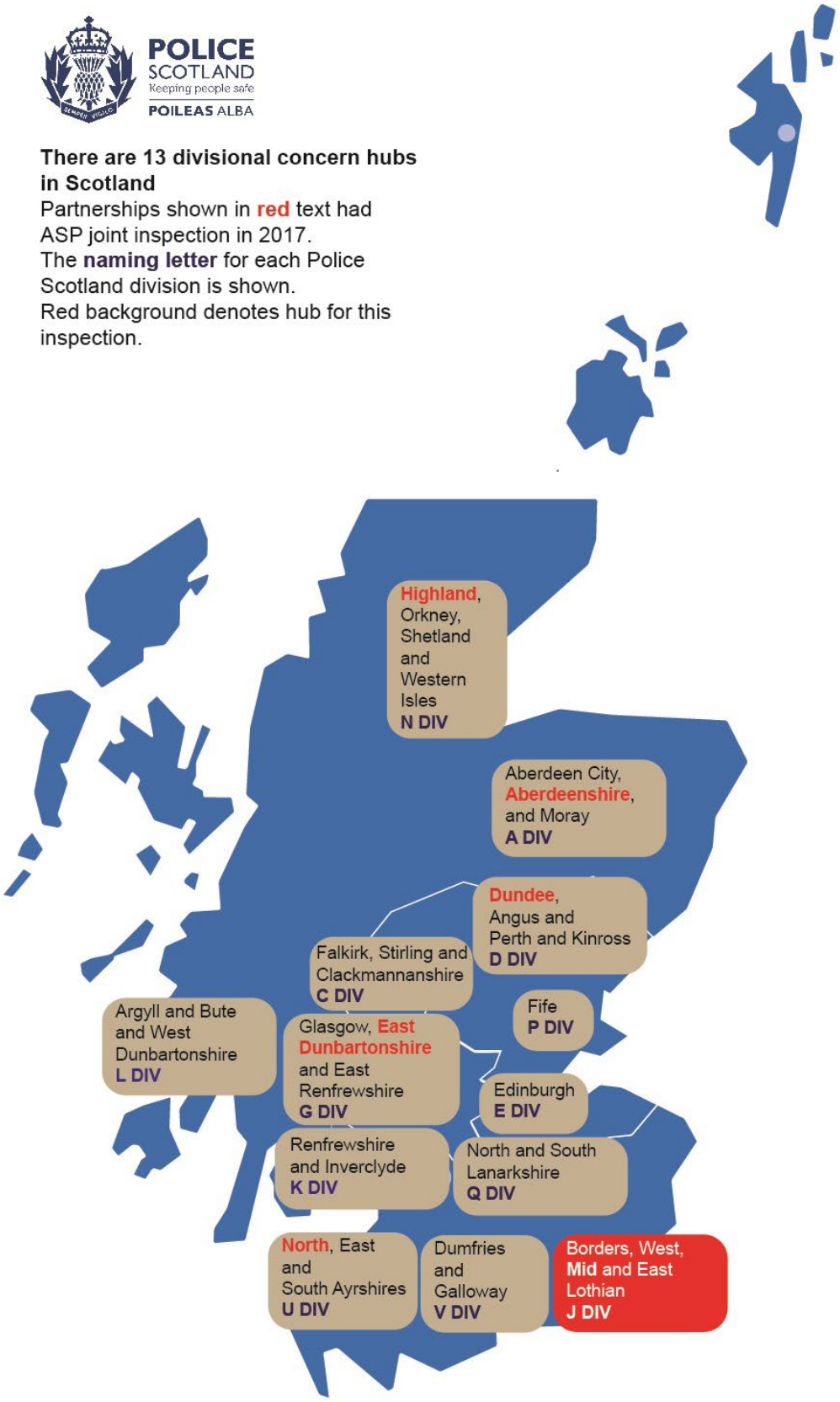
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

East Lothian Partnership June 2023

Contents

Map showing divisional concern hubs



Joint inspection of adult support and protection in the East Lothian 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 operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017-2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the East Lothian partnership area were safe, protected and supported.

The joint inspection of the East Lothian partnership took place between February 2023 and June 2023.

The East Lothian partnership and all others across Scotland faced the unprecedented and ongoing challenge of service recovery as a result of Covid-19 pandemic. We appreciate the East Lothian 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?

