adult protection coordinator(or equivalent).
10. We met with the convener of each partnership’s adult protection committee.
11. We met with representatives from each partnership’s chief officers group and the chief social work officer.

Our **quality indicators** were:

**Quality indicator 1: Outcomes** – are adults at risk of harm safe, protected and supported?

**Quality indicator 2: Key processes** – referrals of adult support and protection concerns including physical and sexual abuse, neglect, emotional abuse and financial harm; initial and subsequent investigations; case conferences; adult protection plans; and the use of removal orders and banning orders.

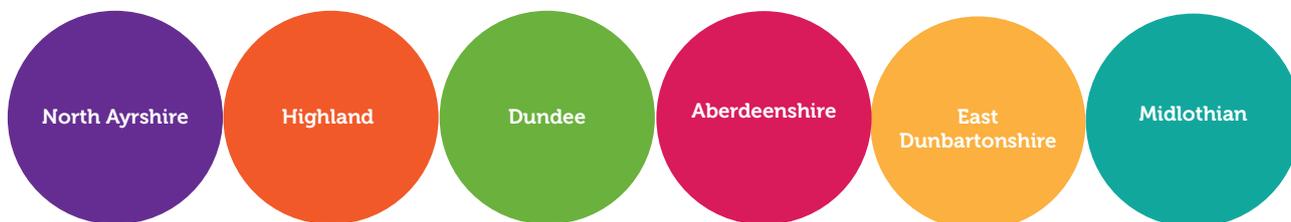
**Quality indicator 3: Leadership and governance** – leadership and governance for adult support and protection exercised by senior leaders and managers, the adult protection committee, the chief officers group and the chief social work officer. We were guided by the precept that leadership for adult support and protection should be inextricably linked to sound operational management and crucial key processes to make adults at risk of harm safe, supported and protected.

## Our six-point scale and evaluation criteria

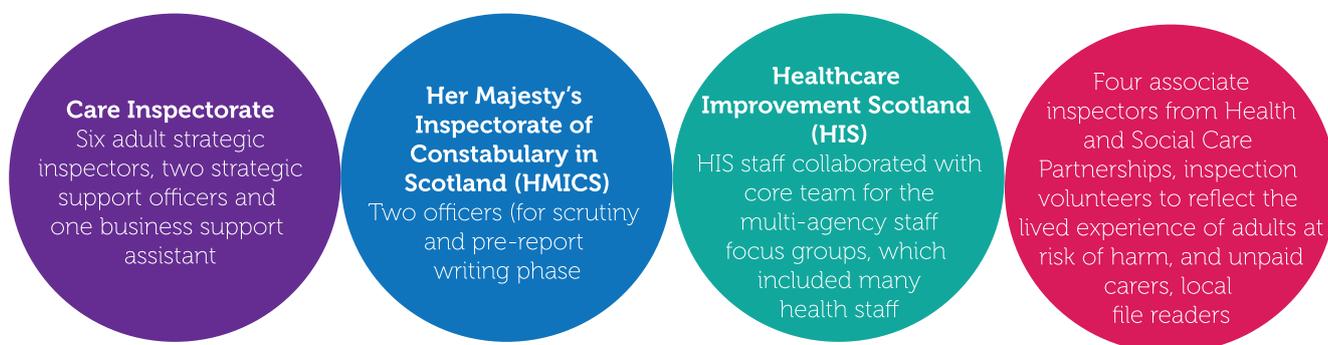
<b>Evaluation</b>	<b>Criteria</b>
EXCELLENT	outstanding, sector leading
VERY GOOD	major strengths
GOOD	important strengths with some areas for improvement
ADEQUATE	strengths just outweigh weaknesses
WEAK	important weaknesses
UNSATISFACTORY	major weaknesses

## Selection of the six partnerships

Our selection of partnerships broadly reflects the diverse geography and demography of Scotland. We consulted with local area networks, led by Audit Scotland, on the six partnerships selected, about scrutiny proportionality and avoiding conflict with other planned scrutiny.

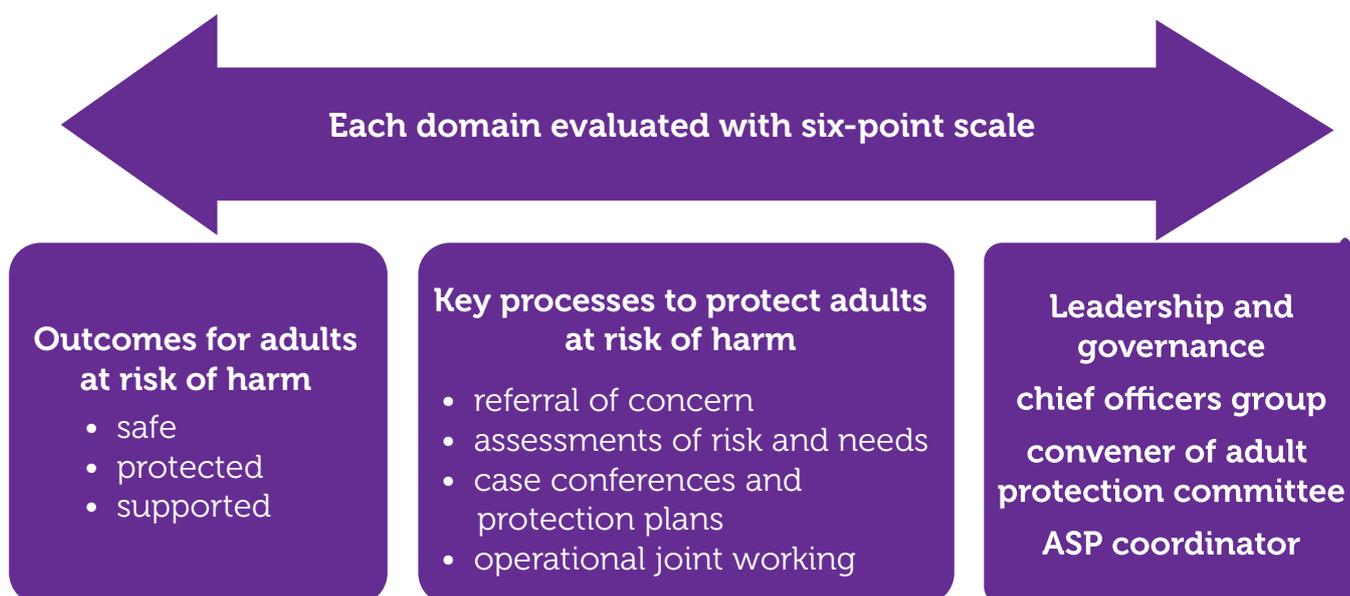


## Our joint inspection team

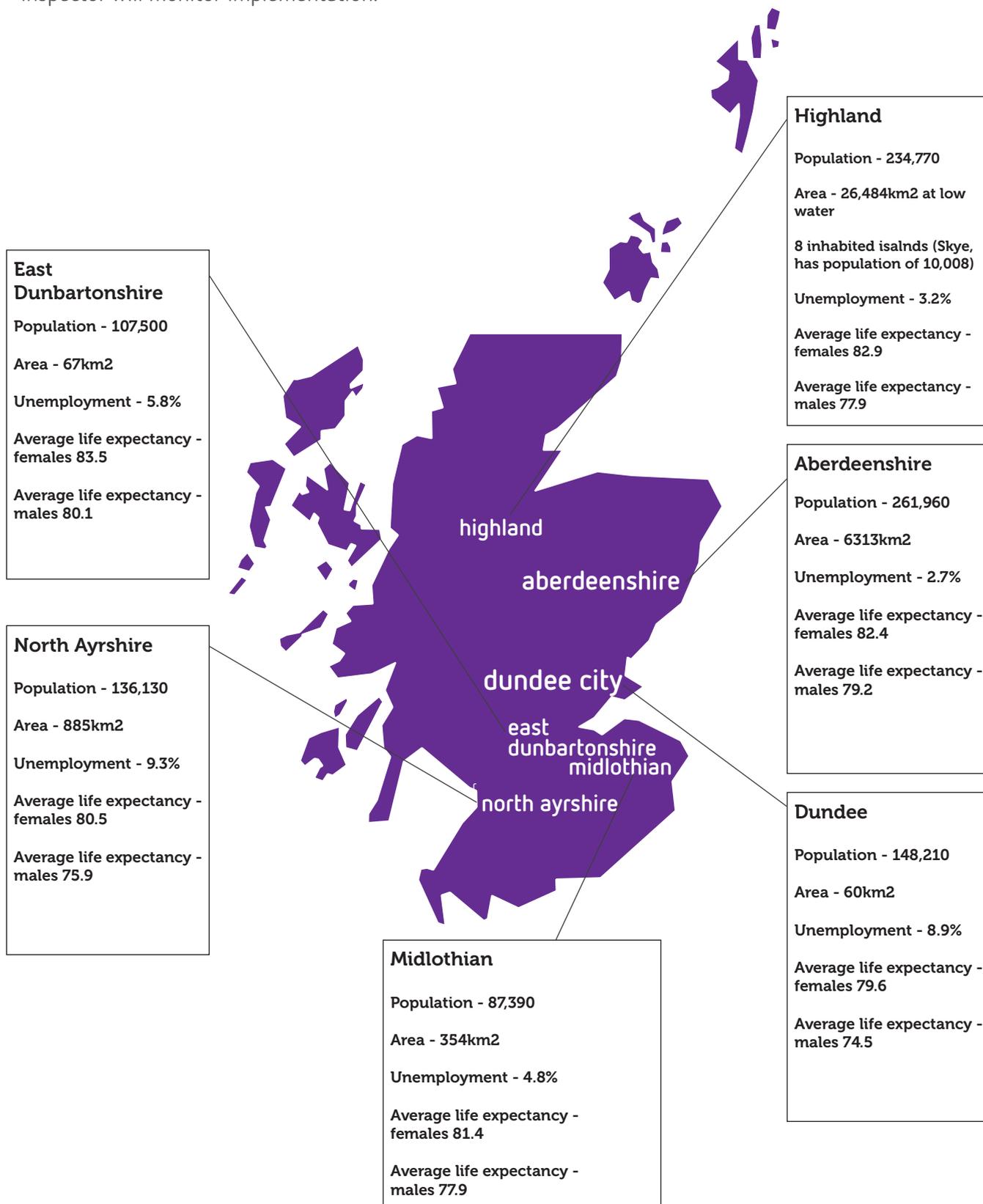


## Reporting

### Report structure



This report gives an overview of our findings across the partnerships, followed by our findings for the partnerships individually. We have made recommendations for improvement for each of the partnerships. We will ask partnerships to prepare an improvement plan, and the Care Inspectorate link inspector will monitor implementation.

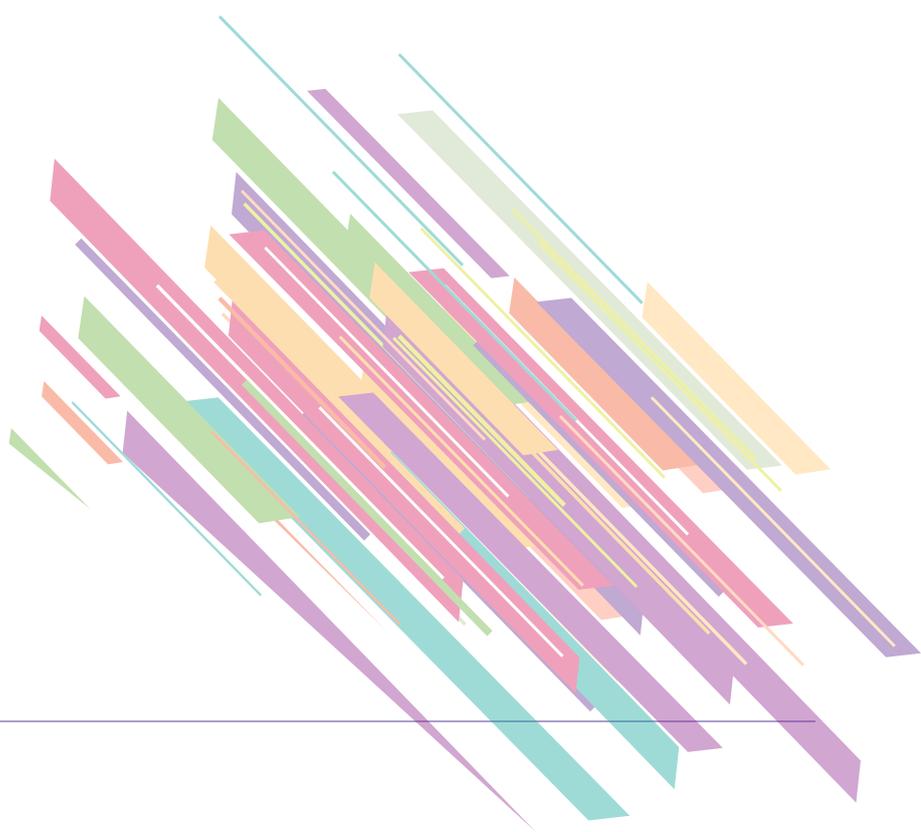


Sources, Life Expectancy for Areas within Scotland 2014-2016, National Records of Scotland, Mid-Year Population Estimates, Regional Employment Patterns In Scotland – Scottish Government 2016

## The terms we use

Terminology	Meaning
Adult Support and Protection (Scotland) Act 2007	This is the main statute that underpins adult support and protection. Most of the provisions of the Act commenced in 2008, hence the reference to 10 years after commencement.
Duty to inquire	S(4) of the Adult Support and Protection (Scotland) Act states: "A council must make inquiries about a person's well-being, property or financial affairs if it knows or believes— (a) that the person is an adult at risk, and (b) that it might need to intervene (by performing functions under this Part or otherwise) in order to protect the person's wellbeing, property or financial affairs".
Three-point test	This is set out in S(3) of the Adult Support and Protection (Scotland) Act 2007  "Adults at risk" are adults who: (1) are unable to safeguard their own wellbeing, property, rights or other interests (2) are at risk of harm, and (3) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.
Adult at risk of harm	An adult is at risk of harm for the purposes of subsection (1) above if: (a) another person's conduct is causing (or is likely to cause) the adult to be harmed; or (b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.
Adult protection investigation	Further detailed inquiries carried out by council officers into the circumstances of the adult at risk of harm
Health and social care partnership	The Public Bodies (Joint Working) (Scotland) Act 2014 sets out how health and social care (includes social work) should integrate to deliver improved outcomes for individuals and seamless health and social care. The health and social care partnership is the name for the overarching partnership body. The governance body for these partnerships is the integration joint board.

Single agency model (unique to Highland)	<p>Highland has a single agency model for integration of health and social care. Broadly speaking this means:</p> <ul style="list-style-type: none"> <li>• Health and social care services for adults are delivered by NHS Highland</li> <li>• Primary care health services for children and social care services for children are delivered by Highland Council</li> </ul>
Council officer	<p>Person – generally a social worker – who carried out adult protection investigations and other adult protection work</p>
Independent advocacy	<p>S(6) of the Adult Support and Protection (Scotland) Act sets out the duty of council to consider independent advocacy for adults.</p>
Police concern hub	<p>Each of the 13 Divisions in Police Scotland has a ‘Concern Hub’ where officers report information about concerns they have identified suggesting a child, young person or adult is vulnerable and at risk of harm. The Hub places this information onto the national Vulnerable Persons Database (VPD). This is then used to ensure that officers attending incidents or receiving reports from members of the public are aware of the previous history involving the vulnerable individual which may have been dealt with by other officers and can alert officers to relationships which may give rise to concerns for the safety and wellbeing of the vulnerable individual.</p>



## Definition of adult protection partnership

For the purpose of this thematic scrutiny of adult support and protection, our definition of what constitutes an adult protection partnership is as follows.

The group of partners who work together operationally and strategically to:

- receive all intimations of adult protect concerns
- determine which concerns require investigation and investigate them
- determine actions required to make sure that adults at risk of harm are safe, protected, supported, involved, and consulted;
- be responsible and accountable for the implementation of these actions.

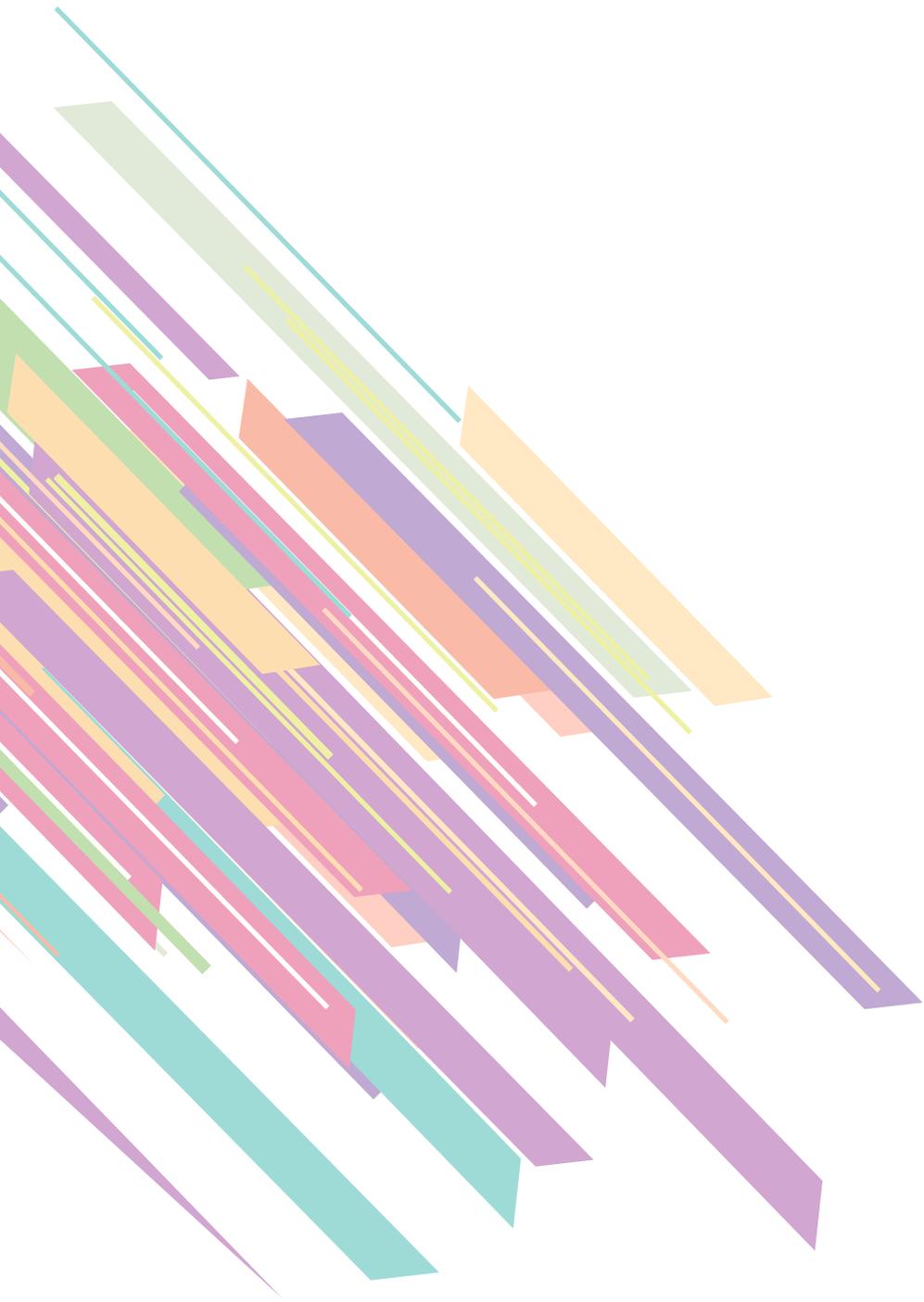
All of the foregoing is pursuant to the Adult Support and Protection (Scotland) Act 2007.

The core partners are:

- The local authority, which is required to discharge its duties under the Adult Protection (Scotland) Act 2007 and related legislation (includes associated bodies such as the community planning partnership and the chief officers group).
- Police Scotland (who also pursue and bring to justice perpetrators of harm to vulnerable adults).
- The NHS board (includes associated bodies such as integration joint boards and relevant contractors, such as GPs).

Other partners include:

- The adult protection committee, which provides leadership, oversight, and governance for adult support and protection.
- Third sector organisations (including those that deliver support to adults and risk of harm and their carers, and organisations that provide independent advocacy).
- Trading standards (in respect of financial harm to vulnerable adults).





**Part one:**  
Overview of key  
themes from  
our joint  
inspection

## **Progress with adult support and protection**

It is 10 years after the commencement of the Adult Support and Protection (Scotland) Act 2007. People who work in the adult protection field often comment that adult support and protection is behind child protection in terms of:

- the priority afforded to it
- maturity of the key underpinning processes
- commitment of the partners
- knowledge and skills of the frontline staff who carry out the critical work.

The overwhelming evidence from our joint inspection of adult support and protection was that adult protection does somewhat lag behind child protection. Scotland has made good progress in 10 years to develop awareness of adult protection, create and train the workforce and put effective governance systems in place. The results of this are that many adults at risk of harm are safe, protected, and supported. Their wellbeing and quality of life has improved. We have come far but inevitably, there is further to travel.

## **Consistency**

The partnerships gave effect to the provisions of the Adult Support and Protection (Scotland) Act 2007 differently. It is likely that this is also the case across adult protection partnerships in Scotland. Just because a partnership does things differently does not mean they are doing it wrong. Partnerships have tailored their adult and protection activity to local circumstances.

A key finding of our joint inspection was that whatever the partnerships' key processes to protect adults at risk of harm, the staff who operate these processes need a clear, well defined and well understood system within which to work. The more complex the system, the harder it is for staff to understand what they need to do.

Staff across the adult protection partnerships were knowledgeable, skilled and highly motivated to carry out adult support and protection work. This is likely to be the case across Scotland.

Adult protection work is complex and challenging. It is all about marginality and balance –The rights of adults at risk of harm to self-determination and choice must be balanced with the need to keep them safe and protect them from harm. Staff working in adult support and protection skilfully walk a tightrope between risk mitigation and positive risk enablement.

## **Successful development of police concern hubs**

There was clear evidence that overall, the police concern hubs were a positive development and working effectively. There was a reduction in the numbers of adult protection referrals arising from the police referrals in some partnerships. This was due to effective screening and triage of reports of adult protection concerns carried out by the police concern hubs. Some of the partnerships had specific staff dedicated to this role. All of this led to a high percentage of police adult protection

referrals to the health and social care partnership that definitely required the initiation of an inquiry into the circumstances of the adult and the episode that engendered the suspicion that they were at risk of harm.

The impact of the concern hubs was very considerable. We discerned a number of positive effects.

- They were a central point for knowledge, information and skills about adult support and protection.
- They fostered good relationships and integrated working – some of the hubs had social workers working in them.
- They supported hard-pressed frontline police officers to do adult protection work.
- All of our evidence pointed to the critical requirement to support frontline police officers, given the burgeoning volume of adult protection and related work with all its myriad of complexities.
- They were an invaluable source of data about adult protection activity and its outcomes. Some of the hubs had audited this data and used the results to bring about improvement.
- They had the potential to act as a focus for innovation, development and improvement of adult support and protection practice.
- The creation of the concern hubs has corresponded to an increase in the time frontline police officers have to spend working with vulnerable individuals.
- Frontline police officers were spending increasing amounts of time looking after vulnerable individuals. There were issues in respect of the support they get from other partners, particularly health and the impact on other areas of policing.

## **Impact of new data sharing standards for Scotland**

Under the Digital Economy Act 2017 and the General Data Protection Regulation (GDPR)<sup>2</sup>, new data sharing standards will apply in Scotland. It is important that their implementation does not detrimentally affect the concern hubs' (and adult protection partnerships generally) ability to share adult support and protection information effectively.

## **Role of health in adult support and protection**

We are encouraged by the growing involvement of health in strategic activities for adult support and protection. Health representatives adopted an increasingly active and energetic role within adult protection committees. We consider this a welcome development. Health was more involved in planning and development for adult support and protection and senior health managers exercised heightened leadership for adult support and protection.

## **Adult support and protection referrals made by health**

We found evidence of increasing numbers of adult support and protection referrals from health in some of the partnerships we inspected. This was from a low baseline of referral numbers.

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<sup>2</sup> GDPR is a European Union Regulation

There was more training for health staff, which stimulated greater awareness of adult support and protection. Overall, there was some progress with the increasing contribution from health to adult support and protection but further progress is required.

## **Raising awareness of adult support and protection in accident and emergency units and the Scottish Ambulance Service.**

In 2014, the Scottish Government carried out useful work designed to make sure that staff in accident and emergency units and the Scottish Ambulance Service know what to do if they suspect an adult might be at risk of harm<sup>3</sup>. Across Scotland, these services should utilise the helpful materials this initiative created.

### **Some excellent work to support adults from risk of harm**

We were privileged to meet a number of people who had experienced an adult support and protection journey. Almost all said that adult support and protection had changed their lives inexorably for the better. Some adults at risk of harm we met gave powerful testaments about how adult protection made them safe, took away their fear, and enhanced their overall wellbeing and quality of life. Some adults at risk of harm told us how their confidence and quality of life had improved because they were no longer constantly afraid.

*"Because of adult protection, I'm still here".*

*(Adult at risk of harm)*

Some adults at risk of harm felt that adult support and protection had made things worse for them by interfering in their lives and restricting their freedom of choice. The fact that a few adults at risk of harm were dissatisfied in this way does not reflect on partnerships' actions. It is however an important tenet of adult support and protection that some adults at risk of harm will not view the efforts of officialdom to keep them safe, favourably.

*Adult protection ruined my life. Before my involvement with adult protection I had a girlfriend and control of my own money - now I don't"*

*(Adult at risk of harm)*

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<sup>3</sup> <http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection/National-Priorities/AdultSupportProtectionASettings>

## **Involvement, consultation, and measurement of outcomes for adults at risk of harm**

Partnerships sought the views of adults at risk of harm about their experiences of adult support and protection. Partnerships acknowledged that more needed to be done in this area. Partnerships also sought the views of unpaid carers who cared for adults at risk of harm.

