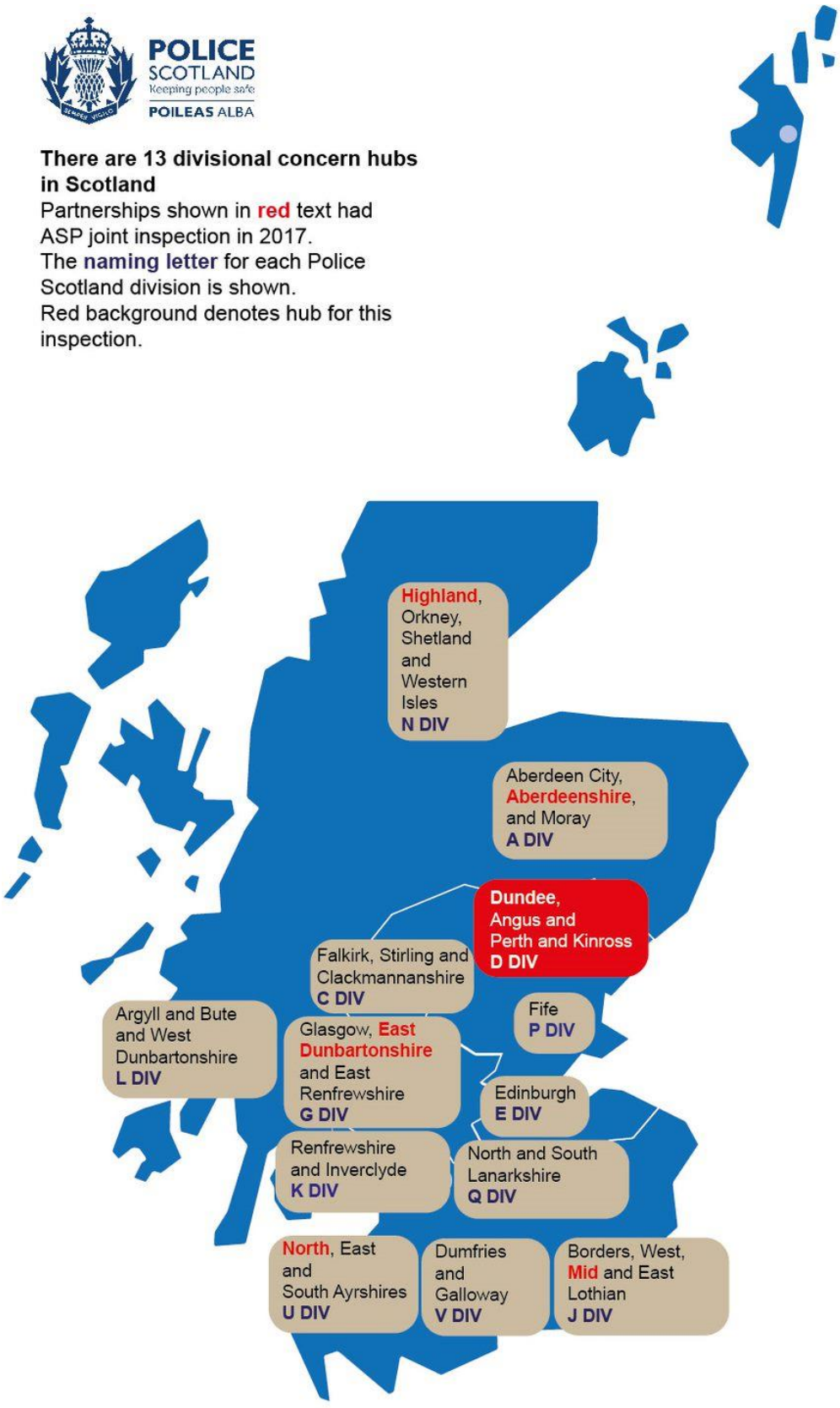
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Angus Partnership January 2023

Contents

Map showing divisional concern hubs



Joint inspection of adult support and protection in the Angus 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 His Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual local partnership[1] areas' effective operation 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 Angus partnership area were safe, protected and supported.

The joint inspection of the Angus partnership took place between September 2022 and January 2023.

The Angus 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 Angus 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.

