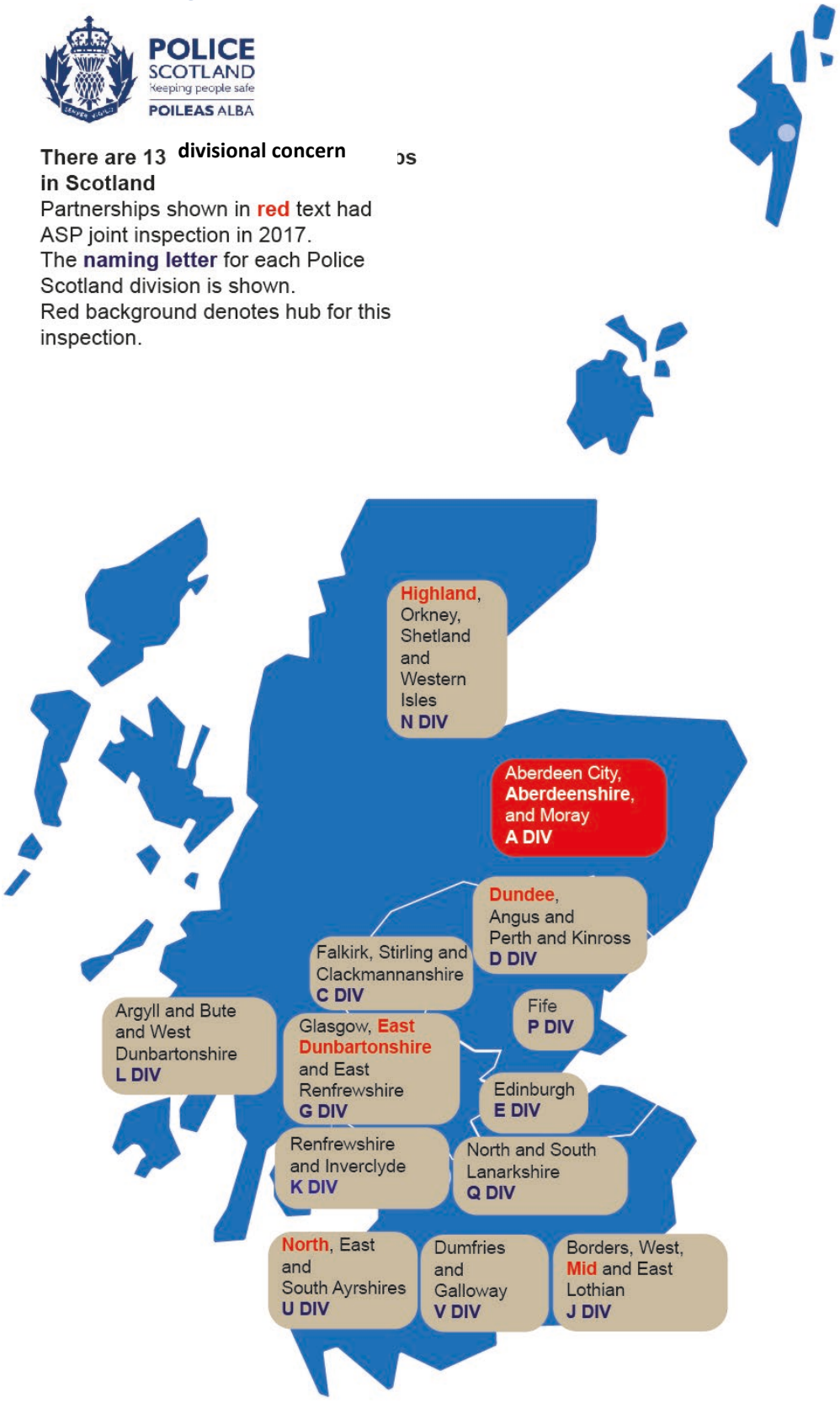
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Aberdeen City Partnership June 2022

Contents

Map showing divisional concern hubs



Joint inspection of adult support and protection in the Aberdeen City partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead these joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017-2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the Aberdeen City area were safe, protected and supported.

The joint inspection of the Aberdeen City partnership took place between January and April 2022. This partnership and all others across Scotland faced the unprecedented and ongoing challenges of recovery and remobilisation because of the Covid-19 pandemic. We appreciate the partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

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

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

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

Progress statements

To provide Scottish Ministers with timely high-level information, this joint inspection report includes a statement about the partnership's progress in relation to our two key questions.

How good were the partnership's key processes for adult support and protection?

