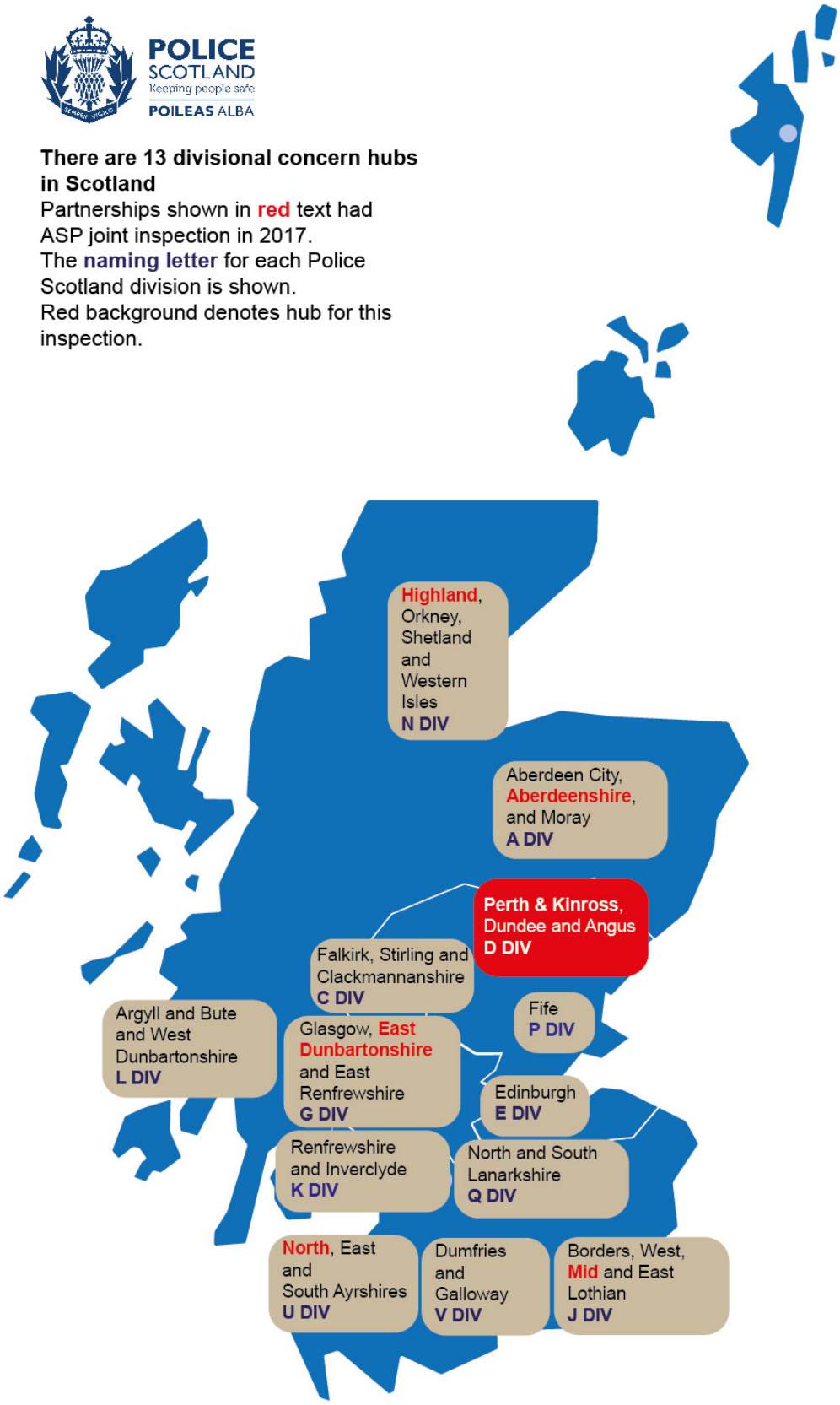
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Perth & Kinross Partnership August 2022

Contents

Map showing divisional concern hubs



Joint inspection of adult support and protection in the Perth & Kinross 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 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 Perth & Kinross partnership area were safe, protected and supported.

The joint inspection of the Perth & Kinross partnership took place between April and August 2022. The Perth & Kinross partnership and all others across Scotland faced the unprecedented and ongoing challenges of recovery and remobilisation as a result of the Covid-19 pandemic. We appreciate the Perth & Kinross 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's 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.