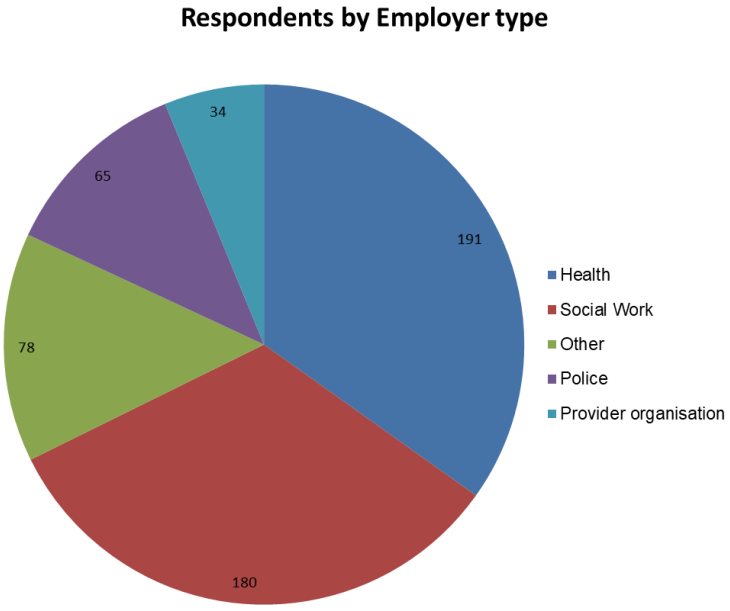
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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 Five hundred and forty-eight 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.

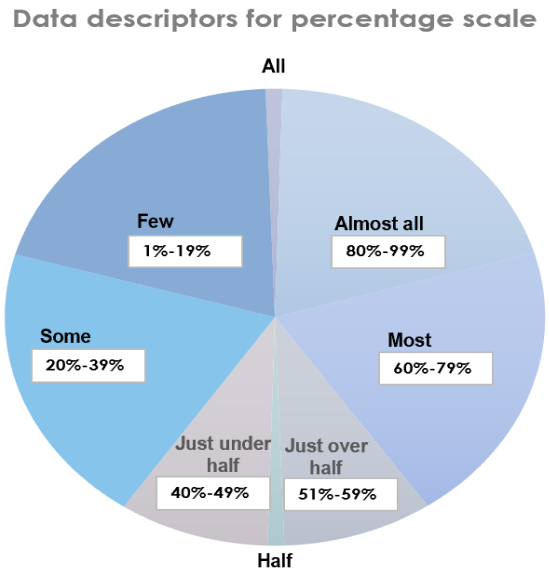


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

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 20 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 a person-centred approach to adult support and protection that included the regular use of advocacy to promote the adult at risk of harm's rights.

- Investment in specific adult support and protection posts across health, police and social work supported effective engagement and collaboration. This enabled the development of initiatives such as the Financial Abuse Support Team and Early Screening Group. These contributed to good outcomes for adults at risk of harm.

- The delivery of inquiries, investigations and case conference were highly effective.

- Core group meetings for adults at risk of harm proceeding to case conference effectively oversaw risk assessment and the management of concerns.

- The partnership had a comprehensive multi-agency learning and development plan. Learning was delivered using a range of digital and face to face methods and was open to all agencies. This had a positive impact on adult support and protection practice.

- The partnership had a clear, well understood vision for adult support and protection. This was supported by an Adult Protection Committee strategic delivery plan.

- The established Adult Protection Committee and sub-group structure had progressed most improvement actions and supported delivery of statutory functions. This included the operation of a risk register to monitor practice and provide reassurance.

- The partnership response to the pandemic was strong. This incorporated a wellbeing approach to supporting staff, structured response to care home assurance and increasing the frequency of overview meetings.

Priority areas for improvement

- Recording of adult support and protection practice in case records varied in consistency and content. This was more evident in the application of the three-point criteria and the recording of actions taken to manage risk for those adults who did not progress beyond inquiry and investigation stages.

- The quality of chronologies had improved but needed progressed to include better recording of multi-agency information, significant life events and impact. This would further enhance decision making around risk.

- The quality assurance framework needed to be further embedded to include a frequent multi-agency approach to monitor change and sustainability more effectively. This should include frontline practitioners and adults with lived experience of adult support and protection.

- The Adult Protection Committee had recently refined their improvement plan, but further consolidation was needed. Both this and the annual performance reporting approach impacted on the visibility of change and timely identification of trends or issues.

- Strategic service user engagement and awareness raising were recognised by the partnership as areas for improvement. Recently developed plans should be progressed to support feedback and engagement with adults at risk with lived experience in the strategic work.

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

Key messages

- Management of risk for adults at risk of harm supported at case conference and beyond was strong. This was facilitated by good use of core groups which incorporated dynamic risk assessment.
- Practice initiatives such as the Financial Abuse Support Team contributed positively to outcomes for adults at risk of harm.
- The partnership had a person-centred approach to adult support and protection that promoted the voice of the adult in all stages of key processes.
- The Angus partnership contributed to the development and implemented the Tayside Capacity Assessment Pathway. This had supported timely informed practice in assessing capacity.
- The partnership had clear and up to date procedures which supported the consistent delivery of good or better key processes across the adult protection journey. This ensured effective collaborative working across the partnership.
- The partnership had a comprehensive and effective learning and development plan. This continued during the pandemic and had been further developed to support good practice.
- The partnership should further develop practice around assessment of risk and chronologies, particularly at the investigation stage.
- Recording particularly at the inquiry stage requires further improvement. This would support a clearer delineation of stages.
- Health staff contributed to good outcomes for adults at risk of harm, there was scope to further improve involvement at the investigation and case conference stages.
- Management oversight and governance of practice was robust. This contributed to the effective delivery of the key processes.