When adults at risk of harm have reached the end of their adult support and protection journey, partnerships should ask them about their experience of adult support and protection and the difference it has made to their lives. Questions should be in line with the national health and wellbeing indicators<sup>4</sup>. Responses should be electronically recorded in a manner that can be collated, aggregated and analysed. The aggregate data can be utilised as evidence of the effectiveness of adult support and protection activity, as well as a tool to drive improvement.

## **Contribution of social work and social workers to adult support and protection**

Social work and social workers were very much “to the fore” in partnerships’ work to ensure that adults at risk of harm were safe, protected and supported. Throughout this report, we emphasise the paramount need for agencies to collaborate and work in partnership to deliver positive outcomes for adults at risk of harm and their unpaid carers. Social work and social workers represent the “glue” that enabled all of the partners to work cohesively, consistently, and effectively. Social workers exercised a pivotal role in respect of:

- correctly identifying adults at risk of harm
- competently carrying out investigations to establish if an adult was at risk of harm
- convening and chairing well-balanced adult protection case conferences that analysed risks for the individual and effectively determining the way forward
- sensitively engaging with adults at risk of harm and their unpaid carers
- taking a lead role in managing risk and positive risk enablement.
- supporting adults at risk of harm to recover from trauma and move on to a safer, better quality of life
- working collaboratively to tackle financial harm to vulnerable adults
- working alongside police colleagues to disrupt the activities of perpetrators of harm to vulnerable individuals, and report alleged criminal offences to the Crown Office and Procurator Fiscal Service
- exercising operational and strategic leadership for adult support and protection
- developing and innovating adult support and protection practice.

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<sup>4</sup> The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care

## Emergence of The Scottish Fire and Rescue Service as a core adult protection partner

A significant and positive development since the commencement of the Adult Support and Protection Act has been the increasing involvement of the Scottish Fire and Rescue Service as a key adult protection operational and strategic partner. Fire and rescue:

- carried out a large number of fire safety checks on the homes of vulnerable individuals
- carried out checks of properties that had a high fire loading, often as a result of the behaviour of the vulnerable occupant, which rendered the property more likely to go on fire
- carried out detailed risk assessments on the homes of vulnerable individuals who were at particular risk from the occurrence of a fire
- made appropriate referrals about adults at risk of harm

In some instances, fire and rescue assessed properties for risk of trips and falls and then carried out some minor work for example, taping down carpet edges to mitigate the risk of falls. We considered that this was a welcome, purposeful development of the role of the Scottish Fire and Rescue Service within the domain of adult support and protection.

The Fire and Rescue Service made more adult protection referrals to the health and social care partnership, when firefighters suspected that a vulnerable adult was at risk of harm.

At a strategic level, the Scottish Fire and Rescue Service was a member of the adult protection committee in all of the partnerships we inspected and it made an invaluable contribution to the work of these committees.

Overall, there was clear evidence that the work of fire and rescue delivered the following positive outcomes for adults at risk of harm:

- enhanced safety
- enhanced security.

In addition to this, the service delivered peace of mind for the unpaid carers of adults at risk of harm.

## Dealing with financial harm

There was increasing positive involvement of trading standards and the banking and financial sector to tackle the pervasive problem of financial harm to vulnerable adults. Tackling financial harm can be a complex and time-consuming activity, with a requirement for specialist skillsets.

We found that financial harm was often accompanied by verbal coercion (threats) and or physical coercion in the form of assaults.

The police undertook some effective work to stop financial harm and disrupt the activities of perpetrators.

## **Advocacy and key role of advocates supporting adults at risk of harm**

Section 6 of the Adult Support and Protection (Scotland) Act 2007 places a duty on councils to consider the provision of independent advocacy for adults at risk of harm. Independent advocacy has a vital role to play in adult support and protection. Independent advocates support adults at risk of harm to articulate their views and make sure they are taken on board by adult protection partners. Adults at risk of harm and unpaid carers were unanimous about the positive support they received from independent advocates to guide them successfully through their adult protection journey.

Independent advocates were particularly effective when there were disagreements between the adult at risk of harm and professionals who were trying to make sure the adult at risk of harm was safe. Equality of access to advocacy for all adults at risk of harm is important, irrespective of where they reside within a partnership, or to which vulnerable group they belong.

## **Non-electronic and electronic information sharing**

### **Non-electronic information sharing**

The general finding from our joint inspections was that adult protection partners shared information effectively. They did this by:

- face-to-face contact
- phone calls
- emails (this is electronic but not related to electronic client/patient record systems)
- attendance at adult protection case conferences and other meetings
- exchange of letters and other documents
- using the concern hub as a repository for adult protection information.

### **Electronic information sharing – shared access to computerised client/patient records**

Electronic information sharing between social work and health was patchy and problematic, despite integration and development of health and social care partnerships.

There was some promising development of portal functionality, whereby an electronic space or platform is created that allows users to securely view selected screens in two or more computer systems. For example, a social work client records system, community-nursing system and an acute health care system. Integration of health and social care will not of itself solve all of the problems associated with electronic sharing of adult protection information. Frontline health and social work staff often express the “forlorn hope” that the inception of health and social care partnerships would make it easier to them to share adult protection information electronically. Despite integration and the development of integration joint boards it remains that case in the partnerships we inspected that social work staff do not have routine access to health computer systems and health staff do not have routine access to social work computer systems. There are exceptions to this, namely staff who work in integrated, co-located teams and staff who work in joint posts.

In our view, partnerships need to surmount the legal, procedural, and cultural barriers that prevent social work staff and health staff accessing key electronic repositories for information and intelligence about adults at risk of harm.

## Crucial role of the adult protection case conference

Our joint inspection very much confirmed the intrinsic value of adult protection case conferences. These forums were invaluable to explore matters of risk and determine the best way forward to secure the safety, security, and support for the adults at risk of harm.

### Partners' attendance at adult protection case conferences

Given the importance of adult protection case conferences, it is crucial that all of the relevant partners attend these forums and partners are well briefed about the nature of the adult protection concerns for the individual and the individual's overall circumstances. Quorate adult protection case conferences, where the views of all relevant partners are represented, best ensure adults at risk of harm are safe, protected and supported.

## Frontline staff should be listened to, valued and supported

Valuing and supporting frontline staff, who carry out highly challenging adult protection work, is critical. Support includes:

- experienced, competent operational management and leadership
- proficient supervision or its equivalent
- high-quality, joint training.
- adult protection procedures that are up to date and fit for purpose
- ICT (information and communication technology) that is capable, efficient and user friendly
- operational and strategic managers and leaders who actively seek the views of frontline staff and respond swiftly and robustly to their expressed needs and concerns.

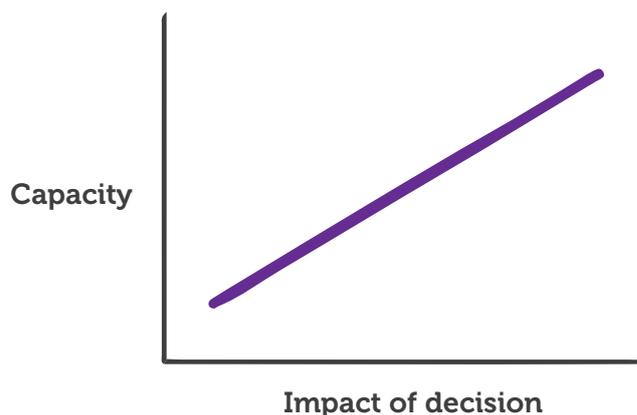
## Capacity assessments

Partnerships sometimes experienced delays obtaining assessments of individuals' capacity. This could be problematic when they needed a capacity assessment quickly to establish the correct route to secure the safety and wellbeing of individuals. Partnerships may wish to consider obtaining an agreement with the relevant clinicians about timescales for carrying out assessments of individuals' capacity.

Our scrutiny of individuals' records highlighted some issues about capacity.

- Capacity can fluctuate depending on the person's condition.
- Capacity is relative, not absolute. The amount of capacity a person needs to make a decision is proportionate to the impact of the decision on their life. A person may have capacity for straightforward day-to-day decisions, such as financial transactions for daily necessities. However, they may lack the capacity to make major, life-changing decisions, such as getting married, selling a house, or beginning an intimate relationship with a potentially violent, abusive partner. (Figure 1)

Figure 1



## Perpetrators of harm

The key issues for partnerships in respect of perpetrators of harm to vulnerable individuals are:

- stopping perpetrators continuing to maltreat adults at risk of harm
- bringing criminal perpetrators to justice
- prevention
- contradiction that perpetrators can also be carers.

Partnerships' first priority, in terms of making adults at risk of harm safe, is quickly stopping perpetrators harming them. This is achievable in a number of ways such as:

- separating the adult at risk of harm from the perpetrator, and the possible use of protection orders, or the adult at risk of harm supported to move to a different residence
- deployment of additional supports for the adult at risk of harm
- warning the perpetrator about the consequences of their behaviour
- arrest and charge of the perpetrator
- dismissal or disciplinary action against the perpetrator if they are a member of staff.

Whatever action the partnership takes against the perpetrator, this must be timely and decisive to stop the perpetrator continuing to maltreat the adult at risk of harm. The requirements of criminal investigations or disciplinary investigations should not detract from the imperative to keep the adult at risk of harm safe.

In some instances, partnerships worked collaboratively to bring perpetrators to justice. It is important that if perpetrators commit alleged criminal offences then they appropriately experience the full force of criminal law.

Partnerships worked to prevent harm to vulnerable adults. They did this by:

- raising public awareness about adult support and protection
- raising staff awareness about adult support and protection
- encouraging staff awareness and vigilance to spot adult protection risk and address it before harm could happen

- preventive activity carried out by trading standards and the financial sector
- robust early action at the first signs that an adult is at risk of harm.

The perpetrator of harm can also be the unpaid carer for the adult at risk of harm and this is challenging. The relationship between the perpetrator and the adult at risk of harm may involve close ties of familial love and affection. If a perpetrator who is also an unpaid carer withdraws, or is forced to withdraw, the care that they give, the results of this might be catastrophic for the adult at risk of harm.

Staff who look after adults at risk of harm need to negotiate such situations with sensitivity and skill. It might be possible to support a stressed carer to mitigate the risk they pose to the adult at risk of harm. This option is not always applicable. Partnerships might need to take robust action to interdict the harmful behaviours of perpetrators who are also carers. Partnerships should follow the precept that there should be no detriment to the adult at risk of harm due to the necessary cessation of care from a carer who is also a perpetrator of harm. This is likely to involve the provision of alternative care and support to the adult at risk of harm.

There is a link to self-directed support. Adults at risk of harm, whose unpaid carer is no longer able to perform this role due to harmful behaviours, should be offered the self-directed support options<sup>5</sup> for the care and support they need to deliver their desired personal outcomes. We have come across instances where self-directed support has effectively enabled adults at risk of harm to remain living independently at home in line with their choice, with boosted wellbeing and enhanced quality of life.

## **Chronologies, risk assessment and risk management**

There is an inextricable link for chronologies, risk assessment and effective risk management. A comprehensive, up-to-date and well-balanced chronology should underpin the associated risk assessment and risk management or protection plan. The Care Inspectorate has produced a helpful guide for staff on the preparation of chronologies.<sup>6</sup>

The Report of The Inspection of Borders Council Services for People Affected by Learning Disabilities (2004)<sup>7</sup> stressed the critical importance of the lack of an up-to-date valid chronology for the adult at risk of harm at the centre of the 30 years of abuse tragedy that unfolded for this individual and for the other individuals involved.

We have encountered a number of computer programmes designed to create chronologies. However we have found these tended not to be effective. This is because they populate the chronology with pulled through case records, which creates duplicate case records rather than a valuable chronology.

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<sup>5</sup> direct payment, individual chooses the service and the service provider, local authority arranges the service, a mixture of any of the previous three options.

<sup>6</sup> <http://www.careinspectorate.com/images/documents/3670/Practice%20guide%20to%20chronologies%202017.pdf>

<sup>7</sup> Report of the Inspection of Borders Council Services for People Affected by Learning Disabilities (2004) SWSI, Scottish Government

The creation of a suitable chronology requires regular input by a member of staff to:

- analyse all of the available information and insert only relevant information into the chronology
- make sure that the entries in the chronology strike a balance between being succinct and providing enough information so that the reader is clear about the meaning and impact on the adult at risk of harm
- avoid non-specific phrases such as 'inappropriate behaviour' (this is very common), and state precisely what has occurred.

We consider that all adults at risk of harm should have a risk assessment and an associated risk management plan. There might be occasional circumstances when they are not required, such as when harm has occurred to a person, but there is no likelihood of recurrence of the harm for example, if the harmer is deceased. In general, the default position for all adults at risk of harm is that they should have:

- a suitable, up-to-date chronology
- an up-to-date risk assessment
- an up-to-date risk management or protection plan.

## **Significant case reviews and initial case reviews**

Adult support and protection is an activity that carries significant risks. It is important when there is an adverse occurrence for an adult, or group of adults, at risk of harm that partnerships review the management of the case and the adult protection journey. The Scottish Government is preparing national guidance for significant case reviews for adults that will bring adults into line with children, where there has been guidance in place since 2015. The planned guidance will include:

- criteria and thresholds for significant case reviews for adults
- how partnerships should carry out significant case reviews for adults and who should be involved
- advice and guidance on reporting and optimal dissemination of the learning from significant case reviews.

Publication of this guidance might result in an overall increase in the number of significant case reviews for adults. This will enhance our collective knowledge of how best to keep adults at risk of harm safe, protected and supported.

We saw few significant case reviews related to adult protection across the six partnerships we inspected. Partnerships had conducted a number of adult protection related initial case reviews and decided not to proceed to the significant case review stage.

All adult protection partnerships should adopt a proactive approach to significant case reviews as a means of learning and improving. Partnerships should ensure that the lessons learned from case reviews are widely disseminated and incorporated into improvement plans. Execution of related improvement activity should be robust and timely.

## Harm to self and self-neglect

Overall, 28% of the adults at risk of harm whose records we scrutinised were adults at risk from harm to self or self-neglect<sup>8</sup>. Partnerships expended a considerable degree of effort in this area.

Some adults at risk from harm to self or self-neglect meet the three-point test and some do not. Individuals who met the three-point test benefited from adult support and protection legislation and the partnerships own procedures and protocols. Partnerships diverted individuals who did not meet the three-point test along alternative pathways to support them to attain their desired personal outcomes.

It is important that partnerships adopt a holistic multi-agency approach to supporting adults at risk of harm to self or self-neglect. Independent advocacy has an important role to play – as do third sector partners. Adults at risk of harm to self or self-harm might respond better to the involvement of third sector agencies, as opposed to statutory agencies. We came across this a number of times during our joint inspection.

Overall, supporting adults at risk of harm to self or self-neglect is a developing area of practice. We have already commented on the work of the fire and rescue services for the purposeful support that they give to this group of people. In the future, partnerships are likely to find innovative, least intrusive ways to support adults at risk from self-harm and self-neglect that make them safe, enhance their wellbeing and improve their quality of life.



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<sup>8</sup> They may have been at risk of other types of harm as well

## Some key messages for all adult protection partnerships

From our joint inspection of adult support and protection, we have a number of key messages for the adult support and protection sector as a whole.

1. Systematically measure outcomes for adults at risk of harm and their unpaid carers.
2. Regularly elicit the lived experiences of adults at risk of harm and their unpaid carers.
3. Support adults at risk of harm to be included and involved throughout their adult protection journey.
4. Support unpaid carers (where appropriate) to be included and involved in the adult protection journey of their cared for person.
5. Ensure the key processes for adult support and protection are as clear and simple as possible so all of the stakeholders understand them, and consistently execute key activities.
6. Council officers and other staff more effectively operate key processes for adult support and protection when the stages of the adult protection journey are clearly defined.
7. Setting out clear, unambiguous timescales for the completion of work related to each phase of the adult protection process is crucial to prevent delays, which could have a seriously adverse impact on the adult at risk of harm.
8. Frontline staff involved in adult support and protection require regular, high-quality, rigorous and knowledgeable supervision and support.
9. Comprehensive and up-to-date chronologies, risk assessments and risk management plans or protection plans for adults at risk of harm are crucial to keep adults at risk of harm safe.
10. All of the required partners should attend adult protection case conferences, particularly police and health.
11. The fast-developing roles of fire and rescue and trading standards should be encouraged.
12. Financial harm is a developing area for integrated practice. The efforts led by trading standards to prevent financial harm stop vulnerable individuals experiencing it. It is also highly cost effective to prevent financial harm happening in the first place, rather than having to deploy staff to the complex and time-consuming task of stopping it once firmly established.
13. Self-evaluation of adult support and protection enables partnerships to sustain and improve best practice.
14. Regular audits of adult protection records determine key areas for improvement.
15. As the volume and pace of adult support and protection increases alongside legislative and practice developments, the leadership within partnerships needs energy, drive, grip and commitment to partnership working.

## Next steps

In order to support partnerships' self-evaluations of adult support and protection, we will make our inspection methodology and tools (such as our electronic application for scrutinising adult protection records) available to them.

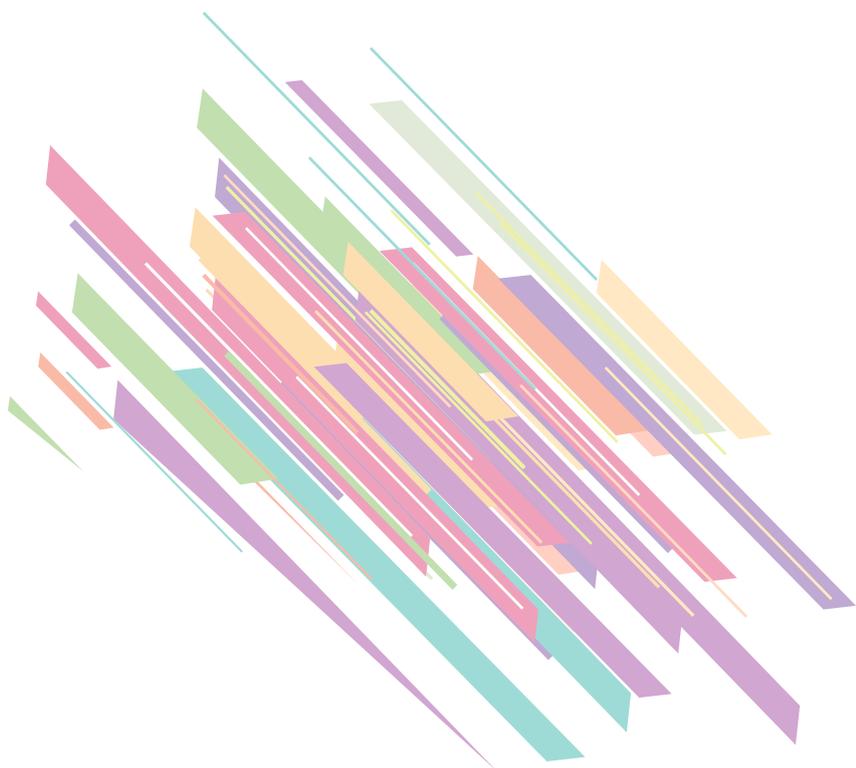
The Care Inspectorate and Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) are committed to working with the Scottish Government and other stakeholders, to disseminate the key messages from our joint inspection. This will inform and support the planning, delivery and evaluation of adult support and protection across Scotland.

We will ask the six partnerships we inspected to prepare an action plan for implementing our recommendations and the other areas we identified as requiring improvement. The Care Inspectorate will jointly monitor and support the delivery of action plans.

In addition to the six partnerships inspected, we would hope that this first independent scrutiny of adult support and protection in Scotland should be used to inform developments in adult support and protection in:

- the Scottish Government
- all other adult protection partnerships in Scotland
- the wider health and social care sector
- Police Scotland.

We have obtained copious invaluable information about adult support and protection. We encourage all adult support and protection stakeholders to make full use of this report to take forward continuous improvement of adult support and protection in Scotland.





## **Part two: inspection of individual partnerships**





# North Ayrshire partnership

Outcomes for adults at risk of harm were

**GOOD** 

important strengths,  
some areas for  
improvement

**because:**

The partnership made sure that the choices of adults at risk of harm were respected and adult protection intervention was pursued in the least restrictive manner. In general, adults at risk of harm were safer, had enhanced wellbeing and an improved quality of life, which was consequential of their adult protection journey.

The partnership had undertaken sound work to identify and measure outcomes for adults at risk of harm. In addition, this was used systematically to drive improvement. There was evidence of some effective work carried out with the perpetrators of harm to vulnerable adults.

## **Recommendations for improvement: The North Ayrshire partnership**

- 1. Minutes of adult protection case conferences should be sent to the police concern hub, where they should be retained and the relevant information extracted and appropriately recorded.**
- 2. The partnership should extend the offer of an independent advocate to all adults at risk of harm.**

# 1. Outcomes for adults at risk of harm in North Ayrshire

## The partnership pursued least restrictive options and respected choice

- 1.1. The partnership performed well on making sure that all adult support and protection activity was conducted within the general principles set out in Section 2 of the Adult Support and Protection (Scotland) Act 2007. Adults at risk of harm we met strongly confirmed this.
  - 1.1.1. The partnership adopted the least restrictive approach to adult protection intervention, and made sure the adult at risk of harm was consulted and involved at every stage of their adult support and protection journey. Again, adults at risk of harm we met confirmed this.
  - 1.1.2. Adults at risk of harm we met attested that they were treated with dignity and respect at every stage of their adult support and protection journey.
  - 1.1.3. The following were quotes from adults at risk of harm we met.

*"At first I was unhappy about being subject to adult protection procedures I changed my mind dramatically as things developed".*

*"The police responded immediately when I pressed my panic button. They were very good".*

*"Adult protection made me feel much safer".*

*"I understand why adult protection has placed restrictions on me. But, at this point in time I don't agree with any of it"*

*"I had to cease contact with family members to keep me safe".*

- 1.1.4. Our file reading revealed that in a number of instances the partnership had tried hard to balance individuals' rights to make their own choices against the partnership's obligations to make sure that they were safe and protected. This was often a very difficult balancing act, which partnerships have to deal with on a daily basis.

## Timely multi-agency response to adult protection concerns

- 1.2. The partnership responded to adult protection referrals in a timely and relatively well-integrated manner. Adult protection partners were clear about how to pursue an adult protection referral.
  - 1.2.1. We met representatives from the third sector and the independent sector. For the most part, they expressed the view that adult protection referral processes were clear and user friendly. Some said that they did not get feedback on the outcomes of their referral. They did acknowledge that there were limitations to the feedback information that the partnership could give for reasons of confidentiality.
  - 1.2.2. The partnership had made strenuous efforts to engage with members of the public about adult support and protection.
  - 1.2.3. The partnership submitted information, including information about the People in Distress project<sup>9</sup>, which evidenced good joint working and a multi-agency response to adult protection referrals. The partnership effectively audited the timeliness of interventions.
  - 1.2.4. One of the important developments in adult support and protection since the commencement of the Adult Support and Protection Act in 2008 was the development of the roles of fire and rescue and trading standards and the enhanced positive outcomes that they bring about for adults at risk of harm. We saw evidence of this for the North Ayrshire partnership.

## Involvement of adults at risk of harm and unpaid carers

### Involvement of adults at risk of harm

- **94%** of adults at risk of harm's views sought and taken into account at initial inquiry stage
- **98%** had views sought and taken into account at investigation stage
- **88%** had views sought and taken into account at implementation of protection plan and review stage.

- 1.3. The evidence from our file reading was that in the main, adults at risk of harm and their unpaid carers were consulted, involved, and included throughout the journey of the adult at risk of harm.
  - 1.3.1. A few unpaid carers we met said that they did not feel consulted and involved in the adult protection activities undertaken by the partnership for the adult at risk of harm they cared for.
  - 1.3.2. We met with a few adults at risk of harm who did not consider that the partnership's adult protection interventions delivered their desired personal outcomes. Rather they considered these interventions were intrusive and restrictive. Adults at risk of harm who held negative views about the adult protection process tended to be at an early stage in their adult protection journey.

<sup>9</sup> This was an initiative for vulnerable individuals who did not meet the three-point test

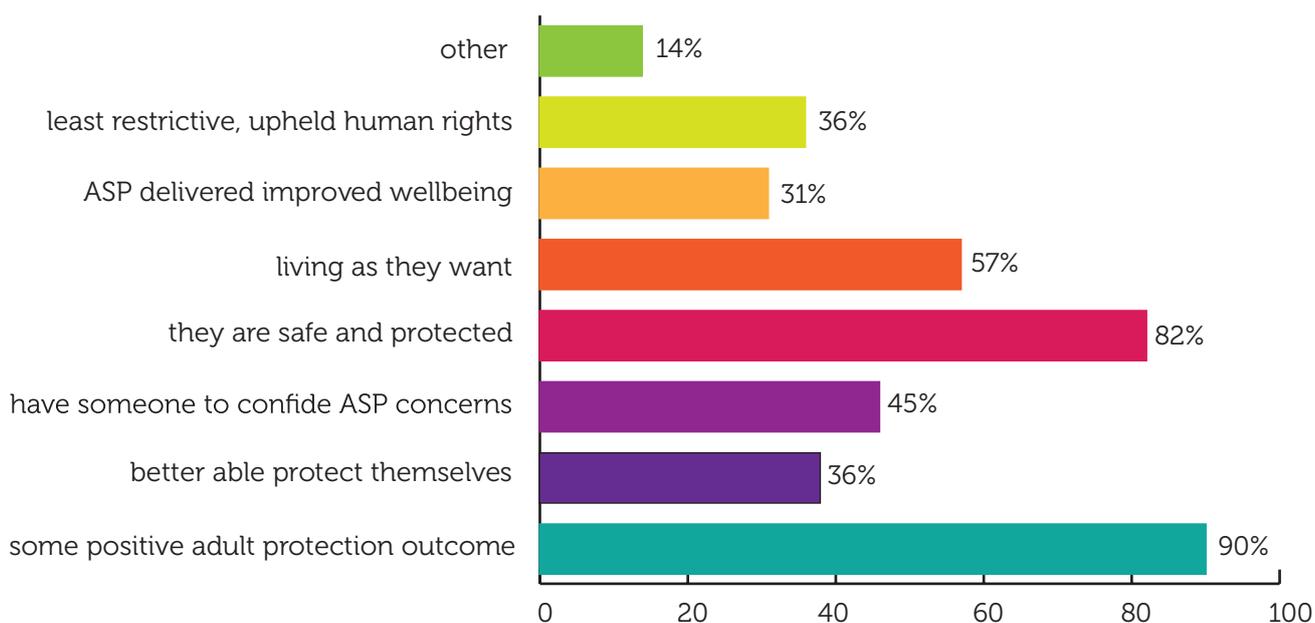
*"Adult protection changed my life for the better. I am not afraid anymore"*

*(Adult at risk of harm)*

## Outcomes for safety, protection and support

1.4. The partnership carried out effective work to determine the outcomes that it delivered for adults at risk of harm. The partnership submitted this work as part of its advanced evidence. The partnership had undertaken purposeful work on outcomes measurement, audits of adult protection records and eliciting the lived experiences of adults at risk of harm and their unpaid carers. This contributed considerably to positive outcome delivery for individuals, highly effective adult protection processes and focused leadership for adult support and protection. This was an important overarching finding for the North Ayrshire partnership.