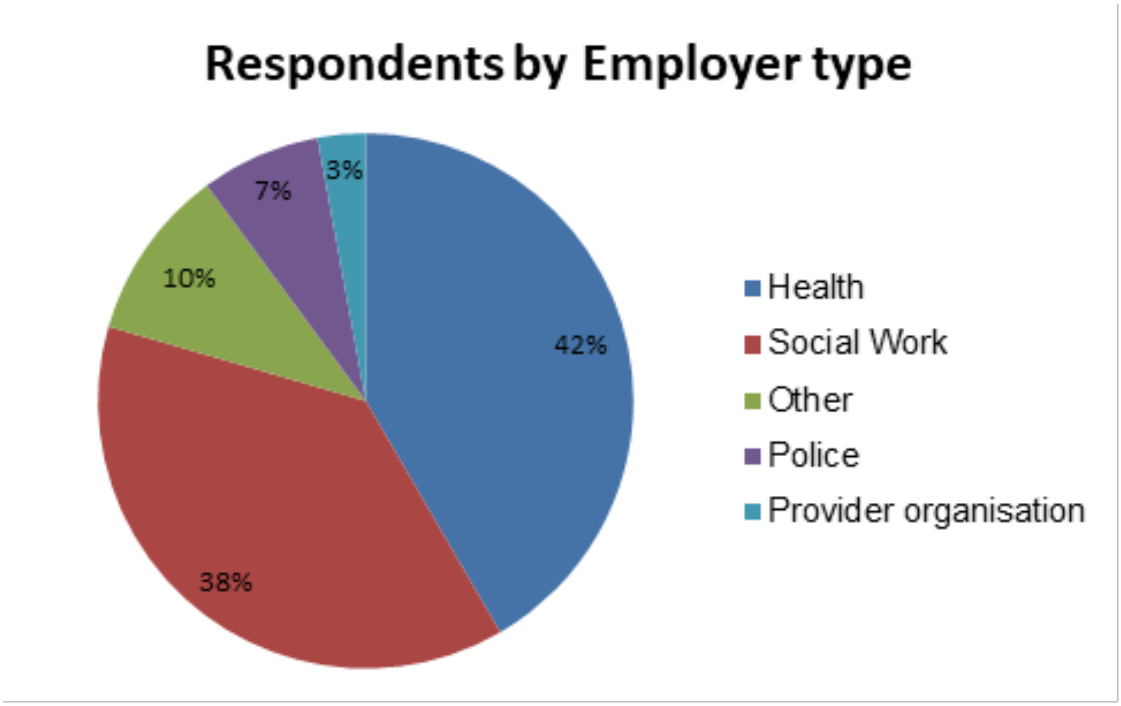
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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

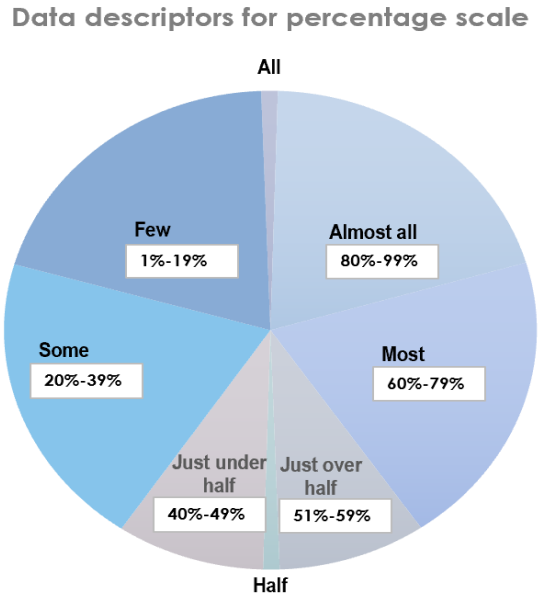


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

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 24 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

- The partnership had strong self-evaluation and quality assurance processes, which determined the performance and impact of adult support and protection arrangements across Perth & Kinross.
- The partnership provided opportunities for collaborative involvement of partner agencies and information sharing through specialist screening and triage arrangements and interagency referral discussions.
- The Council recently procured an electronic case management system to enhance current methods of recording social care information including adult support and protection.
- The partnership had developed initial referral discussion processes, which improved the quality of inquiries and outcomes for adults at risk of harm.
- Strategic leadership, and oversight of adult support and protection arrangements, were very effective. Social work teams, a dedicated adult support and protection lead detective officer, and an NHS team strengthened public protection.
- The partnership provided a number of support groups for adults living in the partnership area, to promote community engagement and reduce risks associated with harm. This further endorsed the partnership's vision and improvement plan.
- The partnership established a Care Home Oversight Group to support outcomes for large scale investigations, and to provide additional guidance and support to staff in care homes at the height of the pandemic. The support remained in place to help meet the needs of adults living in care homes.

Priority areas for improvement

- Medical examinations were not always carried out when they should have been. For a few cases, this impacted negatively on the adult at risk of harm. A more consistent approach was needed to ensure medical examinations were requested and undertaken in a timely manner.
- Some aspects of adult protection practice within the Divisional Concern Hub were inconsistent. The partnership should maximise opportunities to escalate, share and record information more robustly.
- Adults at risk of harm and unpaid carers should be invited and, where necessary, supported to attend case conference. Information regarding attendance and engagement should be clearly recorded to demonstrate the partnership's interventions.