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

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

In Angus there were three pathways for screening adult support and protection (ASP) referrals. The first pathway was for all police referrals for adults that were unallocated. These were screened weekly via the multiagency Early Screening Group (ESG). As part of this robust arrangement, the ASP review officer triaged all referrals to determine if immediate action was required. The ESG process had recently been evaluated by the partnership and considered to support robust screening.

The second pathway was for all other adult support and protection referrals for those who were unallocated to fieldwork social work teams. These referrals were screened by a duty worker overseen by the duty manager. This was arranged via a rota which drew from workers and managers from across social work staff in Angus Health and Social Care Partnership (HSCP).

The third pathway was for adults who were allocated to a social work team. The allocated worker was tasked with screening and taking forward subsequent adult protection activity. There was a high level of confidence amongst staff that the system was effective and timely.

Initial inquiries into concerns about adults at risk of harm

Commendably all inquiries were completed in line with the principles of the adult support and protection legislation. Almost all were completed timeously, correctly applied the three-point criteria and evidenced good communication between key partners. Management oversight was present in almost all inquiries completed. The quality was good or better for most inquiries.

Recordings of inquiries were completed in a combined inquiry and investigation form. It was not always clear when an inquiry ended, and the investigation commenced. If other processes such as the ESG had been implemented this was not always reflected in the record of inquiry. The section for inquiries did not support clear recording of work undertaken or the application of the three-point criteria.

An initial referral discussion (IRD) was convened when required at any point between the inquiry and investigation stage. The two reasons for convening an IRD were the case complexity and/or to further assess the application of the three-point criteria. IRDs were recorded in a separate template. There was variation in the use and comprehensiveness of IRDs, with examples that resembled case conferences in content. Refinement of the use and purpose of IRDs would streamline the process and remove unnecessary repetition. Most staff were confident that adult protection concerns were handled efficiently.

Investigation and risk management

Chronologies

Positively almost all adults at risk of harm had a chronology completed when required. The partnership had contributed to the development of the "Tayside Practitioners Guide" (April 2019) based on the Care Inspectorate good practice guide. This was complemented by a clear operational instruction process which defined the circumstances and recording of chronologies. The application of the process as detailed in the guide was inconsistent.

The quality was good or better for just over half of chronologies. While the guide had a prescribed form, the template used for chronologies varied. The information gathered was incomplete in some cases and lacked analysis of impact on the adult at risk of harm. The partnership recognised this critical activity was an area for improvement.

Risk assessments

Risk assessment at inquiry stage was less evident, as the template for inquiry was limited. The investigation recording template contained a risk section. For IRDs, case conferences and core groups risk assessments were appropriately considered and dynamically applied through discussions and sharing of information. The partnership also had a standalone risk assessment with criteria for use. This was not utilised consistently.

While risk assessment formats varied, almost all adults at risk of harm had a risk assessment completed. All of those completed were timely and informed by relevant multi-agency partners. Most risk assessments were good or better. A significant few risk assessments lacked contingency planning and analysis of risk. These should have been clearer. The partnership identified in their last audit that risk assessment was an area for improvement and were actively developing this area of practice.

Full investigations

Investigations were recorded in a clear and well-designed template that helpfully prompted the council officer to consider and record the main elements of investigation. Notably there was no prompt to confirm that the adult has been advised of their statutory rights under the adult support and protection legislation.

All adults at risk of harm who required an investigation had one completed by a council officer. Almost all deployed a second worker when required and involved the appropriate parties, with information sharing evident. A health professional should have been the second worker for some of the investigations. This was arranged in some cases but not in others indicating collaboration at the investigation stage had room for improvement. Almost

all were timely and effectively determined if the adult was at risk of harm. Investigations were almost always of good or better quality. This supported decision making and management of risk at other stages of the key processes. Most investigations resulted in a case conference; this was considered appropriate for these cases. Crucially a few cases should have also proceeded to case conference but did not.

Adult protection case conferences

The Health and Social Care Partnership had two adult protection review officers who were independent from the social work operational teams. Their remit included chairing all initial and review case conferences.

All case conferences were timely, with almost all inviting the relevant parties to the case conference. Most relevant parties attended when required but some did not, specifically health staff. There was evidence that the NHS Tayside health team were working to ensure health attendance at relevant case conferences improved.

