care inspectorate

Triennial review of initial case reviews and significant case reviews for adults (2019-2022):

Learning from reviews

Contents

Foreword

The 2019 Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review sets out agencies' respective roles and responsibilities in relation to review processes.

From November 2020, the Care Inspectorate has acted as the central repository for both initial case reviews and significant case reviews. By receiving and reviewing all submissions, the Care Inspectorate can support continuous improvement locally, and disseminate common themes to support national learning.

This triennial overview report considers all notifications and completed reviews submitted between 5 November 2019 and 30 September 2022.

We rely on adult protection committees undertaking and notifying reviews in accordance with the national framework requirement. Most committees submitted notifications during this reporting period. We recognise the complex circumstances that adult support and protection services experienced because of the Covid-19 pandemic and the potential impact of this on consistent and accurate reporting.

Progress should continue, to ensure adult protection review processes are as robust as child protection arrangements.

The introduction of the new **National Guidance for Adult Protection Committees: Undertaking Learning Reviews** published in May 2022 replaced initial case reviews and significant case reviews with learning reviews. From 2023, our focus will be on learning reviews.

We would like to thank the adult protection and public protection committees across Scotland for their contributions to this report. This included participation in surveys and focus groups. These were co-facilitated with support from the recently appointed National Adult Protection Co-ordinator for Scotland.

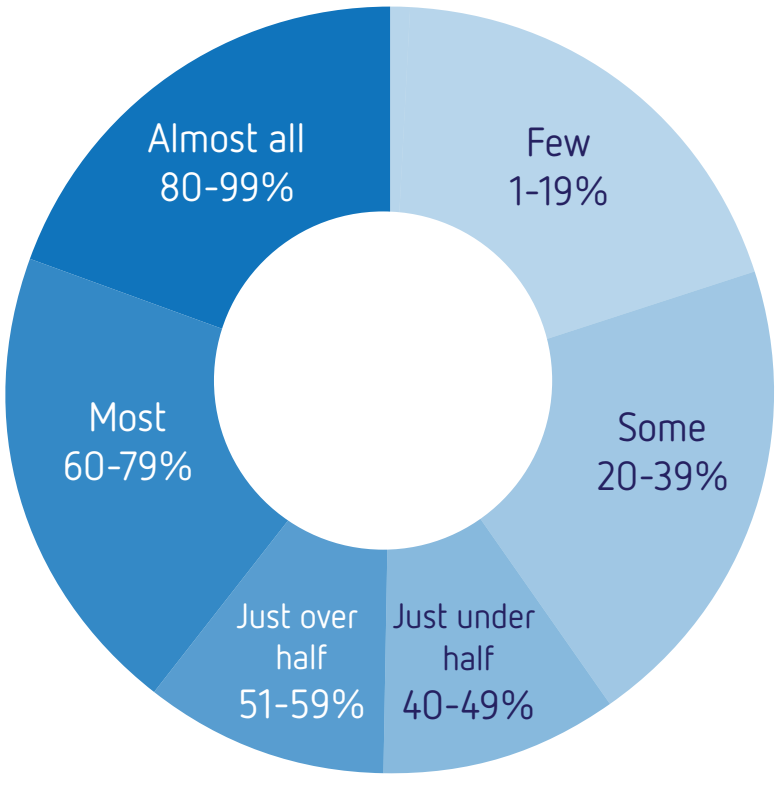
Definitions and standard terms

Each adult protection committee in Scotland should have its own approved procedures and mechanisms for deciding whether a significant case review is required. These can include **initial case reviews** or similar processes. These set out how adult protection committees consider information relating to a case involving an adult at risk of harm, determine the actions required and recommend whether a significant case review or other response is required.

An adult support and protection **significant case review** is a means for adult protection committees to learn lessons from reviewing the circumstances where an adult at risk has died or been significantly harmed. Undertaking these reviews enables committees to keep their procedures and practices under review. They provide information and advice to various public bodies and help or encourage the improvement of skills and knowledge of employees across the adult support and protection sector as set out in section 42 (1) of the Adult Support and Protection (Scotland) Act 2007.

Throughout this report, we use the term **'reviews'** to cover initial case reviews, significant case reviews and any other review submitted that met the framework criteria. Where relevant, we have differentiated by detailing the specific type of review.

Standard terms for percentage ranges



Key messages

- Neglect and self-neglect were the most prominent categories of harm identified. While there was evidence some partnerships were responding to these issues, more needed to be done nationally.
- The circumstances of those affected by mental health and substance misuse were most frequently considered in reviews. Health and social care partnerships should carefully consider this to inform future trauma informed improvement activity.
- Ineffective communication and information sharing contributed to poor outcomes for adults at risk of harm.
- Lived experience is a critical factor and should be proactively embedded and applied in review processes. Reviews did not routinely share information with, or include the views from, people with lived experience or their families/unpaid carers.
- Poorly planned hospital discharges were a significant feature in some reviews. This requires close consideration and improvement across health and social care.
- Improved professional curiosity, understanding of responsibility, effective decision making, and a trauma-informed approach should strengthen risk assessment and risk management.
- Decision making on matters of capacity for adults unable or unwilling to engage in adult support and protection required improvement.
- Learning potential was maximised when frontline staff were involved in review processes.
- Use of technology accelerated during the pandemic. It was innovative and ensured review processes continued. Technology also increased professional participation and supported a wider dissemination of learning.
- Greater transparency of decisions to proceed to a significant case review or when to publish such a review is required.
- Partnerships did not always notify the Care Inspectorate or Mental Welfare Commission in Scotland about reviews or incidents in accordance with national guidance.
- The impact of learning following reviews was difficult to establish due to inconsistencies in approach. A national infrastructure would support consistency and improvement across Scotland.