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

Key messages

- Adult support and protection referrals were triaged effectively by a specialist team made up of health and social work staff, who were able to provide targeted, timely support.
- Almost all of the adults at risk of harm who required a chronology, risk assessment and protection plan had one. The timing and quality of almost all recorded information was good.
- Key stages of the investigation, and case conferences, were carried out when they should have been and in a timely manner.
- The partnership had effective systems in place for referring and assessing capacity for adults at risk of harm. This strengthened the role partner agencies played in protection planning and decision making.
- For a few cases, the partnership failed to recognise the expertise available from police, health and independent advocacy in minimising risks for the adult at risk of harm.
- Interventions to stop financial harm were not always successful. The partnership should continue to develop practice to minimise risks associated with financial harm.

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

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns

The Health and Social Care Partnership (HSCP) established an Adult Social Work and Social Care Intake Team (the Access Team) covering the whole of Perth & Kinross. The team was responsible for screening and triaging adult support and protection concerns and referrals. Telephone inquiries were introduced to screening and triaging processes in 2019. This meant in some circumstances if it was unclear if the adult met the three-point test, a telephone inquiry was used to determine the right course of action. The partnership advised that an audit of appropriateness and efficacy of this approach was planned.

Referrals pertaining to adults at risk of harm already receiving social work services were passed to the allocated team. This maintained continuity of care and support. The processes for making adult support and protection referrals were clear and understood by most survey respondents. Referrals were progressed timeously which enabled early intervention.

Initial inquiries into concerns about adults at risk of harm

All initial inquiries were carried out timeously and in line with principles of the Adult Support and Protection (Scotland) Act 2007. Application of the three-point test was clearly recorded most of the time. Where this was recorded, the three-point test was correctly applied in almost all cases. In a few cases, the application of the three-point test was not clear. While most staff survey respondents said they knew how to apply the three-point test, a few did not or did not understand the three-point test criteria. Most of these were health staff indicating more work was needed in this area of practice.

Commendably, the partnership worked collaboratively with other adult support and protection partnerships to identify ways it could improve adult support and protection practice in the Perth & Kinross adult support and protection partnership. Audits of adult support and protection processes helped to establish potential gaps in practice. As a result, interagency referral discussions were introduced in March 2021. A few initial referral discussions were carried out at initial inquiry, and most were carried out at the investigation stage. This was to promote enhanced, collaborative approaches to information sharing, recording and decision-making processes.

Investigation and risk management

Chronologies

The partnership made considerable effort to improve management of risk through chronologies. Almost all adults at risk of harm who required a chronology of significant events had one. In half of the records, the quality of information recorded in chronologies was rated good or better. Some were weak or unsatisfactory and did not contain sufficient information to further support the management of risk. The partnership continued to support staff to competently complete chronologies through training and the use of chronology templates. For a few adults a chronology template was not used to record information. In these cases, information regarding significant events was recorded in risk assessments and protection plans.

Risk assessments

Risk assessments are a critical aspect of adult support and protection. Almost all adults at risk of harm had a risk assessment. The timing of risk assessments was almost always in keeping with the needs of the adult at risk of harm. For most, there was evidence that multi-agency partners' views helped to inform the assessment. Just under half of risk assessments were rated good or better.

The risk assessment template provided opportunities to record specific information about risks and actions to minimise risks. For some adults at risk of harm, sections of the risk assessment did not need to be completed. In contrast, sections that should have been completed for some adults at risk were not. At times, it was not clear how all the risks were being managed. The partnership should continue to develop its recording process for the management of risk. This will be aided by the introduction of the new social care recording database.

Full investigations

The quality of most investigations was good or better. Almost all cases that should have proceeded to investigation did so. Only a few investigations were not carried out timeously.

Just over half of files in the sample contained information about police involvement. Most of these showed an interagency referral discussion had taken place. The partnership was clear that interagency referral discussions were an effective process for establishing a multi-agency approach to decision-making and information sharing. Creditably, almost all interagency referral discussions demonstrated communication among partners at the initial inquiry stage and investigation.

Other aspects of investigations would benefit from a more collaborative approach. The expertise of health and police staff was not consistently

sought when it should have been. This meant there were missed opportunities for adult protection investigation work. Just under half of the investigations required a second worker. In almost all such instances, a second worker was deployed. Significantly, health professionals were not always deployed as a second worker when they should have been. Health professionals were deployed as second workers as part of large-scale investigations. Medical examinations should have been carried out for some adults at risk of harm. While examinations took place for most, a significant number did not. A few adults at risk of harm experienced delays in assessment and intervention.

The partnership used the same form to record information about initial inquiries and full investigations. In some instances, there were a number of incomplete sections which should have contained information about the inquiry and or investigation. The partnership recognised the current method of recording information about risk could be improved. The Council had procured a new electronic case management system. This along with close involvement of relevant staff will support better recording.