Most adults at risk of harm and unpaid carers were invited to attend case conferences. There were examples of flexible approaches to maximise participation of the adult at risk and their unpaid carer in case conferences. Examples included having meetings in different venues, ensuring with support that the adult at risk of harm understood the concerns and were actively engaged. The reason for not inviting the adult was mostly noted in the case records. When invited most adults at risk and their unpaid carers attended. When independent advocates were involved, they provided support before, during and after the case conference. This supported understanding of the process for the adult and ensured their voice was central to decision making. Almost all case conferences effectively determined risk and safety planning.

Adult protection plans / risk management plans

Almost all adults who required a risk management plan had one. The quality was good or better almost all of the time. All were up to date and reflected the contributions of all agencies that were involved.

For a significant few there was no risk management plan when required. This was more a feature for cases that did not proceed to case conference. More needed to be done to ensure effective risk management for all stages of the adult protection processes. The template for a protection plan was combined with the core group minute so was only completed for adults who had been supported by a case conference. For most adults risk had been addressed.

There were a few cases where banning orders were used to safeguard the adult at risk of harm as part of their protection plan. This was used to positive effect and enhanced the safety of the adult at risk of harm.

Adult protection review case conferences

Almost all adults at risk that required a review case conference had one convened in a timely manner. As part of the process the council officer was required to provide an update report on the activity between case conferences. This was a useful tool that informed decision making at the review case conference. All effectively determined the risk and safeguarding requirements of the adult at risk of harm.

Implementation / effectiveness of adult protection plans

The partnership effectively used core groups meetings as a mechanism for managing risk for adults that were supported under adult protection processes post case conference. Core groups were well attended by relevant agencies and considered risk and mitigations, although there was scope for development around contingency planning. There were some examples of the adult at risk of harm and their unpaid carer taking part in core group meetings. While this was not consistent, engagement was evident throughout the process, this included valuable input from advocacy.

Large-scale investigations

The partnership had a Large-Scale Investigation (LSI) process, which clearly set out each agencies process, roles, and responsibilities. During the period being considered there had been four LSIs processes undertaken. They had effectively utilised this process to safeguard the adults involved. Following review of LSI activity, the process was updated in April 2021 and supporting training materials developed. As part of a Tayside wide arrangement, the partnership shared this learning across the NHS board area.

The partnership had strengthened overview supports to identify concerns, this continued throughout the pandemic. Approaches included analysis of concerns to identify trends and implementing additional support. This included having an allocated resource from health and an identified link manager for care homes from the HSCP.

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

Overall effectiveness of collaborative working

Multi-agency working in Tayside was underpinned by the “Protecting and Supporting Adults at Risk in Tayside” protocol (2019). The protocol provided a basis for a shared understanding of roles and responsibilities across agencies in Angus. To promote accessibility the protocol was publicly available on the Angus adult protection webpage.

Operationally, there was evidence of highly effective engagement and collaboration by all agencies throughout the key stages of adult protection. Although health participation at case conferences and in assuming the role of second worker could be improved. This had already been identified by the partnership as an area for improvement. All agencies were actively engaged in operational groups such as IRDs when convened and the ESG to address concerns proactively. Almost all staff reported they were supported to work collaboratively.

Health involvement in adult support and protection

Health services played a significant role in developing and implementing local and national adult support and protection policy and practice in the partnership. Health leaders supported adult support and protection strategic planning arrangements. This was evidenced in the NHS Tayside Adult Protection Quality Assurance and Improvement Framework (2022-2023).

The dedicated NHS Tayside adult support and protection team worked collaboratively to deliver a coordinated approach for information sharing and learning and development. The team provided training for independent advocacy services and a triage support service for health staff that provided protection guidance. Most health staff who completed our survey said the partnership provided the right level of mandatory adult support and protection training. Almost all health staff reported an increase in confidence and skills after attending.

The partnership had a dedicated adult support and protection adviser who attended adult protection meetings and the ESG. This enhanced collaborative information sharing and decision making within adult support and protection processes.

Health staff working in the partnership contributed positively towards improved outcomes for adults at risk of harm. Requests for medical examinations were made, and completed, for almost all adults who required one. This promoted swift interventions and assessment of harm. Community health services interventions were also supportive, with most rated good or better.

There were opportunities to further develop the involvement of health in relevant key processes including case conferences. The partnership recognised health staff made an important contribution to case conferences and actively encouraged attendance. Health systems continued to be improved to promote information sharing. A health screening tool was being developed to support the collation and sharing of information at adult support and protection meetings, particularly when health staff were unable to attend. Recent performance reports showed the partnership had made improvements in attendance at these meetings.

The quality of record keeping in health records was rated good or better in most cases. The partnership was in the early stages of developing information systems to promote better information recording across health and social care.