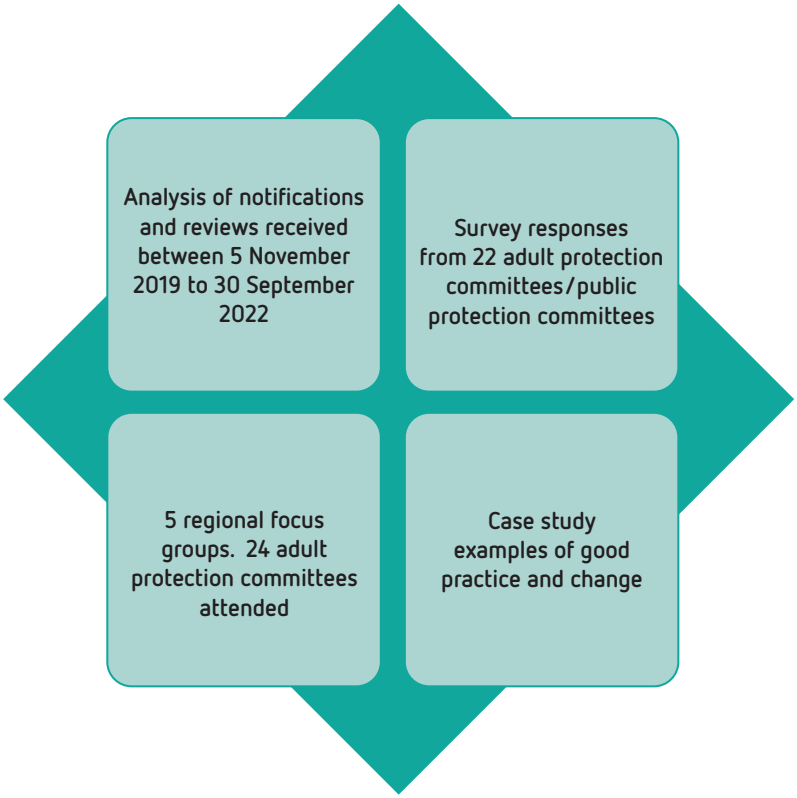
Introduction

The **Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review** designated responsibility to the Care Inspectorate to report publicly on thematic findings across Scotland. We seek to provide independent public assurance on the quality of reviews undertaken and highlight areas of good practice. Further, we aim to share national learning and support improvement across Scotland.

While we have predominantly considered reviews undertaken as initial case reviews and significant case reviews, the Care Inspectorate accepted submissions of other reviews that met the framework criteria. Our adult support and protection inspection activity identified examples of such reviews that should have been submitted but were not.

Throughout, we use the term 'adult protection committee' for simplicity. However, we acknowledge that some areas across Scotland have arrangements for a unified public protection committee.

We surveyed adult protection committees about notifications, and we invited them to contribute to the report by sharing their experiences of the intial case review and significant case review processes in focus groups. Invitations to contribute were extended to all committee areas and accepted by most. We also invited committees to share case examples where they had implemented learning or new approaches that drove improvement work.



Impact of Covid-19

At the start of the pandemic, the Care Inspectorate asked adult protection committees to continue notifying and submitting reviews in line with the national guidance. We acknowledged that significant case reviews might take longer. Commendably, significant delays were not a feature in most of the notifications and reviews we received.

Where delays occurred, just over half of reviews included a rationale for this. The lack of available resources to complete a review was the main reason for delay. Finding reviewers who had the capacity, and were appropriately skilled, became more difficult. Almost all reviews submitted were completed during this period. The approach and conduct of reviews were appropriately adapted and remained in line with the guidance.

Adult protection committees told us that, at the start of the pandemic, there was uncertainty as to how to undertake a review while the 'stay-at-home guidance' was in place. As a result, some activity was paused but quickly restarted when digital solutions were implemented. Measures taken allowed committees to undertake their review functions and engage with a range of professionals. However, there was consensus that this presented challenges for involving adults and families because of issues accessing and understanding technology. This may have been a reason for the low numbers of family involvement in case reviews.

Reviews where the adult lived in a care home presented challenges during Covid-19 because of reduced access. In most cases, information was electronically reviewed. Face-to-face support was limited and had to be risk assessed. It meant adults did not always have access to their family support.

Part 1: Review notification summary and themes

Review notification summary

Of the 22 adult protection committee areas that responded to our survey, 19 indicated that they had been notified by a referrer who viewed a significant case review to be relevant. The numbers of notifications considered by committees varied between 0 and 14. Almost all referrals resulted in an initial case review or other type of review, being undertaken.

Between 5 November 2019 and 30 September 2022, the Care Inspectorate received 90 notifications that initial case reviews had been undertaken or that a learning review (from May 2022 onwards) was considered. Most review processes ended after an initial case review was completed. Seventeen proceeded to a significant case review or a learning review and 15 proceeded to a further review under a different process. The number of notifications received by the Care Inspectorate did not equate to the number of completed reviews we received.

This report includes the key findings from our analysis of 90 notifications, 31 full initial case review reports, 28 initial case review summary reports, seven significant case review reports and six other types of review that met the framework criteria. Almost all reviews were for individual adults at risk of harm.

Overview of initial case reviews and significant case reviews

Adult protection committees reported many reasons for undertaking a case review.