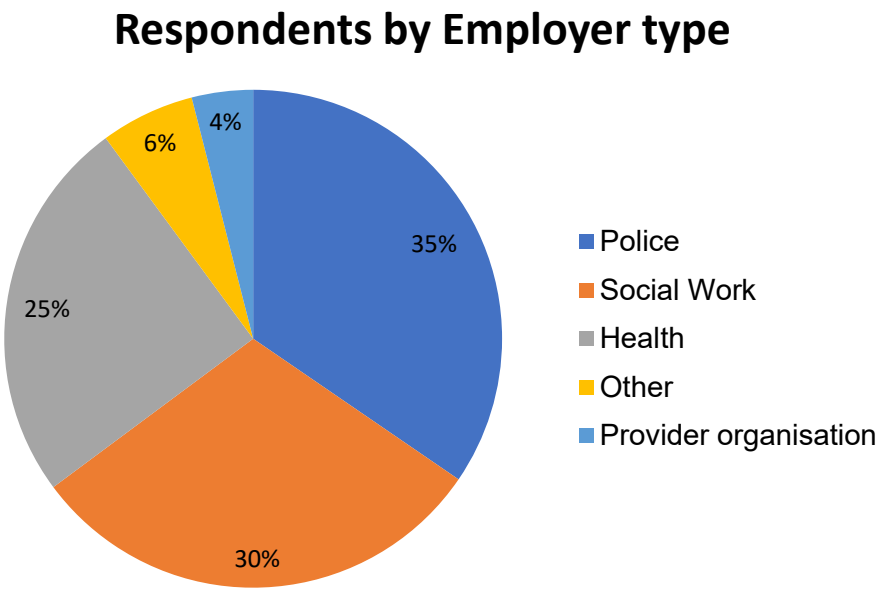
How good was the partnership's strategic leadership for adult support and protection?

Joint inspection methodology

In line with the targeted nature of our inspection programme, the methodology for this inspection included five proportionate scrutiny activities.

The analysis of supporting documentary evidence and a position statement submitted by the partnership.

Staff survey. Three hundred and twenty-seven staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

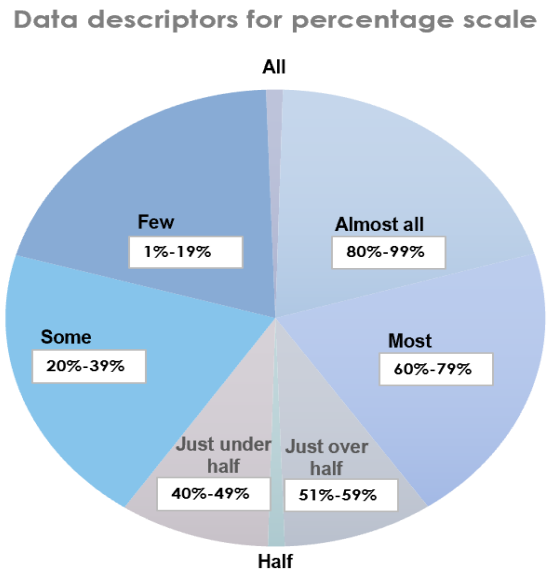


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

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

Staff focus groups. We carried out two focus groups and met with 21 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm. This also provided us with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Standard terms for percentage ranges



Summary – strengths and priority areas for improvement

Strengths

- In October 2021 the Aberdeen City Adult Support and Protection Partnership merged the adult protection unit and the duty social work team and introduced an adult protection social work team. They carried out screening, triage and inquiry work collaboratively and effectively.

- There was effective communication and information sharing between agencies at every stage of adult support and protection activity. The quality of risk assessment work was central to improvements in nearly every adult's safety and protection.

- The partnership was committed to joint training and development and a recently implemented framework was in place to ensure this was delivered and governed effectively.

- The partnership's vision was well embedded and supported by a strong culture of strategic change and improvement.

- Working relationships across the strategic leadership team had strengthened during the last few years. They worked closely together to address priority areas of work collaboratively and effectively.

- The partnership had recently implemented a refreshed engagement strategy and accompanying initiatives with adults at risk of harm and unpaid carers at the heart of protection processes. It was too early to determine the full impact of the measures and ongoing work was needed to ensure they made a positive difference.

Priority areas for improvement

- While the partnership's tools and templates were well designed, the quality of chronologies and protection planning was mixed.

- Some adult support and protection investigations and initial case conferences took too long to be initiated or conclude. This exposed a few adults to ongoing risk. There was room for improvement in these important areas of practice.

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

- More adults at risk of harm needed access to independent advocacy. This will ensure adults subject to protection processes have their views represented.

  The partnership's strategic leadership team should develop their multi-agency evaluation approach. Ways of better involving staff in the subsequent change and improvement work should be implemented.

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

Key messages

- There were improvements in nearly all adult at risk of harm's circumstances in relation to safety and protection.