Capacity and assessment of capacity

The partnership participated in the development of a pan-Tayside Capacity Assessment Pathway. This promoted greater consistency in capacity referral and assessment processes. Findings indicated that the recently implemented pathway was supportive of practice, although availability of medical practitioners with section 22[3] approval was challenging.

An assessment of capacity was required for some adults at risk of harm in the records we read. In almost all cases a request for assessment was made, and subsequently completed by a relevant health professional. The timing of the assessment was always in keeping with the needs of the adult.

Police involvement in adult support and protection

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

In almost all cases initial attending officers' actions were evaluated as good or better, with critical interventions delivered in support of adults at risk of harm. There was evidence of effective practice and meaningful contribution to multi-agency responding. Officer assessment of risk of harm, vulnerability and wellbeing was accurate and informative in almost all cases. The wishes and feelings of the adult were always appropriately considered and properly recorded.

[3] Approved medical practitioners (AMPs) Section 22- AMPs are those doctors who have undertaken requisite training in the Mental Health (Care and Treatment) (Scotland) 2003 Act. They must be fully registered medical practitioners who are either: Have four years' continuous experience in the specialty of psychiatry and are sponsored by their local medical director.

Where adult concerns were referred, officers did so efficiently and promptly on almost all occasions, using the interim vulnerable persons database (iVPD). Frontline supervisory input was evident in almost all cases and the contribution rated good or better in most.

Divisional Concern Hub staff actions/records were good or better in almost all cases, with evidence of diligent assessment, research and recording by staff. Meaningful input to the iVPD chronology was a reoccurring feature and viewed as adding value to the police records. Almost all cases showed a resilience matrix and relevant narrative of police concerns. Inclusion of the resilience matrix for partners was more apparent in recent cases due to a change in local process to align with national practice. On almost every occasion the referral was shared swiftly with partners

The point at which the escalation protocol was activated (following repeat police involvement) was not always consistent. While there was evidence of well-considered use of the protocol, enhanced intervention and related decision making was more likely where matters had escalated to critical levels, both in the volume of calls, and the needs of the adult at risk. Opportunities remained to better evidence strategic input from local area police command, particularly in more complex and repeat adult support and protection events.

Police attended almost all case conferences, when invited, with engagement almost always good or better. The police adult support and protection officer made a significant contribution to the functioning of local multi-agency arrangements. The value of the role was noted through consistent contribution to, and involvement in meetings (including Initial Referral Discussions), information sharing and recording, and appropriate professional challenge across the peer group.

Third sector and independent sector provider involvement

Provider organisations reported confidence in the referral pathway in Angus. All provider organisations were encouraged to make referrals and most reported that the process was well understood.

Positively, training delivered by the partnership was open to all providers. Most reported the training delivered strengthened practice in adult protection. The third and independent sector had been involved in the development of guides such as the practitioner's guide for chronologies. There were opportunities to further engage representatives from the third and independent sector in the adult protection agenda, particularly in strategic groups.

Key adult support and protection practices

Information sharing

The partnership had established processes for sharing information that met general data protection regulations and duties under the adult support and protection legislation. Almost all adult protection partners shared information effectively. The partnership had recognised that the social work recording system required updating and work had already commenced. The partnership was keen to progress improved recording alongside enhanced information sharing by implementing systems that were more jointly accessible by health and social work. There was a section in the forms used for inquiry and investigation for feedback from referrals. While most staff survey respondents agreed they received feedback, this would be further strengthened by routinely using the feedback form.

Management oversight and governance

Commendably, almost all records evidenced recording of decisions or discussions from supervision. Most health, police and social work records had evidence of governance. The effective use of supervision was reflected in the staff survey with almost all respondents reporting that they receive supportive regular supervision.

Involvement and support for adults at risk of harm

Almost all adults were involved and consulted at the inquiry stage. All adults were involved and consulted at every other stage. There were many examples of practice that demonstrated a trauma informed, sensitive and person-centred approach. Almost all potential barriers were addressed and support for the adult at risk of harm to be involved was present for all adults. This support was good or better for almost all adults at risk of harm.

Independent advocacy

The involvement of independent advocacy in adult protection was considered key to ensuring the rights of the adults at risk of harm were promoted and safeguarded. There was an established advocacy provider, who indicated demand sometimes exceeded available resources.

Almost all adults at risk of harm who should have been offered advocacy were provided the opportunity to engage with that service. In just over half these cases advocacy was accepted and received. In all cases where advocacy was accepted, the provision of service was timely and made a positive contribution for the adult at risk of harm.

Financial harm and alleged perpetrators of all types of harm

Where financial harm was identified the partnership almost always acted to safeguard the adult. This always involved multi-agency working.