Adult protection case conferences

Almost all case conferences effectively determined what needed to be done to ensure the adult at risk of harm was safe and protected.

Case conferences were almost always convened and carried out timeously when required. The involvement of partner agencies at case conference was commendable. There was health representation at all case conferences they were invited to, and police attended almost all case conferences when invited. This strengthened decision-making processes and assessment of risk for adults at risk of harm, and unpaid carers.

Most of the time, the adult at risk of harm was not invited to attend their case conference. The rationale for not inviting the adult was recorded in just under half of the files. When the adult at risk of harm was invited to attend case conference, few did. Reasons for not attending were documented in some records. Unpaid carers were invited to just under half of the case conferences where appropriate, and, when invited, almost all attended.

Adult protection plans / risk management plans

Protection planning for adults at risk of harm was particularly strong. A specific template used for this purpose also provided a useful structure for risk management. Protection plans were easily identifiable and almost all adults at risk of harm who required a protection plan had one. Almost all plans were up to date and the quality was impressive, with most rated as good or better. Adult carers' support plans were offered during assessment and review processes to support protection planning for unpaid carers.

Adult protection review case conferences

Review case conferences were convened when they should have been most of the time. Significantly, some were not which could have had a negative impact on protection planning for the adult at risk of harm. Review case conferences were timely. All review case conferences effectively determined the required actions to keep adults safe.

Implementation / effectiveness of adult protection plans

When protection plans were in place, the partnership implemented and effectively reviewed these in almost all cases. This meant adults at risk of harm experienced improved outcomes and reduced risk associated with harm. In almost all cases, protection plans clearly identified the contribution of relevant partner agencies, which further supported positive outcomes for adults at risk of harm.

Large-scale investigations

The partnership implemented proactive and collaborative approaches to large-scale investigations (LSIs). Since 2021, 10 LSIs had been conducted. Most of these related to care homes and care at home services. A few files in our sample indicated the adult at risk of harm was included in an LSI. Safeguarding measures were in place to identify and manage risks for these adults.

Outcomes from the audits of LSIs carried out by the partnership and other stakeholders provided enhanced opportunities to improve care and support and reduce risks for adults at risk of harm.

The partnership developed LSI guidance for practitioners and delivered learning and development sessions to improve knowledge and skills in this area. The partnership responded well to concerns in care homes through their care home oversight group. The oversight group worked in partnership with care home staff and providers, to offer support, guidance and leadership to care homes and care at home services.

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

Overall effectiveness of collaborative working

Partnership agencies worked collaboratively to reduce risks and improve outcomes for adults at risk of harm. Interagency referral discussion processes increased multi-agency involvement, assessment of risk and protection planning. Almost all staff felt they were supported to work collaboratively, to achieve positive outcomes for adults at risk of harm. Staff said the interagency referral discussions promoted positive multiagency relationships, and sharing of tasks and responsibilities, to help keep the adult at risk of harm safe.

The partnership's adult support and protection multi-agency guidelines (2018) required updating, to ensure procedural guidance was current.

Health involvement in adult support and protection

NHS Tayside recently reviewed the governance and assurance arrangements across child and adult protection, to support a combined approach to public protection. The dedicated adult support and protection health team oversaw operational practice and reported directly to the adult protection executive group. This strengthened the governance of the health contribution to adult support and protection.

Commendably, health professionals contributed to improved safety and protection outcomes for almost all adults at risk of harm. Where an adult protection concern was initiated by health, feedback regarding the outcome of the referral was provided by social work in most cases. Had health workers been more consistently deployed as second workers where necessary, this would have strengthened the partnership's approach to adult support and protection investigations.

Where there was evidence of repeat referrals for community health services related to the adult at risk of harm, intervention from health was effective in almost all cases. In some cases, interventions from hospital services did not minimise readmission to hospital. NHS Tayside should explore the cause for referral and health interventions for adults at risk. This may reduce the risks associated with recurrent admissions to acute care services.

Significantly, some adults at risk of harm who should have had a medical examination as part of an adult support and protection investigation, did not get one. The reasons for this were not always recorded. In the few instances where information was recorded, a medical examination had either not been requested, or it was carried out too late into the adult support and protection process.

Almost all health staff were confident about their role in relation to adult support and protection and knew where to get advice if they were unclear about an adult at risk of harm concern. Some health staff said they did not have access to systems that allowed for the accurate recording of adult at risk concerns. The partnership should continue to develop adult support and protection training for health staff.

Capacity and assessment of capacity

Where a formal request for assessment of capacity was made by social work to health, a timely assessment was always carried out by a suitably qualified health professional. However, in a few instances, a referral for capacity assessment was not requested when it should have been. In response NHS Tayside developed a decision-specific screening tool. Implementation was in the early stages, but this comprehensive tool should assist staff in considering when a formal assessment of capacity should be sought.