Figure 2: outcomes for adults at risk of harm in North Ayrshire<sup>10</sup>



## Compliance with integration delivery principles and delivery of national health and wellbeing outcomes

1.4.1. Section 54 of the Public Bodies (Joint Working) Scotland Act 2014 set out the duty of the Care Inspectorate in respect of "reviewing and evaluating the extent to which the social service is complying with the integration delivery principles and contributing to achieving the national

<sup>10</sup> This chart for the North Ayrshire partnership, and its equivalent for the other five partnerships, shows the positive outcomes file readers were able to discern directly from the records, using their professional judgement. 82% individuals safe and protected does not imply 18% were not. The foregoing applies to the other results.

health and wellbeing outcomes". The integration delivery principles include provision that "improves the safety of service-users". The outcome data we obtained from our file reading (Figure 2) broadly showed that for adults at risk of harm partnerships complied with the integration delivery principles in respect of improving the safety of service users and the realisation of national health and wellbeing outcomes.

1.4.2. Some of the adults at risk of harm we met gave powerful testament to the life-changing, positive outcomes that the partnership delivered for them. Adult protection interventions had secured their safety, enhanced wellbeing and freed them from fear of harm. Their quality of life had improved immeasurably. Some adults at risk of harm we met did say that it had taken some time for them to fully appreciate that the partnership's actions had kept them safe and improved their wellbeing and quality of life. Initially, at the start of their adult protection journey, they had been resistant to the partnership's efforts to help and support them.

### Financial harm

- **32%** of cases there was evidence of financial harm to the individual.
- **32%** of cases this was greater than £10,000 - 6% over £50k.
- **94%** of cases evidenced that the partnership had acted to stop the abuse.
- **73%** of cases showed that this had been effective.
- **38%** of cases rated the effectiveness of the partnerships actions as good or better.

1.4.3. Our file reading revealed the partnership carried out effective work to stop financial harm to vulnerable individuals. This improved outcomes for adults at risk of harm by alleviating the trauma and loss of amenity that results from this type of harm.

*One-third of the cases of financial harm involved amounts of over £10,000.*

## Remedial work with perpetrators (harmers)

1.5. The partnership carried out some valuable remedial work with perpetrators of harm to vulnerable adults. In some instances, the partnership found it hard to positively engage with perpetrators.

1.5.1. Evidence from our file reading was that the partnership took some effective action to interdict the behaviours of perpetrators of harm to adults at risk.

## Perpetrators

- **62%** of cases evidenced that there was a perpetrator (alleged perpetrator) of harm to the individual.
- **61%** of cases showed that the partnership had taken actions/sanctions against the alleged perpetrator.
- **100%** of cases that we considered appropriate showed that the partnership carried out work with the perpetrator.
- **71%** of cases rated this work as good or better.

*We found a very positive emerging role of the fire and rescue service supporting adults at risk of harm and ameliorating their circumstances.*

# North Ayrshire partnership

**Key processes for adult support and protection were**

**VERY GOOD**

**major strengths**

**because:**

There was effective operational management for adult protection. Adult protection initial inquiries and investigations were undertaken competently, skilfully, and timeously and staff attained meritorious practice. Risk assessment and protection planning were carried out to a high professional standard, as were adult protection case conferences.

The partnership acknowledged that the capacity of independent advocacy to work with all adults at risk of harm was an area for improvement.

## 2. Key processes for adult support and protection in North Ayrshire

### Operational management of adult support and protection

2.1. All of our evidence pointed to the partnership's decisive and consistent operational management of adult support and protection.

2.1.1. The partnership's adult protection procedures were clear and fit for purpose.

### Progressing of adult protection referrals

#### ASP referral handling

- **92 %** correctly applied three- point test.
- **94%** recorded application of three-point test.
- **43%** ASP referral handling rated good or better.
- **2%** showed delays in processing (in **20%** we could not discern timescales).
- **73%** evidenced communication among partners, **27%** did not.
- **43%** referral handling rated good or better. **53%** adequate.

2.2. The partnership's initial response to adult protection referrals was timely and effectual. This was the first time we have asked partnerships to prepare a redacted version of highly confidential material, which presented a number of challenges. This is the likely explanation for the 20% timescale not evident figure given above. We did not see evidence of delays in the records we read at our on-site file reading stage.

2.2.1. There was a suitable single point of contact (an email account) for all adult protection referrals and related reports.

2.2.2. Effective communication among partners was an area for improvement. This might reflect an issue with the referral redaction process.

2.2.3. Positively, adult protection referrals from the NHS had doubled across Ayrshire from a low base. The appointment of a health link worker was a contributory factor to this improvement.

2.2.4. Our analysis of redacted adult protection referrals and police and social work records for adults at risk of harm showed that in almost all cases the partnership correctly and consistently applied the three-point test and clearly recorded its application.

2.2.5. The police concern hub generally screened reported adult protection concerns in a proficient manner.

- 2.2.6. Health did not make many adult protection referrals, but was alerting social work of adult support and protection concerns through duty systems. This frustrated social workers who were left to complete referral information on forms.
- 2.2.7. Performance reporting of adult protection activity data and making maximum use of electronic performance reports were areas for improvement for the police concern hub.
- 2.2.8. Police officers spent a very substantial amount of time supporting vulnerable adults – some of whom met the three-point test and some of whom did not. Officers expressed frustration with mental health triage services that they considered could be unhelpful. Community psychiatric nurses assessed distressed and vulnerable individuals over the telephone and determined if they needed to be taken to the accident and emergency unit. Health staff felt this kept people away from hospital and at home.
- 2.2.9. Accident and emergency staff said they would appreciate if it were easier to find what other professionals were involved when an adult at risk of harm presented to them, as they did not always have access to the relevant information.

## Information sharing

### Police records

- **59%** of police records had all information about adult support and protection incidents.
- **5%** of police records contained case conference minutes.
- **49%** of police records contained a chronology.
- **60%** of records contain a police vulnerable person's database report.
- **70%** of the vulnerable person's database entry contains details of adult protection concerns.

- 2.3. There was compelling evidence that, in general, practitioners shared adult protection information appropriately.
- 2.3.1. Adult protection case conference minutes were not always put on the vulnerable person's database unless they contained police actions. The partnership acknowledged this was an area for improvement.

### Recommendation for improvement

Minutes of adult protection case conferences should be sent to the police concern hub, where they should be retained and the relevant information extracted and appropriately recorded.

2.3.2. GPs and consultants were at times reluctant to give views about risk or undertake capacity assessment work. Capacity assessments were sometimes delayed while GPs' fees were sorted out.

## Initial inquiries (duty to inquire)

2.4. The partnership carried out relatively competent and cohesive multi-agency initial inquiries into referrals of adult protection concerns.

## Full adult protection investigations

### Adult protection investigation

- **98%** of adults at risk of harm had a full adult protection investigation.
- **100%** of cases the full investigation effectively determined if the individual was at risk of harm.
- **83%** of investigations quality - rated good or better.

2.5. We were highly impressed with the manner in which the partnership carried out and recorded its investigations into adult protection concerns. Partnership staff carried out adult protection investigations in a highly competent, meticulous, and skilful manner and these investigations effectively determined the right course of action for the adult at risk of harm going forward.

2.5.1. Reports of adult protection investigations were predicated on risk throughout. Council officers completed reports of adult protection investigations to a consistent, commendably high standard.

*We were impressed with this partnership's risk-focused investigations.*

## Chronologies, risk assessment and risk management

### Chronologies

- **94%** of adults at risk of harm had a chronology when we considered they should have had one.
- **82%** of chronologies were of an acceptable standard.

## Risk assessment and protection plans

- **98%** of adults at risk of harm had a risk assessment.
- **84%** of risk assessments we rated good or better – over half rated as very good.
- **86%** of adults at risk of harm who required one had a risk management plan.
- **90%** of risk management plans / protection plans rated good or better.

2.6. Overall, the partnership managed the risks for adults at risk of harm in an accomplished manner. This was evidenced in high-quality chronologies, risk assessments, risk management, and associated protection plans that we analysed.

## Large-scale investigations

2.7. We read reports from a number of large-scale investigations. The partnership carried out these investigations commensurate with the Scottish Government's code of practice. Where appropriate, Care Inspectorate staff were involved in large-scale investigations. These were episodes where there were potentially multiple adults at risk of harm. These large scale investigations involved adults who generally lived in the same place and or received their care and support from the same service.

2.7.1. The partnership carried out multi-agency, large-scale investigations to a high standard. They engendered positive outcomes for the adults at risk of harm who were the subject of the investigation. They were safe, protected and had enhanced wellbeing as a result of the large-scale investigation activity.

## Adult protection case conferences

### Adult protection case conferences

- **95%** of cases the partnership convened an adult protection case conference for the individual.
- **94%** of case conferences rated good or better - over half very good.
- **82%** attended by adult at risk of harm where invited.
- **94%** of case conferences effectively determined right actions to protect adult at risk of harm.

2.8. Adult protection case conferences effectively analysed all of the circumstances of the adult at risk of harm and determined the best way forward.

2.8.1. The partnership successfully included and supported adults at risk of harm at the case conferences, which discussed the circumstances of their lives. One adult at risk of harm told us *"We felt included and listened to. Any jargon or technical language was explained to us so we understood it."*

2.8.2. Our file reading showed police and health attendance at adult protection case conferences was an area for improvement.

- Thirty-two per cent of adult protection conferences did not have a police representative in attendance.
- Thirty-eight per cent of adult protection conferences did not have a health representative in attendance.

2.8.3. There was persuasive evidence from our focus group with police officers that the partnership needed to make sure that frontline police officers who attended adult protection case conferences were suitably trained and were well briefed on the circumstances of the subject of the case conference.

## Independent advocacy

### Independent advocacy

- **53%** individuals offered advocacy when needed. **42%** of them received advocacy support.
- **47%** of individuals who should have been offered advocacy were not.
- **100%** of cases showed evidence that advocacy has helped the individual articulate their views.

2.9. The partnership was only able to offer independent advocacy to adults at risk of harm who had a diagnosed mental health problem. This was due to lack of capacity within independent advocacy services. This service was not available to adults at risk of harm who did not have a mental health problem. This was an area for improvement acknowledged by the partnership.

2.9.1. In the instances where they were deployed, independent advocates played a very important role in respect of guiding the adult at risk of harm through the adult support and protection process. Advocates made sure that the views of adults at risk of harm were paramount at all stages of the adult support and protection process.

### Recommendation for improvement

The partnership should extend the offer of an independent advocate to all adults at risk of harm who require it.

## Staff knowledge and use of legislation

2.10. Partnership staff were skilled and knowledgeable about legislation related to adult support and protection. One said insightfully *"We are getting better at making use of the Adult Support and Protection Act to make people safe and protected"*.

2.10.1. There were some instances of delays in carrying out capacity assessments for adults at risk of harm. This was an area for improvement.

*"We are getting better at making use of the Adult Support and Protection Act to make people safe and protected".*

## **Support for adults at risk of harm to achieve personal outcomes other than adult protection**

2.11. In general, the partnership delivered (in addition to adult protection outcomes) the desired personal outcomes for adults at risk of harm, in terms of living independently, enhanced wellbeing and quality of life.

## **Review adult protection case conferences**

2.12. The evidence from our file reading was the partnership carried out adult protection review case conferences appropriately and cogently. One hundred percent of adults at risk of harm who required a review case conference got one timeously.

# North Ayrshire partnership

**Leadership for adult support and protection was**

**VERY GOOD**



**major strengths**

**because:**

Strategic leaders within the partnership strove to engender good partnership working across the adult protection partnership. There was a pervasive embedded culture for adult support and protection. There was unequivocal evidence that self-evaluation activity had delivered significant improvement to adult protection practice on the ground. There was sound governance for adult support and protection exercised by senior leaders and the various forums in which they were involved.

# 3. Leadership for adult support and protection in North Ayrshire

## Leaders support for partnership working

3.1. Representatives of the chief officers group demonstrated a mature, supportive and appropriately challenging partnership and a passionate commitment to making sure adults at risk of harm were safe, protected and supported.

3.1.1. The chief officers group (up to 20 delegates attending) understood the inextricable links between adult protection and child protection and agendas for their meetings reflected this.

3.1.2. We were highly impressed with the leadership exercised by the chief officers group in respect of their knowledge, commitment, and improvement focus in relation to adult support and protection.

*"The culture was right to support good (adult support and protection) practice across partnership".*

*(multi-agency focus group)*

3.1.3. The partnership had a positive, well-embedded culture for adult support and protection. Partnership staff we met were acutely aware of how critical this work was and afforded it a high level of priority.

3.1.4. There was ample evidence of this positive culture at all levels in the partnership, from the senior management and leadership teams to the frontline staff. This positive culture was an important contributory factor to the positive safety, support and protection outcomes that the partnership delivered for adults at risk of harm.

3.1.5. There was evidence from a number of focus groups of the commendable emergence of fire and rescue as a key adult protection partner, which was making an important contribution to delivering positive outcomes for adults at risk of harm.

## Vision

3.2. Partnership leaders we met clearly articulated and promoted a cogent, aspirational, and motivational vision for adult support and protection.

3.2.1. Overall, there was a comprehensive suite of aspirational strategic plans and improvement plans for adult support and protection. A comment from one of the multi-agency focus groups was *"the health and social care partnership's strategic plan was developed in a very inclusive manner".*

## Leadership for delivery of adult protection practice

- 3.3. Representatives of the chief officers group we met displayed strong commitment to staff training and staff development in respect of adult support and protection.
- 3.3.1. We found that the council officers (who carry out adult support and protection investigations and other work) and mental health officers we met were well trained, highly motivated to carry out adult support and protection work, knowledgeable, very confident about their role and committed to integrated adult support and protection practice.
- 3.3.2. Chief officers group representatives acknowledged that the police processes to support officers to attend adult protection case conferences were not as efficient and well developed as they were for child protection case conferences. The frontline police focus group we held strongly confirmed this.
- 3.3.3. Senior clinicians said that awareness of adult protection and practice among accident and emergency staff was improving.
- 3.3.4. The adult protection committee was exploring the partnership's adoption of the 'Rochdale' model for escalating high-risk adult protection cases to senior officers. Workers could refer a case to a senior officer panel when they had taken all reasonable steps to mitigate the risks to the individual, but significant risks remained. This process ensured managerial accountability and support for frontline staff.

## Quality assurance

- 3.4. The chief officers group and the adult protection committee had engendered a suite of self-evaluation and audit activities (for example, a number of adult support and protection case record audits). These had been used successfully to identify areas for improvement and to drive progress.
- 3.4.1. The partnership carried out an innovative (and possibly unique) exercise to map adult protection referrals on to areas of multiple deprivation in North Ayrshire. They analysed the data for patterns. They planned to use this to inform their planning of adult support and protection.
- 3.4.2. The partnership developed and implemented an initiative to elicit the lived experience of adults at risk of harm. The results showed that adults at risk of harm thought:
- staff who worked with them were respectful, helpful, and professional
  - they were safer as a result of their adult protection journey.

The partnership determined a number of areas for improvement from this exercise.

- 3.4.3. The chief officers group and the adult protection committee were acutely conscious of the relatively low number of adult support and protection referrals from health. One of a number of actions to address this was the appointment of an adult protection coordinator for acute health

services. Training for GPs was proffered by the chief officers group as another factor improving the adult support and protection referral rate from health.

## **Leadership exercised by the adult protection committee and chief officers group**

- 3.5. The independent convener of the adult protection committee was perceived as a key strength by representatives of the chief officers group.
  - 3.5.1. Our perception was of a strong, confident, competent and committed independent convener of the partnership's adult protection committee.
  - 3.5.2. The health clinical director, who was also a GP, attended the adult protection committee. The partnership rightly perceived this as a catalyst for the continuous improvement of an integrated approach to adult support and protection.
  - 3.5.3. There were industrious and effective sub groups to deliver key aspects of the role of the adult protection committee, such as service user and unpaid carer involvement, and policy and procedure development.
  - 3.5.4. The adult protection committee engendered a recent and productive training initiative to improve adult protection practice among staff in certain care homes. These care homes generated a high number of adult protection referrals, many of which the partnership perceived as inappropriate.
  - 3.5.5. Our evidence pointed to an effective, well-functioning chief officers group, which afforded appropriate priority to adult support and protection.
  - 3.5.6. We noted that no adult protection cases perceived to have adverse elements had prompted a significant case review. Seven adult support and protection cases were subject to initial case reviews, and the reports of these were submitted by the partnership as advanced evidence. These initial case reviews were carried out competently.
  - 3.5.7. Some council officers expressed the view that audits of adult support and protection case records focused too much on social work, with not enough focus on the adult support and protection related activities of police and health. Council staff did allude to some excellent work by the police on securing convictions for perpetrators of harm to vulnerable adults.

## The role of the chief social work officer

- 3.6. The chief social work officer carried out their role in respect of adult support and protection competently and professionally.

*Vigorous, improvement-focused leadership for adult support and protection in North Ayrshire had had a positive impact on outcomes for adults at risk of harm and the key processes to make them safe.*

# Highland partnership

Outcomes for adults at risk of harm were

**ADEQUATE** 

strengths, just outweigh  
weaknesses

**because:**

The partnership made sure that the choices of adults at risk of harm were respected and adult protection intervention was pursued in the least restrictive and beneficial manner. There were improved outcomes for adults at risk of harm in terms of safety, wellbeing and quality of life. The police concern hub operated efficiently and effectively and made a considerable contribution to the safety of adults at risk of harm. The partnership was not doing enough to elicit the lived experiences of adults at risk of harm on their outcomes and experience of their adult protection journey. Outcomes measurement for adult support and protection was patchy and not systematic. Deficits in the partnership's adult protection key processes had the potential for an adverse impact on the outcomes for adults at risk of harm.

## **Recommendations for improvement: The Highland partnership**

- 1. The partnership should make sure that all adult protection referrals are processed timeously.**
- 2. The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.**
- 3. The partnership's review of the governance of adult support and protection should streamline the governance landscape and strengthen the links between the chief officers group and the adult protection committee.**

# 1. Outcomes for adults at risk of harm in Highland

## Partnership pursues least restrictive options and respects choice

- 1.1. The partnership supported least restrictive options and respected the choices of adults at risk of harm. This was evidenced from case record reading. One adult at risk of harm said *"I think my wishes were taken into consideration, they wanted to protect me and not restrict me too much"*.
  - 1.1.1. The partnership was trying to rationalise the number of meetings adults at risk of harm and unpaid carers were exposed to and make processes much more proportionate.
  - 1.1.2. The police acknowledged they still had challenges with the understanding and application of consent, capacity and the three-point test by frontline officers. They were working to address these issues.

## Timely multi-agency response to adult protection concerns

- 1.2. The partnership responded to adult protection referrals collaboratively. Our analysis of redacted referrals evidenced communication among partners for almost all referrals. See 2.2 for our findings on delays in the partnerships processing of adult protection referrals. In the main, adult protection partners were clear about how to pursue adult protection referrals. Accident and emergency unit staff were an exception to this.
  - 1.2.1. Fire and rescue had undertaken over 3,000 home safety visits and estimates that 50% of the people visited were "high risk". They worked very closely with the council's telecare staff.
  - 1.2.2. Fire and rescue had a rapidly growing positive role in respect of adult support and protection.

*Fire and rescue had carried out over 3,000 fire safety checks on the homes of vulnerable people.*
  - 1.2.3. Trading standards planned a festive season campaign for adult support, protection about scams that targeted vulnerable people. They had secured good involvement from the banks and trading standards on the adult protection committee financial harm group.
  - 1.2.4. There was a new trading standards and police financial concern pathway, which had a positive impact on collaboratively identifying those at risk.

- 1.2.5. There had recently been a productive adult support and protection training event for 50 GPs. This was part of a wider tranche of GP training.
- 1.2.6. The police concern hub dealt very efficiently with vulnerable-person reports. This had the potential to strengthen the identification of adults at risk of harm and deliver positive outcomes for them.
- 1.2.7. Questionnaire responses from adults at risk of harm and unpaid carers evidenced a person-centred approach. Not all respondents welcomed intervention under adult support and protection. However, individuals who were less positive about their adult protection journey still reflected an inclusive approach in meetings, where they felt they could share their opinions.
- 1.2.8. Independent advocacy for adults at risk of harm and their unpaid carers had a strong, positive and highly active role in this partnership. Unpaid carers expressed the following views.

*"We would never have got through this situation without advocacy."*

*"I was able to talk to my advocate and she would help with things I found difficult to explain. I could speak to her."*

*"Both carer and user advocates played key roles. They made an incredible noise and banged the drum on our behalf but nobody listened."*

- 1.2.9. Some advance practitioners who chaired case conferences tried to meet with the adult at risk of harm and unpaid carers immediately before the case conference and to build breaks into the discussion. We considered this was a beneficial approach.
- 1.2.10. Meeting timescales for convening case conferences timeously was a challenge. In one district, only two of the last five case conferences were held on schedule.
- 1.2.11. Fire and rescue had undertaken about 10 reviews of fatal or near fatal fires. A number of staff who had attended these said they provided a good opportunity for joint learning.

## Involvement of adults at risk of harm

- **88%** of adults at risk of harm's views sought and taken into account at initial inquiry stage.
- **94%** had views sought and taken into account at investigation stage.
- **78%** had views sought and taken into account at implementation of protection plan and review stage.

### Involvement of adults at risk of harm and unpaid carers.

- 1.3. In general, the partnership made sure that adults at risk of harm were included and involved throughout their adult protection journey.
  - 1.3.1. Some unpaid carers rated adult support and protection intervention highly, but in terms of outcomes, they said the benefits were marginal.

*"At the meetings everyone was really good. I get help quickly, when I need it. I raise the alarm and things happen. Things were perfect for a few days after I complain but it goes back to how it was."*

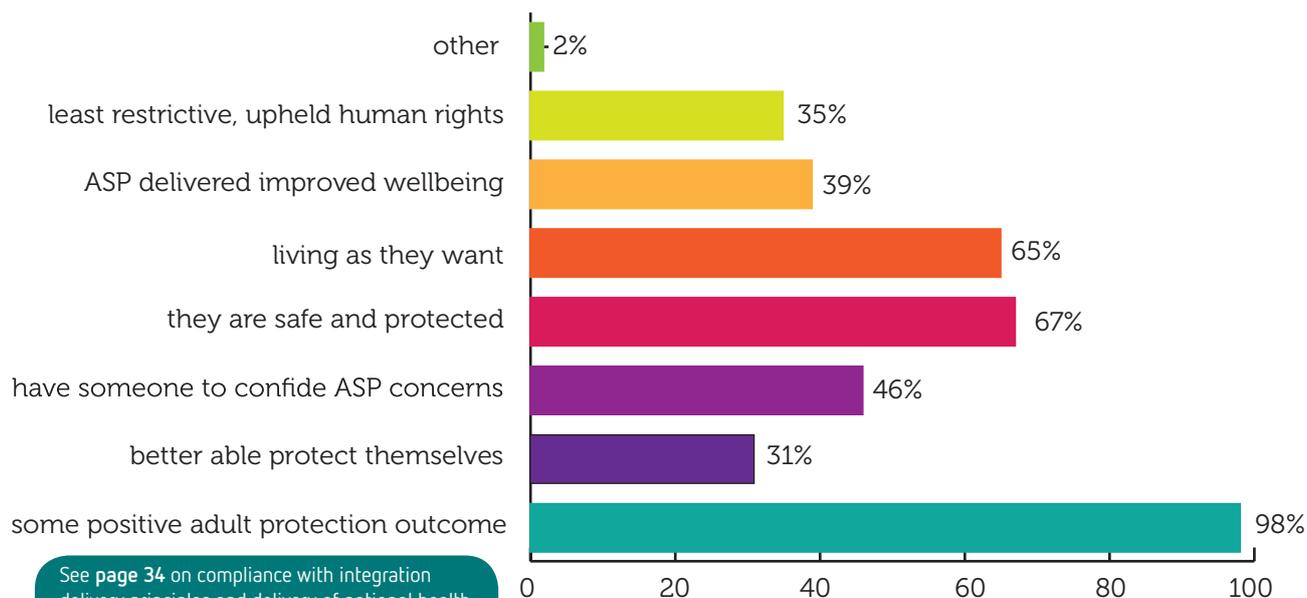
*"I come out full of hope then I get disappointed because it doesn't last. They just need to learn to care."*

- 1.3.2. Eighty per cent of respondents to an internal survey said adult protection had effectively mitigated the risks that were extant.
- 1.3.3. Monthly adult support and protection performance reports focused entirely on quantitative activity data. There was no outcome related data.

### Outcomes for safety, protection and support

- 1.4. Overall, the partnership delivered safety, protection and support to adults at risk of harm (Figure 3). We considered that the areas for improvement we identified in the partnership's key processes had the potential for adverse impact on adults at risk of harm and their unpaid carers.
  - 1.4.1. Large-scale investigations were robust and comprehensive. There was strong evidence of good outcomes for residents in terms of safety and enhanced wellbeing for the adults at risk of harm involved.

**Figure 3: outcomes for adults at risk of harm in Highland**



See page 34 on compliance with integration delivery principles and delivery of national health and wellbeing outcomes.