The partnership's response to financial harm was complemented by the Financial Abuse Support Team (FAST). The group was multi-agency including representation from trading standards. The relevant agencies convened early meetings as required in response to concerns around financial harm and ensured timely interventions. While not exclusively for adults at risk of harm the adult often met the three-point criteria, occasionally resulting in duplication between duty to inquire activity and the work of FAST. There were opportunities to refine and develop the link between FAST and adult protection. This would support clearer recording and closer alignment of the key processes. There were examples of adults being safeguarded effectively by interventions from this group. The partnership had recently completed an evaluation of this group. Findings were positive about the interventions and identified some areas for improvement, like those identified by the inspection, which the partnership planned to progress.

Work was mostly undertaken when appropriate with the alleged perpetrator of harm, this was of a good or better quality.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced improvements in their circumstances. Adult support and protection processes delivered improved wellbeing for most adults. For a significant few poor outcomes were identified. For half of this small population this was due to the adult's inability or unwillingness to engage with services. Most staff were positive about outcomes for adults that are supported under adult support and protection processes in Angus.

Staff were positive around outcomes for adults at risk of harm and there was high degree of confidence in the intervention and approaches used.

Adult support and protection training

Adult support and protection training was delivered as part of the wider Angus Protecting People Learning and Development Framework. The framework was comprehensive and covered all aspects of public protection including adult support and protection. Training was supported and delivered on a multi-agency basis and open to all agencies. Most staff reported that participation in training had strengthened their adult support and protection practice. Attendance levels from different key partners varied. Single agency training was also available and may have been the reason for the lack of health and police attendance at some joint training.

The HSCP had a dedicated training adviser who supported the delivery of training.

Training continued to be delivered during the pandemic, and delivery was adapted to include online options. Learning from this had been capitalised on to develop a hybrid model of delivery moving forward that included remote and face to face attendance options. The learning and development framework also signposted staff to useful learning resources and there was a regular newsletter to raise awareness of relevant information and training opportunities. The partnership had useful packs including the findings of adult support and protection learning reviews that had taken place.

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

Key messages

- The partnership had a clear vision and strategic plan that was well understood by most staff.
- The leadership decision to appoint specific strategic adult protection posts across all key partnership agencies had positively impacted on adult protection practice and policy.
- The strategic leadership response to the pandemic was strong including enhanced governance, a focus on the wellbeing of workers and prioritisation of adult support and protection.
- The partnership had a comprehensive improvement plan and had made considerable progress in refining the plan and addressing areas for improvement. Further consolidation into SMART[4] learning and action plans would support more effective monitoring and embedding of change.
- Awareness raising and strategic engagement with adults with lived experience of adult support and protection had stalled. Work had commenced to address this, but more progress was needed.
- The adult protection committee was well established with delivery supported by well performing multi-agency sub-groups and risk register.
- Strategic leaders should strengthen their governance by improving feedback from the Chief Officer's Group and review performance data more frequently.
- The last audit of practice took place in 2020. A plan was in place to address this but more needed to be done to involve frontline practitioners and feedback from adults at risk of harm.

We concluded the partnership's strategic leadership for adult support and protection was 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.

[4] Specific, Measurable, Achievable, Relevant, Time-based

Vision and strategy

The partnership's shared vision was clearly stated as "Working together to protect adults at risk of harm in Angus."

This was supported by the Angus Adult Protection Committee (APC) strategic plan dated 2020-2023. This plan referenced the functions of the committee and the national ASP improvement plan. Key priorities, aims and objectives were detailed. The plan would benefit from being streamlined, but it usefully outlined well the strategic direction of the partnership. Most staff reported that local leaders provided staff with a clear vision for their ASP work.

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

The APC was well established and had an experienced independent chairperson. Attendance at the committee included a range of relevant agencies, with some agencies being represented by more than one person. The APC was supported by five sub-groups including a shared public protection group for learning and development. Activities of the sub-groups had been impacted by the pandemic, however four of them continued to operate, although the approaches were adapted. Each sub-group provided written reports to the APC on progress linked to the improvement plan.

Decisions taken by the APC were clearly noted in the minute but not routinely reviewed at each APC meeting. This made it challenging to track progress of decisions taken. The APC maintained a risk register which was reviewed at each meeting and provided an up-to-date overview of strategic risk.

The Chief Officers Group (COG) was also an established group with appropriate membership. The APC provided a copy of the last minute, as well as exception reporting to the COG. To support management of risk, the COG oversaw the APC risk register. The COG effectively promoted links between all the relevant public protection groups/committees and there was a link with the Integration Joint Board. This promoted an integrated approach to protection work. There was good evidence of information being reported to the COG, there was less evidence of feedback from the COG at APC meetings.

While there were comprehensive reports provided to the APC, these did not always include performance data. There was an annual performance report that helpfully compared activity over a two-year period. More frequent, timely, updates from all partner agencies, along with feedback from adults at risk of harm would improve governance and provide further reassurance to the APC and COG.