Most commonly identified rationale for completing a review

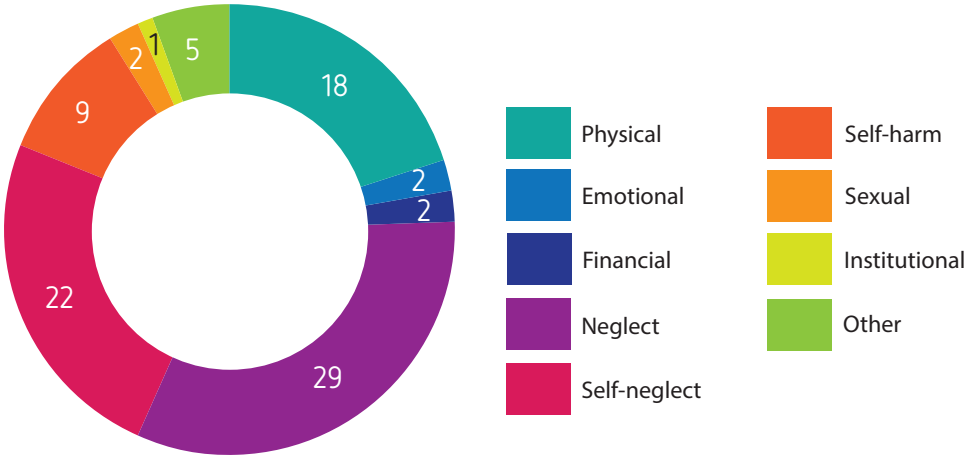
- There is additional learning to be gained from a review being held that may inform improvements for adults at risk of harm.
- When an adult has died and significant harm or neglect is known or suspected to be a factor in the adult's death.
- The adult has or should have been subject to adult support and protection procedures.

Reviews often referenced ongoing parallel processes including reviews or visits by the Mental Welfare Commission for Scotland, large-scale investigations, or NHS adverse event reviews.

Parallel processes also make relevant recommendations affecting adults at risk of harm but do not require to be submitted to the Care Inspectorate. These overlapping processes, in addition to inconsistent submission of initial and significant case reviews to the Care Inspectorate, impacted on the evidence available to be considered.

We categorised significant harm or death using the language detailed in the review reports we received. Where there was more than one type of harm, we used the primary cause of harm.

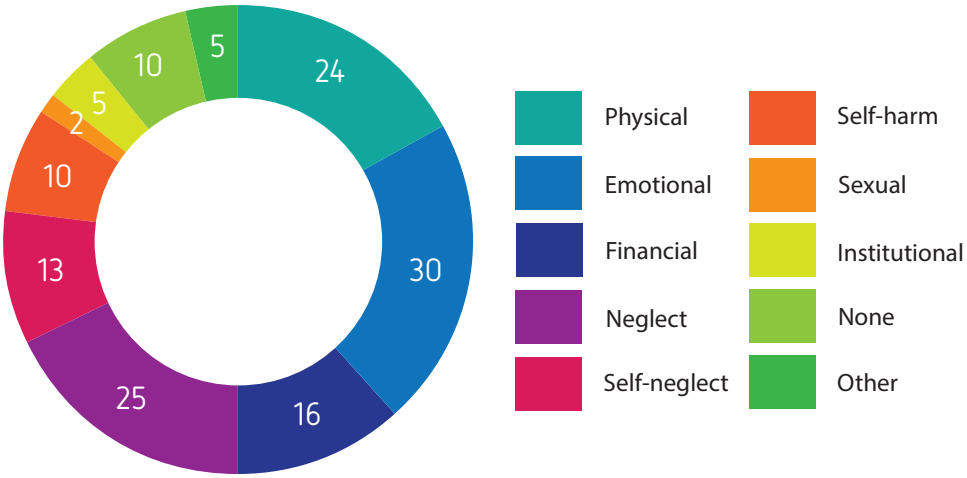
Table 1. Primary type of harm



Neglect (including self-neglect) was the prominent type of harm in most of the reviews submitted. Neglect from others was more prominent than self-neglect. Neglect from others included neglect by a family member/unpaid carer or by a paid professional. The prevalent characteristics varied with the type of neglect. For self-neglect, most adults were female, aged between 66-75 years. The main client groups were substance misuse, frail older adult and mental health. In comparison, for neglect, most adults were male, and aged 86 or older, and the main client group was frail older adult.

Secondary types of harm were identified in almost all cases. The main secondary types of harm were emotional harm followed by neglect.

Table 2. Other types of harm



It is clear that neglect was a key theme that is complex and needs a holistic response. While there is currently no adult framework in place, there are opportunities to build on the **briefing on self-neglect published by IRISS** in July 2022. This would support the development of a national multiagency response.

We identified that most (75%) of the adults considered for review had died. The main type of harm identified in this cohort was neglect, with older adults being more prominent than younger adults. Processes for reviewing adult deaths are different from children. For child deaths there is a **National Hub** that reviews learning from deaths of children and young people. For adults, depending on the circumstances, there may be a review under an alternative standalone process, with limited opportunity to share learning. Examples included adverse event reviews (as conducted by the NHS) and reviews conducted by the Mental Welfare Commission for Scotland.

Just over half of adults subject to a review were aged 65 or over with the main location of harm identified as the adult's own home.