- The partnership had invested and re-structured their screening, triage, and initial inquiry arrangements. The work was of a consistently high standard.

- Risk assessments were comprehensive, timely and completed to a high standard. These were a clear strength in the partnerships key processes.

- Communication and information sharing was a strong feature of adult protection activity, but health staff needed to accurately record their work more consistently.

- Tools and templates incorporating chronologies and protection planning were well designed but these were inconsistently applied in practice.

- Closer collaboration and quicker decision making between key agencies was required during adult protection investigation work. Particularly where adults had very complex needs and their capacity was unclear.

- Adult protection case conferences were carried out to a high standard. More work was needed to ensure they were timely and that both health staff and adults themselves attended and meaningfully participated.

- Risk assessments were comprehensive, timely and completed to a high standard. These were a clear strength in the partnerships key processes.

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

Inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

A new system for carrying out adult support and protection inquiries was established in October 2021. This was the central point for all adult protection referrals. Administrative staff were responsible for receiving the initial information and accurately recording referrals before passing them on to social work staff for further interventions. Processes were clear and well delivered.

Initial inquiries into concerns about adults at risk of harm

The quality of the referral screening process was mostly good or better. Commendably, inquiries were carried out in a timely manner on every occasion. The new adult support and protection team was well resourced. There was a high degree of confidence amongst wider staff in the new duty system. Staff felt encouraged to make referrals to the adult support and protection team, and nearly all were confident in the newly developed guidance and key processes. Almost all initial inquiries had clearly recorded the three-point test, been completed in a timely manner and evidenced good communication between agencies.

The partnership had jointly implemented new initial referral discussion (IRD) guidance upon the introduction their adult support and protection team. Implementation was at an early stage and there was limited evidence of this policy in practice. It was often difficult to tell the difference between the recording of informal inquiry discussions and a formal initial referral discussion process. The template would benefit from adjustment to make this clearer. The partnership had plans to implement a new recording system later in 2022 to address this. Evidence of clear management oversight also needed strengthened. In some instances, the person completing the inquiry and signing it off was the same. The introduction of the new adult support and protection team and system for carrying out inquiry work had strengthened practice in this area.

Investigation and risk management

Chronologies

Chronologies are an important element of risk assessment and risk management. While most adults at risk of harm had a chronology some (32%) did not. This represented a significant minority. Just over half of the chronologies were evaluated as good or better. The template used by council officers supported good practice but a more consistent approach to its use and quality of completion was required.

Risk assessments

Risk assessments are crucial to adult support and protection work. Commendably nearly every adult at risk of harm had one in their record. The risk assessments were typically detailed in the investigation report and laid out in a way that helped staff describe a well-balanced picture of both risks and protective factors. Most were evaluated as good or better. They were also completed in a timely and collaborative manner. Risk assessments were a clear strength in adult support and protection practice.

Full investigations

Almost all adults (98%) at risk of harm whose case should have been progressed to investigation were. Investigations were of a good standard, and they almost always effectively determined if the adult was at risk of harm. Council officers appropriately led every investigation, and second workers were deployed nearly every time. In some instances, it would have been beneficial to have a health member of staff as the second worker. The operational procedures allowed for this, but practice was that council staff undertook these roles with health supporting with clinical input where required. In a few cases (14%) the police should have been more closely involved. Collaboration needed strengthened for this critical point in adult protection work.

Most investigations were carried out in a timescale that met the needs of the individual, but a significant minority (27%) did not. Adults experiencing delays by a month, or more were typically those with complex needs who refused support and or where their capacity to make informed decisions was uncertain and needed assessed. Importantly, the partnership had identified this area for improvement through audit work. The introduction of the initial referral discussion protocol at the inquiry stage will help to address delays as would better use of multi-agency professional planning meetings for complex cases.

Adult protection case conferences

Most (67%) case conferences were convened in a timescale that met the needs of the adult at risk of harm. When they took place, they were of good quality and effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported. Some case conferences (33%) were delayed, and in many instances for lengthy periods, leaving a few adults exposed to ongoing risk. Critically, those adults who should have progressed to case conference but did not, were not afforded the opportunity to have their risks and protection needs formally considered.

Key people were invited to case conferences nearly every time with police officers attending routinely. Both GP and health board colleagues attended less frequently with room for improvement in this area of practice. Some GPs who did not attend submitted reports to the chair of the case conference. Similarly, just over half of the records evidenced that the adults at risk of harm had been invited to the case conference. The reasons for those not invited were not consistently recorded in the records. Of all those adults at risk of harm invited to attend case conferences only a very small number attended. The partnership recognised improvement was needed and had plans to address this. More positively, unpaid carers were invited and attended most of the time.