1.4.2. The partnership acknowledged it needed to do more to elicit the lived experiences of adults at risk of harm. There was no systematic approach to asking adults at risk of harm about their outcomes. There was no system for the aggregation and digitisation of outcome data for adults at risk of harm. This was an area for improvement.

1.4.3. A coalition of partners – police, social work, trading standards and the financial sector – collaborated in an increasingly adept manner to tackle financial harm to vulnerable adults, thereby delivering positive outcomes for them.

<b>Financial Harm</b>	<ul style="list-style-type: none"> <li>• <b>16%</b> of cases there was evidence of financial harm to the individual.</li> <li>• <b>63%</b> of cases this was greater than £1000.</li> <li>• <b>100%</b> of cases evidenced that the partnership had acted to stop the abuse.</li> <li>• <b>100%</b> of cases showed that this had been effective.</li> </ul>
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**Remedial work with perpetrators (harmers)**

1.5. The evidence from our file reading was that the partnership carried out some efficacious work with perpetrators of harm to vulnerable adults.

<b>Perpetrators</b>	<ul style="list-style-type: none"> <li>• <b>58%</b> of cases there was a perpetrator.</li> <li>• <b>72%</b> applicable episodes partnership took action against perpetrators.</li> <li>• <b>33%</b> of actions rated good.</li> </ul>
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# Highland partnership

Key processes for adult support and protection were

**ADEQUATE** 

**strengths just outweigh  
weaknesses**

**because:**

The partnership acknowledged the key process deficits that we identified from analysis of individuals' adult protection records, and interviews with the staff who operated and managed them. Deficits in the recording of initial adult protection inquiries and investigations could cause delays in the processes designed to make sure that adults at risk of harm were made safe and protected. The partnership had recently made improvements in this domain, which we considered was a necessary and positive development. Risk assessment and risk management practice was variable. Adult protection case conferences operated in a constructive and productive manner to analyse all of the circumstances of the adult at risk of harm and determine the optimal way forward.

## 2. Key processes for adult support and protection in Highland

### Operational management of adult support and protection

- 2.1. The partnership evinced competent operational management of adult support and protection. The recently revised adult support and protection procedures were broadly clear and fit for purpose, apart from failing to set timescales for the completion of adult protection investigations.

### Progressing of adult protection referrals

#### Adult protection referrals

- **96%** referrals had evidence of communication among partners.
- **90%** applied three-point test correctly.
- **47%** of ASP referrals recorded the application of the three-point test.
- **69%** referrals progressed timeously.
- **29%** of referrals evidenced delays in processing.
- **53%** referral handling rated good or better, **47%** adequate or worse.

- 2.2. Overall, the effectiveness of the partnership's systems to process adult protection referrals was variable.

- 2.2.1. Our analysis of redacted adult protection referrals determined there were delays in the processing of referrals in just under one-third of them. The partnership needed to improve on this to make sure all adult protection referrals were progressed in a timely manner.

#### Recommendation for improvement

The partnership should make sure that all adult protection referrals are processed timeously.

- 2.2.2. The partnership consistently applied the three-point test, but did not always record its application on Care First, making scrutiny and quality assurance challenging.
- 2.2.3. The partnership had recently reviewed its adult protection procedures. They contended these would address the weaknesses we found in the inspection.
- 2.2.4. In this partnership, adult support and protection stages (for example, referral, duty to inquire, investigation and case conferences) were not clearly separated and defined; they tended to overlap.

- 2.2.5. The partnership populated observations fields (case progress notes) rather than investigation report forms (AP3) to record details of the investigation process and findings, including the assessment of risk.
- 2.2.6. When the partnership carried out formal adult support and protection investigations, quite a lot of information gathering and risk assessment activity occurred in the duty to inquire phase.
- 2.2.7. There were sometimes delays with frontline staff filling in the adult support and protection forms – reports of initial inquiries, reports of investigations.
- 2.2.8. There were sometimes delays with nominated officers (managerial role) filling in the adult support and protection form, resulting in a backlog.
- 2.2.9. Managers acknowledged the quality of the completion of the adult support and protection forms was variable. There was no stated timescale for the completion of adult support and protection investigations. We considered this was an area for improvement and prescribed clear timescales.
- 2.2.10. More work was needed to improve police officers’ understanding of consent and capacity and how to apply them accurately when attending adult protection related incidents.
- 2.2.11. Accident and emergency unit medical staff we met said that they commonly made adult protection referrals. However, they expressed a strong view that, for them, structures and pathways into adult support and protection pathways were not clear.

## Information sharing

### Police records

- **73%** of police records contain all information about adult support and protection related incidents.
- **59%** of police records contain case conference minutes.
- **66%** of police records contained a chronology.
- **81%** of records contained a police vulnerable person’s database on file.
- **90%** of the vulnerable person’s database entry contains details of adult protection concerns.
- **64%** of the vulnerable person’s database entry contained a chronology.

- 2.3. The police concern hub shared information timeously, appropriately and succinctly.
- 2.3.1. The police were confident social work responded well to their vulnerable persons’ database reports and said that if certain priority cases arose they phoned social work as well as passing on the vulnerable person’s report. Responses were typically very positive.
- 2.3.2. They had a daily multi-agency clinical ‘huddle’ at Newcraigs psychiatric unit, which they considered worked effectively, including productive discussions about application of the three-point test.

2.3.3. The police risk and concern hub introduced additional escalation protocols to supplement the national requirements. These management reports provided enhanced risk identification and prioritisation tools.

2.3.4. Police reported that due to the Highland single-agency model, incidents they attended resulting in an adult's referral to other services (such as health) removed the need to submit the relevant police concern report. Police managers intimated this was subject to appropriate quality assurance.

## Initial inquiries (duty to inquire)

2.4. The partnership accepted there was a significant area of overlap between what constituted duty to inquire activity and what constituted investigation activity. Figure 4 illustrates the process we saw in most of the records we read; Figure 5 illustrates the revised and improved process.

Figure 4

ASP1 - referral form  
ASP2 - report of initial inquiry  
ASP 3 - investigation report  
ASP4- - protection plan

ASP 1 - staff member recorded the details of the adult protection referral

ASP 2 - Council officer appointed to carry out initial inquiry, nominated officer completed and signed off the ASP 2

- Could be delay in nominated officer completing and signing off forms.
- Nominated officer recorded the outcome of initial inquiry rather than an account (narrative) of inquiry.
- Account of inquiry might be included in observations (case notes) by allocated worker.

ASP 3 - if episode to proceed to investigation council officer appointed. Second person appointed. Council officer completed ASP 3

- ASP 3s we read tended to contain a risk assessment and outcome of the investigation, rather than an account of the investigation. Account might be in observations.
- No timescale for the completion of investigations.

ASP 4 - this contained the risk management plan / protection plan (post ASP case conference)

## Figure 5

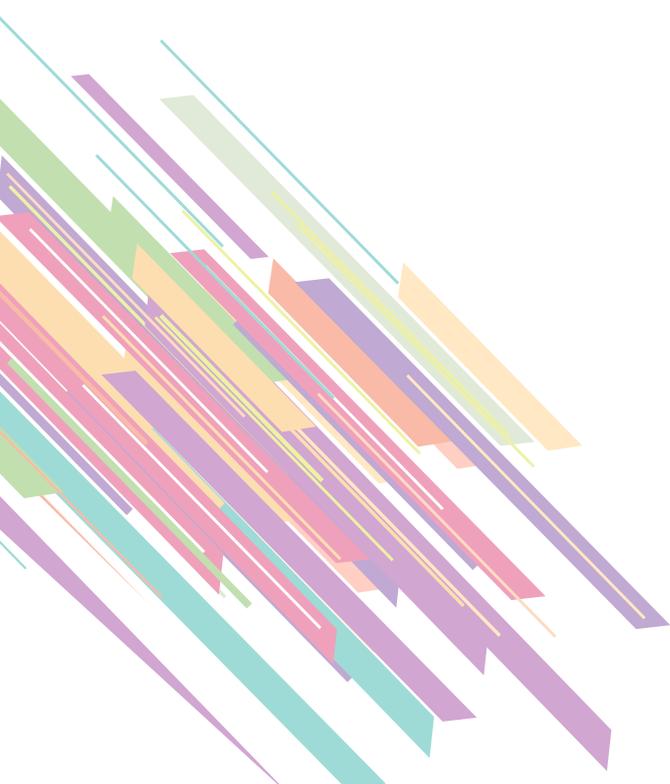
ASP 1- staff member records details of adult protection referral

ASP 2 - council officer appointed to carry out initial inquiry, council officer completes ASP 2, nominated officer signs off

ASP 3 - if episode to proceed to investigation council officer appointed. Second person appointed. Council officer completes ASP 3

- Still no timescale for the completion of investigations.

ASP 4 - this contains the risk management plan / protection plan (post ASP case conference)



## Full adult protection investigations

### Adult protection investigations

- **98%** of investigations effectively determined if the adult was at risk of harm.
- **67%** of investigations rated good or better.
- **33%** of investigations rated adequate or worse.

2.5. Team leaders confirmed that the detail of investigations was recorded in the CareFirst observations screens rather than in the requisite form (AP3), which tended to only contain very limited detail of the investigation process and findings. They agreed that this meant that staff from other agencies who attended case conferences only received limited information in advance of the case conference.

2.5.1. The partnership acknowledged current adult support and protection key processes needed to be changed, hence the revised process shown in Figure 5. Staff were consulted on this and they have been trained. They agreed the revised process was an improvement on the current key process.

2.5.2. The issue of capacity was a challenge, particularly where capacity fluctuated. There were no real issues with requesting capacity assessments although there were sometimes delays; on occasion, this could be weeks.

2.5.3. Mental health officers required two weeks' notice to attend adult protection case conferences<sup>11</sup>. If it took two weeks to assign a mental health officer to an adult protection case, this meant that the stated 10-day timescale (on completion of the investigation stage) for the convening of an adult protection case conference would not be met.

*"The council officer's role once the investigation commenced was excellent. They put the family at the centre. Everything was made clear, except timescales".*

*(Unpaid carer)*

## Chronologies, risk assessment and risk management

### Chronologies

- **60%** of adults at risk of harm had a chronology when we considered they should have had one.
- **40%** of adults at risk of harm did NOT have a chronology when one should have been present.
- **89%** of chronologies were of an acceptable standard.

<sup>11</sup> Mental health officers also required two week's notice to attend case conferences related to the Adults with Incapacity (Scotland) Act 2000

## Risk assessment and management

- **98%** of adults at risk of harm had a risk assessment.
- **53%** of risk assessments rated good or better.
- **96%** of individuals who required a risk management plan had one.
- **56%** of risk management plans rated good or better.

2.6. The partnership performed well on preparing risk assessment and risk management plans (protection plans) for adults at risk of harm. The quality of risk assessments and risk management practice was variable.

2.6.1. The partnership completed valid chronologies for just over half of the adults at risk of harm who required one. We considered this was an area for improvement.

### Recommendation for improvement

The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

2.6.2. Managers spoke of a strong multi-agency focus on actions to increase protective factors. They confirmed that they were unable to use the chronology screen on CareFirst.

2.6.3. GPs were frustrated about requests for capacity assessments as a matter of routine, where no medical concern was evident. This sidetracked them from providing treatment. The police expressed some frustration that it continued to be challenging getting capacity assessments.

## Large-scale investigations

2.7. The partnership undertook large-scale investigations appropriately and conducted them in a very thorough and professional manner. They delivered outcomes of enhanced safety and wellbeing for the adults at risk involved.

## Adult protection case conferences

### Adult protection case conferences

- **96%** appropriate cases the partnership convened an adult protection case conference for individual.
- **81%** of relevant professional parties were invited.
- **51%** more than half, of the invited parties failed to attend the case conference.
- **56%** of case conferences invited the adult at risk of harm.
- **63%** of adults at risk of harm attended if invited.
- **72%** of case conferences rated good or better.

2.8. Almost all of the interested parties viewed adult protection case conferences very positively. Case conferences diligently pulled together all of the relevant information about the circumstances of the adult at risk of harm and then determined how best to protect and support the adult at risk of harm. There was good involvement from third sector and independent sector providers.

2.8.1. Our file reading showed police and health attendance at adult protection case conferences was an area for improvement.

- Nineteen per cent of adult protection conferences did not have a police representative in attendance.
- Thirty-three per cent of adult protection conferences did not have a health representative in attendance.

2.8.2. Unpaid carers who attended case conferences said their views were listened to and taken on board.

2.8.3. Some adults at risk of harm and their advocates said that despite attending the case conference at the specified time, they were kept waiting and only invited into the meeting once a decision had been made.

2.8.4. On a positive note, one adult at risk of harm said *"I had spoken to some of the people before the meeting. They encouraged me to talk at the meeting. I knew it was to keep me safe"*. Another expressed a more negative view *"Too many people at the meeting, the room was small and hot and I felt overwhelmed by it all. I started to feel paranoid"*.

## Independent advocacy

### Independent advocacy

- **43%** individuals who needed advocacy were offered it.
- **57%** of individuals who needed advocacy were not offered it.
- Only **54%** of individuals offered advocacy actually received it.
- **80%** of individuals who got advocacy were supported to articulate their views.

2.9. Independent advocacy played a vital role in making sure that the views of adults at risk of harm and their unpaid carers were articulated and taken into account by the partnership. This was particularly important when there was tension between adult protection professionals and the adult at risk of harm or the unpaid carer. Ensuring the appropriate offer and deployment of independent advocacy to adults at risk of harm was an area for improvement.

## **Staff knowledge and use of legislation**

2.10. In general, council officers and other staff were suitably knowledgeable about the legislation applying to adult protection. They received good support with this from adult protection managers.

## **Support for adults at risk of harm to achieve personal outcomes other than adult protection**

2.11. The partnership generally delivered positive (non-protection) desired personal outcomes for adult at risk of harm.

## **Review adult protection case conferences**

2.12. In the main, adult protection review case conferences were convened timeously and appropriately. These were conducted regularly and appropriately, where the three-point test still applied to the adult at risk of harm.



# Highland partnership

Leadership for adult support and protection was

**ADEQUATE**



**strengths just outweigh  
weaknesses**

**because:**

There was some evidence to support leaders' assertions that the Highland single agency model delivered benefits for adult support and protection – particularly communication between social workers and health professionals. Despite the single agency model, challenges around electronic information sharing between social work and health staff remained a persistent challenge. Chief officers' governance of adult support and protection was an area for improvement, which leaders acknowledged. The governance and associated quality assurance and performance management roles of the adult support and protection committee needed to be refreshed and strengthened, as did the links between the adult protection committee and the chief officers group.

# 3. Leadership for adult support and protection in Highland

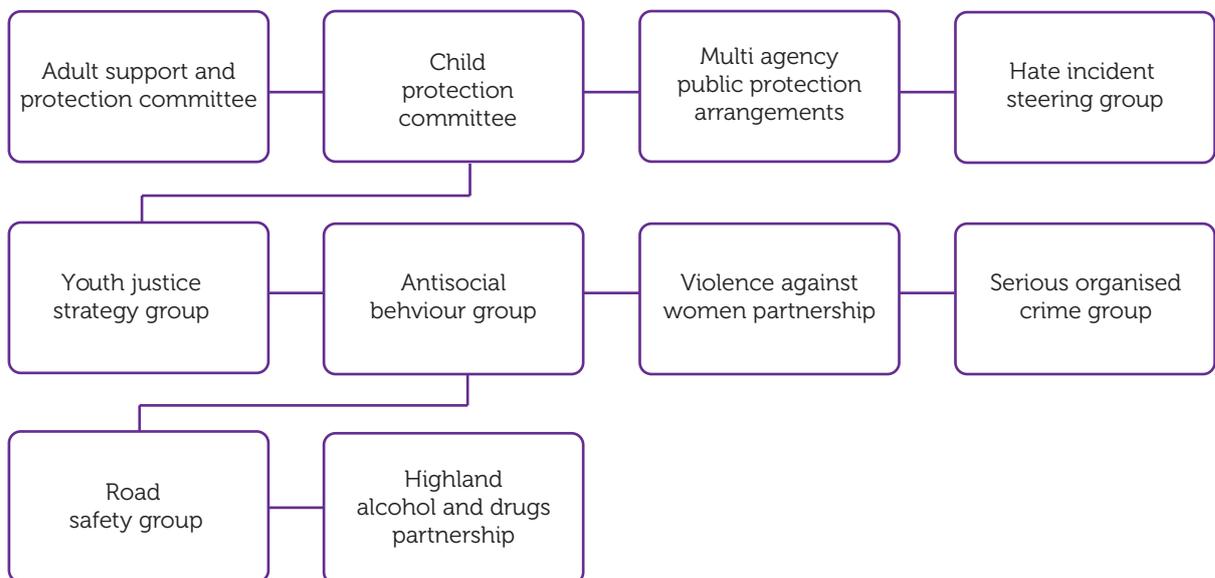
## Leaders support for partnership working

- 3.1. There was evidence from, among others, the chief officers group of the benefits (added value for adult protection) resultant from the single agency model.
  - 3.1.1. Senior managers asserted that conversations for example, between police and health, which would not have happened under the previous structure, were happening regularly now.
  - 3.1.2. The single budget, single management model has created shared responsibility and while adult support and protection was previously viewed as a social work issue, this was now a shared adult services responsibility. Adult support and protection was well established as a high priority.
  - 3.1.3. There was recognition that the role of the adult support and protection committee was not just about social work – much of their work was with the police. The Adult Support and Protection Committee had a very good working relationship with colleagues in the police.

*"I just have to pick up the phone."*

## Vision

- 3.2. The partnership had clearly articulated its vision for adult support and protection. The complex structure of the Safer Highland grouping did not always best facilitate the promulgation of this vision.



Safer Highland Grouping 1

## Leadership for delivery of adult protection practice

- 3.3. There was joint training involving police officers and council officers. They have had 'crossing the acts' training, about the suite of legislation pertaining to adult support and protection.
  - 3.3.1. Members of the adult support and protection committee attested to the need to train staff who worked in NHS accident and emergency units. Those emergency medicine doctors we met intimated they knew little about adult protection compared to the knowledge and experience that they had about child protection.
  - 3.3.2. Our evidence from the focus group of frontline police officers was of high morale and motivation to carry out adult support and protection work. While some specialist areas felt well trained in relation to adult protection, frontline officers were not confident about consent, capacity, and the three-point test.
  - 3.3.3. Team leaders and council officers considered that the recently revised adult support and protection procedures were clear and helpful.
  - 3.3.4. There were well-established escalation protocols in place that delivered a joint and robust decision making framework even where individuals were out of services reach and harm was difficult to prevent.
  - 3.3.5. Adult support and protection training was well received, and deemed helpful by staff from different agencies and disciplines.

## Quality assurance

- 3.4. Senior police officers were very positive about their risk and concern model and described the risk and concern hub as the "engine that drives the police adult protection activity". The staff working in the concern hub were very well motivated.

*Police concern hubs have been a very positive development.*

- 3.4.1. The partnership was reaching the end of the implementation phase of the current adult support and protection improvement plan. There would be a new plan. One of the actions in the plan was the preparation of a refreshed adult support and protection procedure and significant changes to the adult support and protection processes and recording (see graphics on pages 57 and 58). There was a drive to deliver improvement with the much-needed changes to adult support and protection key processes.

- 3.4.2. The police used audits successfully to engender improvement, rather than expose poor practice.
- 3.4.3. The police audited 178 adult protection episodes for one month. Concern hub officers gave feedback to shift officers about good work and this was very well received by them.
- 3.4.4. The concern hub made good use of performance data to inform and drive improvement.
- 3.4.5. The fire control group worked well to review and learn from significant fires. The work of this group had attracted national recognition.

### **Leadership exercised by adult protection committee and chief officers group**

- 3.5. Adult support and protection committee members recognised the committee needed to find out about the difference adult support and protection activity made to the lives of adults at risk of harm. We considered relatively little had been done to give effect to this.
  - 3.5.1. The adult support and protection committee did initiate some self-evaluation and audit activity but this was somewhat lacking in direction, leadership and implementation of required improvements.
  - 3.5.2. The adult support and protection committee had played a leading and positive role in the development of adult protection training.
  - 3.5.3. The adult support and protection committee was effectual in its promotion of partnership working with the third sector and partnership working in general.
  - 3.5.4. Third sector partners we met said “all adult committee meetings were productive”.
  - 3.5.5. The improvement group (sub group of the adult support and protection committee) did exercise a governance and oversight role for adult support and protection. It initiated audits of adult support and protection case records, prepared an improvement plan, and attempted to drive and deliver the required improvements. But there was a clear disconnect between this group and the wider membership of the adult support and protection committee .
  - 3.5.6. Adult support and protection committee members acknowledged that Highland has never had a significant case review related to adult protection. They recently had an initial case review, which they decided not to progress to a significant case review. We considered the partnership should include significant case reviews in its review of the governance arrangements for adult support and protection.

*This partnership acknowledged governance of adult support and protection needed to be reviewed the refreshed.*

- 3.5.7. There was a degree of disconnect between the chief officers group and the adult support and protection committee.
- 3.5.8. Partnership leaders acknowledged that the Safer Highland grouping (see graphic on page 65) was complex and encompassed a wide range of issues and stakeholders. This had implications for the sound governance of adult support and protection.
- 3.5.9. On a positive note, police were very clear about the need for the governance arrangements for adult protection to be reviewed and streamlined. Other members of the chief officers group strongly supported this view.

#### **Recommendation for improvement**

The partnership's review of the governance of adult support and protection should streamline the governance landscape and strengthen the links between the chief officers group and the adult support and protection committee.

### **Role of the chief social work officer**

- 3.6. The chief social work officer asserted that the professional leadership of social work and social workers was well established and embedded. This included leadership for the social work role and contribution to adult support and protection.
- 3.6.1. The chief social work officer asserted that the single agency model – some social workers were employed by Highland Council and some were employed by NHS Highland - was no barrier to exercising effective leadership and support for social workers.

*The partnership thought that the single agency model was no barrier to exercising of leadership for social work.*



# Dundee City partnership

Outcomes for adults at risk of harm were

**ADEQUATE** 

strengths, just outweigh  
weaknesses

because:

The partnership made sure that the choices of adults at risk of harm were respected and adult protection intervention was pursued in the least restrictive manner. In general, adults at risk of harm were safer, had enhanced wellbeing and an improved quality of life, which was consequential of their adult protection journey. The partnership had not undertaken enough work to identify and measure outcomes for adults at risk of harm. The deficiencies in the partnership's adult protection key processes – readily accepted by the partnership – had the clear potential to have an adverse impact on the outcomes for adults at risk of harm.

## **Recommendations for improvement: The Dundee City partnership**

- 1. The partnership should make sure that its key processes for adult support and protection follow a clearly defined path, which council officers and other staff fully understand and implement.**
- 2. The partnership should make sure that full implementation of its ICT system is achieved in order to meet the user needs of council officers and other users to record all adult protection information clearly and effectively.**
- 3. The partnership should make sure that it prepares valid chronologies, risk assessments and risk management plans for all adults at risk of harm who require them.**

# 1. Outcomes for adult support and protection in Dundee City

## Partnership pursues least restrictive options and respects choice

- 1.1. Practitioners were well aware of their obligation to pursue the least restrictive protective options for adults at risk of harm that benefited the individual and respected their choice.

## Timely multi-agency response to adult protection concerns

- 1.2. There was compelling evidence of a timely, multi-agency response to adult protection referrals. In the main, adult protection partners were clear about how to pursue an adult protection referral. Accident and emergency unit staff were an exception to this.
  - 1.2.1. Frontline police officers considered adult protection pathways through the police and their services had become clearer. They perceived they were required to support increasing numbers of marginalised individuals.
  - 1.2.2. The police response to adult protection concerns was more timely and effective as they had increased resources to clear their backlog of adult protection referrals and implemented a revised triage system.
  - 1.2.3. All unpaid carers we met said that once an adult support and protection issue was identified, professionals from different agencies and disciplines reacted in a timely and effective way.
  - 1.2.4. Adult protection referrals from banks were increasing. There was a banking network. This was a good response from the banking sector that delivered good outcomes for adults at risk of financial harm.

## Involvement of adults at risk of harm and unpaid carers

### Involvement of adults at risk of harm

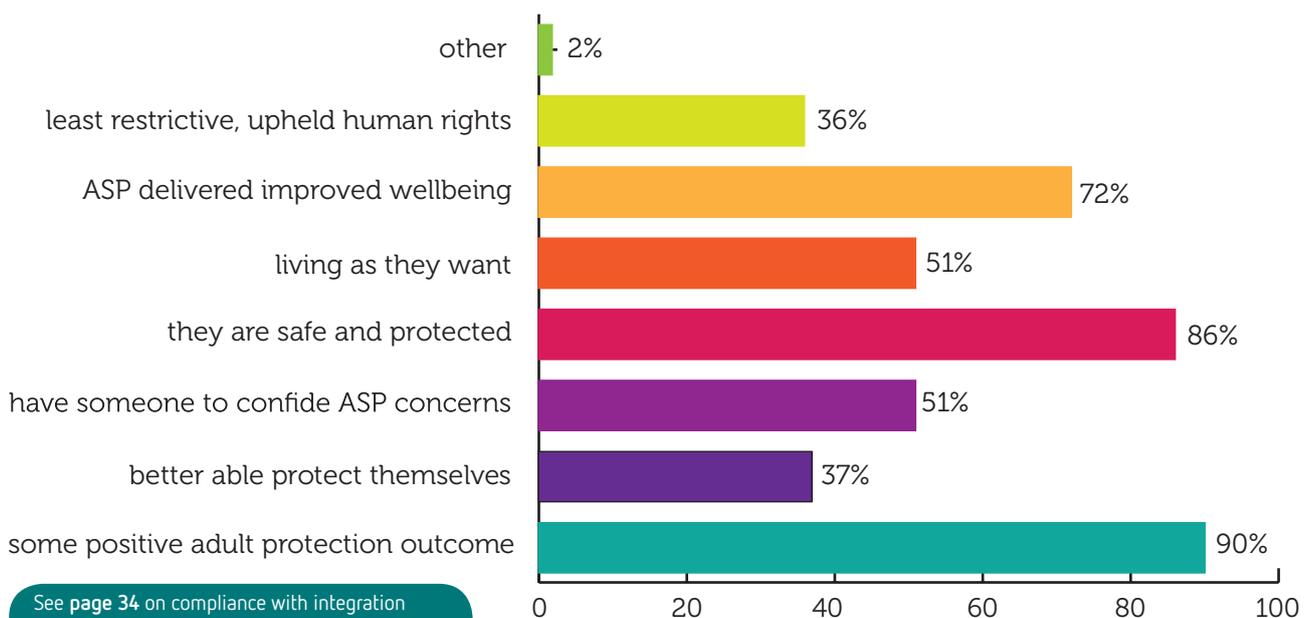
- **93%** of adults at risk of harm's views sought and taken into account at initial inquiry stage.
- **79%** had views sought and taken into account at investigation stage.
- **90%** had views sought and taken into account at implementation of protection plan and review stage.