Police involvement in adult support and protection

Contacts made to the police about adults at risk were almost always effectively assessed by area control rooms for threat of harm, risk, investigative opportunity and vulnerability (THRIVE). Most cases had an accurate STORM Disposal Code (record of incident type).

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

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

In most instances, frontline supervisory input was evident. This contribution was good or better in most cases. A few cases identified criminality where no crime report was recorded or investigation initiated.

Divisional Concern Hub staff's actions were good or better in just over half of cases, with officers and staff working collaboratively with partners. This included evidence of meaningful input and appropriate professional challenge. Police Scotland's contribution to the interagency referral discussions was almost always evaluated as good or better. A few instances were described as adequate. Divisional Concern Hub staff raised iVPDs following attendance at interagency referral discussions and other professional discussions, even when the police were not the initial referral agency. This practice allowed for good information management on partner

engagement and informed future assessments in respect of the vulnerable adult.

Police Scotland guidance states that the divisional concern hub should "facilitate information sharing within legal parameters". Resilience matrix (assessments of resilience, threats, vulnerability and protective factors) were not routinely shared with partners. This policy did not support a holistic approach to enable partners in the identification of early and effective interventions and preventions. Resilience matrix research and assessments lacked rigour, with minimal research and assessment recorded. Divisional Concern Hub staff shared most referrals with partners timeously. In some cases, there was scope to improve the time interval between receipt and sharing. The partnership recognised the resilience matrix needed to be shared to improve information sharing and assessment of risk. Subsequently, the sharing of the Resilience Matrix by the Divisional Concern Hub was fully embedded in practice, in line with Police Scotland guidance. The partnership should monitor changes in practice for effectiveness.

When Divisional Concern Hub staff initiated the escalation protocol (following repeat police involvement), the early interventions considered were not consistently recorded. Evidence of diligent and determined research and assessment, and clear decision making was more likely where matters had further escalated, both in the volume of calls, and the needs of the adult at risk. There were opportunities to further develop existing practice. These may include the timely support of local area command and accurate recording of single agency actions and interventions.

Third sector and independent sector provider involvement

The third and independent sector played a key role in supporting adults at risk of harm. Representatives from the third sector were part of the Adult Protection Committee (APC) and involved in key decisions about service delivery and improvement.

Some adult support and protection referrals were raised by the third and independent sector. Most referrals from these sectors were raised timeously, which enabled swift screening and triaging of initial inquiries. On a few occasions, referrals from these providers were not instigated early enough and resulted in delays and early intervention responses.

Adult protection referrals about care in the third and independent sector and care homes were mostly investigated by the local authority. Where appropriate, the local authority invited third and independent sector services and care homes to carry out an exploration of the circumstances leading to the concern. This was identified in a few cases, and most of these were carried out well. Significantly, a few were not. These investigations were closed without the support and expertise of police or health services. All

investigations should be overseen by the appropriate partner agency to ensure outcomes for adults at risk of harm are optimum and risks are reduced as far as practicable. The partnership continued to share learning and develop good practice to reduce risks for all adults, including those receiving care from third and independent sector providers and care homes.

Key adult support and protection practices

Information sharing

The partnership had good processes for sharing information. Social work and health staff shared information appropriately and effectively almost all of the time. Interagency referral discussions were common to cases where police were involved. This approach supported open and timely communication between professionals, and officer involvement was good or better in most instances.

Almost all staff surveyed were confident sharing information and escalating concerns about an adult at risk of harm. Most respondents said they had access to recording systems, although some staff said these were cumbersome and did not always promote information sharing.

Management oversight and governance

Almost all social work and most police records demonstrated good levels of governance. Exercise of governance was evident in just under half of health records. This is not necessarily a deficit due to the types of health records reviewed. Just over half of files in the sample demonstrated that a line manager had periodically read the file.

Involvement and support for adults at risk of harm

The partnership made considerable effort to involve adults at risk of harm from the inquiry to investigation stage, including in protection planning and beyond. However, this was not consistently recorded. The support provided to adults at risk of harm was rated good or better for almost all adults. Staff believed adults were supported to participate meaningfully in decisions that affect their lives. Where there was an unpaid carer, they were almost always involved in the adult support and protection process.

Independent advocacy

Overall, the involvement of independent advocacy was mixed. Some files lacked information about independent advocacy involvement when we would have expected to see this. When advocacy workers were involved in key stages of the adult protection process, such as case conference, their contribution benefitted the adult at risk of harm. In a few cases, the adult at risk of harm was not offered advocacy when they should have been. Even when advocacy was offered, it was not accepted by most adults. The partnership needed to ensure support and input from independent advocacy was arranged and clearly documented when requested.

Financial harm and alleged perpetrators of all types of harm

The Adult Protection Committee (APC) established a financial harm group. Financial harm was identified through the partnership's adult support and protection audits and our inspection. Delays in interventions were apparent in some cases. Furthermore, a few police records showed evidence of financial harm which was not recorded in the social work record and should have been.