Adult protection plans / risk management plans

Most adults at risk had a risk management or protection plan. While this was very positive, the quality of these was mixed with just over half evaluated as good or better. Nearly all were up to date and evidenced the contribution of other agencies.

Adult protection review case conferences

Review case conferences were convened most of the time and in a timelier manner than initial case conferences. Importantly, not all convened when they should have. When they were held, almost all determined what needed to happen to keep the adult safe from harm.

Implementation / effectiveness of adult protection plans

Protection plans were collaborative and used well, although their quality was variable. The templates being used in both the duty to inquire, and investigation stages were thoughtfully designed and helped the social work staff to consider risk and reflect on how this should be managed from an early stage. The templates encouraged staff to address the immediate risks and consider the required support for the adult at risk of harm. The design of the templates also encouraged protection planning to naturally evolve from the inquiry to investigation stages. On a few occasions protection plans would have benefitted from being updated, particularly when there

were delays at the investigation stage. This can be a period of high risk for adults at risk of harm and up to date protection plans would support better outcomes.

Initial case conferences effectively determined what needed to be done to keep the adult safe and protection plans reflected this. However, some review case conferences did not re-visit key factors detailed in protection plans and a few were not convened at all. This meant opportunities to determine progress in protection management were missed.

Large-scale investigations

There were no cases subject to large scale investigations in the records we read. However, there were two large scale investigations (LSI) in the partnership over the last two years. Recently refreshed Grampian wide large-scale investigation guidance was in place which supported the process. The health and social care partnership had a well-defined lead role in the process with a clear governance and reporting structure through the adult protection committee. As a follow up the adult protection training lead officer also provided large scale investigation training to provider organisations. This offered clarity to key processes, including better understanding of adult protection thresholds and the three-point test.

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

Overall effectiveness of collaborative working

Nearly all (95%) duty to inquire episodes evidenced good communication between partners. There was a similarly positive picture for information sharing in adult protection cases that went to investigation or beyond. In nearly every case that progressed to investigation and beyond, all agencies were sharing information and communicating well. Social work and police records effectively captured and recorded the joint work well.

Health involvement in adult support and protection

NHS Grampian took the positive step of appointing an adult public protection lead. The post is well positioned to consider and lead improvement. The partnership undertook audit work in 2018 that showed good levels of health participation at case conferences, but we found that both GP and health board staff attendance could be improved. e welcome the partnership's plan to repeat this audit process and to introduce training that encourages, and better prepares health staff for, attendance at case conferences.

The multi-agency care home oversight group was established to support care home homes during the pandemic and was recently made a permanent part of the partnership's governance arrangements. The health and social care partnership had a care home team and the support and assurance visits undertaken enabled early identification and response to any protection issues.

Health staff effectively collaborated, shared information, and participated in adult support and protection activity. They played key supporting roles and this confidence was reflected in their responses to our staff survey. Overall, this was positive with more work to be done around health staff's understanding of the three-point test and other agency roles with respect to adult protection. Crucially, more needed done by NHS Grampian to encourage health staff to record their adult support and protection activity routinely and accurately. Despite high confidence in the recording system, records did not reflect the true extent of the valuable support health staff provided. This should be better governed.

Capacity and assessment of capacity

Where there were concerns about an adult at risk of harm's capacity independent advocacy was not consistently offered and accepted. A significant minority (28%) of adults at risk who would have benefitted from such a critical service were not offered an advocate. This is a critical service that adults at risk of harm need when they cannot make decisions for themselves. Only some of those who were offered this service accepted it. Overall, the partnership had more work to do to embed this important service in adult protection practices.

In almost all cases where there was a concern about capacity a formal request was made to a health practitioner for an assessment. These were completed in a timely manner most of the time. Some were not and for nearly all that were delayed, this exceeded one month. The partnership recognised improvement was required and had taken proactive measures to introduce a Grampian wide capacity assessment tool. This allowed staff to make routine or urgent referrals to health staff for capacity assessments. Early performance information being gathered by the partnership showed an upward trend in performance around response times by health staff which the partnership should build on. This was a commendable joint approach to addressing an important practice issue.

Police involvement in adult support and protection

Almost all contacts made to the police about adults at risk of harm were effectively assessed by staff thereafter most incident types were coded accurately on the system.

Initial attending officers' actions were evaluated as good or better in almost all cases. Evidence of effective practice and meaningful contribution to the multi-agency response was included. In almost all cases the assessment of risk of harm, vulnerability and wellbeing was accurate and informative. The wishes and feelings of the adult were properly considered and recorded in almost all instances.