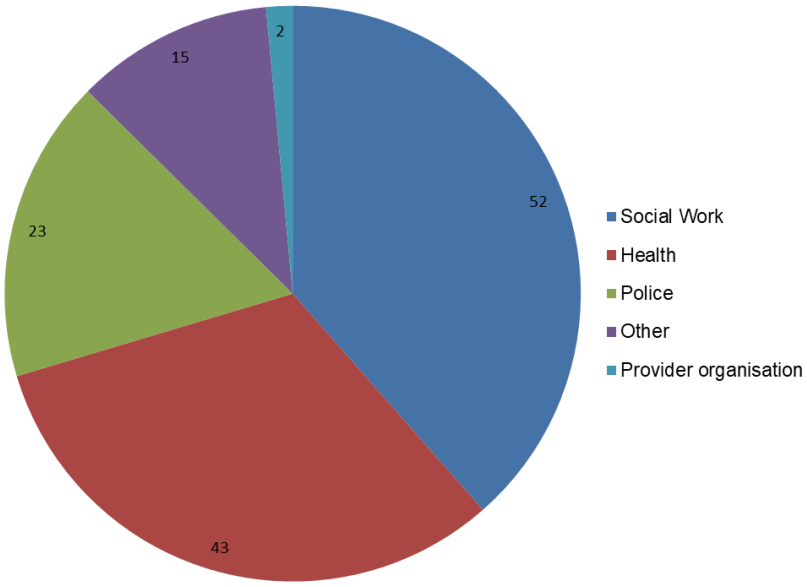
Joint inspection methodology

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. One hundred and thirty-five 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.

Respondents by Employer type

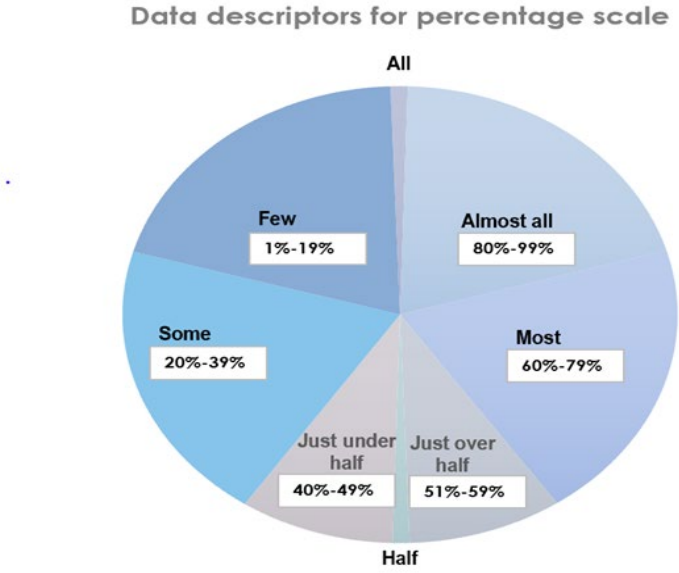


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

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 27 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's approach to adult support and protection inquiries was robust.
- Person-centred engagement and consultation with the adult at risk of harm was evident throughout the delivery of all key processes. This supported effective consideration of risk.
- Effective social work management, support and supervision was consistently recorded and contributed to the effective delivery of key processes.
- Almost all adults at risk of harm who required a risk assessment had one completed. The quality of risk assessment had improved significantly following the implementation of the Type, Imminence, Likelihood and Severity (TILS) framework. Subsequent risk management work needed improved.
- The partnership's large scale investigative process was established and included a useful reflective element that supported improvement actions.
- The partnership's vision was well understood. The delivery of strategic aims was supported by the public protection committee improvement plan.
- The public protection committee and critical services oversight group were well established. There was synergy between these groups that supported the effective delivery of strategic aims.
- The partnership responded appropriately to the demands of the pandemic. They ensured the continued delivery of adult support and protection services and provided good support to practitioners.

Priority areas for improvement

- Adult support and protection improvements were positively impacting on key areas of practice. Importantly, procedural updates had not kept pace. The guidance should be updated as a priority.
- Findings from adult support and protection audits and improvement actions about risk management and chronologies should be fully implemented.

- A multi-agency approach to audit would strengthen joint improvement work. This should involve frontline practitioners from across the partnership.

- Relevant professionals should engage more collaboratively with critical processes. This includes attendance from police and health at case conferences and the consideration of second workers from all agencies.

- Strategic planning and improvement work should include feedback from, and engagement with adults at risk of harm with lived experience. This should be progressed as soon as possible.

- Interventions with alleged perpetrators and financial harm needed significant improvement to ensure appropriate action is taken on a multi-agency basis.