Table 3. Age range

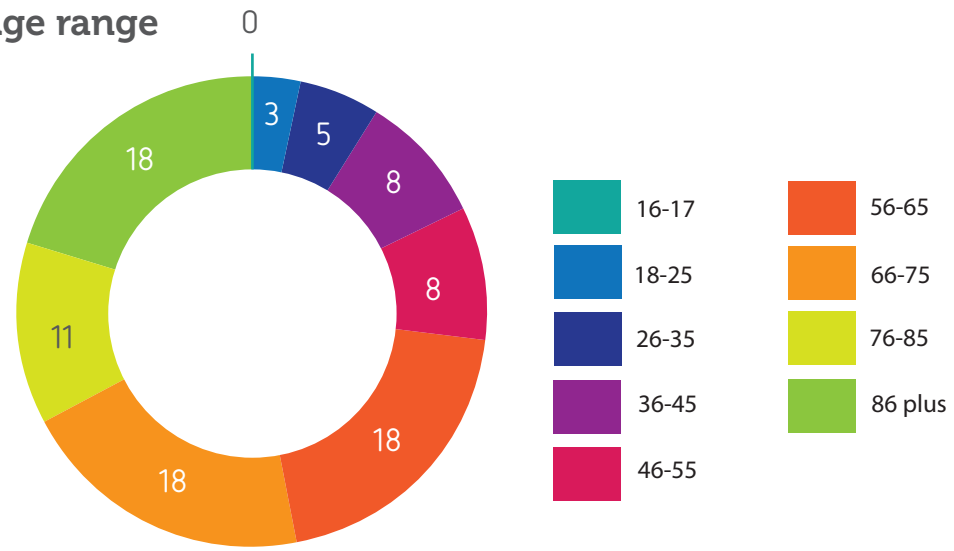
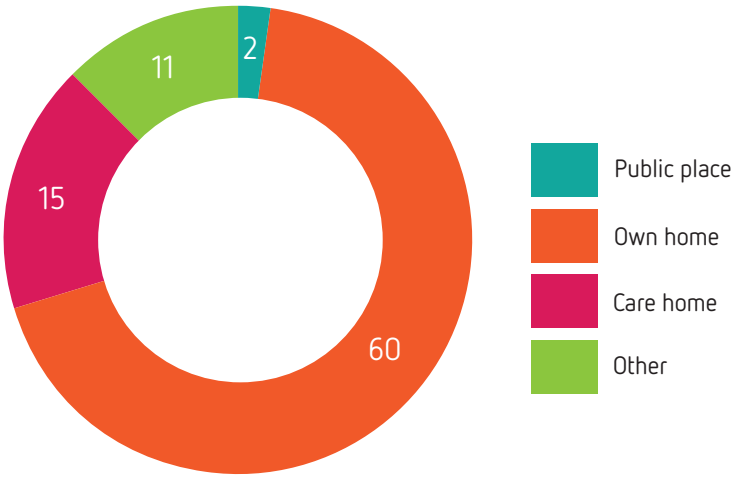


Table 4. Location of harm



For a significant few (17%) the adult was residing in a care home when the harm occurred. Overall, formal care and support was in place for just over half of adults that were reviewed. These adults were known to social work and had a care or housing support service provided based on an assessed care plan. The support provided had not mitigated the risks and often there were missed opportunities to protect the adult.

The primary case type was adults with a diagnosed mental disorder. This client group also featured heavily in the secondary case type category.

Table 5. Primary case type

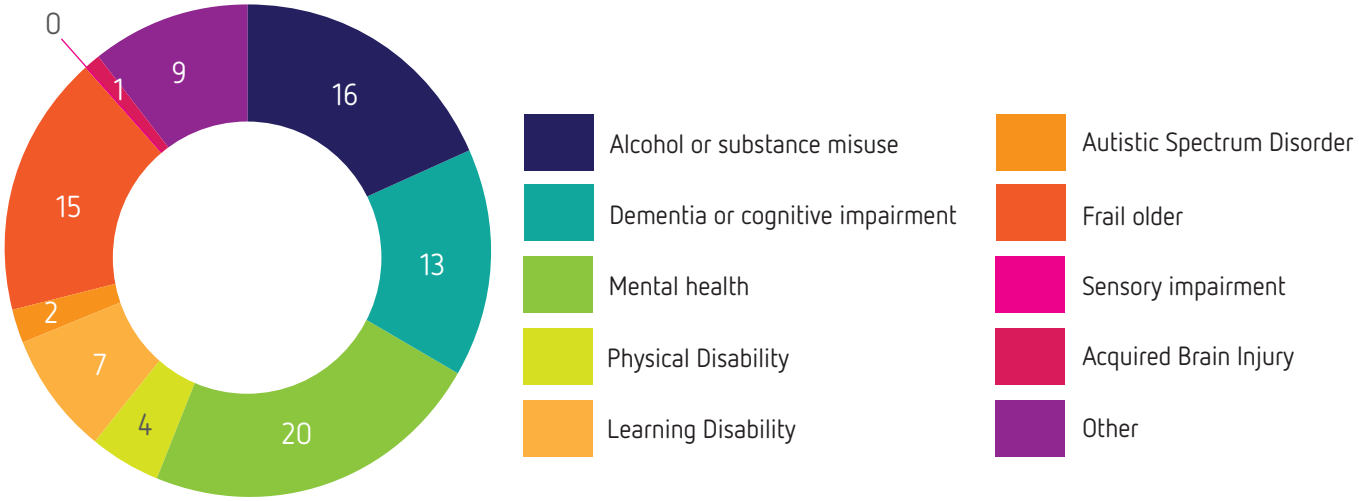
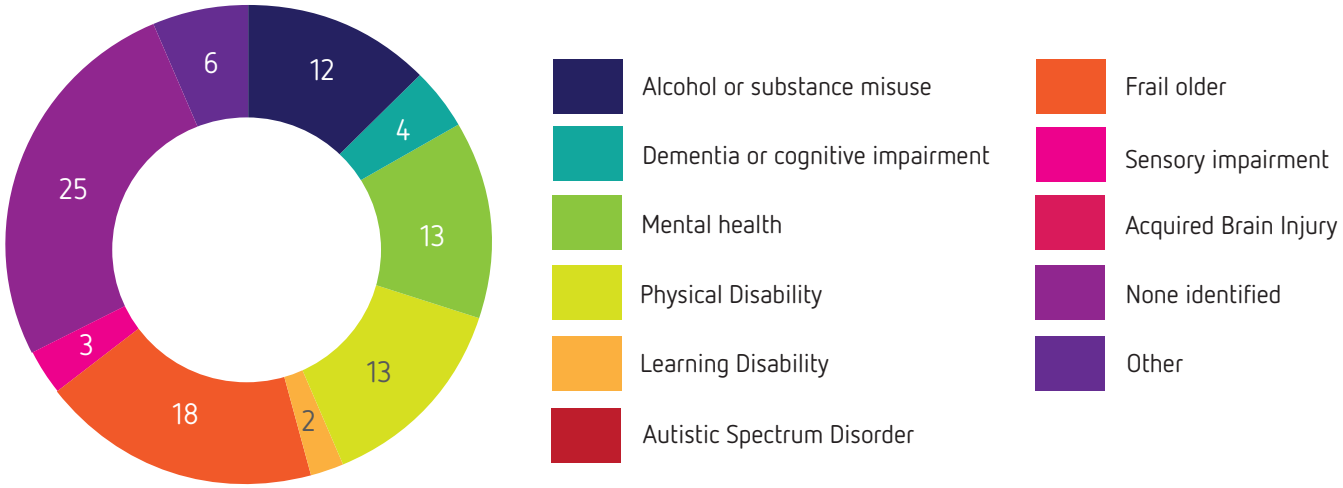