In response to the pandemic the APC chairperson convened weekly multi-agency meetings and regularly reported to the COG. ASP practice was made a priority, this was written into the guidance provided to workers. This was a demanding time for the partnership, and they experienced a significant increase in adult protection referrals. The weekly meetings focused on ensuring staff capacity and provision of technology to respond to these concerns. The partnership recognised the impact on wellbeing of staff during the pandemic and proactively implemented initiatives to provide support. Most staff reported a confidence that leadership was effective in Angus. At both the leadership and frontline practitioners focus group there was a sense of positivity around direction and leadership.

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

While there were no adults with lived experience on the APC, there was representation from the advocacy group on the committee. The partnership recognised that this was an area for improvement and highlighted that the communication sub-group had stalled, along with the service user engagement plan due to the demands of the pandemic. The staff survey response reflected that raising public awareness was an area for improvement with just under half agreeing local leaders led this work effectively.

More positively, work had commenced on reinvigorating these two workstreams and a service user engagement strategy was developed that included human rights training. It was too early to identify any impacts from this strategy. It was important to develop the person-centred approach further by seeking feedback and involvement from adults at risk of harm and their unpaid carers strategically as well as operationally.

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

The partnership was committed to effective collaboration in adult support and protection. The partnership made the decision to have specific adult protection posts across health, police, and social work.

In social work this provided capacity for dedicated personnel to chair all case conferences, lead on specific supportive constructs such as FAST, and contribute to training and strategic work. In health there was a dedicated adult support and protection health team. This team supported both operational practice and was involved and led on some of the key strategic developments such as the capacity assessment pathway. Police Scotland had a dedicated officer allocated, although if they were not available operational input and collaboration from police was more limited. Strategically police involvement was evident in a number of sub-groups and the wider work of the APC. All key partners supported the learning and development framework and participated or led in the development of adult

protection practice in Angus. There were a few examples that indicated more needed to be done to ensure timely information sharing within the Health and Social Care Partnership. This was being addressed by training on roles and responsibilities.

Other relevant agencies such as Scottish Fire and Rescue Service, housing and the Scottish Ambulance Service had also made a positive contribution to adult protection practice and collaborated well. An example being the development of the self-neglect and hoarding toolkit, with associated training being delivered.

Commendably, it was evident that the partnership worked collaboratively to support the wellbeing of the workforce. The Wingman initiative was a wellbeing bus that travelled across Angus providing time out and support to frontline practitioners. The senior leadership team participated in peer support training and there was a clear commitment to continue to ensure staff development and wellbeing were considered across the partnership.

The partnership recognised adult support and protection as a factor that needed to be considered as part of the response to the pandemic. The Care Home Operational Group convened provided multi-agency oversight and was complemented with a dedicated adult protection adviser from the NHS Tayside health team.

Quality assurance, self-evaluation, and improvement activity

Quality assurance and the improvement plan were routinely overseen by the self-evaluation and continuous improvement sub-group reporting to the APC. The last audit was single agency and completed in 2020. This audit identified 41 recommendations for improvement including the recording of risk, use of chronologies and evidencing involvement of the adult at risk. Some of the areas for improvement were still evident in our inspection. Therefore, progress relating to these areas for improvement should be accelerated.

The APC had progressed the improvement plan arising from the audit in 2020 and the improvement work identified through various case reviews. It was recognised that there was significant work in this area which was having a positive impact on practice. The structure and the content of the improvement plan had been refined. However, it was extensive with overlapping areas and was not consistently updated. There were opportunities to further refine the improvement plan to consolidate actions, embed measures of change and more clearly monitor impact.

Audit activity was further delayed because of the pandemic. The partnership recognised that quality assurance was an area for improvement and had developed a plan for regular auditing and were piloting a quality assurance framework. A multi-agency approach to audits would enhance learning in this area. The partnership had undertaken multi-agency self-evaluation of discrete areas of practice including the operation of the FAST process. They also arranged workshops to consider practice and the APC held a development day.

Just over half of staff survey respondents agreed that change was well managed, but most did not feel they had the opportunity to be involved in evaluating the impact of ASP work or improvement activity. The partnership planned to implement networks of support involving different tiers of workers and managers as part of the quality assurance framework. This should improve the workforces' meaningful involvement in quality assurance and improvement activity.

Initial case reviews and significant case reviews

The partnership completed two significant case reviews, two initial case reviews and there was a third that was ongoing. These were completed under the Angus APC Initial and Significant Case Review guidance 2021 which was aligned with the Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019). All reviews have resulted in multi-agency improvement plans and have informed training materials and content across the partnership. Following the publication of the P19 review report, the partnership was involved in improvement work supported by the Care Inspectorate and Healthcare Improvement Scotland. A report detailing the work undertaken was recently published.