The partnership took steps to stop financial harm in all cases, although the effectiveness of interventions was rated adequate for just under half and weak for a few. The partnership should continue to minimise risks associated with financial harm and continue to work collaboratively with other agencies, banks and the Office of Public Guardian to reduce financial harm.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced positive outcomes as a result of interventions from partner agencies and third and independent service providers. For a few adults, outcomes had not improved. Lack of engagement from the adult at risk of harm and a lack of multi-agency working were some of the reasons recorded.

Adult support and protection training

In 2022, the partnership introduced an Adult Support and Protection Learning Framework. The framework was appropriately aligned to adult support and protection guidelines and outcomes of audits carried out by the partnership.

That said, just over half of staff survey respondents agreed that they participated in regular training which strengthened their contribution to adult support and protection joint working. The partnership should continue to develop additional adult support and protection training where necessary to improve knowledge and management of risk. For example, some staff lacked knowledge of application of the three-point test. When staff had participated in training, it had a positive impact on their knowledge, confidence and skills to undertake their role. As a result of the pandemic, some training was delayed.

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

Key messages

- Strategic leadership was collaborative and very effective. Opportunities were available to be involved in developing and implementing the adult support and protection strategic vision and strategy.
- The partnership demonstrated its commitment to involving carers in strategic interventions required to promote health and wellbeing and to keep people safe.
- The partnership's leadership response to risk management was commendable. The Gold Command structure and approach to risk assessment provided a robust framework for oversight of adult support and protection.
- Quality assurance processes were very effective, enabling ongoing assessment and improvement of adult support and protection outcomes. The adult support and protection improvement plan provided a framework for enhanced quality assurance and improvement.
- To promote a safer community, a range of support groups and targeted interventions were in place and continually assessed to determine their effectiveness.
- The partnership was proactive in analysing findings and developing processes to support the learning attained from initial case reviews and significant case reviews.
- The partnership should maximise opportunities to involve the adults at risk of harm in key stages of inquiry and investigation. This will ensure their views and experiences are considered and recorded.

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 Adult Protection Committee's (APC) vision was central to the partnership's self-evaluation and adult support and protection improvement plan. The vision focused on supporting people to live independently with minimal intervention, and to 'support and protect adults who may be at risk of harm or neglect and who may not be able to protect themselves'.

The partnership expressed there was a "bottom up" approach to improvement to ensure that staff views, suggestions and ideas inform any changes of service delivery and evaluation. Strategic leads, including the chief social work officer, provided visible leadership across Perth & Kinross. Leads attended recognition awards and development sessions and visited staff teams to understand some of the pressures staff faced delivering care during the pandemic.

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

The strategic leadership team experienced some significant changes since 2020. The chair of the Chief Officers Group (COG) and HSCP chief officer had changed. In addition, the Head of Adult Social Work and Social Care and the coordinator for Multi Agency Adult Support and Protection had changed. Despite this, continuity had been maintained through collective leadership of public protection in Perth & Kinross. This ensured the focus on public protection was unhindered and adult protection was afforded high priority.

The COG was responsible and accountable for adult support and protection arrangements across the partnership. The COG had good representation from relevant stakeholders. The COG worked collaboratively with the APC and Integration Joint Board (IJB), to identify and support the implementation of targeted interventions to manage risks pertaining to public protection. The establishment of the Protecting People Coordinating Group, along with a dynamic public protection risk register, added to the pro-active leadership and management of risk.

Strategic leaders worked collaboratively with partner agencies to implement the council's 'Gold Command' structure initially introduced during the Covid-19 pandemic. The structure had evolved and provided improved collaborative self-evaluation and management of adult support and protection.

The APC and front-line staff were committed to reducing harm. The frequency of APC meetings was increased to promote strategic governance and to allow for more regular opportunities to share information. Positively, front-line staff also recognised the need to minimise risks for adults at risk of harm. Front-line staff worked flexible hours to meet the demand required

for care, support and risk management. The subgroups led various initiatives which were well received by the community and adults at risk of harm. Support groups were evaluated to measure their effectiveness.

Staff survey results were mixed in respect of staff's perception of the quality of leadership in the partnership. Almost all leadership questions contained a significant number of 'don't know' responses, indicating some uncertainty regarding the effectiveness of leadership.

The partnership provided opportunities for staff to get involved in operational and strategic decisions through focus groups and development days. This further contributed to the partnership's vision and strategy of a 'bottom up' approach.

The Perth & Kinross adult support and protection multi-agency operational guidance (2018) reflected national adult support and protection guidelines. The partnership planned to refresh its guidance when the updated code of practice is published.

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

The APC and subcommittees had representation from carers who informed strategic decisions around adult support and protection. In addition to the already established community harm reduction support and engagement groups, the APC planned to implement and evaluate further engagement through its 'lived experience' work. The partnership recognised there was a gap in literature available to adults at risk of harm, which meant some people may not have got the support they needed to stay safe. Subsequently, the partnership produced leaflets about safeguarding in a range of languages. These were widely available and also on the partnership website.