Table 6. secondary case type



Analysis showed that challenges pertaining to mental health and a lack of diagnosis was a feature. Local authorities are required to notify the **Mental Welfare Commission for Scotland** in specific circumstances including when there has been a deficiency in care or treatment. Based on these criteria, we would have expected to see more referrals made to the Commission than was noted in the reviews submitted to the Care Inspectorate.

Review notification themes

Communication, engagement, and involvement

Effective professional communication, information sharing, and joint working are critical components in adult support and protection work. Despite these well-understood principles, poor communication was a feature in half of all submitted reviews. Reviews detailed numerous examples of poor communication between professionals that adversely impacted both recognition and effective investigation of adult support and protection concerns. Poor communication with the adult and/or their unpaid carer or family was also evident.

The 2019 national framework guidance states that "family/carers should be kept informed of the various stages of the review" at the significant case review stage. Involvement at initial case review stage is not referenced in the guidance. Most reviews we received ended at the initial case review stage and this may explain why there was little evidence of appropriately involving the adult, their family or unpaid carer. Ongoing parallel processes also complicated engagement with the adult. The linkage between parallel processes and limited involvement of the adult and/or their family is an area for further consideration. The Scottish Government's recently published 'undertaking learning review' guidance is clear and should strengthen practice in this area. It states reviews should be "Participatory and collective, involving all relevant professionals, managers, agencies, and the adult and their family where appropriate."

Some adult protection committees had developed guidance and leaflets that informed adults and/or their families about review procedures and they had supportive processes that placed the adult at the centre of the review. South Lanarkshire adopted a model that ensured adults would always be invited unless there were exceptional circumstances.

Professional curiosity

Lack of professional curiosity was evident in just under half of reviews. Examples included council officers not challenging situations where they should have, and harm not being recognised by professionals across different agencies and organisations. Consideration of these issues in reviews was limited and further work was needed. Often, reviews focused more on individual practice than the wider systems and context that workers practiced within. Some adult protection committees had developed practice guidance to address these issues, but it was too early to determine the extent of their impact.

There was a clear link between self-neglect and an adult's willingness or ability to engage. Often, reasons behind the presenting behaviours were not fully explored. Consideration of a trauma-informed approach was not referenced in most reports but should have been considered. The Scottish Government's refreshed **adult support and protection code of practice**, **learning review guidance for adults** and the **national trauma training programme** all promote this approach and should be catalysts for improvement in this complex area of practice.

Application of legislation

Most adults subject to a review were either not known or they were known but were not being supported/protected by a protection or risk management plan as required, under adult protection legislation. Better recognition of concerns and undertaking the duty to refer adult support and protection matters more effectively was required. Specifically, this was needed where issues of both adult support and protection and adults with incapacity converged.

Hospital discharges were a significant feature in a quarter of reviews. Identified themes included poor communication, delays in the assessment of capacity, and not ensuring appropriate resources were in place to meet the adult's needs on discharge. This resonated with the **Authority to Discharge report** (2021) published by the Mental Welfare Commission for Scotland. A contributing factor for some adults was that their stay in hospital was during the Covid-19 pandemic.

Methodology

Methodology for case reviews is not prescribed. Regardless of this, we expected the methodology used for reviews to be more clearly set out. This was not recorded in most reviews. Many areas reported challenges in finding suitably skilled reviewers. As a result, the

approach taken was often based on the experience of the lead reviewer and the resources available. For significant case reviews, the methodology frequently applied was the Social Care Institute of Excellence (SCIE) Learning Together model. Other review methodologies included appreciative inquiry and root-cause analysis.