- 1.3. In general, the partnership supported involvement and inclusion for adults at risk of harm.
- 1.3.1. In general, unpaid carers said that they had been appropriately involved in the partnership's efforts to delivering personal outcomes for the adult at risk of harm.
- 1.3.2. On occasions, adults at risk of harm wanted to attend case conferences but staff advised them that it was not in their best interests. More could be done to overcome barriers to adults at risk of harm attending case conferences.. The partnership should consider the needs of adults at risk of harm when setting venues for case conferences.
- 1.3.3. The chief officers group considered that measuring outcomes for adults at risk of harm and responding to the pace of change had been challenging.
- 1.3.4. There was compelling evidence that The Fire and Rescue Service delivered positive enhanced outcomes for adults at risk of harm. They made an important contribution to assessing and managing risk to vulnerable individuals.
- 1.3.5. The integrated substance misuse service successfully assessed and managed the risks for many vulnerable individuals who did not meet the three-point test.

### Outcomes for safety, protection and support

- 1.4. Overall, the partnership delivered positive outcomes for adults at risk of harm (Figure 5). They were made safe and had enhanced wellbeing and quality of life. They no longer lived in a state of fear and anxiety.

**Figure 6: outcomes for adults at risk of harm in Dundee City**



See page 34 on compliance with integration delivery principles and delivery of national health and wellbeing outcomes.

- 1.4.1. The partnership had developed a lead-agency model for vulnerable people who were not subject to adult support and protection but did have complex needs and continually presented to services. This model delivered improved outcomes for these individuals. We considered this was a commendable development.
- 1.4.2. All unpaid carers we met reported that the person they cared for was safe and protected as a consequence of the partnership's adult protection interventions.
- 1.4.3. The revised police triage system contributed to a process that provided reassurance that adults at risk of harm were made safe and protected as a consequence of police actions.
- 1.4.4. The partnership's internal adult protection evaluation work found that outcomes for adults subject to adult support and protection were positive. However, it found that delivery of key processes was not as strong as it could be and evidence to support decision making was often absent from files. This self-assessment by the partnership was entirely congruent with our analysis.

#### Financial harm

- **27%** of cases there was evidence of financial harm to the individual.
- **54%** of case this was greater than £1000.
- **77%** of cases evidenced that the partnership had acted to stop the abuse.
- **80%** of cases showed that this had been effective.

- 1.4.5. The partnership did effective work on financial harm. This stopped the harm and ended the trauma and loss of amenity for the victims.

### Remedial work with perpetrators (harmers)

#### Perpetrators

- **63%** of cases evidenced that there was a perpetrator of harm to the individual.
- **77%** of cases showed that the partnership had taken actions against the alleged perpetrator.
- **100%** of cases showed that the partnership carried out work with the alleged perpetrator where appropriate.

- 1.5. The partnership carried out some effective work with the perpetrators of harm to vulnerable adults.

# Dundee City partnership

Key processes for adult support and protection were



**because:**

The partnership readily acknowledged the deficiencies in their key processes that we identified. Indeed, their own internal audits had shown similar deficits. The pace of improvement activity had been relatively slow. For most adult protection episodes, all of the partnership's adult protection activity was squeezed into the duty to inquire stage and there was no clear and consistent delineation between the adult protection stages of initial inquiry, investigation, case conferences, post case conference protection activities and implementation of protection plans. The partnership acknowledged it had not convened enough adult protection case conferences, but this was improving, with increased numbers of case conferences. Chronologies, risk assessments and risk management plans for adults at risk of harm were key areas for improvement. The partnership was optimistic that its relatively new ICT system would support improvement in key processes for adult support and protection. But implementation was beset with a number of significant problems that required to be rectified. Despite the issues outlined above, adults subject to adult support and protection were generally safe and protected.

## 2. Key processes for adult support and protection in Dundee City

### Operational management of adult support and protection

- 2.1. Operational management for adult support and protection was variable. This was reflected in a number of key process deficits, which both the partnership and we considered were areas for improvement.
- 2.1.1. Frontline practitioners were confident there was decisive and consistent operational management of adult support and protection.
- 2.1.2. The partnership's adult support and protection procedures had recently been revised and they addressed some of the key process issues that we discerned at our file reading.
- 2.1.3. The partnership had placed many of its aspirations for key process improvement in the setting up of its new ICT system, Mosaic<sup>12</sup>. Unfortunately, from a frontline practitioner perspective, the new system and its implementation was beset with teething problems, which were proving difficult and time consuming to rectify.

*There were significant issues with the full implementation of the main partnership IT system.*

- 2.1.4. We found evidence that the adult support and protection procedures and associated documentation were not readily accessible online to staff from across the partnership. We considered this was an issue that the partnership could quickly rectify.

### Progressing of adult protection referrals

#### ASP referral analysis

- **94%** showed communication between partners.
- **89%** applied three-point test correctly.
- **90%** recorded application of three point test.
- **95%** of referrals processed timeously.
- **54%** of referral handling rated good or better.
- **46%** rated adequate or worse.

<sup>12</sup> The health and social care partnership's ICT issues were related to how it had configured the Mosaic system for users to record adult protection information. This does not constitute any criticism whatsoever of the system itself.

- 2.2. The evidence from our analysis of redacted referrals was that the partnership processed adult protection referrals timeously.
- 2.2.1. The police concern hub operated effectively to assess, triage and pass on the abundance of information about adults at risk of harm it received.
- 2.2.2. Police focus groups highlighted frontline officers' lack of understanding of consent, capacity and the three-point test.
- 2.2.3. In general, we found that the partnership correctly applied the three-point test for adult protection referrals and it clearly recorded its application.
- 2.2.4. We considered that the early screening group (which the partnership had positively evaluated) made a valuable contribution to making sure that intimations of concern about adults at risk of harm were dealt with appropriately.

## Information sharing

### Police records

- **74%** of police records contain all information about adult support and protection related incidents.
- **0%** of police records contain case conference minutes.
- **59%** of police records contain a chronology.
- **77%** of records contain a police vulnerable person's database on file.
- **68%** of the vulnerable person's database entry contains details of adult protection concerns.
- **65%** of the vulnerable person's database entry contains a chronology.

- 2.3. The main electronic information sharing issue for the partnership was in addressing information security and governance concerns that acted as barriers to achieving full implementation of the Mosaic system across all relevant staff groups. We considered this was an area for improvement.

### Recommendation for improvement

The partnership should make sure that full implementation of its ICT system is achieved in order to meet the user needs of council officers and other users to record all adult protection information clearly and effectively.

- 2.3.1. Accident and emergency unit staff at Ninewells Hospital did not know if an individual was subject to adult protection. This was a clear gap in the system for adults at risk of harm and this constituted a definitive area for improvement.

2.3.2. In the main, the police concern hub shared and recorded adult protection information relatively effectively.

2.3.3. Police adult protection records did not contain minutes of adult protection conferences. Police managers intimated this was due to the decision not to include these minutes in the bundle of police records prepared for our joint inspection.

## Figure 7

### Dundee and its protracted initial inquiry stage (IRD stage)

#### Initial inquiry

- This stage could be somewhat protracted and in some instances involve a number of interviews with the adult at risk of harm.

#### Initial referral discussion (IRD) meetings

- In Dundee, all of the stages of the adult protection process were frequently squeezed into the IRD stage.
- These were quasi ASP case conferences, without the presence of the adult at risk of harm, unpaid carers or independent advocates. In some cases there were three or four IRD meetings required to identify whether or not the adult met the criteria for intervention under the Act and to establish if they had capacity.
- The adult at risk of harm's adult protection journey often stopped at this point.

#### Full investigation stage

- We did not see many reports of full investigations at file reading.

#### Adult protection case conference

- The partnership acknowledged there had been a limited number of adult protection case conferences. Our file reading results were skewed by that fact that we had to analyse 15 reserve records to find adult protection case conferences. This was changing and staff reported more case conferences were convened.

#### Post ASP case conference protection activity

- We saw very few protection plans and implementation thereof at file reading.

## Initial inquiries (duty to inquire)

2.4. Figure 7 sets out the key process deficits we identified for the partnership. The partnership concurred with our analysis of what key processes needed to improve.

### Recommendation for improvement

The partnership should make sure that its key processes for adult support and protection follow a clearly defined path, which council officers and other staff fully understand.

## Full adult protection investigations

### Adult protection investigations

- **79%** of individuals subject to ASP investigation.
- **21%** should have had an investigation but did not.
- **100%** of investigations effectively determined if the adult was at risk of harm.
- **83%** of investigations rated good or better.

2.5. The partnership carried out fewer adult protection investigations than we considered it should. Where it did, they were carried out to a high standard.

## Chronologies, risk assessment and risk management

### Chronologies

- **66%** of adults at risk of harm had a chronology when we considered they should have had one.
- **34%** of adults at risk of harm who should have had a chronology did NOT have one.
- **65%** of chronologies were of an acceptable standard, **35%** were not of an acceptable standard.

### Risk assessment and protection planning

- **57%** of adults at risk of harm had a risk assessment.
- **43%** of adults at risk of harm who should have had a risk assessment did not have one.
- **67%** of risk assessments rated good or better.
- **65%** adults at risk of harm had risk management plan if required.
- **30%** of the adults at risk of harm who should have had a risk management plan did not have one.
- **61%** of risk management plans rated good or better.

- 2.6. Our file reading results indicated that there was considerable scope for improvement for:
- chronologies
  - risk assessments
  - risk management/protection plans.

2.6.1. The fact that 43% of the adults at risk of harm did not have a risk assessment was not conducive to their safety. We considered that this was a critical area for improvement.

### Recommendation for improvement

The partnership should make sure that it prepares valid chronologies, risk assessments and risk management plans for adults at risk of harm who require them.

## Large-scale investigations

- 2.7. The partnership had comprehensive guidance for conducting large-scale investigations and it executed them competently. We read about a number of large-scale investigations at our file reading. Our analysis of one was *"The large-scale investigation delivered a safer environment in the care home for the adult at risk of harm and for all of the other residents"*.

*"The large-scale investigation delivered a safer environment in the care home..."*

## Adult protection case conferences

### Adult protection case conferences

- **94%** case conferences convened when required (see skewed).
- **32%** of invited parties did not attend.
- **38%** of case conferences, adult at risk invited.
- **58%** of adults at risk attended if invited.
- **85%** of case conferences rated good or better for effectiveness.

- 2.8. Within this partnership, initial referral discussions operated more or less as case conferences. We saw comparatively few case conference reports at our file reading. This was changing and staff reported more case conferences were convened for adults at risk of harm who clearly met the three-point test. It was too early to tell if this welcome change to the key processes was effective.

2.8.1. Our file reading showed health attendance at adult protection case conferences was an area for improvement. Commendably, the police attended almost all adult protection case conferences.

- Six per cent of adult protection conferences did not have a police representative in attendance.
- Twenty-six per cent of adult protection conferences did not have a health representative in attendance.

2.8.2. All but one of the unpaid carers we met who had attended a case conference were well prepared for this experience by social work. However, our file reading evidence demonstrated that unpaid carer attendance at case conferences was an area for improvement (almost half of those who should have been invited were not).

2.8.3. Supporting adults at risk to attend adult protection case conferences was another area for improvement.

## Independent advocacy

### Independent advocacy

- **90%** of adults at risk of harm who needed advocacy were offered it.
- **78%** of them received advocacy, **22%** did not.
- **94%** of individuals who received advocacy were supported to articulate their views.

2.9. The partnership performed reasonably well on delivery of independent advocacy to adults at risk of harm.

2.9.1. Advocates expressed a desire to participate in joint training to enhance mutual understanding of roles, and break down barriers.

2.9.2. The partnership elicited some feedback from independent advocacy services, but did not always respond to this timeously. The partnership acknowledged this was an area for improvement.

## Staff knowledge and use of legislation

2.10. In general, staff were knowledgeable about legislation applicable to adult support and protection.

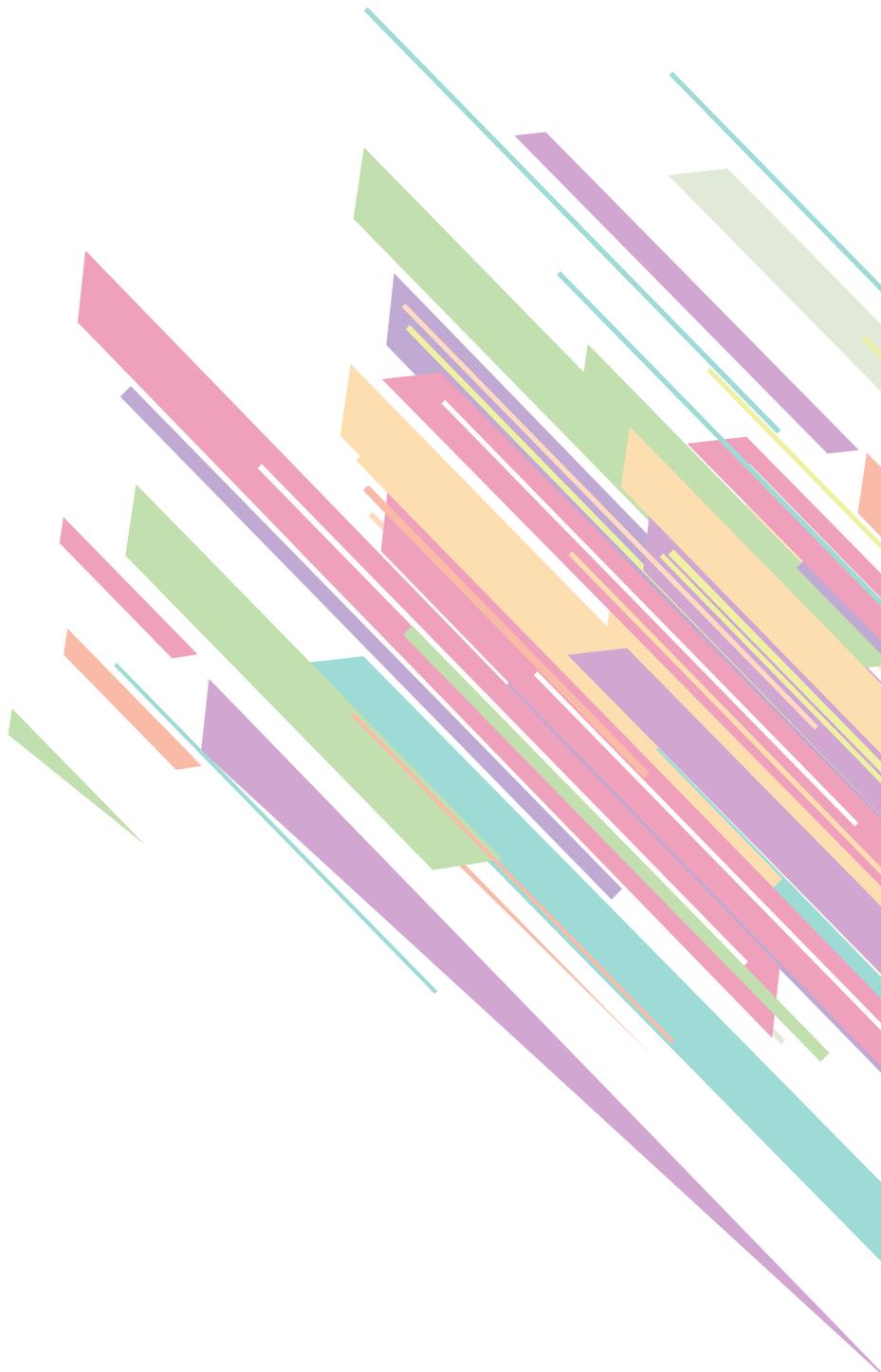
2.10.1. There was a mixed picture about access to capacity assessments for adults at risk of harm. There were delays obtaining an assessment in some cases – to the potential detriment of the adult at risk of harm.

## **Support for adults at risk of harm to achieve personal outcomes other than adult protection**

2.11. In the main, the partnership deployed suitable services and support to successfully deliver desired personal outcomes for adults at risk of harm that were not related to protection.

## **Review adult protection case conferences**

2.12. The partnership mainly conducted adult protection review case conferences timeously and appropriately.



# Dundee City partnership

**Leadership for adult support and protection was**

**ADEQUATE** 

**strengths just outweigh  
weaknesses**

**because:**

The adult protection committee and the chief officers group afforded positive leadership for adult protection. Leaders within the partnership accepted all of the findings of our joint inspection and recognised that they needed to stimulate improvement in a number of critical domains. We considered this was a very helpful approach, which was commensurate with delivering progress with adult support and protection in the partnership. The adult protection committee actively promoted the welcome development of admirable initiatives to promote safety and fairness for vulnerable individuals in Dundee.

# 3. Leadership for adult support and protection in Dundee City

## Leaders support for partnership working

3.1. Leaders within the partnership afforded a high priority for adult support and protection and effectively promulgated this to all levels of the partnership.

3.1.1. Evidence for this included the favourable views of frontline police officers we met.

*"Adult support and protection is high priority from top to bottom."*

*"We see people we refer to social work helped within a couple of hours."*

*"Historical barriers to sharing information are down. This was happening before adult support and protection legislation but this has consolidated the cultural shift well."*

*"There is a positive culture of leadership in the partnership."*

3.1.2. The health and social care partnership had cemented strong strategic relationships with the police, which modelled supported and developed good partnership working.

## Vision

3.2. Staff from across the partnership were able to articulate a clear vision and cogent strategy for adult protection.

3.2.1. The police showed commendable commitment to improvement, by deployment of additional resources to clear a backlog of vulnerable person reports.

## **Leadership for delivery of adult protection practice**

- 3.3. Partnership leaders accepted our findings on deficits in key adult protection processes. This was a positive indicator of capacity for improvement.
- 3.3.1. Partnership leaders acknowledged that previously identified adult protection key process deficits had not been subject to a robust and timely drive for improvement.

## **Quality assurance**

- 3.4. There was evidence that the partnership carried out the following performance management, self-evaluation and related audit activities:
- balanced scorecard
  - small sample audits of adult protection case records
  - self-evaluation of adult protection.
- 3.4.1. Leaders intimated they were very keen to try to elicit information about outcomes from adults at risk of harm but this had proved elusive and difficult. Despite this, operational staff indicated that there were no specific fields in the Mosaic system to record outcomes for adults at risk of harm (that is, data that could be digitised and aggregated). We considered this was an area for improvement.
- 3.4.2. The health and social care locality manager with a portfolio lead for protecting people and the NHS adult protection lead jointly chaired the adult support and protection and public protection quality assurance group. We considered this reflected a strengthening approach to partnership working.
- 3.4.3. The partnership needed to make sure that when it identified areas for improvement, this was followed up with robust action.

## **Leadership exercised by adult protection committee and chief officers group**

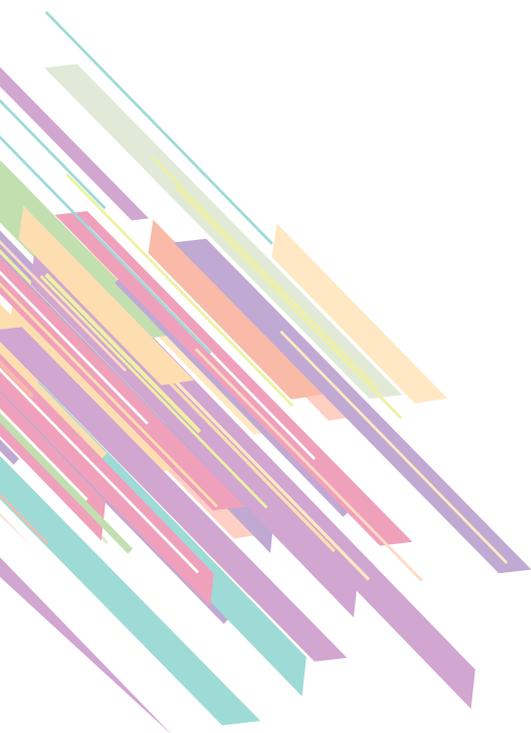
- 3.5. Governance for the quality of adult support and protection and other public protection activity was in transition following the newly introduced health and social care partnership strategic planning and delivery structures.
- 3.5.1. The adult protection committee had overseen a number of positive developments for adult support and protection.
- 3.5.2. Trading standards had appointed a dedicated officer to work on financial harm to vulnerable adults and to enhance the partnership between trading standards and the other adult protection partners.

- 3.5.3. There was a representative from the banking sector on the adult protection committee. We considered this was a very positive development.
- 3.5.4. The convener considered that the work with the banking sector to prevent and stop financial harm to vulnerable adults had not yet reached its full potential.
- 3.5.5. The banks were keen to get information from the adult protection partnership about who the vulnerable individuals were. Understandably, this presented confidentiality challenges for the partnership.
- 3.5.6. The multi-agency roles and responsibilities training (initiated by the adult protection committee) had been relatively successful.
- 3.5.7. Members of the adult protection committee were aware that under the revised adult support and protection key processes there should be more case conferences and less initial referral discussion activity.
- 3.5.8. The adult protection procedures had not been updated commensurate with the inception of the Mosaic ICT system, and this caused confusion for operational staff. The partnership was in the process of addressing this.
- 3.5.9. The partnership undertook productive work with GPs, which improved their knowledge of adult protection and their involvement in it.
- 3.5.10. There were briefing sessions for key staff across all agencies. There was a practitioner forum that included staff from every sector, which frequently discussed adult support and protection matters.
- 3.5.11. There was a representative from independent advocacy services who attended and made a valuable contribution to the adult protection committee.
- 3.5.12. Independent advocacy services strategic managers were proactive in representing their service, and highlighting adult support and protection issues at various forums both locally and nationally.
- 3.5.13. The adult protection committee had championed the development of the Dundee Safe Place Initiative (designated town centre venues where vulnerable individuals were assured of safety and help) and the Dundee Fairness Commission (which sought to enhance and develop equality, equity and inclusion in Dundee).
- 3.5.14. Fire and rescue was now a full member of the adult protection committee. It fulfilled a very positive role on delivering the outcomes of safety, security and enhanced wellbeing to adults at risk of harm and peace of mind to their unpaid carers.

- 3.5.15. There were no significant case reviews in respect of adult protection over a three-year period. Relatively recently, there had been one completed significant case review and one that was in the process of completion. There was one episode where they decided to go down the route of the NHS adverse event procedure.
- 3.5.16. The chief officers group evidenced good working relationships and an associated, developing capacity to exercise governance over adult support and protection.

### **Role of the chief social work officer**

- 3.6. The chief social work officer exercised leadership and support for partnership staff who carried out adult support and protection work.



# Aberdeenshire partnership

Outcomes for adults at risk of harm were

**ADEQUATE** 

strengths, just outweigh  
weaknesses

**because:**

The partnership made sure that the choices of adults at risk of harm were respected and adult protection intervention was pursued in the least restrictive manner. In general, adults at risk of harm were safer, had enhanced wellbeing and an improved quality of life, which was consequential of their adult protection journey. There was an inconsistent approach to adult support and protection across the varied and at times highly rural localities in Aberdeenshire. The partnership needed to do more to measure outcomes for adults at risk of harm and elicit their lived experiences. There was evidence of some effective work carried out with the perpetrators of harm to vulnerable adults.

## **Recommendations for improvement: The Aberdeenshire partnership**

1. The partnership should make sure that all adult protection referrals are processed timeously.
2. The partnership should make sure that adult protection key processes are applied consistently across the partnership.
3. The partnership should set specific timescales for the prompt completion of each phase of the adult protection process.
4. The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.
5. The partnership should make sure that council officers and other staff are appropriately trained to carry out all adult support and protection work.

# 1. Outcomes for adult support and protection in Aberdeenshire

## Partnership pursues least restrictive options and respects choice

- 1.1. The partnership adopted a least-restrictive approach to adult protection interventions, which they perceived would benefit the adult at risk of harm and respect their wishes and choices.
  - 1.1.1. Some carers we interviewed were very positive about the partnership's approach, indicating that interventions were appropriate and that the adults at risk and they themselves were included and treated with respect throughout the adult protection process.
  - 1.1.2. Some unpaid carers considered adult protection should have been implemented much sooner for the individual they cared for and this had a detrimental impact on the adult at risk of harm.
  - 1.1.3. The partnership operated a tiered response to adult protection and concern referrals. The lowest tier offered screening, advice and guidance to referrers, including signposting where applicable. The partnership considered this was effective in providing preventative input and support to individuals, thereby reducing the need for statutory involvement. The partnership was evaluating this approach.
  - 1.1.4. Our analysis of redacted adult protection referrals demonstrated that in 100% of episodes the partnership adhered to the general principles of the Adult Support and Protection (Scotland) Act 2007.

## Timely multi-agency response to adult protection concerns

- 1.2. Partnership staff dealing with adult protection referrals communicated together effectively, to execute a multi-agency response to adult protection referrals. Adult protection partners were clear about how to pursue an adult protection referral.