To better understand adults at risk of harm and unpaid carers' experience of the quality of care and support received, the partnership developed a questionnaire. Evaluation of participation and responses to the questionnaire indicated low levels of engagement and minimal useful information. Commendably, strategic leads recognised this as an area for improvement and were working with the APC subcommittee to plan alternative engagement methods to ensure better evaluation of care experience.

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

The governance of adult support and protection had evolved over the preceding two years. The partnership continued to develop and improve its adult support and protection arrangements and was committed to public protection across NHS Tayside. The adult protection committee (APC) and sub-committees brought together a range of partner agencies and skills, to inform adult support and protection commitments. The Chief Officers Group, APC, NHS Public Protection Executive Group and Health and Social Care Partnership worked in partnership with the APC subcommittee to develop and support the implementation of the partnership Adult Support and Protection Improvement Plan. All areas for improvement identified through the audit and performance assurance framework were included in the improvement plan. Timescales and actions for improvement were continually monitored for impact.

The partnership went to great effort to involve partner agencies in the operational and strategic direction of adult support and protection. The introduction of interagency referral discussions strengthened the Divisional Concern Hub's position in inquiries and investigation. To better manage adult support and protection referrals, a multi-agency access team was established. The impact of this was apparent in the files we read. Initial inquiries and investigations were carried out to a high standard. Adults at risk of harm clearly benefited from the enhanced screening and triage process, and adults who did not meet the three-point test were afforded the right support timeously. Almost all staff survey participants said they were encouraged and confident about making adult support and protection referrals when they had concerns.

The Scottish Fire and Rescue Services and housing services managed risks proficiently, promoting safety for adults at risk of harm and others around them. Information sharing between these services and partner providers allowed for better management of risk and early intervention.

A dedicated adult support and protection health team was in place to better integrate health expertise within adult support and protection. Opportunities to involve partners agencies in assessing risks and delivering interventions should be maximised. This will further promote the partnerships strategic vision for collaborative working.

The partnership recognised further action was needed to manage suicide prevention and subsequently the COG agreed to bring the local Suicide Prevention strategy into its remit as key to the public protection agenda. Two suicide prevention coordinators were recruited to support this work. To promote enhanced screening and triage of initial inquiries, mental health staff were employed to work alongside social workers and police staff.

Community health teams, allied health professionals, and the Acute Hospital Discharge Hub worked in partnership to provide targeted interventions for adults at risk of harm. The Care Home Oversight Group provided valued support and oversight of adult support and protection in care homes and care at home. Interventions to manage financial harm should continue to be monitored and developed to improve outcomes for adults at risk of harm.

Quality assurance, self-evaluation and improvement activity

The partnership's adult support and protection self-evaluation processes were strong. The quality assurance framework influenced improvement, innovation and change. Outcomes from audits carried out in the partnership demonstrated improvements in a number of areas. The number of inquiries completed on time had improved as had the quantity and quality of chronologies, risk assessments, and protection plans. The effectiveness of engagement opportunities with staff and adults at risk of harm and carers was continually assessed by the adult protection committee and subcommittee. Where improvement was not apparent, revised approaches were implemented. An example of this was the work the partnership carried out to improve the quantity and quality of chronologies.

Collaborative engagement with partner agencies, coupled with the results from audits, identified financial harm and anti-social behaviour as ongoing areas for improvement. Initiatives remained in place to support this.

Most staff survey respondents were uncertain about aspects of leadership, and some staff said they did not always feel valued for the work they did. Staff were asked if they had been involved in evaluating the impact of the adult support and protection work that they did. The number of positive responses was low, and a significant number said they had not been involved, while some did not know. In contrast, staff who attended our focus group said they received very good support from strategic leaders and were kept abreast of, and involved in, improvements and change.

The partnership should continue to evaluate staff experiences and provide opportunities such as focus groups to ensure the workforce is engaged in quality assurance, self-evaluation and improvement.

Initial case reviews and significant case reviews

The partnership had conducted three initial case reviews (ICRs) in the period from 2020. One of these had proceeded to significant case review (SCR). Approaches to the management of ICRs and SCRs fostered a positive culture of multi-agency collaborative improvement. The partnership embraced learning from ICRs and SCRs carried out locally, and published guidance in line with national guidance to develop and improve practice. An ICR review group was set up to review themes emerging from ICRs. An

SCR improvement plan was in place to help address key recommendations across NHS Tayside from a more recent SCR. The Adult Protection Committee and Chief Officers Group took cognisance of ICRs and SCRs, providing critical governance and reflection internally through regular meetings and externally on the Health and Social Care Partnership public webpage.

Summary

The partnership demonstrated it was committed to achieving excellence in matters pertaining to adult support and protection practice and improvement.