Officers referred adult support and protection concerns promptly and efficiently on almost all occasions, using the interim vulnerable persons database (iVPD). In most instances frontline supervisory input was evident. This contribution was good or better in just under half all cases reviewed. There were occasions where greater evidence of supervisory input to assessment and management of risk was required, particularly in more complex incidents.

Divisional Concern Hub staff actions and recording were good or better in most cases with a resilience matrix in each record. Almost all included a well-developed narrative in support of police concerns. There was evidence of considered assessment and input by staff, and on every occasion the referral was shared swiftly with partners.

Where the escalation protocol was initiated following repeat police involvement, it was used to good effect. On occasions, adult support and protection trigger plans (pre-agreed interventions) formed part of the response to escalating circumstances. These were innovative, clearly referenced and developed in collaboration with partners.

In a few of the cases communication between social work and police could have been better in the early stages of the adult protection intervention. Initial referral discussions (IRD's) have recently been introduced within the partnership and they should help enhance local practice and information sharing across the professionals group. Police almost always attended Case Conference, when invited. The contribution of officers was viewed as being good or better on almost all occasions.

Third sector and independent sector provider involvement

The third sector worked collaboratively with partner agencies to ensure additional health and social care needs were met for adults at risk of harm. Almost all of those working in the third sector agreed they were making a positive difference to people's lives. Provider organisations were central to both the partnership's refreshed learning strategy and framework and plan for practice improvement.
Following learning arising from a large-scale investigation, and as part of care home assurance work, the partnership engaged with provider organisations to develop awareness of adult support and protection duties and to improve collaborative working.

The third sector was well represented and embedded in the work of the adult protection committee. They were actively involved in driving the partnership's engagement work forward, overseen by the adult protection committee's stakeholder engagement subgroup.

Key adult support and protection practices

Information sharing

Staff were encouraged and supported to work collaboratively and in almost all instances adult protection partners were effectively sharing information. Inquiry, investigation, and adult protection case conference activity all supported a timely and positive joint approach to information sharing and protecting adults at risk of harm.

Management oversight and governance

Evidence of management oversight in social work duty activity should be more clearly recorded. This was being strengthened under the new system for handing inquiries. In social work records for adults at risk of harm who progressed to investigation or beyond management oversight was clearer. There was good evidence of discussions and decisions taken in partnership with seniors in nearly every record. This strengthened governance. This was also evident in the police records but much less so in health records with just under half indicating management oversight. This was not necessarily a deficit due to the types of health records scrutinised.

Involvement and support for adults at risk of harm

Almost all adults were well supported at the duty to inquire, investigation and protection planning stages. There was more work to be done to involve adults in case conferences. Only some (39%) adults were invited. Records indicated that adults lacking capacity was a factor in decisions not to involve adults. However, the reasons for not inviting adults were not consistently outlined in case records or the minutes of meetings. The small number of adults at risk of harm who did attend were well supported and contributed meaningfully.

The partnership identified these challenges and had taken several important steps to strengthen the voice of adults and unpaid carers. These included a user forum that met prior to adult protection committees. There was also a dedicated stakeholder engagement adult protection sub-committee and lived experience feedback initiatives. These were all initiatives that should increase participation in case conferences.

Independent advocacy

Some (28%) adults at risk of harm should have been offered independent advocacy but were not despite refreshed guidance in place. Similarly, only some of those who were offered this critical service accepted it. The partnership commissioned an independent advocacy service that provided support and they jointly worked on a few initiatives to effectively engage and support adults at risk of harm. While progress was needed to ensure adults got more timely access to independent advocacy, the partnership was clearly committed and had steps in place to address this.

Financial harm and alleged perpetrators of all types of harm

There was evidence of financial harm in some of the records we read. On most occasions the partnership took measures to stop the harm. Where action was taken it was multi-agency and almost always stopped the harm from re-occurring. While this was positive, the quality of this collaborative work could be further strengthened with only some of this work evaluated good or better. The perpetrator of harm was known in nearly every case, but actions were not consistently applied. Where work with them occurred, the quality was of a good standard. Overall, better adherence to the partnership's operational procedures was needed to achieve consistency in this area of practice.

Safety outcomes for adults at risk of harm

There were improvements in almost all the adult at risk of harm's circumstances in relation to safety and protection. Some adults on the margins of capacity who were difficult to engage experienced poor outcomes. The partnership should continue to embed initial referral discussions and professional meetings as means to help plan, and mitigate the risks for this group of adults.