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

Key messages

- Adult support and protection inquiries were timely, proportionate, and highly effective.
- The approach of council officers was person centred and focused on engaging and consulting with the adult at risk of harm throughout the process. This supported effective risk assessment.
- Independent advocacy was offered to most adults at risk of harm who needed it. This important service was provided timeously and accepted most of the time.
- Social work case recording and supervision was robust.
- The quality of risk assessment in the partnership was strong. Recently introduced and improved templates supported more effective risk assessment.
- The partnership had an established multi-agency approach to large scale investigations. This usefully included reflective learning at the end of the process.
- The quality of investigations and case conferences was good for most adults at risk of harm. However, they did not consistently involve agencies when appropriate including attendance at case conference and the use of second workers.
- Risk management required further development. This included the consistent use of core groups and chronologies to support adult support and protection decision-making.
- The partnership always took action to address financial harm. There was scope to improve the quality of the intervention by strengthening multi-agency working.
- The partnership's work with, and actions against, alleged perpetrators needed to be more effective.

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

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns

All referrals, including internal referrals, were received via the contact centre. There was no standard referral form. The contact centre was operated by unqualified social work staff. There were some discrepancies in recording the referral category. Crucially, this did not impact on the quality of the response which was positive overall. Training and guidance for staff relating to types of harm would support more accurate recording.

The partnership operated a duty system for adult protection activity. The contact centre passed all referrals for screening on the same day as they were received to the social worker led duty team. Information forwarded included a clear rationale for decision-making and outcome.

Initial inquiries into concerns about adults at risk of harm

Creditably, all inquiries were completed in line with the principles of the legislation. The three-point criteria was correctly applied and clearly recorded. Almost all inquiries were timely, included effective communication with key partners and were rated as good or better. Almost all were considered to have ended at the correct stage.

Management oversight was evident for almost all inquiries completed. There were examples of comprehensive multi-agency inquiries being completed with appropriate action taken to manage risk. Almost all staff were confident that referrals were effectively dealt with. In November 2022, the partnership developed an internal escalation protocol to support gathering of health information from a general practitioner. Feedback letters for referrals was introduced in April 2023. Both developments were innovative, but it was too soon to measure the impact of these developments. Overall, the use of inquiries to assess, manage and support the adult at risk of harm was strong in East Lothian.

As part of the partnership's processes there was an option to convene an interagency referral discussion. This could be convened at any point in the process. Their use was inconsistent, and the quality was variable. When convened they did not always involve key partners or enhance the decision-making process. The practice, function, and engagement from key partners around the interagency referral discussion process needed further developed.

Investigation and risk management

Chronologies

East Lothian were members of the pan-Lothian development group for chronologies. This had supported the development of templates and intended aims for chronologies. Resultingly chronologies became part of the investigative process in November 2022.

Despite this the use of templates and application of chronologies was inconsistent and not in line with local procedures. Just over half of adults at risk of harm had a chronology completed when expected, some were rated good or better. Improvement was needed in the recording of significant life events, the impact on adults at risk of harm and relevant analysis instead of listing service interventions.

Risk assessments

Almost all adults at risk of harm who required a risk assessment had one completed in a timely manner that involved multi-agency views to inform the assessment. Most risk assessments were of a good or better quality.

The partnership had developed their approach to risk assessment over the past two years. In August 2022 this culminated in using the Type, Imminence, Likelihood and Severity (TILS) framework embedded in the recording templates for each aspect of adult protection. This supported the practitioner to consider, analyse and measure risk at each stage of the process and review progress from the previous stage. This resulted in more robust assessments and recording of risk.

An escalation concern procedure was implemented in September 2022 to support management of adults with complex needs assessed as not meeting the three-point criteria but still at high risk of harm. This was a positive multi-agency approach that involved senior managers overseeing assessments and agreeing measures to mitigate risk. It was too early to identify the impact of this procedure.

Full investigations

The updated template for recording investigations was well designed and supported accurate recording of investigations. Almost all adults that required an investigation had one completed by a council officer and involved the appropriate parties. Most investigations were rated good or better with almost all being timely and effectively determining if the adult was at risk of harm.

Despite effective templates, the local procedures did not promote routine consideration of second workers as part of the process. Just under half of investigations required a second worker. While most involved a second worker for some, this was not provided. Clearer promotion of a second worker was required with an enhanced criteria beyond where there was a risk of harm to the practitioner.

Adult protection case conferences

Case conferences were convened for almost all adults at risk of harm who required one. Almost all were timely, although a significant few were delayed between one to three months. Most of the time relevant professionals were invited but attended only half of all case conferences. This impacted adversely on the opportunity for operational collaboration, assessment, and management of risk. Police and health professionals were the main group of stakeholders who did not attend when invited. Where convened, most case conferences were rated good or better.