Self-evaluation processes were threaded through adult support and protection practice and governance arrangements. The audit and performance framework provided an effective structure for assessing risk and targeted improvements. Positive outcomes were identified for adults at risk of harm as a result of the effective quality assurance framework. Collectively, data measurement informed the adult support and protection improvement plan, further adding to effective governance of risk management.

Collaborative arrangements to minimise risks, and support the health and wellbeing of adults at risk of harm, were mostly effective. This had a positive impact on adults at risk of harm and unpaid carers. For a few adults, the partnership did not consistently ensure the expertise of partner agencies and independent advocacy was utilised. Equally, adults at risk of harm could have been more involved in decision-making processes. The partnership should continue to build on a tripartite approach to adult support and protection, acknowledging the expertise and benefits of including health and police services in improving adult support and protection outcomes.

Developing additional training opportunities for staff would help to ensure they are further equipped with the skills required to carry out their roles effectively. Staff should continue to be included in self-evaluation and improvement work, to ensure they feel valued and part of service development and change.

The partnership recognised the current social care recording system was no longer ideal and invested in an information technology database, to allow for enhanced information sharing and assessment of social care. Adult support and protection initial inquiries and investigations were improved as a result of the partnership's willingness to engage with other partnerships, including utilising audits to analyse current practice. Learning from initial case reviews, significant case reviews and large-scale investigations promoted a better understanding of the events leading up to failures in practice. Measures to mitigate future risks were subsequently prioritised to improve public protection in the partnership.

Next steps

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

Appendix 1 – core data set

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

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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 75% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 95% of episodes where the three-point test was applied correctly by the HSCP
- 88% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 0% less than one week, 80% one to two weeks, 0% two weeks to one month, 20% one to three months
- 88% of episodes evidenced management oversight of decision making
- 86% of episodes were rated good or better.

Staff survey results on initial inquiries

- 76% concur they are aware of the three-point test and how it applies to adults at risk of harm, 13% did not concur, 11% didn't know
- 73% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 6% did not concur, 21% didn't know
- 81% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 7% did not concur, 13% didn't know

Information sharing among partners for initial inquiries

- 93% of episodes evidenced communication among partners

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

Chronologies

- 98% of adults at risk of harm had a chronology
- 50% of chronologies were rated good or better, 50% adequate or worse

Risk assessment and adult protection plans

- 98% of adults at risk of harm had a risk assessment
- 48% of risk assessments were rated good or better
- 93% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 64% of protection plans were rated good or better, 36% were rated adequate or worse

Full investigations

- 98% of investigations effectively determined if an adult was at risk of harm
- 95% of investigations were carried out timeously
- 76% of investigations were rated good or better

Adult protection case conferences

- 83% were convened when required
- 95% were convened timeously
- 17% were attended by the adult at risk of harm (when invited)
- Police attended 93%, health 100% (when invited)
- 68% of case conferences were rated good or better for quality
- 89% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 79% of review case conferences were convened when required
- 100% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 92% of adult protection concerns were sent to the HSCP in a timely manner
- 83% of inquiry officers' actions were rated good or better
- 59% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 85% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 70% good or better rating for the quality of ASP recording in health records
- 81% rated good or better for quality information sharing and collaboration recorded in health records

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

Information sharing

- 88% of cases evidenced partners sharing information
- 91% of those cases local authority staff shared information appropriately and effectively
- 77% of those cases police shared information appropriately and effectively
- 80% of those cases health staff shared information effectively

Management oversight and governance

- 58% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 84%, police 76%, health 47%

Involvement and support for adults at risk of harm

- 88% of adults at risk of harm had support throughout their adult protection journey
- 92% were rated good or better for overall quality of support to adult at risk of harm
- 79% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 5% did not concur, 16% didn't know

Independent advocacy

- 87% of adults at risk of harm were offered independent advocacy
- 38% of those offered, accepted and received advocacy
- 90% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 76% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 92% of these adults had their capacity assessed by health
- 92% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 10% of adults at risk of harm were subject to financial harm
- 40% of partners' actions to stop financial harm were rated good or better
- 75% 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
- 96% of adults at risk of harm who needed additional support received it
- 71% concur adults subject to ASP, experience safer quality of life from the support they receive, 6% did not concur, 23% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 61% concur local leaders provide staff with clear vision for their adult support and protection work. 13% did not concur, 27% didn't know

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

- 58% concur local leadership of ASP across partnership is effective, 10% did not concur, 33% didn't know
- 56% concur I feel confident there is effective leadership from adult protection committee, 10% did not concur, 34% didn't know
- 43% concur local leaders work effectively to raise public awareness of ASP, 16% did not concur, 41% didn't know

Quality assurance, self-evaluation, and improvement activity

- 50% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 10% did not concur, 40% didn't know
- 47% concur ASP changes and developments are integrated and well managed across partnership, 13% did not concur, 40% didn't know