Adult support and protection training

The adult protection committee had an overarching learning strategy and framework which incorporated its plan for practice improvement. This plan set out priority learning and development requirements across the partnership's general, specific and specialist adult protection roles. The framework and plan were progressed by the new adult protection committee learning & development sub-committee, with sound governance arrangements in place to assess progress. The committee had provided funding for a dedicated lead trainer and appointed someone to this role. This role oversaw the planning and implementation of the adult protection training needs of the partnership with other professionals, agencies, and sector support. These measures should help to increase more joint training initiatives and complement the existing single agency training resources for public protection already in place. Where joint training was delivered almost all staff agreed it helped them to understand protection risks better. Council officer training was well received and underpinned understanding of the legislation and critical role.

A Grampian wide multi-agency training needs analysis was undertaken in late 2021. Aberdeen City specific requirements were identified and aligned to the plan for practice improvement. A public protection website was developed with plans to include an adult support and protection training calendar aimed at growing existing interest. NHS Grampian put in place a dedicated pathway for council officers to seek clinical advice on skincare and pressure ulcer concerns where there was a risk of neglect. Tissue viability staff provided training and awareness in this area for staff from across the partnership. There were also plans in place for practitioner groups to be developed around areas of interest/specialisms such as self-neglect and hoarding and service user engagement

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

Key messages

- The partnership's vision was well embedded in strategic and operational adult support and protection documents and policies. It was well understood by staff.
- Revised engagement policies and reform of adult support and protection committee structures put adults and unpaid carers at the centre of the partnership's vision.
- The partnership had a well-structured governance framework in place for adult support and protection. It was appropriately aligned to other public protection, health and social care and community planning groups. Some areas of practice required closer oversight of required change and improvement.
- The partnership demonstrated a strong culture of audit, self-evaluation and learning and this had driven positive adult support and protection changes. A rolling multi-agency self-evaluation framework to review the quality of joint adult protection work needed implemented.
- Strategic leaders took effective measures to support staff over the last few years. These helped to ensure staff remained optimistic and well-motivated to undertake adult support and protection activity going forward.
- During the pandemic the strategic leadership team commendably invested and progressed their vision for adult support and protection. This was through a programme of well delivered operational and structural change and improvement.

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

Vision and strategy

The Aberdeen City adult support and protection partnership had a clear, and recently refreshed, vision. This was dedicated to an inclusive approach to preventing and responding to harm and protecting adults at risk. This was well understood across agencies and embedded in the work of the community planning partnership, health and social care partnership and the adult protection committee. The vision was also threaded through the committee's new strategy and terms of reference. There was a clear focus on family support, early intervention, and prevention. These areas of focus were reflected in the partnership's inter-agency guidance and 'Aberdeen protects' website. Most staff agreed strategic leaders provided a strong vision.

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

The Chief Officer Group in Aberdeen shared a close and effective working relationship which was consolidated through the pandemic. This was reflected in the clear governance arrangements in place that connected the work of the adult protection committee and its sub-groups to the health and social care partnership, child protection committee and wider public protection arrangements. Over the last few years strategic leaders demonstrated an ongoing commitment to improving adult support and protection practice. This was a clear and obvious priority recognised by most staff who agreed there was effective leadership driving change and improvement.

The partnership ensured the frequency of key meetings was stepped up during the pandemic. Attendance remained positive and the necessary oversight and decision-making structures provided a flexible and responsive governance framework. Public protection was a recognised priority. The partnership took positive steps to re-align its adult protection committee sub-committees with those of the child protection committee. This allowed a more cohesive approach to how it delivers its 'whole family' agenda. The partnership also established and increased resources to a dedicated adult support and protection team which enabled them to recognise and respond to protection matters more effectively. Early performance indicators relating to this investment were positive. NHS Grampian was committed to support adult support and protection activity and had appointed an adult public protection lead. Police Scotland's Northeast division was progressively included in adult and public protection processes. There was a strong shared responsibility across the partnership with each agency sharing lead roles for areas of work and the joint child and adult protection committee chairing arrangements.

The chief officers' group for public protection recognised the need for change and improvement prior to the pandemic. Work already started was aligned to the requests to implement change from the Scottish Government during the Covid-19 pandemic, meaning national requests for data and performance information translated well for the partnership.

Effectiveness of leadership's engagement with adults at risk of harm and their unpaid carers

Most staff agreed that adults at risk of harm were involved in decisions that affected their lives. This positive view was aided by the partnership's inclusive and person-centred approach. There was a helpful engagement strategy and guidance for staff to follow. A higher-level communication and engagement strategy further supported this positive messaging. The adult protection committee embedded the underpinning principles of these policies into their refreshed terms of reference. Evidence that this was delivered was highlighted in commissioned work. This oversaw the formation of a user forum which met in advance of adult protection committee meetings and provided views on a range of topics and user feedback. They also oversaw the implementation of the 'making safeguarding personal' initiative which invited adults subject to harm to share their experiences. A dedicated service user and carer involvement officer supported this work.