Most reviews were completed by an internal reviewer or internal review group. This had the potential to impact on transparency and impartiality. Participants in our focus groups were keen to have an effective process that captured learning in a timelier manner. The Dundee partnership shared a community-of-practice approach that raised awareness and encouraged better engagement in reviews. Work in this area had started and sought to ensure a wide variety of adult protection partners had the opportunity to learn from case reviews.

The timescales for completing reviews were variable and took between two and 36 months to complete. While most were timely, the reasons for those delays included lengthy legal proceedings and challenges accessing all the required information. Delays were not always explained in the reviews. They impacted on the value of timely learning when the duration was extensive.

Adult protection committees consistently referenced the criteria from the Interim National Framework when determining whether to proceed to a significant case review. However, the rationale and recording of such decision-making processes were not always as clear as they should be. We identified four general overlapping themes.

Rationale for not proceeding to a significant case review

- Unspecified statement that criteria for significant case review is not met.
- No potential for national learning.
- Other review processes and/ or more immediate learning opportunities were in place.
- Initial case review findings were like the learning from a previous initial or significant case review, with an associated improvement plan already in place.

Quality and outcome of reviews

The quality and comprehensiveness of initial case reviews was variable. Some were extensive and resulted in numerous improvement actions, meaning a significant case review was unlikely to identify any significant further learning. A few did result in further reviews outwith the significant case review process. For example, the thematic review conducted by Dundee.

This was conducted by the adult protection committee in conjunction with Stirling university and produced learning on fire safety which could be applied nationally.

We found most reviews ended at the right stage. That said, the rationale for undertaking further reviews outwith the national guidance was less clear. Particularly when the criteria for a significant case review was evidently met. The National Guidance for Adult Protection Committees Undertaking Learning Reviews (2022) replaced the 2019 national guidance and outlines the key features, principles, and values of learning reviews. Adult protection committees were enthusiastic about the new guidance, and they found feedback letters from the Care Inspectorate regarding significant case review submissions to be helpful. While this has the potential to support local improvement, adult protection committees also wanted more opportunities for national learning from reviews to support improvement in adult protection practice.

Part 2: Review recommendation summary and themes

Recommendation summary

The overall number of recommendations that emerged from reviews was 213. The number of recommendations in individual reviews varied between two and 58.

Recommendation themes

Key processes

Risk assessment and risk management were commonly identified as requiring improvement and there were two broad categories.

The first category included cases where the risk was not identified or recognised as an adult support and protection concern. This mainly involved adults who were repeatedly referred and known to services, but no or limited action was taken. This often meant the adult was never assessed under the auspices of the Adult Support and Protection (Scotland) Act 2007 when they should have been.

The second category included the management of risk where adults were subject to adult protection legislation. Specifically, where support to the adult was not effectively coordinated and did not collaboratively manage the risks. Risk assessment and management are critical components for protecting adults at risk of harm and continue to require close oversight from adult protection committees.

The need to improve information sharing was identified in most reviews and related to two main areas.

Firstly, there was a lack of recognition and effective information sharing about concerns, hampering robust collaboration between individual workers and agencies. Working in integrated teams did not necessarily increase the quality of information shared between professionals. However, where professionals had a good understanding of their legislative responsibilities, outcomes were more positive. Angus adult protection committee had developed learning packs that encouraged reflection on various professional roles.

Secondly, poor information sharing was a feature of work undertaken with the adult at risk and/or their family. Often, family members or unpaid carers had difficult relationships with services, making effective communication hard to establish. Engagement with adults at risk and their carers forms a core part of the adult support and protection code of practice national implementation plan. The subgroups dedicated to implementation plans for

advocacy and the voices of adults at risk of harm and their carers provide an opportunity for adult protection committees to reframe and enhance practice in this area.

Poor decision making and weak leadership were closely linked. When we refer to leadership in this context, we are referring to both frontline managers and strategic leaders. Line managers were typically involved in decision making regarding the outcomes of adult support and protection referrals and the management of risks and protective measures.

There were 22 findings aimed at refining decision making processes by establishing escalation protocols to improve outcomes for adults at risk of harm. In the reviews, escalation protocols were developed for two main reasons. Firstly, to improve responses to cases that included multiple presentations to services including accident and emergency departments and Police Scotland. Secondly, to improve responses where health and social care staff raised multiple concerns to their line managers that did not progress to an adult protection action.

Capacity and use of applicable legislation were evident in just over a third of review recommendations. Some of these focused on improving access to capacity assessments. There were also some reviews that sought improvement in how adults with diminished capacity were supported to better understand decision making processes.

The rationale for requesting assessments of capacity that were specific to decision making, and ensuring they were carried out in a timely manner were frequently identified as areas for improvement in reviews. Some adult protection committees took action to improve practice in this area and introduced referral templates, encouraging more timely access to capacity assessments.

Many recommendations were about capacity assessments, legal literacy and the challenges partnerships experienced when protecting adults who were unable or unwilling to engage with support and protection processes. Delays and failures to reach decisions about how to best protect these adults was a critical factor in the outcomes. Assessments of capacity for this population of adults are complex and not binary. We were reassured to find that many adult protection committees planned to review their guidance and training on capacity and engagement approaches with adults who are unable or unwilling to engage with professional help.

Dissemination of learning

Adult protection committees employed a range of resources to share learning locally. Participation in the review added to the learning experience. However, more work was required to fully engage frontline staff. Committees were positive about the introduction of the learning review model. It was seen as an opportunity to develop practice in a positive manner and develop a learning culture away from deficit-focused approaches. A case example from Glasgow included the use of 7-minute briefings and learning packs.