Summary

The partnership had positively responded to the challenges of the pandemic, a significant increase in referrals and their considerable improvement activity agenda. This included updating procedures with associated templates and adding additional financial and staff resources to strengthen adult protection practice.

The delivery of key processes overall was highly effective. This included investigations and case conferences which were person-centred thus ensuring that adults at risk and their unpaid carers were supported, consulted, and involved. The management of risk was particularly strong for adults supported at case conference and beyond although less so for a few who did not progress to that stage. The quality of chronologies and recording were areas for improvement, the partnership had already commenced work in these areas.

The partnership had a vibrant learning and development culture for adult protection this was part of a wider protecting people framework. This supported increased confidence and skills in adult protection practice.

The partnership had a clear vision with established governance structures that ably supported the operation of the APC. Though the link with the Chief Officer's Group would be further strengthened by having increased reporting and feedback between the committees. The APC had helpful links with other relevant committees and groups. Collaborative working was strong but there were opportunities to enhance this further by having more frequent multi-agency audits and feedback. The adult protection committee oversaw improvement actions. Further refinement of the improvement plan and timely performance data would improve measuring impact and identify barriers to change.

Person-centred, rights-based approaches were evident throughout adult support and protection operational practice. Strategic awareness raising and engagement with adults with lived experience had stalled but work had recommenced in this area. It was important to ensure that this be progressed to support further improvement work to be shaped by this valuable feedback.

Overall, the partnership has demonstrated the capacity to deliver positive change that improved outcomes for adults at risk of harm.

Next steps

We asked the Angus 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 His Majesty's Inspectorate of Constabulary in Scotland 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.
- 30% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 93% of episodes where the three-point criteria was applied correctly by the HSCP
- 95% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% less than one week, 50% more than three months
- 93% of episodes evidenced management oversight of decision making
- 83% of episodes were rated good or better.

Staff survey results on initial inquiries

- 89% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 5% did not concur, 6% didn't know
- 79% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 3% did not concur, 18% didn't know
- 79% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 9% did not concur, 12% didn't know

Information sharing among partners for initial inquiries

- 98% 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
- 55% of chronologies were rated good or better, 46% adequate or worse

Risk assessment and adult protection plans

- 98% of adults at risk of harm had a risk assessment
- 63% of risk assessments were rated good or better
- 83% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 83% of protection plans were rated good or better, 17% were rated adequate or worse

Full investigations

- 98% of investigations effectively determined if an adult was at risk of harm
- 98% of investigations were carried out timeously
- 84% of investigations were rated good or better

Adult protection case conferences

- 100% were convened when required
- 100% were convened timeously
- 61% were attended by the adult at risk of harm (when invited)
- Police attended 88%, health 83% (when invited)
- 86% of case conferences were rated good or better for quality
- 88% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 93% 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

- 97% of adult protection concerns were sent to the HSCP in a timely manner
- 95% of inquiry officers' actions were rated good or better
- 86% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 75% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 71% good or better rating for the quality of ASP recording in health records
- 86% 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

- 98% of cases evidenced partners sharing information
- 100% of those cases local authority staff shared information appropriately and effectively
- 96% of those cases police shared information appropriately and effectively
- 96% of those cases health staff shared information effectively

Management oversight and governance

- 80% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 86%, police 88%, health 73%

Involvement and support for adults at risk of harm

- 100% of adults at risk of harm had support throughout their adult protection journey
- 88% were rated good or better for overall quality of support to adult at risk of harm
- 80% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 4% did not concur, 15% didn't know

Independent advocacy

- 93% of adults at risk of harm were offered independent advocacy
- 54% of those offered, accepted and received advocacy
- 100% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 88% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 87% of these adults had their capacity assessed by health
- 100% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 28% of adults at risk of harm were subject to financial harm
- 78% of partners' actions to stop financial harm were rated good or better
- 80% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 94% of adults at risk of harm had some improvement for safety and protection
- 100% of adults at risk of harm who needed additional support received it
- 74% concur adults subject to ASP, experience safer quality of life from the support they receive, 5% did not concur, 21% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 66% concur local leaders provide staff with clear vision for their adult support and protection work. 10% did not concur, 24% didn't know

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

- 67% concur local leadership of ASP across partnership is effective, 5% did not concur, 28% didn't know
- 67% concur I feel confident there is effective leadership from adult protection committee, 4% did not concur, 29% didn't know
- 49% concur local leaders work effectively to raise public awareness of ASP, 11% did not concur, 40% didn't know

Quality assurance, self-evaluation, and improvement activity

- 55% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 9% did not concur, 36% didn't know
- 55% concur ASP changes and developments are integrated and well managed across partnership, 7% did not concur, 37% didn't know