The partnership sought to improve further in this area. Both the adult protection committee and chief officers' group were well placed to keep progress under review through their risk register and improvement plan activity. This provided a strong platform to demonstrate how the voices of adults at risk of harm were shaping strategic improvement.

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

Strategic leadership was integrated and had been galvanised over the last few years. Oversight arrangements were increased and strengthened including the role of provider organisations. Both local and pan-Grampian governance arrangements were maintained and consolidated. Performance reporting and subsequent improvement work was progressed, and strategic leadership of change and improvement was evident. Care home oversight arrangements and the approach to 'hidden harm' were robust. There was evidence of this throughout the delivery of adult protection work from the revision of the duty system arrangements through to investigation activity and case conferences.

Changes to policy, guidance, tools, and templates were significant, but at an early stage of implementation. That said, there was signs of early impact and progress. Most staff however, had confidence in the delivery of revised key processes and in the strategic leadership team's ability to steer them through what had been a difficult time. An ongoing commitment to training during the pandemic was initially led by the adult protection committee and Grampian working group. The learning and development sub-committee had advanced this work further and it was underpinned by coherent overarching strategies. This will have helped to embed the changes needed to the delivery of key processes.

Crucially, there was evidence of initiatives from each agency that had been introduced by the partnership to support staff in their daily work. This included ensuring the availability of personal protective equipment, providing various on-line briefings, dedicated council officer update sessions and measures to promote staff resilience. The partnership also ensured adults at risk of harm remained their priority at the outset of the pandemic. A host of measures were put in place to ensure the wellbeing and continued participation of adults at risk of harm. These included reviewing the protection plans of everyone subject to one and the introduction of a risk rating system to determine who needed the most support during the restricted period.

New digital arrangements and ways of working were deployed, and others were in development. There was innovation around the design and development of new client information systems for social workers and a public facing website. Digital devices for use at case conferences had also been jointly resourced and implemented by independent advocacy services and the third sector. These measures helped to keep staff and adults at risk of harm engaged. Sustainability and capability were issues already being considered by the partnership's strategic leadership team. This was an important factor in the development of their vision for a hybrid approach that balanced face to face activity and digital alternatives.

Quality assurance, self-evaluation, and improvement activity

The partnership's over-arching adult support and protection strategy was recently informed by a process of self-evaluation and development events facilitated by an external improvement agency. This process clearly set out the strategic priorities and areas of focus in the adult protection committee improvement plan. The development of the strategy led to the adult protection committee structures and implementation of four new sub-committees.

Social work had its own overarching quality assurance framework embedded into their operational procedures. These were established processes that involved the sampling and reading of adult support and protection casework where adults at risk progressed to the investigation stage of adult support and protection and beyond. The aim was to

undertake at least 200 case audits a year. Both health and police undertook aspects of self-evaluation work, but these were limited in scope. The partnership acknowledged there was more work to do to design and implement a rolling programme of multi-agency self-evaluation activity. Our staff survey also showed that staff did not feel as involved in self-evaluation and improvement work as they should be. The adult protection committee performance & quality assurance sub-committee were well positioned to respond and drive forward the necessary improvement work needed.

The partnership made good use of audit and evaluation of outcomes. Positive examples of collaborative measures to address areas for improvement included the re-design of adult support and protection duty system including the single point of contact with health, a more consistent approach to initial referral discussions, changes to requests for capacity assessment processes, and the refreshed involvement focus.

The adult protection committee had a risk register in place. The independent convener oversaw the actions arising and updated the committee and chief officer's group at each meeting. The social work client information system was being replaced across children and adult services. This was co-designed with stakeholders and the risk register had appropriately recognised the potential to significantly improve the quality of data harvesting and performance reporting.

Initial case reviews and significant case reviews

There were seven cases that progressed to initial case review since the beginning of 2020. None have yet progressed to significant case review, but two have led to the initiation of alternative multi-agency review meetings. The development of the self-neglect and hoarding guidance was a good example of multi-agency collaboration following these meetings. The partnership's initial and significant case review processes have been undertaken in accordance with the national guidance and in consultation with appropriate stakeholders. We noted the adult protection committee improvement plan showed a continued focus on improving how learning from initial and significant case reviews are taken forward and we support this view. The Scottish Fire and Rescue Service were partners in the initial case review pathway and protocols.

A Grampian-wide multi-agency external significant case review group chaired and facilitated by NHS Grampian was established to enable appropriate reflection, discussion and learning from national significant case reviews with actions and findings reported to the adult protection committee and chief officers' group. Findings augmented those from the partnership's own processes providing a comprehensive learning review approach. This work was at an early stage and strategic leaders recognised this. They acknowledged more work was needed to link the learning from this group to improved outcomes for adults at risk of harm.