Publication of reviews was valuable for learning. For instance, Aberdeenshire mandated their serious case review group to benchmark all relevant publicly available case reviews and identify any learning that could improve their own adult protection practice. From our engagement with staff, we found that learning gained from published case reviews promoted improvement and supported a more consistent approach.

Practice improvement stalled when reviews did not produce clear and concise recommendations. Implementation was also delayed when adult protection committees undertook further internal analysis to agree and plan actions to address findings. This was often the case when the outcomes of reviews were framed as 'key questions' for consideration.

Most reviews were not published. This was a missed opportunity to share learning nationally. Where the outcome was no further action, this was often because the adult protection committee or mandated subgroup was satisfied that there were no concerns or further learning to be gained regarding practice. Initial case reviews occasionally had two outcomes including actions that addressed immediate risk and those that needed further review.

Staff training was often detailed as a review recommendation. These were mostly described in general terms around wide themes. There were several examples of training and practice guides such as those developed in Aberdeen and Dumfries and Galloway. This resulted from work undertaken to meet these recommendations, particularly relating to hoarding and self-neglect. Given the helpful resources being developed locally, there should be more opportunities to develop a co-ordinated national repository and approach. When the Adult Support and Protection (Scotland) Act 2007 came into force, the Scottish Government implemented a training framework to support adult protection practice development. There are opportunities to refresh and develop this on a national basis that incorporates learning from local initiatives.

Strategic collaboration

Care homes featured in 28 recommendations from reviews. Many of these recommendations said that health and social care partnerships should improve their clinical oversight arrangements and strengthen communication and pathways between community nursing services and care homes. Our adult support and protection joint inspection work has shown that care homes make a high number of adult support and protection concern referrals to health and social care partnerships. We also saw that the Covid-19 pandemic had strengthened multi-agency care home assurance activity. These factors should encourage stronger practice in this area over time.

Implementing recommendations where health boards covered multiple adult protection committee areas was complex. In these circumstances, it was not always possible to make changes in a regional hospital where adults from varying adult protection areas were subject

to different processes. In such circumstances, recommendations were being implemented but progress was more protracted.

Recommendations involving the third sector were also complicated as adult protection committees did not have the authority to direct staff time or resources. Work to support the third sector during the pandemic, through regular hub meetings, was viewed as positive. The hubs' meeting model was considered a potential vehicle for helping committees to build positive and productive relationships that influenced the required change.

Leadership of change and improvement

Quality assuring that change had taken place was both time consuming and time limited. As participants stated, "if we don't let things drop off our checklists once reported to the chief officers group then checklists would become too large [to achieve other work]."

Positively, all adult protection committees and chief officers groups had progress reporting arrangements in place although the methods for monitoring progress varied. Several areas devolved responsibility to oversee recommendations and improvements to mandated subgroups of the adult protection committee. These usually had multi-agency membership. Their remit included producing improvement plans, reports and overseeing the dissemination of learning. This involved activities such as:

- feedback from practitioners directly or through practitioner forums
- supervision processes
- feedback from service user forums
- single agency oversight reports, feeding into a multi-agency report
- 7-minute briefings to local teams then feedback from those teams
- learning packs distributed to local teams
- performance and quality, and learning and development subgroups
- practitioner group feedback sessions
- management group feedback sessions.

All reviews were conducted under the same national guidance but were formatted differently even where they used the same approach or methodology. Review conclusions therefore included recommendations, key questions, areas to consider, further review or no further action outcomes. The content, quality and language in reviews also varied.

Adult protection committees recognised the number and type of recommendations were important. Too many meant there were challenges evidencing their completion. Recommendations need to be SMART (specific, measurable, achievable, realistic, time-bound).

The table below outlines the main outcomes from all reviews.

Outcomes from reviews (Some reviews have more than one outcome)	
Further review or action through a significant case review, learning review or other process.	**27**
Reviews with recommendations.	**20**
Reviews with key questions/findings and identified areas for improvement.	**28**
No further action or recommendations for improvement not identifiable from available information.	**18**

Recommendations required greater clarity. Vague or complicated recommendations were a barrier to effective implementation. A standard approach using shared language and understanding would build greater consistency, opportunities to benchmark and improve shared learning opportunities.

An example of a focused recommendation made following a case review in Aberdeenshire was as follows:

> **"There should be a protocol in place that ensures that no patient who is subject to adult support and protection procedures [starting either before, or initiated during, admission] is discharged without a full multi-disciplinary and multi-agency meeting to consider the potential risks and any control measures required to reduce such risks to an acceptable level. For the avoidance of doubt, such meetings must include community health and social care representatives."**

Another example of a focused recommendation was when NHS Grampian and the Scottish Ambulance Service took action to address a recommendation that communication methods were improved between acute and primary care services by establishing a dedicated help desk for adult support and protection concerns.

Part 3: Impact of reviews on practice

Review reports do not extend to determining the impact of the recommendations and findings on practice or systems improvement. As such, we conducted a survey and focus groups with adult protection committee representatives. Respondents were also interested in understanding the impact reviews made to improvements. Sharing and discussing learning at national fora such as the national convenors or leads groups was identified as helpful. It should be noted while we have referenced case examples, we do not know the impact these have had on practice in the relevant area.

Measuring the impact of change was difficult to quantify for adult protection committees. Particularly evidencing the minimisation of poor outcomes in the future. There were some positive examples of how adult protection committees were tackling this. South Lanarkshire had introduced an annual impact assessment to review the impact of changes. Some committees demonstrated limited progress in this area. All participants identified the need to strengthen practice and were keen to engage nationally to support development in this area.