### Adult protection network



- 1.2.1. Multi-agency staff across the partnership attested to good working relationships. Overall, the single point of contact through the concern hub and adult protection network provided an informed approach to prioritising adult support and protection concerns and a coordinated, focused and proportionate response.
- 1.2.2. The introduction of virtual community wards had a positive impact on information sharing with frontline staff. They met daily to discuss the needs of vulnerable individuals. This approach efficiently promoted early identification of harm and prevention of harm.
- 1.2.3. The health Datix was an adverse event reporting system. Health staff used it relatively effectively to engender adult protection referrals.
- 1.2.4. The NHS Grampian public protection intranet site informed health staff about adult protection and when to make an adult protection referral.
- 1.2.5. Timely involvement of advocacy service was an issue, whereby the adult at risk of harm sometimes did not receive the required advocacy support throughout their adult protection journey.
- 1.2.6. The partnership identified challenges obtaining timely capacity assessments. Staff confirmed this and viewed it as a significant barrier to timely intervention to protect adults at risk of harm.
- 1.2.7. While there was evidence of awareness-raising activity amongst adult support and protection stakeholders, the impact of this within the community was negligible. All the adults at risk of harm and unpaid carers we interviewed said they had little knowledge of adult protection before their direct involvement in it.
- 1.2.8. The most recent citizen's panel questionnaire indicated that perceptions were mixed about the council's performance in raising public awareness of adult protection issues.
  - Most respondents indicated they would contact police or the council if they suspected an adult was being harmed.
  - Only 27% of respondents gave a positive rating about the council's performance of raising public awareness of adult support and protection.
  - Only 21% respondents positively rated the council provided enough information on what to do if you suspected an adult was at risk of harm.
- 1.2.9. While these results were somewhat disappointing, we considered that it was commendable that the partnership carried out this survey.

## Involvement of adults at risk of harm and unpaid carers

### ASP referral analysis

- **93%** of adults at risk of harm's views sought and taken into account at initial inquiry stage.
- **98%** had views sought and taken into account at investigation stage.
- **85%** had views sought and taken into account at implementation of protection plan and review stage.

1.3. In the main, the partnership supported adults at risk of harms' inclusion and involvement at each stage of their adult protection journey.

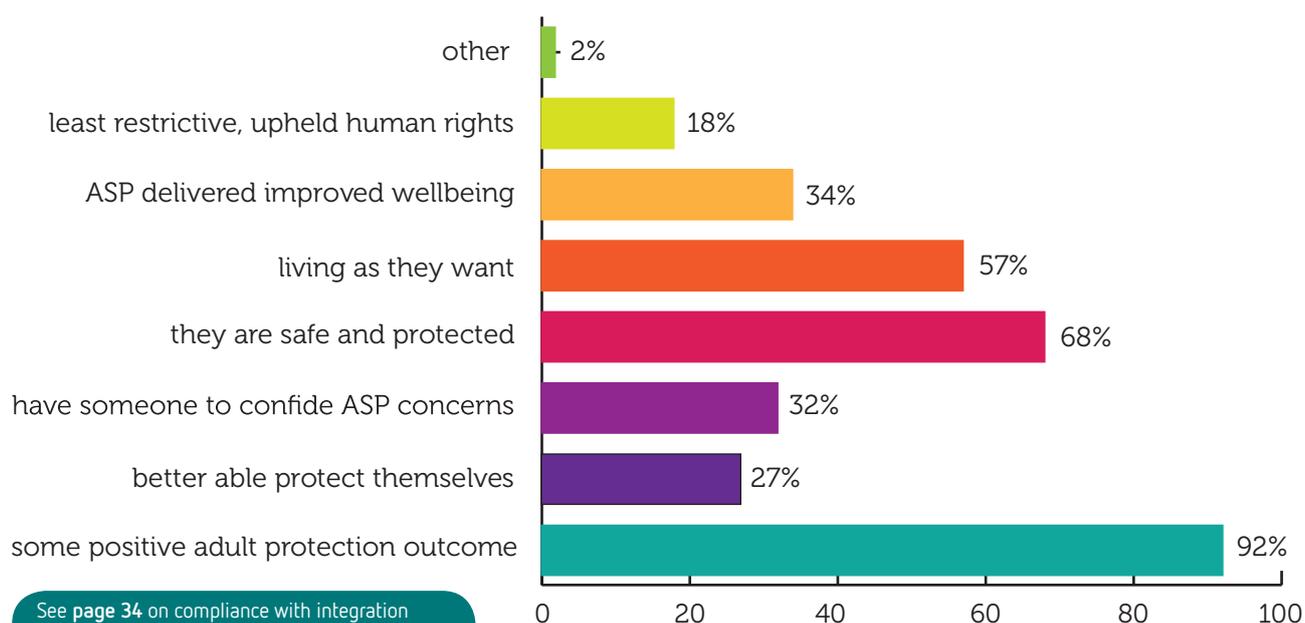
1.3.1. Generally, there was a good sense of consultation, involvement, and provision of information for adults at risk of harm and carers to facilitate participation in adult support and protection processes.

1.3.2. Council officers confirmed that the views of individuals and carers were sought. Carers we interviewed during inspection confirmed that they were included throughout, as was the adult at risk. They were provided with timely information, which allowed them to participate in meetings.

1.3.3. Advocates were of the view that more could be done to involve them more regularly and at an earlier stage, to ensure that individuals were supported to be involved as fully as possible in the adult protection process.

## Outcomes for safety, protection and support

Figure 8: outcomes for adults at risk of harm in Aberdeenshire



See page 34 on compliance with integration delivery principles and delivery of national health and wellbeing outcomes.

- 1.4. The partnership generally delivered good outcomes for individuals and unpaid carers involved in adult support and protection processes. Adults at risk of harm were safer, had enhanced wellbeing and an improved quality of life.
  - 1.4.1. Figure 8 shows the partnership engendered a range of positive safety, wellbeing and quality-of-life outcomes for adults at risk of harm.
  - 1.4.2. Unpaid carers we met were clear that desired outcomes were achieved (by the partnership) for individuals in relation to safety, wellbeing and support to remain healthy.
  - 1.4.3. The partnership acted relatively cohesively to stop financial harm to individuals. This enhanced their safety and wellbeing.
  - 1.4.4. The partnership struggled to generate specific aggregate data on outcomes for adults at risk of harm.
  - 1.4.5. The partnership had a mechanism to elicit feedback from adults at risk of harm about outcomes. The response rate was relatively low.
  - 1.4.6. The partnership had undertaken work with vulnerable adults targeted by serious and organised crime groups. Police Scotland and the council worked collaboratively to break the cycle of exploitation by criminals.

*In one-third of cases, financial harm to individuals was over £1000.*

#### Financial harm

- **16%** of cases there was evidence of financial harm to the individual.
- **38%** of case this was greater than £1000.
- **88%** of cases evidenced that the partnership had acted to stop the abuse.
- **57%** of cases showed that this had been effective.
- **26%** of cases rated the effectiveness of the partnership's actions as good or better.

### Remedial work with perpetrators (harmers)

- 1.5. Independent advocates attested to successful work undertaken with perpetrators of harm that preserved relationships and mitigated the risk of harm. For example, where formal interventions were put in place to reduce financial harm.

## Perpetrators

- **48%** of cases evidenced that there was a perpetrator of harm to the individual.
- **50%** of cases showed the partnership had taken actions against the alleged perpetrator.
- **89%** of appropriate cases showed the partnership carried out work with the alleged perpetrator (harmer).
- **38%** of cases rated this work as good.

*Half the individuals whose records we read were victims of a perpetrator of harm.*

# Aberdeenshire partnership

Key processes for adult support and protection were

**ADEQUATE**

**Strengths just outweigh  
weaknesses**

**because:**

The partnership had significant challenges maintaining a consistent and equitable approach to adult support and protection for all of the adults at risk of harm in Aberdeenshire. The partnership did not process all adult protection referrals in a timely manner. The partnership needed to set out clear timescales for each phase of the adult protection process to prevent deleterious delays. The partnership was not giving sufficient attention to ensuring its council officers were able to carry out adult support and protection work in a knowledgeable, skilled and proficient manner. Over half of the adults at risk of harm who should have had a chronology did not have one. This needed to improve. The police concern hub operated effectively and made an ultimately invaluable contribution to the drive to make sure adults at risk of harm were safe, protected, supported, and freed from fear. The concern hub needed to avoid backlogs with progressing vulnerable persons database reports.

## 2. Key processes for adult support and protection in Aberdeenshire

### Operational management of adult support and protection

- 2.1. There were up-to-date and detailed Grampian interagency policy and procedures in place - although they lacked timescales for completion of work.
  - 2.1.1. Generally, staff across the partnership were clear about how and where to raise adult protection concerns.
  - 2.1.2. Council officers were supported by their line managers and by the adult protection network throughout the adult support and protection process. The establishment of the adult protection network brought a more consistent approach to operational management of adult support and protection.

### Progressing of adult protection referrals

#### ASP referral analysis

- **86%** of referrals demonstrated communication among partners.
- **94%** correctly applied three-point test.
- **90%** clearly recorded application of three-point test.
- **68%** of referral handling rated good or better.
- **32%** rated adequate or worse.
- **28%** of referral episodes had time delays with progressing - **10%** of them were significant time delays.

- 2.2. Time delays in the partnership's progressing of nearly one-third of adult protection referrals was a significant deficit. We considered this was an area requiring prompt and robust improvement action.

#### Recommendation for improvement

The partnership should make sure that all adult protection referrals are processed timeously.

- 2.2.1. The partnership did not have a formal system in place to gather data that measured timeframes for response and intervention. We considered there should be a more structured approach to measuring and evaluating their performance to ensure timely and effective response.
- 2.2.2. The partnership effectively applied the three-point test and recorded its application.

- 2.2.3. Standardised national concern hub business processes were in place for the triage, research, assessment and proportionate information sharing. These arrangements were effective.
- 2.2.4. There was a backlog of over 200 vulnerable persons' database reports. However, this included all concern types (including child, adult and domestic abuse). All were standard and medium priority. The police deployed additional staff to clear this backlog. We considered this was an area for improvement.
- 2.2.5. There was a systems analyst in the concern hub in Aberdeen who was dedicated to the vulnerable persons' database. Their role included preparing performance management reports for local police operational managers to consider further protective and prevention action. This was a critical post for identifying patterns and trends.
- 2.2.6. Police Scotland's deployment of a full-time member of support staff as adult protection co-ordinator had made a positive impact on the co-ordination and development of adult protection business and its delivery. A coherent process was in place within Police Scotland where, during triage, concern reports were separated into high, medium, and standard priority, based on the range of relevant factors. Adults at risk of harm who met the three-point test were assigned the appropriate priority.
- 2.2.7. National escalation policies were in place for appropriate management of repeated adult protection concerns.
- 2.2.8. Partnership staff were sometimes unclear about how they should apply adult protection processes and there was a lack of consistency across the partnership. For example, different staff groups interpreted the purpose of adult protection meetings (multi-agency meetings and adult protection case conferences) differently.
- 2.2.9. There was a need to re-introduce and embed Grampian interagency adult protection policy and procedures across the partnership to ensure:
- clarity of the role and remit for all adult protection meetings
  - agreed, clearly stated timescales for each of the phases of the adult protection process – duty to inquire, investigation and case conference.
- 2.2.10. Team managers introduced local practice to meet local need and the volume of adult support and protection work. This detracted from embedding a more consistent approach to adult support and protection.
- 2.2.11. There were designated adult support and protection posts within Police Scotland, the NHS, as well as social work within the health and social care partnership.
- 2.2.12. Issues of capacity within the adult protection network over the last 18 months had adversely impacted on their ability to provide timely support to council officers when they needed it.

2.2.13. The partnership's position was that the adult support and protection process was person-centred and therefore, prescribed timescales for adult protection activities were not helpful. We considered that clearly prescribed timescales were essential.

#### **Recommendation for improvement**

The partnership should make sure it applies adult protection key processes consistently across the entire partnership.

#### **Recommendation for improvement**

The partnership should set specific timescales for the prompt completion of each phase of the adult protection process.

### **Information sharing**

#### **Police records**

- **90%** of police records contain all information about adult support and protection related incidents.
- **35%** of police records contained case conference minutes.
- **81%** of police records contain a chronology.
- **86%** of records contain a police vulnerable person's database on file.
- **93%** of the vulnerable person's database entry contains details of adult protection concerns.

2.3. Partners shared adult protection information effectively.

2.3.1. Some partnership staff were co-located, and there were well-established, integrated teams. This supported good information sharing for adult protection.

2.3.2. Some GPs had undertaken some positive, productive work with joint home visits with council officers.

2.3.3. The police concern hub was an invaluable resource for efficient sharing of adult protection information.

### **Initial inquiries (duty to inquire)**

2.4. Managers acknowledged issues with recording processes not supporting progression from initial inquiry to investigation timeously. Staff sometimes did not conclude the inquiry phase timeously thereby delaying investigations.

2.4.1. Council officers' responses to adult protection referrals could vary across the partnership, depending on the particular team and the locality.

2.4.2. Lack of prescribed timescales for completion of adult protection processes adversely affected practice in a range of ways. There could be a time gap between the initial inquiry stage and the investigation stage.

## Full adult protection investigations

### Adult protection investigations

- **86%** of records had investigation.
- **93%** of investigations effectively determined if the individual was at risk of harm.
- **86%** of investigations rated good or better.

2.5. Council officers confirmed they carried out adult protection investigations and that they were accompanied by a second person. They felt supported by their line manager.

2.5.1. Adult protection network staff were responsible for calling professionals together for meetings. This approach avowedly provided continuity and consistency of practice across the partnership but our findings were that this remained a significant challenge.

2.5.2. Our file reading determined that the partnership carried out adult protection investigations competently and to a good professional standard.

2.5.3. Council officers we met were concerned at a lack of joint interview training. They professed to lacking confidence in their abilities to lead an investigation. This is incongruent with our file reading analysis, which suggests they were more confident than they thought.

## Chronologies, risk assessment and risk management

### Chronologies

- **45%** of individuals had a chronology when we considered one should be present.
- **55%** of individuals who should have had one did not have a chronology.
- **73%** of chronologies present were of an acceptable standard.

### Risk assessment and protection plans

- **77%** of adults at risk of harm who should have had a risk assessment had one.
- **23%** adults at risk of harm who should have a risk assessment did not have one.
- **90%** of risk assessments rated good or better – over half rated as good.
- **97%** of adults at risk of harm who required a risk management plan had one.
- **74%** of risk management plans rated good or better.

2.6. The partnership had a risk assessment policy and tools, which were included in care management documentation.

2.6.1. There was no specific guidance for the creation of chronologies and staff we met confirmed the IT system did not support the creation of a credible, useful chronology. Over half of adults at risk of harm who should have had a chronology did not have one. We considered this was an area for improvement.

### Recommendation for improvement

The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

2.6.2. Our file reading results indicated that the presence and quality of risk assessments and risk management plans was variable. Over one-fifth of the adults at risk of harm who should have had a risk assessment did not have one.

2.6.3. The partnership's internal file audits found that risk assessments varied across records and they identified this as an area for consistent monitoring and improvement. Our file reading results were entirely congruent with the partnership's self-assessment.

## Large-scale investigations

2.7. The partnership competently carried out six large-scale investigations in the last two years. Staff attested to very good partnership working, with invaluable contributions from the health and social care partnership's commissioning team and the Care Inspectorate. These large-scale investigations delivered enhanced safety and wellbeing outcomes for the adults at risk of harm involved.

## Adult protection case conferences

### Adult protection case conferences

- **96%** of adult protection episodes that warranted a case conference got one.
- **68%** of case conferences all invited parties did not attend.
- **91%** case conferences effectively determined right actions to make the adult at risk of harm, safe, protected and supported.

2.8. The partnership purposefully convened and conducted adult protection conferences.

2.8.1. Our file reading showed police and health attendance at adult protection case conferences was an area for improvement.

- Twenty-nine per cent of adult protection conferences did not have a police representative in attendance.
- Sixty-two per cent of adult protection conferences did not have a health representative in attendance.

The fact that nearly two-thirds of adult protection case conferences did not have a health representative in attendance was insupportable.

2.8.2. Some unpaid carers spoke very positively about their experience of adult protection case conferences. Information was accessible and staff explained things to them. They received papers in advance, which allowed them to prepare for case conferences.

2.8.3. GP attendance at adult protection case conferences was variable.

## Independent advocacy

### Independent advocacy

- **22%** of cases evidenced that the individual was offered independent advocacy when needed.
- **73%** of cases evidenced that when offered the individual received advocacy support.
- **100%** of cases showed evidence that advocacy has helped the individual articulate their views.

2.9. We found independent advocacy was not routinely offered to adults at risk of harm or always available if they wanted it. We heard from a range of professionals about tension with advocacy.

2.9.1. Advocacy confirmed that referrals to its service were low. They tended to receive referrals at the case conference stage rather than at the initial stages in the process.

2.9.2. The partnership's internal file audits also highlighted deficits in offering and delivering independent advocacy to adults at risk of harm. We considered this was an area for improvement.

## Staff knowledge and use of legislation

2.10. There was evidence from our file reading and from discussions with staff that banning orders had been used productively. The partnership used the Adults with Incapacity (Scotland) Act 2000 effectively.

## **Support for adults at risk of harm to achieve their desired personal outcomes other than protection**

2.11. In the main, the partnership deployed appropriate supports to deliver adults at risk of harms' desired (non-protection) personal outcomes of enhanced wellbeing and quality of life.

## **Review adult protection case conferences**

2.12. The partnership consistently carried out adult protection case conference reviews within the prescribed six months' timescale.

# Aberdeenshire partnership

Leadership for adult support and protection was

**ADEQUATE**

**strengths just outweigh  
weaknesses**

**because:**

Chief officers' governance of adult support and protection was an area for improvement, Partnership leaders acknowledged this and had commissioned a report, which recommended a joint governance framework for support adult support and protection. Progress to implement the report's recommendations was slow. Staff were unclear at times about their adult protection role, as recent restructuring had changed responsibilities, and the extent of these changes was not fully embedded. Adult protection training opportunities were not routinely available.

The chief social worker arrangements were not working as effectively as they should, despite the introduction of the lead social work officer post.

# 3. Leadership for adult support and protection in Aberdeenshire

## Leaders support for partnership working

- 3.1. The chief officers group had commissioned a report completed in April 2017, which proposed the development of a joint governance framework to support adult support and protection work on a multi-agency, multi-professional basis. It was intended to be practical and helpful to frontline staff and build confidence in making the right decisions. We considered this was a potentially productive initiative.

## Vision

- 3.2. The partnership had an aspirational vision for adult support and protection, which it communicated to stakeholders.

## Leadership for delivery of adult protection practice

- 3.3. The adult protection network held the lead for allocation of work and decision making. Staff were unsure at times of the role that they were asked to perform when conducting adult protection investigations.
  - 3.3.1. The adult protection network processed adult protection referrals, arranged all formal meetings and case conferences, and was responsible for minute taking. The adult protection network and council officers made operational decisions about adults at risk of harm. We considered that the partnership needed to make sure the adult protection network had sufficient capacity to fulfil its designated role and remit.
  - 3.3.2. The NHS Grampian public protection intranet site – only accessible to NHS staff – was informative. It had ecard downloads covering a range of public protection themes such as adult protection, prevent duty, female genital mutilation and human trafficking.
  - 3.3.3. There was mandatory adult support and protection training for NHS staff. Routine refresher courses were offered every few years.
  - 3.3.4. GP trainees received comprehensive adult protection training and at graduate level. We considered that this was a promising development.
  - 3.3.5. Advocates received regular refresher training and considered they were highly skilled and well trained. Advocacy contributed meaningfully to the training of partnership staff.

- 3.3.6. Although adult protection training could be accessed through Aberdeen City Council, there were no guaranteed places. Some staff considered that there was insufficient numbers of staff trained in adult support and protection. The partnership should monitor this.
- 3.3.7. No adult protection training for council officers had taken place over the last year. We considered this was an area for improvement.

### **Recommendation for improvement**

The partnership should make sure that council officers and other staff are appropriately trained to carry out adult protection work.

## **Quality assurance**

- 3.4. The partnership purposefully carried out multi-agency reviews of aspects of adult support and protection, and effectively shared the learning from these.
- 3.4.1. Health used learning from large-scale investigations to influence health training. It had developed a useful document about the thresholds for initiation of adult protection referrals. Care homes used this document constructively.
- 3.4.2. The partnership had made limited progress systematically seeking feedback from adults at risk of harm. We considered this was an area for improvement.
- 3.4.3. From April 2017, adults at risk of harm were asked to complete a questionnaire on their experience of their adult protection journey. Numbers completed were very low, but nonetheless we considered this was a pleasing development.
- 3.4.4. There was a lack of co-ordination across the partnership so, while the north locality provided learning opportunities for its council officers, this was not replicated across the partnership.
- 3.4.5. The practice of carrying out audits of adult protection case records was variable across the partnership. This was another example of inconsistency across the partnership.

## **Leadership exercised by the adult protection committee and chief officers group**

- 3.5. The convener of the adult protection committee<sup>13</sup> had no contact with team managers, who were not fully aware of what the committee did. We considered that communication between the adult protection committee and frontline managers responsible for managing operational adult support and protection practice was an area for improvement.

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<sup>13</sup> Aberdeenshire adult protection committee shared its convener with the Aberdeen City adult protection committee.

- 3.5.1. The adult protection committee had an action plan covering seven areas for achievement. Some actions did not have a specific responsible lead identified. In the document submitted by the partnership, 36% of actions were assigned a green rating for progress, 28% were assigned an amber rating for progress, and 36% were assigned a red rating for progress.
- 3.5.2. The chief officers group was well-established and its members had cemented good working relationships over time. The group was overseeing the creation of the remit for a planned public protection review, which was to include adult support and protection, and child protection.

### **Role of the chief social work officer**

- 3.6. The chief social work officer was not a full member of the partnership's senior management team. The role was aligned within education and children's services.
- 3.6.1. The chief social worker arrangements were not working as effectively as they should. The partnership needed to clearly set out the roles, responsibilities, and accountabilities for adult support and protection across the partnership.
- 3.6.2. The partnership had carried out five initial case reviews into adverse occurrences for adults at risk of harm. The partnership had not carried out a significant case review related to adult protection.

*The partnership needed to improve frequency of adult protection training.*



# East Dunbartonshire partnership

**Outcomes for adults at risk of harm were**

**GOOD** 

**important strengths,  
some areas of  
improvement**

**because:**

The partnership made sure that the choices of adults at risk of harm were respected and adult protection intervention was pursued in the least restrictive manner. In general adults at risk of harm were safer, had enhanced wellbeing and an improved quality of life, which was consequential of their adult protection journey. The partnership carried out some effective, collaborative work to tackle financial harm. The partnership acknowledged the following areas for improvement:

- seamless transition of vulnerable young people to the adult support and protection system
- systematic measurement of outcomes for adults at risk of harm and capturing their experience of their adult support and protection journey.

**Recommendations for improvement:  
The East Dunbartonshire partnership**

1. The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

# 1. Outcomes for adult support and protection in East Dunbartonshire

## Partnership pursues least restrictive options and respects choice

- 1.1. The partnership invested in learning and development opportunities for staff, equipping them with knowledge and understanding of the principles of the Adult Support and Protection (Scotland) Act 2007.
  - 1.1.1. Staff groups described a proportionate approach to intervention and demonstrated knowledge and understanding of wider safeguarding legislation. Legal services support and advice was available for staff. Our redacted referral analysis confirmed that almost all referrals were progressed in line with the general principles of the Adult Support and Protection (Scotland) Act. Adults at risk of harm and unpaid carers we interviewed confirmed that involvement was proportionate and beneficial.

## Timely multi-agency response to adult protection concerns

- 1.2. In the main, adult protection partners executed a timely, multi-agency response to adult protection referrals. Adult protection partners were clear about how to pursue an adult protection referral.
  - 1.2.1. There was good evidence of timely and effective support to adults at risk of harm. There was active participation from a range of partners including social work, advocacy, police and health colleagues. Good joint working arrangements were in place for statutory partners and advocacy services. East Dunbartonshire Council legal services team was flexible and responsive.
  - 1.2.2. The partnership was proactive in its work with GP colleagues to reduce barriers to participation, which had resulted in improved communication and year-on-year improvement of GP involvement in multi-agency meetings (55% in 2016).
  - 1.2.3. The partnership had instituted adult protection threshold guidance for residential establishments to inform them about when to make an adult protection referral. Its impact on reducing numbers of inappropriate referrals from care homes was variable.

## Involvement of adults at risk of harm and unpaid carers

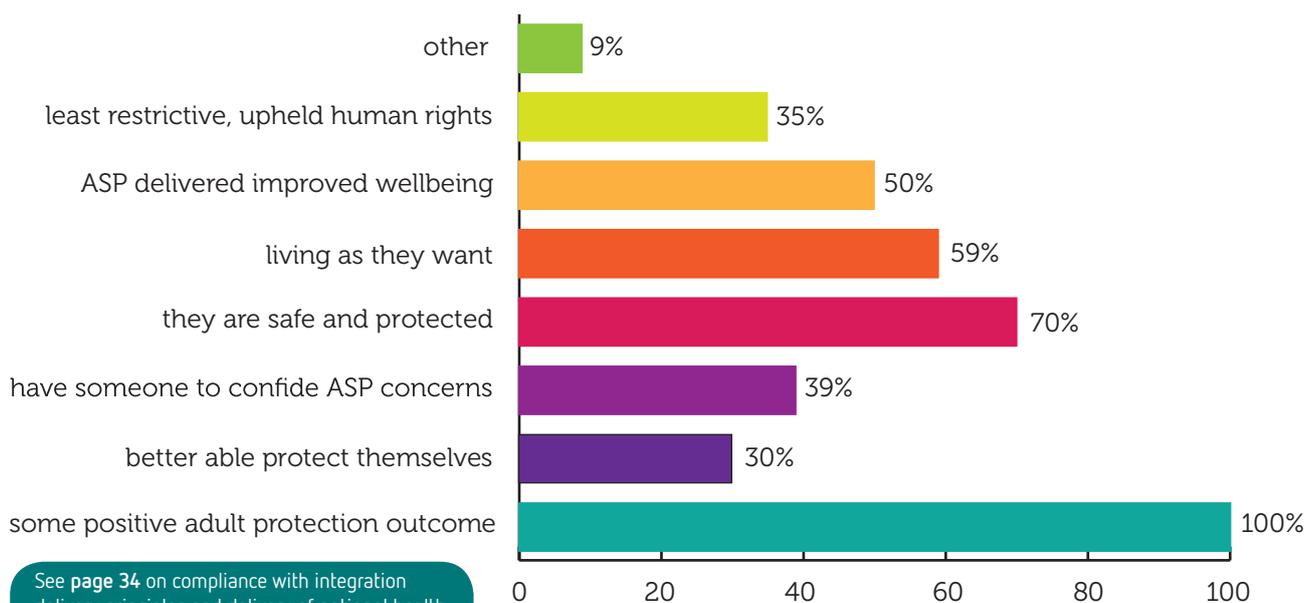
### Involvement of adults at risk of harm

- **94%** of adults at risk of harm's views sought and taken into account at initial inquiry stage.
- **85%** had views sought and taken into account at investigation stage.
- **91%** had views sought and taken into account at implementation of protection plan and review stage.