Summary

The partnership had a strong and well understood vision for adult support and protection which was threaded throughout the appropriate key strategies, policies, and procedures. Resources and capacity to undertake key activity had been positively invested. The adult protection committee showed effective strategic leadership and had driven significant structural and procedural change forward during the pandemic. It was well led and aligned closely to child protection and a 'whole family' approach with good links to other public protection groups. Audit, aspects of self-evaluation and improvement work were collaborative and well embedded. Lead officers from across agencies were working well together and there was evidence of innovation embedded throughout the re-design of their key process, including capacity assessments, initial referral discussions and screening and triage and links to early intervention and prevention pathways. The changes to key processes were significant and new, making it difficult for us to measure impact, but there were some early indicators of progress in their key performance indicators. Some areas for improvement to key processes required to be addressed with ongoing work to be done. Tools and templates were well designed and implemented and overall, this supported collaboration and involvement with good outcomes for almost all adults at risk of harm.

Strategic leaders had successfully led on the necessary changes required as set out in the 2018 'Services for Older People in Aberdeen City' progress review. Staff were very positive about the strategic leadership team's ability to continue delivering this and our findings fully support this view.

Next steps

We asked the Aberdeen City partnership to prepare an improvement plan to address the priority areas for. The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and HMICS will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key process 1

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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 88% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 88% of episodes where the three-point test was applied correctly by the HSCP
- 95% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% less than one week, 50% one to two weeks.
- 68% of episodes evidenced management oversight of decision making
- 71% of episodes were rated good or better.

Staff survey results on initial inquiries

- 90% concur they are aware of the three-point test and how it applies to adults at risk of harm, 6% did not concur, 3% didn't know
- 78% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 5% did not concur, 17% didn't know
- 83% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 7% did not concur, 10% didn't know

Information sharing among partners for initial inquiries

- 95% of episodes evidenced communication among partners

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

Chronologies

- 68% of adults at risk of harm had a chronology
- 53% of chronologies were rated good or better, 47% adequate or worse

Risk assessment and adult protection plans

- 88% of adults at risk of harm had a risk assessment
- 62% of risk assessments were rated good or better
- 87% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 54% of protection plans were rated good or better, 45% were rated adequate or worse

Full investigations

- 94% of investigations effectively determined if an adult was at risk of harm
- 73% of investigations were carried out timeously
- 73% of investigations were rated good or better

Adult protection case conferences

- 78% were convened when required
- 67% were convened timeously
- 29% were attended by the adult at risk of harm (when invited)
- Police attended 90%, health 47% (when invited)
- 72% of case conferences were rated good or better for quality
- 94% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 79% of review case conferences were convened when required
- 82% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 97% of adult protection concerns were sent to the HSCP in a timely manner
- 80% of inquiry officers' actions were rated good or better
- 77% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 72% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 44% good or better rating for the quality of ASP recording in health records
- 48% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 50 adults at risk of harm and staff survey results (purple)

Information sharing

- 94% of cases evidenced partners sharing information
- 98% of those cases local authority staff shared information appropriately and effectively
- 96% of those cases police shared information appropriately and effectively
- 98% of those cases health staff shared information effectively

Management oversight and governance

- 72% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 86%, police 84%, health 41%

Involvement and support for adults at risk of harm

- 85% of adults at risk of harm had support throughout their adult protection journey
- 62% were rated good or better for overall quality of support to adult at risk of harm
- 78% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 6% did not concur, 16% didn't know

Independent advocacy

- 36% of adults at risk of harm were offered independent advocacy
- 25% of those offered, accepted and received advocacy
- 50% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 87% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 69% of these adults had their capacity assessed by health
- 72% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 22% of adults at risk of harm were subject to financial harm
- 36% of partners' actions to stop financial harm were rated good or better
- 72% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 88% of adults at risk of harm had some improvement for safety and protection
- 94% of adults at risk of harm who needed additional support received it
- 77% concur adults subject to ASP, experience safer quality of life from the support they receive, 7% did not concur, 16% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 68% concur local leaders provide staff with clear vision for their adult support and protection work. 9% did not concur, 23% didn't know

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

- 70% concur local leadership of ASP across partnership is effective, 7% did not concur, 23% didn't know
- 67% concur I feel confident there is effective leadership from adult protection committee, 6% did not concur, 26% didn't know
- 51% concur local leaders work effectively to raise public awareness of ASP, 15% did not concur, 35% didn't know

Quality assurance, self-evaluation, and improvement activity

- 58% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 9% did not concur, 32% didn't know
- 63% concur ASP changes and developments are integrated and well managed across partnership, 8% did not concur, 30% didn't know