Locally, adult protection committees were gathering evidence of change from a variety of sources. Audits, self-evaluation work, collation of action plan updates and consultation were the most frequently applied mechanisms. Despite these pockets of innovation this remained challenging.

Identifying common themes across multiple reviews and emerging recommendations enabled improvements in practice in a few adult protection committees. This was enhanced by thematic follow-up reports for the committee and the chief officers group.

Fife undertook work to consider themes from reviews. It was identified that financial harm was a recurrent theme. This led to a review of the financial harm strategy and resulted in the introduction of a banking protocol that included work to prevent scams, advice, guidance, and information. This action reduced financial harm cases over the following year. While the committee considered it too early to draw a direct correlation between the changes and this reduction in harm, it was a promising initiative.

In Dundee, there was a positive response from the adult protection committee to common findings in the thematic review for adults who died because of fires and the subsequent development of new protocols and tools.

Some adult protection committees effectively influenced practice through training and research, particularly regarding missed opportunities to support adults at risk of harm. Often, where there were concerns about an adult's ability to make autonomous decisions (usually due to mental ill health or substance dependency issues) situations were not escalated on

the presumption of capacity. Aberdeen and Dumfries and Galloway committees had both introduced measures to improve practice in these areas of practice.

We learned that staff were less anxious to discuss their practice within the learning review model approach. Several adult protection committees said that they helped prepare staff for the implementation of learning reviews by having information sessions, producing guidance, and setting up practice sessions. Dumfries and Galloway created a reflective learning tool, which they encouraged multi-agency teams to use to support learning where cases did not meet the criteria for a learning review.

A number of adult protection committees combined public protection review processes. This supported decision making about the type of review employed, and ensured learning was shared across services through a central point. The pool of expertise was therefore extended. This removed duplication from the process, benefitting all involved. It also reduced the burden on adults and families who were involved in case reviews.

Some adult protection committees maintained separate review processes but had established protocols to share relevant learning from reviews. Information and, where possible, processes from these concurrent reviews were combined.

The Scottish Government's 2019 Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review does not detail a specific timeframe for initial and significant case reviews to be completed. The Scottish Government's refreshed national guidance published in May 2022, helpfully addressed this, stating "Once a decision has been made to undertake a learning review, the process should aim to be completed within a timeframe of six to nine months."

Delays in undertaking reviews impacted on practice improvement. Lengthy delays meant the landscape (including national guidance, key personnel, and protocols) could change. Lengthy delays could result when the reviews were concurrent to criminal proceedings. Current learning review guidance states there may be no need to delay learning review interviews pending the outcome of a parallel process. However, a public interest balance must be achieved between the need to capture learning to protect adults at risk of harm and the investigation of a death or prosecution in a criminal case.

Part 4: Conclusions and next steps

Our triennial report for initial case reviews and significant case reviews is based on information gathered from notifications, reviews, focus group discussions, case examples and a staff survey. This approach provided us with a national overview of review experiences from adult protection committees across Scotland. It has highlighted how important strong and effective leadership is during difficult times. Driving change and improvement while supporting staff remains challenging. It has reinforced the value of efficient systems that identify and support learning to ensure improved outcomes for adults at risk of harm.

We found the quality and conduct of reviews varied considerably due to diverse review approaches.

Unlike child protection, there is no central system to share learning from all relevant reviews including initial and significant case reviews. This limits consistency and improvement nationally.

Too often, reviews did not include or reflect the views of the adult or their family. This meant reviews lacked insight from people with lived experience. Reviews should clearly record the reasons for this. Other avenues should be more routinely explored such as the use of an impact statement for inclusion in the final report. Guidance and practice in this area has begun to be addressed by some adult protection committees.

Poor communication and information sharing was a recurrent theme, particularly when hospital discharge was a feature. This highlighted the need for a better understanding of roles, responsibilities, and collaborative working.

Risk assessment and risk management are critical elements of the adult support and protection processes. Without more effective risk assessment and risk management approaches, adults at risk of harm will continue to experience poor outcomes. The updated adult support and protection code of practice provides clear guidance on this longstanding issue.

Neglect and self-neglect cases are complex and require practitioners to be trauma informed and use relationship-based practice. Reviews showed there was a lack of understanding of these complex issues. Locally, some adult protection committees had begun to address this, but a national response is required to coordinate resources, capability, and experience.

Next steps

It is important to create strong pathways and links between local and national learning. For adults, there are more diverse review mechanisms and currently less opportunities to communicate and learn from each other because adult protection is less established and operates in a different context from child protection. Coordinated leadership is required at a national level to implement, support and govern review activity and improvement work. This national approach to learning should help to improve practice in adult support and protection and outcomes for adults at risk of harm.

Next steps should include the following.

- Development of a national pool of well trained and skilled reviewers. This would provide a valuable resource to adult protection committees across Scotland and support a more consistent application of methodology and approach.

- Implementation of a national toolkit for good practice in conducting a review and implementing and measuring the impact of change is required. This should ensure that lived experience is at the centre of protection planning.

- Establishing a national co-ordinated approach to address the recurrent thematic issues identified in this report such as neglect, self-neglect, and hospital discharge. A refreshed training framework and approach for addressing national themes and issues identified in reviews would support improvement across the sector.

- Care Inspectorate continue to disseminate learning. This will include making best use of links to the adult support and protection national strategic forum, leads and convenors forums, as well as other relevant national groups. Learning review overview reports will be published annually.

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