- 1.3. Adults at risk of harm, unpaid carers, and independent advocates we met felt that the partnership meaningfully consulted and included them in its activities to secure safety and protection for adults at risk of harm.
- 1.3.1. The evidence from our file reading was that less than one-third (26%) of adults at risk of harm had their views sought and taken into account at the adult protection case conference stage. We considered this was an area for improvement.
- 1.3.2. Adults at risk of harm said that delays to appropriate psychiatric assessment and treatment resulted in poor mental health outcomes for them.
- 1.3.3. The partnership identified the transition of vulnerable young people to adult services as an issue. They did this by eliciting their views. The partnership acknowledged this was an area for improvement.

## Outcomes for safety, protection and support

Figure 9: outcomes for adults at risk of harm in East Dunbartonshire



See page 34 on compliance with integration delivery principles and delivery of national health and wellbeing outcomes.

- 1.4. The partnership delivered positive outcomes for adults at risk of harm for safety, enhanced wellbeing, and improved quality of life (Figure 9).
  - 1.4.1. We received positive feedback from adults at risk of harm, unpaid carers and advocates that desired outcomes were achieved for individuals through a partnership approach.
  - 1.4.2. The partnership recognised that gathering and reporting data on outcomes for adults at risk of harm was work in progress.
  - 1.4.3. The partnership intended that adults at risk of harm's evaluations of the impact of adult support and protection would be evident in their annual self-evaluation exercise from 2018.
  - 1.4.4. The partnership had undertaken positive work to lessen the impact of the high-level of bogus callers and unscrupulous workers. This was done through awareness raising and effective joint working with Trading Standards.
  - 1.4.5. Our file reading revealed that the partnership acted collaboratively and effectively to stop financial harm. Thereby ending the trauma and loss of amenity that this causes for vulnerable individuals.
  - 1.4.6. Adults at risk of harm and unpaid carers confirmed that independent advocates and social workers supported them to be fully involved in the adult support and protection process. They were provided with information and support and their views and choices were respected.

#### Financial harm

- **20%** of cases there was evidence of financial harm to the individual.
- **60%** of cases this was greater than £1,000.
- **100%** of cases evidenced that the partnership had acted to stop the abuse.
- **90%** of cases showed this was effective.

#### Remedial work with perpetrators (harmers)

- 1.5. Partners provided anecdotal evidence of work undertaken with perpetrators and were clear that this was an important part of addressing and reducing risk. Criminal justice social work confirmed that work was undertaken with perpetrators when they have been convicted of an offence and subject to an order.

#### Perpetrators

- **51%** of cases evidenced that there was a perpetrator (alleged perpetrator) of harm to the individual.
- **56%** of appropriate cases showed that the partnership had taken actions/sanctions against the alleged perpetrator.
- **86%** of appropriate cases showed that the partnership carried out work with the alleged perpetrator (harmer).
- **34%** of cases rated weak or unsatisfactory.

# East Dunbartonshire partnership

**Key processes for adult support and protection were**

**GOOD**



**Important strengths,  
some areas of  
improvement**

**because:**

The partnership's key processes for adult support and protection made adults at risk of harm safe and protected. The co-location of social work and health staff in integrated teams afforded productive sharing of adult protection information. The partnership had a unique adult protection process that had two routes; the adult protection route and the RAMP (risk assessment management process) route. Preparation of well-balanced valid chronologies for adults at risk of harm was an area for improvement.

## 2. Key processes for adult support and protection in East Dunbartonshire

### Operational management of adult support and protection

2.1. The partnership exercised relatively decisive operational management for adult support and protection.

Figure 7 The partnership's two routes for ASP concerns



2.1.1. Generally, staff from across the agencies were clear about how and where to raise adult support and protection concerns. There were guidance and procedures for adult support and protection and related activity – for example the RAMP (**risk assessment management process**).

2.1.2. We considered the RAMP procedure was complicated and might be hard for staff to comprehend. Thirty-three per cent of the individuals in our sample of adult protection records were routed via the RAMP process. We did not discern that adults at risk of harm were disadvantaged by this route.

2.1.3. We found that in some cases planning meetings (professionals' meetings) were used as an alternative to adult protection case conferences.

2.1.4. Council officers and team leaders were well supported by service managers and the adult protection co-ordinator.

## Progressing of adult protection referrals

### ASP referrals

- **73%** evidenced communication among partners.
- **27%** did not evidence communication among partners.
- **84%** application of three-point test correct.
- **88%** application of three-point test recorded.
- **10%** showed time delays in progressing referral.
- **54%** referral handling rated good or better (**32%** very good), **46%** adequate or worse.

2.2. The partnership's response to most adult protection referrals was timely. The partnership correctly applied the three-point test for most referrals and clearly recorded its application. Communication among partners was an area for improvement.

2.2.1. The police concern hub had the standardised national concern hub business process in place. This set out the processes for the triage, research, assessment, and appropriate proportionate information sharing of all adult concern reports. This allowed a full review and therefore a reduction in forwarding inappropriate referrals to social work.

2.2.2. All adult protection referrals went through the adult intake team. This provided a useful overview of referral activity. Senior practitioners in social work teams (except the older people team) helped ensure continuity for the screening and progression of adult protection referrals.

2.2.3. Police Scotland had constructively introduced a national escalation protocol for multiple-repeat adult protection concern reports within a 30-day period. Multiple-repeated concerns triggered a multi-agency discussion.

2.2.4. Social work staffs' view was that although the proportion of "inappropriate" police adult support and protection referrals had reduced, this could be further improved.

## Information sharing

### Police records

- **46%** of police records contain all information about adult support and protection related incidents.
- **2%** of police records contain case conference minutes.
- **36%** of police records contain a chronology.
- **60%** of records contain a police vulnerable person's database on file.
- **81%** of the vulnerable person's database entry contains details of adult protection concerns.
- **56%** of the vulnerable person's database entry contains a chronology.

2.3. Co-location of health and social work staff within the health and social care partnership improved information sharing between health and social work.

- 2.3.1. Some partnership staff were able to share adult protection information electronically. Co-location had also supported other aspects of multi-agency working. Partnership staff and the GPs' representative attested to good information sharing, including prompt response to phone calls.
- 2.3.2. Police officers acknowledged some problems with vulnerable persons databases and delays (for example where consent was not clearly recorded and also in instances of domestic abuse). However, they thought it was better than the previous system, because it is a national system that allows cross-boundary viewing of vulnerable persons databases.
- 2.3.3. Communication and information sharing with health staff who were not located in the health and social care partnership office was less prevalent and more challenging.
- 2.3.4. Social work staff were reasonably positive about information sharing with the police.
- 2.3.5. A number of stakeholders (for example, accident and emergency staff<sup>14</sup> and independent sector care providers) said they rarely received feedback on the outcome of adult support and protection referrals they have made. NHS Greater Glasgow and Clyde had invested heavily in adult protection training for accident and emergency staff. We considered that the partnership providing timely appropriate feedback to partners who make adult protection referrals was an area for improvement.

## **Initial inquiries (duty to inquire)**

- 2.4. The partnership carried out initial inquiries into adult protection concerns effectively.
  - 2.4.1. The adult duty team held any new short-term work arising from adult support and protection referrals for a three-month period (there was some flexibility around this) before transfer to the other teams. This arrangement worked well.
  - 2.4.2. The partnership did not use initial referral discussions. Some staff and managers expressed an interest in adopting initial referral discussions. But, surprisingly, social work staff were unaware that the police were actively developing an initial referral discussion approach for consideration in East Dunbartonshire.

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<sup>14</sup> There are no accident and emergency units in East Dunbartonshire.

## Full adult protection investigations

### Adult protection investigations

- **40%** of cases proceeded to full investigation.
- **95%** of cases the full investigation effectively determined if the individual was at risk of harm.
- **95%** of full investigations rated good or better for quality.

2.5. When the partnership carried out a full investigation, this was done professionally, competently and effectively.

2.5.1. Two council officers normally undertook investigations. They had received training in investigative interviewing.

2.5.2. Staff considered that when they were involved in investigations they were well briefed and supported by line managers. Our file reading data showed that the partnership undertook relatively few adult protection investigations. Partnership staff said this was because they undertake detailed initial inquiries, including interviewing the adult at risk of harm.

2.5.3. The partnership relatively frequently (one-third of the individuals in our file reading sample) invoked the RAMP (risk assessment management process) as an alternative to the adult protection route. We considered that this was one likely reason why less than half of the adult protection episodes in our sample proceeded to the full investigation stage (from our file reading analysis).

## Chronologies, risk assessment and risk management

### Chronologies

- **57%** of records had a chronology when we considered one should be present.
- **33%** of records did not contain a chronology when we considered they should have.
- **71%** of chronologies present were of an acceptable standard.

### Risk assessment and risk management

- **90%** of adults at risk of harm had a risk assessment.
- **75%** of risk assessments rated good or better.
- **95%** of adults at risk of harm who required a risk management plan had one.
- **94%** of risk management plans rated good or better.

2.6. Risk assessment and risk management practice was of a good standard. The preparation of well-balanced, valid chronologies for adults at risk of harm was an area for improvement. One-third of the adults at risk of harm who should have had a chronology did not have one.

### Recommendation for improvement

The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

## Large-scale investigations

2.7. The partnership carried out one large-scale investigation in the last year. The partnership considered this went well. We concurred with this view.

## Adult protection case conferences

### Case conferences

- **29%** of case conferences invited the adult at risk of harm.
- **67%** of case conferences were attended by the adult at risk of harm if invited.
- **100%** if they attended, the adult at risk of harm was effectively supported to participate.
- **100%** case conferences effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported.
- **87%** of case conferences were rated as good or better.

2.8. Adult support and protection case conferences were well structured and proficiently chaired. They were chaired by a service manager, who effectively identified the risks and the protection actions required. Staff produced minutes quickly and to a good standard.

2.8.1. Our file reading showed health attendance at adult protection case conferences was an area for improvement. Laudably, the police attended all adult protection case conferences.

- All adult protection conferences had a police representative in attendance.
- Thirty per cent of adult protection conferences did not have a health representative in attendance.

2.8.2. Staff made good efforts to encourage and support the attendance of adults at risk of harm and unpaid carers at case conferences.

2.8.3. Frontline police officers who attended case conferences sometimes lacked understanding of their role and the purpose of the case conference.

## Independent advocacy

### Independent advocacy

- **53%** of cases evidenced that the individual was offered independent support or advocacy when needed.
- **62%** of cases evidenced that the individual received advocacy support if this was offered.
- **88%** of cases showed evidence that advocacy helped the individual articulate their views.

2.9. We saw evidence of the purposeful involvement of independent advocacy services. This included their attendance at relevant case conferences. Comments from staff about Ceartas advocacy service were generally very positive.

2.9.1. Adults at risk of harm we met said they benefited greatly from independent advocacy and their relationship with their advocate.

*"The greatest help I have received was from my advocate".*

## Staff knowledge and use of legislation

2.10. Council officers and other staff we met were knowledgeable about legislation pertaining to adult support and protection and were skilled in its application. Staff were positive about timely and positive support from the council's legal services.

2.10.1. Police officers' knowledge of the relevant legislation was variable. They were well informed on application of the three-point test. Although they still had a tendency to record episodes involving vulnerable individuals as adult support and protection rather than adult wellbeing.

## Support for adults at risk of harm to achieve their desired personal outcomes other than protection

2.11. Staff concluded that assessment and care planning for adults at risk of harm included the provision of practical and financial support, and that this generally engendered individuals' desired personal outcomes.

## Review adult protection case conferences

2.12. Case conference reviews took place within the required and appropriate timescales. There had been an issue with this and the partnership had made the necessary improvements.

# East Dunbartonshire partnership

**Leadership for adult support and protection was**

**GOOD**



**Important strengths,  
some areas for  
improvement**

**because:**

Strategic leaders modelled and promoted productive partnership working for adult support and protection. There was sound and effective oversight of multi-agency adult protection practice. The partnership constructively used self-evaluation and audit of adult support and protection to identify areas for improvement. The partnership exercised relatively strong informed governance over adult support and protection.

# 3. Leadership for adult support and protection in East Dunbartonshire

## Leaders support for partnership working

- 3.1. Strategic leaders promoted cohesive partnership working and support for adult protection operations. The partnership evidenced a strong commitment to council officer training and succession planning. There was an organisational expectation that newly qualified social workers would progress to act as council officers after 12 months in post.
  - 3.1.1. The partnership recently conducted a staff survey. This found that staff morale in the teams was generally good, although there were some concerns about workloads and structural changes.

## Vision

- 3.2. The partnership had a clear and articulate vision for adult support and protection, and pervasive ownership of it.

## Leadership for delivery of adult protection practice

- 3.3. The partnership strongly endorsed the RAMP (risk assessment and management process). One of the consequences of this was relatively low numbers of adult protection case conferences.
  - 3.3.1. Our file reading found that in 28 cases where a case conference should have been convened, five (18%) were not convened and in these cases, the partnership followed the RAMP route.
  - 3.3.2. In this way, the partnership sometimes used the RAMP process as an alternative to adult protection case conferences<sup>15</sup>. The partnership was aware of the issue and the chief officers group commented on the need for monitoring. We considered this was constructive and an important area for chief officers' continued attention. In our view, the key issues for the partnership to review were:
    - the rationale for around one-third of adults at risk of harm routed via the RAMP
    - clarity of RAMP procedure
    - individuals' safety outcomes from adult support and protection route and RAMP route.
  - 3.3.3. Police frontline and concern hub staff reported good operational management. Their economic crime unit had the overview on financial harm. We considered this was a constructive approach.

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<sup>15</sup> As previously stated, we discerned no detriment to individuals subject to the RAMP.

3.3.4. The partnership expected all children and families social workers to undertake adult support and protection training. We considered this was an example of valuable positive practice.

## **Quality assurance**

3.4. The partnership asserted that they build quality assurance into processes. The adult protection co-ordinator reviewed case conference minutes to promote consistency.

3.4.1. Laudably, the partnership determined its priorities for adult support and protection from regular file audits. The annual multi-agency file audit began in 2013.

3.4.2. The adult protection committee priorities were capacity and sexual harm –they emerged from the file audit.

3.4.3. The partnership’s senior managers meaningfully took account of the views of adults at risk of harm and their unpaid carers.

3.4.4. Team leaders were positive about the quality of the performance management reports they received. These reports allowed them to monitor their team’s performance for a number of key adult protection processes. Team leaders were required to read and sign off the various adult support and protection reports. This was how they productively assured adult the quality of support and protection activity.

3.4.5. The partnership produced quarterly adult protection performance reports. The quality of the reports had improved significantly since they went electronic and the adult protection committee had to spend much less time checking the data accuracy. The partnership made the required improvements when its performance data revealed delays convening adult protection case conferences.

## **Leadership exercised by adult protection committee and chief officers group**

3.5. Adult protection committee members said that person-centred policies and procedures were operational. They emphasised proportionate and least-restrictive approaches. They were confident that East Dunbartonshire was a “robust adult protection environment” and that there were positive relationships and joint working between agencies. The chief officers group strongly endorsed this view.

3.5.1. The adult protection committee received presentations from other areas and was cognisant on crosscutting adult protection themes. At least one annual conference was held, focusing on a particular theme.

3.5.2. Advocacy services felt recognised and valued by the partnership, which invited their participation in developing consultation groups.

- 3.5.3. The chief officers group considered the annual self-evaluation of inter-agency practice and service delivery evidenced consistency and timely action to protect adults at risk of harm. In general, we concurred with this view.
- 3.5.4. The chief officers group had set a number of self-evaluation targets for improvements to adult support and protection. Commendably, most of these were achieved.
- 3.5.5. There were less robust arrangements for quality assurance of adult protection case records than for reports. Team leaders did not routinely scrutinise records as part of their staff supervision. The partnership identified this as an issue in its annual self-evaluation exercise and acknowledged it was an area for improvement.
- 3.5.6. The adult protection committee was a relatively strong, cohesive partnership with mature working relationships. Tension within the partnership was unusual and quickly resolved.
- 3.5.7. Multi-agency staff groups were confident that the community safety partnership was improvement-focused. The partnership was committed to joint training. Examples of training sessions delivered included domestic violence, dementia and self-directed support. These areas reflected the partnership's adult protection strategic priorities.
- 3.5.8. The independent convener of the adult protection committee had been in post for two years and had not met with the chief officers group. There was a lack of clarity about the route to be taken for adult support and protection issues to be considered by the chief officers group. The partnership acknowledged this was an area for improvement.
- 3.5.9. A review of Police Scotland's attendance at the adult protection committees was underway, with a view to improving the consistency of police participation in them.

## **Role of the chief social work officer**

- 3.6. The chief social work officer had a critical role in improving understanding of adult support and protection and implementation of adult support and protection procedures and strategic improvement plans.
- 3.6.1. The clinical and care governance group, which incorporated social care chief officers, health and third-sector partners, oversaw professional and clinical practice. Staff viewed this as a positive development. We considered it was a valid, constructive response to health and social care integration.
- 3.6.2. The chief social work officer was a member of the adult protection committee, the child protection committee and the community planning committee, and was active on all in promoting the partnership's learning and development strategy.

3.6.3. There was purposeful use of a deputy chief social work officer to ensure consistent advice was available to staff.

3.6.4. The chief social work officer was responsible for delivering the annual adult support and protection stakeholders' awareness-raising conference. We considered that this event was a very positive effort to increase the profile of adult support and protection.





# Midlothian partnership

Outcomes for adults at risk of harm were

**GOOD** 

Important strengths,  
some areas for  
improvement

because:

The partnership pursued the least restrictive interventions that benefited adults at risk of harm. Adults at risk of harm had their views and choices taken into account. In the main, adults at risk of harm were made safe, had enhanced wellbeing and improved quality of life because of the partnership's adult support and protection efforts. The partnership needed to do more to elicit the lived experiences of adults at risk of harm and their unpaid carers.

## **Recommendations for improvement: The Midlothian partnership**

1. The partnership should make sure that all adult protection referrals are processed timeously.
2. The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

# 1. Outcomes for adult support and protection in Midlothian

## Partnership pursues least restrictive options and respects choice

- 1.1. There was evidence that the partnership took the appropriate action where required to protect adults at risk of harm. And in most cases, they pursued the least restrictive protective options, respected individuals' choice and took account of individuals' abilities and backgrounds.
  - 1.1.1. The partnership's internal audit findings, confirmed they were effective in providing preventative input and support to adults at risk of harm, which reduced the need for statutory involvement while appropriately addressing the risk.
  - 1.1.2. Our analysis of redacted referrals demonstrated that 100% of cases were handled in line with the principles of the Adult Support and Protection (Scotland) Act 2007.
  - 1.1.3. The partnership's own audits also found compliance with the principles of:
    - least restrictive interventions
    - appropriate action that benefited the adult at risk of harm, and adults' views were listened to and respected.
  - 1.1.4. The partnership recognised the challenge balancing its statutory duties against the rights of individuals. They saw this as an area for continued professional development.
  - 1.1.5. Staff were confident that they took appropriate action when required and they received good support from legal services. All of the adults at risk of harm and the carers we met were very positive about the partnership's approach, confirming their intervention was appropriate and they were included throughout.

## Timely multi-agency response to adult protection concerns

- 1.2. There was compelling evidence that the partnership's multi-agency responses to referrals of adult protection concerns were effective.
  - 1.2.1. There was a quality and improvement group and a performance framework with a suite of indicators, which monitored and supported the partnership's proportionate and timely response to adult protection referrals. But see our findings on delays in the progressing of adult protection referrals in 2.2.
  - 1.2.2. Some adults at risk of harm we met said they felt it took too long for adult support and protection processes to be triggered and this intervention should have happened sooner. Professionals were actively involved with them long before the adult protection process commenced.

**"Adult protection could have moved quicker".**

(Adult at risk of harm)

- 1.2.3. Generally, other partners were confident about the processes in place to support timely and effective responses to adult protection concerns. Third sector partners had a clear and well-understood pathway to make referrals. Multi-agency staff across the partnership described very positive working relationships.
- 1.2.4. The police lead officer and the lead social work team manager provided a consistent approach to the handling of adult protection concerns. The establishment of some co-located and integrated teams afforded continuity of multi-agency response to adult protection concerns.
- 1.2.5. The partnership acknowledged the need to improve some of the performance indicators. It intended to change the target for the number of inquiries completed within five working days from 75% to 90%. It also acknowledged the need to deliver regular adult support and protection training to contact centre staff.
- 1.2.6. There was some evidence to suggest that timely involvement of advocacy services could be improved.

## **Involvement of adults at risk of harm and unpaid carers**

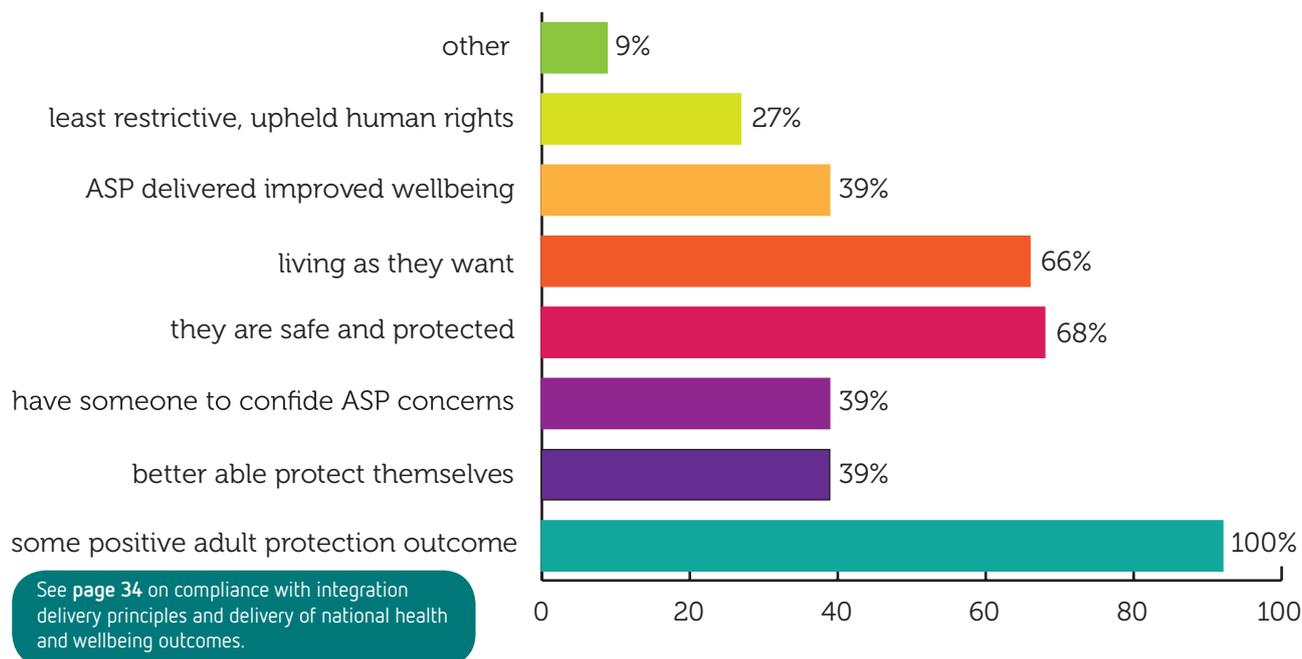
### **Involvement of adults at risk of harm**

- **95%** of adults at risk of harm's views sought and taken into account at initial inquiry stage.
- **98%** had views sought and taken into account at investigation stage.
- **82%** had views sought and taken into account at implementation of protection plan and review stage.

- 1.3. Adults at risk of harm and unpaid carers we met were clear that they had been consulted, involved, informed and included throughout the adult support and protection process. They said they were provided with information timeously and given copies of all minutes and reports.
- 1.3.1. The partnership strived to ensure that adults at risk of harm and their unpaid carers were included and involved at each stage of the adult at risk of harm's adult protection journey.

## Outcomes for safety, protection, and support

Figure 10: outcomes for adults at risk of harm in Midlothian



1.4. We were impressed with the partnership’s commitment to working in an outcome-focused manner. Some of its audit activity evidenced improved outcomes for adults at risk of harm. The partnership was able to provide invaluable, aggregate, quantitative data about the personal outcomes for adults at risk of harm.

1.4.1. The partnership generally delivered good outcomes for adults at risk of harm and unpaid carers (Figure 10). Adults at risk of harm were safer, protected and supported, and had the burden of fear lifted from them. They had enhanced wellbeing and improved quality of life.

1.4.2. Adults at risk of harm confirmed they felt much safer – one young person asserted that because of adult protection, “I’m still here”.

*“I’m still here, because of adult support and protection”.*

*(Adult at risk of harm)*

1.4.3. The partnership had tried issuing questionnaires to adults at risk of harm, but response rates were poor. The lead officer was to undertake evaluations of individuals’ experience of their adult protection journey.

1.4.4. Adults at risk of harm indicated that they were treated with dignity and respect. We also met a few adults who were well-supported after adult support and protection intervention ended.

1.4.5. Adults at risk of harm, who had gone through the adult support and protection process, were generally very positive about the whole experience. Some did comment they *"found the volume of paperwork overwhelming"*.

### Financial harm

- **33%** of cases there was evidence of financial harm to the individual.
- **50%** of cases this was greater than £1,000.
- **87.5%** of cases evidenced the partnership had acted to stop the abuse.
- **79%** of cases showed that this had been effective.
- **20%** of cases the effectiveness of the partnerships actions rated good or better.

1.4.6. Trading standards carried out effective work on scams that targeted vulnerable individuals. Thereby preventing financial harm to vulnerable adults, and sparing them the trauma financial harm causes.

1.4.7. Our file reading showed the partnership worked productively to stop financial harm to some vulnerable adults. This delivered outcomes of enhanced:

- safety
- wellbeing
- amenity
- peace of mind and freedom from fear.

## Remedial work with perpetrators (harmers)

1.5. The partnership had taken action to interdict and disrupt the behaviour of perpetrators for half of the adults at risk of harm who were victims of a perpetrator. We considered this was an area for improvement.

1.5.1. The partnership carried out some effective work with the perpetrators of harm to vulnerable adults.

### Perpetrators

- **75%** of cases evidenced that there was a perpetrator (alleged perpetrator) of harm to the individual.
- **50%** of cases showed that the partnership had taken actions against the perpetrator.
- **100%** of appropriate cases showed that the partnership carried out work with the perpetrator.
- **100%** of cases work rated as adequate.

# Midlothian partnership

Key processes for adult support and protection were

**GOOD**



**Important strengths,  
some areas of  
improvement**

**because:**

The partnership's key processes operated effectively to create a coherent protective framework for adults at risk of harm. Operationally, partners worked effectively and collaboratively to support the adult protection journey of adults at risk of harm and make them safe. Timely processing of adult protection referrals was an area for improvement, as were the police concern hub's processes for:

- screening and triaging adult protection concerns and then making appropriate onward referral to the health and social care partnership
- implementing the standardised national concern hub business process.

Nearly one-third of adults at risk of harm who should have had a chronology did not have one.

## 2. Key processes for adult support and protection in Midlothian

### Operational management of adult support and protection

- 2.1. There were inter-agency procedures that were up to date and detailed, and council staff were clear about their implementation. Multi-agency staff agreed that adult support and protection guidance was up to date and fit for purpose.
  - 2.1.1. A dispute resolution protocol was in place however, this had yet to be used as the partnership was able to resolve differences of opinion without recourse to the protocol.
  - 2.1.2. Generally, staff across the partnership attested to sound operational management for adult support and protection. They were clear about how and where to raise adult support and protection concerns.
  - 2.1.3. Council officers were supported well by their line managers. They regularly participated in a rota that provided regular practice experience and opportunity to develop their knowledge and skills.

### Progressing of adult protection referrals

#### ASP referral analysis

- **86%** showed communication among partners.
- **88%** showed correct application three-point test.
- **80%** application three-point test recorded.
- **76%** of referral handling rated good or better, 24% adequate or worse.
- **20%** of referral episodes showed time delays.

- 2.2. There were too many delays (in one-fifth of the referral episodes we analysed delays were extant) in the partnership's processing of adult protection referrals. We considered this was an area for improvement.

#### Recommendation for improvement

The partnership should make sure that all adult protection referrals are processed timeously.

- 2.2.1. There was some scope for improvement with partner communication at the initial response stage.
- 2.2.2. The partnership correctly applied the three-point test and recorded this appropriately for most adult protection referrals, although there was some scope for improvement. Adult support and

protection referrals that did not meet the three-point test were screened and signposted to relevant services.

- 2.2.3. The police concern hub was well established, worked relatively effectively and had an experienced and well-motivated staff team. There was normally no backlog of vulnerable persons databases. An escalation protocol was in place and was used effectively.
- 2.2.4. The police considered adult protection systems worked less well out of hours, where social work cover was provided by City of Edinburgh Council. The police purposefully used the TRACK management information system to compensate for this and to check what happened out of hours then liaise with social work.
- 2.2.5. All adult support and protection referrals went through the dedicated social work mailbox and were screened by the same social work team leader. This provided a consistent overview of referral activity.
- 2.2.6. Unlike other police divisions, the triage of adult protection concern reports was not undertaken by a supervisory officer. Although the guidance allowed experienced officers to perform this role, we considered the removal of a supervisor from the triage process was a retrograde step and an area for improvement.
- 2.2.7. Large numbers of referrals that did not meet adult support and protection criteria took up a lot of team leader resource to screen and dispose of appropriately. There was a high volume of adult support and protection referrals from care homes. Multi-agency staff were clear that more could be done by the partnership to support care homes and reduce referrals.

## Information sharing

### Police records

- **77%** of police records contain all information about adult support and protection related incidents.
- **10%** of police records contain case conference minutes.
- **82%** of police records contain a chronology.
- **86%** of records contain a police vulnerable person's database on file.
- **81%** of the vulnerable person's database entry contains details of adult protection concerns.
- **71%** of the vulnerable person's database entry contains a chronology.

- 2.3. The partnership shared adult protection information smoothly and effectively. Electronic systems were in place to facilitate this and staff indicated that good relationships fostered good information sharing.
- 2.3.1. Social work staff said that Mosaic worked well generally and supported adult support and protection processes. Co-located integrated health and social work teams such as the mental

health team supported very good informal and formal opportunities to share information timeously.

- 2.3.2. The police concern hub was central to the smooth, efficient flow of information about adults at risk of harm.
- 2.3.3. The police concern hub recently implemented the resilience matrix (October 2017). The standardised national concern hub business process was not yet embedded. The delay implementing and embedding the resilience matrix was detrimental to the continuous improvement of information sharing.
- 2.3.4. Our redacted referral analysis demonstrated evidence of communication among adult support and protection partners in 86% of cases.
- 2.3.5. Where consent to share information was not recorded by frontline police officers or was refused by the adult at risk of harm, authority to override was in place, depending on the nature and level of concern.
- 2.3.6. There was an information-sharing protocol in place that staff described as reasonable and proportionate. When an investigation was triggered, social work could ask for police information, even though an initial referral discussion was not deemed necessary.

### **Initial inquiries (duty to inquire)**

- 2.4. The partnership's initial referral discussion process – between police and social work – generally worked well. Health was not routinely involved in initial referral discussions. Health struggled to identify a single person to be the initial referral discussion link contact, although there was a named NHS adult support and protection specific point of contact, who could be contacted when necessary.
  - 2.4.1. Social work staff expressed mixed views about the use of initial referral discussions. There was some confusion among social work staff about the purpose of them.
  - 2.4.2. Police partners were much clearer about the purpose of initial referral discussions and the approach was well embedded.
  - 2.4.3. Frontline police officers could be inconsistent in obtaining and recording the consent of the adult at risk of harm to share information. Concern hub staff sometimes contacted the frontline officer to clarify the position however, this did not always happen.
  - 2.4.4. Staff experienced challenges in relation to GP contact at all stages of adult support and protection work. The partnership's performance reports showed that exceptions to meeting the timescale for adult protection inquiries were mainly due to delays in information sharing by GPs. Council officers emailed GPs and this was an improvement over previous arrangements.

2.4.5. Social work staff said that periodic failures to meet timescales for initial inquiries was due to:

- service capacity (a team leader post was vacant)
- delays receiving health information
- delays completing capacity assessments.

## Full adult protection investigations

### Adult protection investigations

- **94%** of records showed a full investigation conducted.
- **93%** of cases the full investigation effectively determined if the individual was at risk of harm.
- **84%** of investigations - quality rated good or better.

2.5. Investigations were largely robust, detailed and competently conducted. Investigations demonstrated details of the process, initial risk assessment and analysis in preparation for a case conference where appropriate.

2.5.1. Council officers reported that investigations were carried out in a robust and timeous manner. They were now recorded on a single form, which they regarded as an improvement on previous practice. A team leader supervised investigations.

2.5.2. Council officers had undertaken valuable investigative interviewing training.

2.5.3. The adult protection procedure advised that the deployment of a second investigative interviewer was at the discretion of the operational manager and staff confirmed this. The partnership was reviewing this practice.

## Chronologies, risk assessment and risk management

### Chronologies

- **71%** of individuals who should have had a chronology had one.
- **29%** of individuals who should have had a chronology did not have one.
- **60%** of chronologies present were of an acceptable standard, **40%** were not.

### Risk assessment and protection planning

- **94%** of individuals who should have had a risk assessment had one.
- **71%** of risk assessment rated good or better.
- **100%** of individual who should have had a risk management plan had one.
- **78%** of risk management plans rated good or better.

- 2.6. The quality of risk assessments and risk management plans was generally good. Council officers confirmed there was specific, cogent risk assessment and risk management guidance for adult support and protection. Council officers advised that multi-agency risk assessments and risk management plans were completed and appropriately shared.
- 2.6.1. Multi-agency staff felt that their practice was personalised and person-centred and they made great effort to work with individuals, rather than doing things to individuals. Staff were good at engaging with adults at risk of harm whose situations were chaotic or complex. They appropriately utilised support from third sector and other partners.
- 2.6.2. Council officers were expected to complete chronologies prior to case conference. But these quite often only included information relating to the adult support and protection concerns, rather than a thorough comprehensive chronology. This meant that worrying patterns of harm to individuals might not be apparent.
- 2.6.3. Users reported the recording of chronologies on Mosaic was “clunky”. They uploaded Word documents rather than populating the designated system for chronology creation.
- 2.6.4. The partnership aimed to move to multi-agency chronologies by January 2018. This was a highly ambitious target. Health partners did not participate in the chronology process.
- 2.6.5. The partnership acknowledged that completion of apposite chronologies was an area for improvement. This was strongly congruent with our analysis.

### **Recommendation for improvement**

The partnership should make sure that social workers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.

## **Large-scale investigations**

- 2.7. A detailed multi-agency large-scale investigation protocol was in place. This was clear and afforded sound guidance to staff. Generally, staff were aware of the protocol and some had used this. Large-scale investigation practice was well established and there were good working relationships with all partner agencies. Staff were confident about carrying out large-scale investigations.
- 2.7.1. The partnership carried out three large-scale investigations in the last year. There were two-multi-agency strategy group meetings to discuss concerns about specific care homes. We considered that the partnership carried out large-scale investigations competently, comprehensively and productively.
- 2.7.2. Team leaders said that there were challenges in making staff available for large-scale investigations.

## Adult protection case conferences

### Adult protection case conferences

- **74%** of case conferences invited the adult at risk of harm.
- **50%** of case conferences were attended by the adult at risk of harm where invited.
- **100%** if they attended, the adult at risk of harm was effectively supported to participate.
- **96%** case conferences effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported.
- **77%** of case conferences were rated as good or better.

2.8. The partnership's audit processes revealed an issue with meeting timescales for adult protection case conferences. This had been addressed and performance was stated to be improving.

2.8.1. Our file reading showed police and health attendance at adult protection case conferences was an area for improvement.

- Thirty-three per cent of adult protection conferences did not have a police representative in attendance.
- Thirty-seven per cent of adult protection conferences did not have a health representative in attendance.

2.8.2. Police acknowledged that there were some instances when there was no police presence at case conferences. They always submitted reports for case conferences.

2.8.3. Attendance at case conferences was challenging for health staff. Social work staff confirmed that case conferences were more robust when health partners and GPs were able to attend.

2.8.4. Staff said that adults at risk of harm were always invited to attend adult protection case conferences and that support was offered to them. Police confirmed that when adults at risk of harm attended case conferences, they were well supported to fully express their views.

2.8.5. Many staff said that adult protection case conferences were poorly attended. They felt that some agencies did not attend case conferences, as they had "no more to tell". Some inquirers said case conferences had to be cancelled and reconvened. Social work staff perceived partners did not always understand that the case conference was not only for sharing information but also for multi-agency decision making about the optimal way forward to secure safety and support for the adult at risk of harm.

2.8.6. Most other professionals agreed that the absence of health staff rendered the case conference process less robust. Resource issues made attendance challenging for health professionals. The partnership constructively attempted to secure GP attendance by holding case conferences in GP surgeries.

2.8.7. Attendance at case conferences by adults at risk of harm was challenging, despite council officers attempting to reduce barriers to attendance.

## Independent advocacy

### Independent advocacy

- **39%** of cases evidenced that the individual was offered independent support or advocacy when needed.
- **47%** of cases evidenced that the individual received advocacy support if this was offered.
- **57%** individuals offered advocacy did not receive it.
- **88%** of cases showed evidence that advocacy helped the individual articulate their views.

2.9. The adult protection investigation form prompted council officers to consider a referral to independent advocacy. There were positive relationships between advocacy and social work services. Advocacy services were accessible and responsive.

2.9.1. Two of the three advocacy services indicated that they received a low volume of referrals and that these were often received too late in the process. Advocacy services would prefer to be involved at an earlier stage. Referrals were mainly received from social workers and mental health officers.

## Staff knowledge and use of legislation

2.10. Staff were knowledgeable about statutory powers to protect adults at risk of harm. They reported securing two banning orders recently and that one prevented the harmer from contacting the victim, while the other did not.

2.10.1. There was a positive relationship with local authority legal services, who gave sound advice timeously.

2.10.2. Training on the 'three acts'<sup>16</sup> was well attended and well received by multi-agency groups, including GPs.

2.10.3. NHS Lothian had helpfully developed a decision specific assessment tool for capacity assessment, which was accessible to council officers requesting capacity assessments.

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<sup>16</sup> The Adult Support and Protection (Scotland) Act 2007, The Adults with Incapacity (Scotland) Act 2000 and The Mental Health Care and Treatment (Scotland) Act 2003

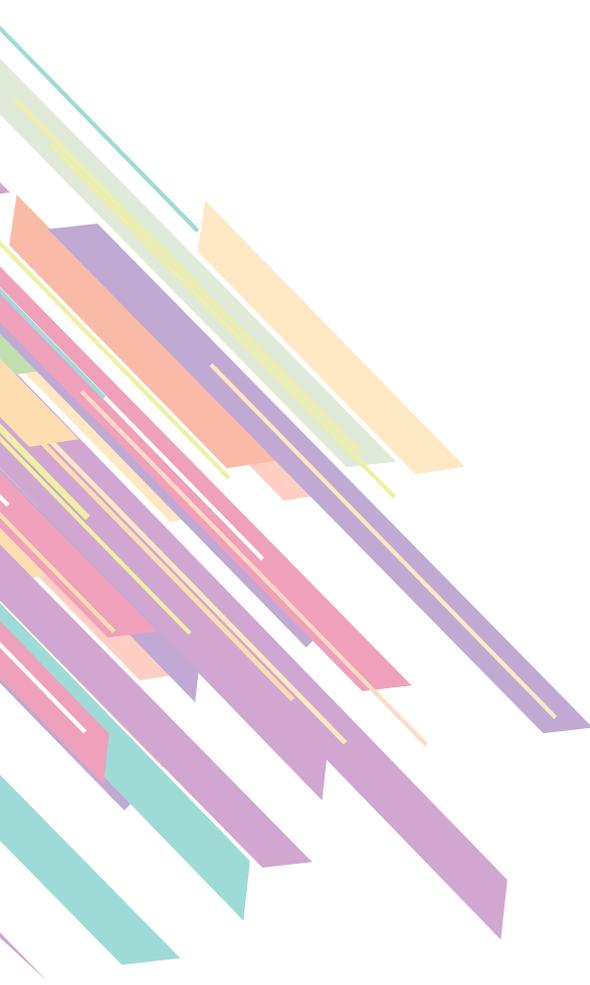
2.10.4. Staff had mixed experiences of obtaining capacity assessments. It could be difficult to obtain them timeously for some adults at risk of harm, where capacity was an issue.

### **Support for adults at risk of harm to achieve their desired personal outcomes other than protection**

2.11. In general, adults at risk of harm received support to deliver their non-protection desired personal outcomes of health, wellbeing and enhanced quality of life.

### **Review adult protection case conferences**

2.12. Adult protection case conference reviews (where appropriate) were convened regularly and within appropriate timescales. They constructively determined the optimal way forward for adults at risk of harm.



# Midlothian partnership

## Leadership for adult support and protection was

**VERY GOOD**

**Major strengths**

### because:

Senior leaders within the partnership modelled and promoted accomplished partnership working for adult support and protection. Our evidence was that the partnership's public protection approach worked well and was well embedded. There was a conjoined Midlothian and East Lothian adult protection committee and child protection committee, which was called the public protection committee. Thus, four committees were conjoined into one. Governance and oversight of adult support and protection was robust and effective. The partnership had carried out a number of purposeful audits of adult support and protection practice. And this was reflected in our overall findings on the good quality of the partnership's key processes for adult support and protection. The partnership had a suite of meaningful performance indicators related to adult support and protection.

# 3. Leadership for adult support and protection in Midlothian

## Leaders support for partnership working

- 3.1. There was a generally strong and robust approach to partnership working.
  - 3.1.1. Midlothian and East Lothian had worked together on adult support and protection and broader public protection for almost 10 years. There was evidence that this partnership had evolved and strengthened over time, and that there were benefits in terms of shared capacity, economies of scale and shared learning.
  - 3.1.2. The public protection unit based in Musselburgh in East Lothian was an example of this joint approach. The approach also afforded opportunities for benchmarking and peer review.
  - 3.1.3. The joint, combined approach to public protection in the partnership worked relatively well. The partnership prioritised adult support and protection in a well-balanced manner.
  - 3.1.4. The critical services oversight group worked collaboratively to exercise governance over adult support and protection.
  - 3.1.5. The Fire and Rescue Service and Trading Standards made an invaluable contribution to the partnership and to the delivery of enhanced positive outcomes for adults at risk of harm and their unpaid carers

## Vision

- 3.2. Leaders ensured that there was a compelling, clearly articulated vision for adult support and protection, and this was communicated effectively across the partnership.

*"It's everyone's responsibility to support and protect people at risk of harm."*

## Leadership for delivery of adult protection practice

- 3.3. Generally, staff we met were well supported by their managers (for example, council officers and police officers involved with the public protection unit and the concern hub).
  - 3.3.1. At a strategic level, there was a protection lead for health at directorate tier (this was a Lothian initiative). This individual chaired the public protection committee.
  - 3.3.2. Although advocacy representatives described positive joint working relationship with health and social work services at the operational level, advocacy services were not represented on the public protection committee or any of its subgroups.

- 3.3.3. Staff groups we met highlighted specific initiatives to raise the profile of adult support and protection (for example, financial harm). Generally, staff had a clear understanding of their and their agency's role in adult support and protection.
- 3.3.4. Public protection unit and concern hub officers we met were not very well informed about some of the national and divisional initiatives related to adult protection for example, disruption of the activities of bogus workmen.
- 3.3.5. In the main, the critical services oversight group, public protection committee, public protection unit and concern hub worked collaboratively and effectively. Partners shared information appropriately and delivered most adult protection processes in a timely, competent and proportionate manner.
- 3.3.6. There was a good level of both single and multi-agency adult protection training. The vast majority of references to adult support and protection training and development we encountered were very positive.

## Quality assurance

- 3.4. Laudably, the partnership was committed to carrying out audits of adult support and protection. The police had been involved in national audits.
- 3.4.1. The partnership's current file audit activity was single-agency, rather than multi-agency and largely focused on social work activity. However, the partnership recognised the need to address this. The sample size of social work case file audits was relatively small.
- 3.4.2. The group that oversaw initial referral discussions operated effectively as a quality assurance mechanism for reviewing decision making at initial referral discussions.
- 3.4.3. There were a number of examples where quality assurance and audit activity led to improvements. These included:
- improved management and delivery of case conferences within timescales
  - council officers seeking to meet with adults at risk two weeks after a case conference in an effort to improve user feedback
  - improvements to the completion of chronologies supported by chronology training.
- 3.4.4. The partnership's assertion of improvement in chronology preparation does not fully resonate with our file reading findings. Only 71% of the records we thought should have contained a chronology did so, meaning 29% of adults at risk of harm who should have had a chronology did not.
- 3.4.5. The critical services oversight group had undertaken two purposeful self-evaluation events, one of which was supported by a specialist corporate facilitator.

## **Leadership exercised by adult protection committee and chief officers group**

- 3.5. There was a well-established and effective public protection committee. We did not hear any comments to the effect that adult protection was the poor relation in to child protection.
- 3.5.1. The two public protection committee subgroups worked well. Again, the benefits of the broader public protection approach outweighed any disadvantages. Officers did not have to attend multiple different committee meetings.
- 3.5.2. The convener of the public protection committee provided energetic and positive leadership. The convener was a partnership employee and therefore not an independent chair. For this partnership, we could not discern any obvious disadvantages from this arrangement.
- 3.5.3. The critical services oversight group had a clear understanding of the roles and responsibilities of this group. They had a sound grip of the strategic adult support and protection agenda.
- 3.5.4. The partnership had a well-developed set of performance indicators and a performance framework. It was positive that the partnership was reviewing this, with completion of the review due in 2018.
- 3.5.5. The partnership had made a number of improvements to its adult support and protection procedures and processes in the last two years. Senior leaders, including the chief social work officer, were closely involved in driving this improvement activity.
- 3.5.6. The partnership had not carried out any significant case reviews related to adult protection in the previous two years. They said this was because there had not been any adult protection cases with adverse elements that met the significant case review criteria. The partnership had carried out a number of initial case reviews and disseminated any lessons learned.

## **Role of the chief social work officer**

- 3.6. The chief social work officer chaired a 'changing lives' overview group. The focus of this energetic group was the maintenance of high standards of professional social work practice. Public protection was a standing item on the agenda.
- 3.6.1. The chief social work officer provided solid professional leadership for social work in Midlothian and for the exercise of the social work role and contribution to adult support and protection.

# Appendix 1: Quality indicators for adult support and protection

**QI-1:**  
**Outcomes:**  
**is the at-risk adult safe and supported as a result of our (see page 13 for our definition of adult protection partnership) activity?**

## QUALITY INDICATORS FOR ADULT SUPPORT AND PROTECTION

- 1.1 We pursue least restrictive protective options and respects individuals' choice.
- 1.2 Our multi-agency response to referrals of adult protection concerns was timely and effective to create a proportionate, protective framework for adults at risk of harm and others for whom risk was identified, including children. We strive to identify adults at risk of harm.
- 1.3 We deliver the desired personal outcomes for adults at risk of harm - enhanced safety, wellbeing, and support to keep healthy. They and their unpaid carers (if appropriate) were involved throughout. Adult protection outcomes and general health and wellbeing outcomes were inextricably linked.
- 1.4 Adults at risk of harm, subject to physical, sexual, emotional, financial harm, neglect, self neglect, and harm to self were safe and protected as a consequence of our actions.
- 1.5 We carry out effective work with perpetrators (harmers) when necessary.

**QI-2:**  
**Key processes:**  
**How good were our partnership's policies, procedures and practice for referral handling, screening, effective initial response to secure safety of adult at risk of harm, investigation of adult protection concerns intimated to our partnership? And how effective were our actions to secure sustained safety, protection, and support for adults at risk of harm?**

- 2.1. There was decisive and consistent operational management of ASP cases.
- 2.2. We have a valid system for timely, accurate screening of all adult protection concerns intimated to it. The three-point test was correctly and consistently applied.
- 2.3. We share information (electronic and non electronic) about adults at risk of harm effectively and timeously. Robust protocols were in place.
- 2.4. We carry out timely and cohesive initial investigations of adult protection concerns - including ASP concerns related to regulated services - which competently determine whether to proceed to a full investigation. And any other measures to protect and support the adult at risk of harm.
- 2.5. We carry out competent, timely, multi-agency, in-depth investigations into adult protection concerns that correctly identify the way forward. These were timeously and fully recorded.
- 2.6. We prepare detailed risk assessments and risk management plans - including chronologies - for adults at risk of harm, who require them.
- 2.7. We conduct large-scale inquiries (large scale investigation) competently, commensurate with the national code of practice. These exercises ensure the adults currently at risk of harm were safe and protected, and diminish the risk of future harm to individuals.
- 2.8. We correctly convene multi-agency case conferences for adults at risk of harm. These effectively determine what needs to be done to secure the individuals' ongoing safety and other positive personal outcomes. Adults at risk of harm and their carers were invited and supported to attend.
- 2.9. Independent advocacy is offered to individuals and was available if they want it. Staff are fully aware of role of advocacy. Appropriate adults were deployed when required.

**QI-2:**  
**Key processes:**  
**How good were our partnership's policies, procedures and practice for referral handling, screening, effective initial response to secure safety of adult at risk of harm, investigation of adult protection concerns intimated to our partnership? And how effective were our actions to secure sustained safety, protection, and support for adults at risk of harm?**

- 2.10. We make timely effective use of statutory powers to protect adults at risk of harm, pursuant to the:
- Adult Support and Protection (S) Act 2007
  - Adults with Incapacity (S) Act 2000
  - Mental Health Care and Treatment (S) Act 2003.

Competent assessments of capacity were done when required.

- 2.11. We carry out multi-agency assessments of need and prepare care plans that were focused on individuals' desired personal outcomes. Apposite services and supports deployed as a result. Care plans were reviewed periodically.
- 2.12. Regular reviews were carried out for adults at risk of harm, reviews were timeously convened if there were significant changes of circumstances.

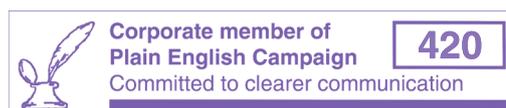
**QI-3:  
Leadership:  
How good  
were our  
leadership and  
governance?**

- 3.1. Our strategic leaders model, support, and develop good partnership working.
- 3.2. Our leaders ensure there was a clearly articulated vision and a cogent, cohesive strategy for adult support and protection within our partnership.
- 3.3. Our leaders ensure the delivery of robust, competent, and effective adult protection practices.
- 3.4. Our leaders ensure sound quality assurance and audit processes were extant within our partnership. Our partnership carries out periodical self-evaluations of ASP. And delivers improvements identified. Our leaders ensure the views of adults at risk of harm and their carers were integral to policy and planning.
- 3.5. Our adult protection committee and the Chief Officers Group (or equivalent) competently fulfil their statutory roles, supports and drives improvement, and exercises sound oversight and governance over adult support and protection within our partnership. They were instrumental in the development of harm-prevention strategies.
- 3.6. In respect of adult support and protection, our Chief Social Work Officer exercises cogent, cohesive leadership for:
  - The delivery of professional support to council officers and other staff working in the field of adult support and protection.
  - The maintenance of high standards of professional social work adult protection practice.
  - Driving improvements in professional social work adult protection practice where necessary.
  - Ensuring that systems were in place to learn from critical adult protection incidents that occur – including the convening of initial case reviews (ICR) and significant case reviews (SCR) where this was appropriate.
  - Carrying out the statutory duties of Chief Social Work Officer for adults at risk of harm, who may require appointment of a proxy, pursuant to Adults with Incapacity (Scotland) Act 2000.

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