The adult at risk of harm was invited to most case conferences and attended just under half of the time. The reason for non-attendance was not always clearly recorded. When they attended, the adult at risk was always effectively supported and there were examples of person-centred engagement with the adult. When relevant, the unpaid carer was invited to attend almost all case conferences and mostly accepted this offer. Case conferences attended by relevant adults at risk and or unpaid carers took a more robust approach to the consideration of risk. All case conferences convened were recorded and effectively determined actions required to ensure the adult at risk of harm was safe and protected.

Adult protection plans / risk management plans

Almost all adults at risk of harm who required a risk management or protection plan had one in place. For a few there was no risk management plan, adversely impacting on protection arrangements.

Almost all plans were timely and reflected the contributions of other multi-agency partners. The quality of most plans was rated as good or better. For some, improvement was required. Reasons for this included a lack of contingency planning, protection plans lacking detail and allocation of actions being unclear. The embedding of the Type, Imminence, Likelihood and Severity (TILS) approach had improved risk management planning. However, this was a recent development, and the full impact could not yet be determined. Positively, almost all concerns regarding protection type risk had been adequately dealt with.

Adult protection review case conferences

Almost all adults that required a case conference had one convened in a timely manner. For a significant few a review case conference was not convened when it should have been. This was due to overlapping processes, such as intervention under other legislation. When a review case conference was convened, they almost always effectively determined what needed to be done to ensure that the adult at risk of harm was supported and protected.

Implementation / effectiveness of adult protection plans

Non-attendance by key professionals at case conferences impacted on the depth of information shared and a robust consideration of risk. Sometimes, it was unclear how actions for partners that did not attend were communicated or implemented. The partnership had core groups as part of the process of managing protection plans. When these were held, they improved the management of risk. The use of core groups was inconsistent and there were opportunities to further enhance practice and consistency of approach in this area.

Large-scale investigations

The partnership had a well-established large scale investigation process. The partnership had completed five LSIs over the past two years. The partnership effectively utilised their local LSI process to investigate and manage risk. There were examples of good multi-agency involvement in LSIs to protect adults at risk of harm. As part of the process, the partnership completed a closure report that usefully included a reflection of the process and identified areas for future learning. This report was completed by the chair of the LSI and presented to the public protection committee for assurance and improvement.

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

Overall effectiveness of collaborative working

Multi-agency working in the partnership was underpinned by the East Lothian and Midlothian public protection committee adult support and protection procedures which were last updated in 2020. While these procedures were useful, they did not reflect the updated code of practice or reflect the numerous operational improvements that had been made since 2022. The partnership was in the process of updating the procedures.

Operationally, there was evidence of effective communication and collaboration by all agencies, particularly at inquiry and investigation stage. Participation by health and police colleagues in case conferences was less evident adversely impacting on effective collaboration at this stage. Further promotion and a review of the second worker criteria would strengthen wider collaboration. This would improve the overall effectiveness of collaborative working.

Health involvement in adult support and protection

In March 2023 NHS Lothian updated and implemented their adult support and protection procedures for all health staff. This was specific guidance aimed at providing guidance for health staff on how to support and protect adults at risk of harm.

Most health records we read appropriately recorded adult protection concerns. Some did not despite social work records confirming health staff were providing interventions to support adults at risk of harm. The quality of record keeping and documentation in health records was good or better in most cases. Information relating to shared discussions such as interagency referral discussion and case conferences were not fully reflected in the health recordings. Health staff had only recently become full participants in the IRD process.

When involved, health staff made a positive contribution to improved outcomes for adults at risk of harm most of the time. A few adults at risk of harm required interventions from accident and emergency departments and hospital services to help keep the adult safe and protected. Interventions from staff were good in all cases. Similarly, a few adults at risk of harm required interventions from community health services, the quality of interventions from community health staff was also positive.

Opportunities for health staff to be more involved at the initial inquiry and investigation stage were not always maximised. Some health staff were not always given timely feedback after they shared information with social work. Health staff were invited to all case conferences when they should have been, although representatives did not always attend. This meant relevant information was not always shared, adversely impacting on risk assessment and protection planning.

Capacity and assessment of capacity

An assessment of decision-making capacity was required for just under half of adults at risk of harm whose records we read. These were consistently requested with the relevant health professional completing the assessment most, but not all the time. Almost all capacity assessments completed were timely.

The partnership, as part of the learning and development plan, had included raising awareness of Adults with Incapacity (Scotland) Act 2000. There were prompts within updated adult support and protection templates to assist council officers to consider decision specific capacity, although there was scope to further refine this.

Police involvement in adult support and protection

Contacts made to the police about adults at risk were always effectively assessed by control room staff for threat, harm, risk, investigative potential, vulnerabilities, and engagement required (THRIVE). Just over half the cases had an accurate STORM Disposal Code (record of incident type). There was an opportunity to improve STORM disposal code recording.

In almost all cases initial attending officers' actions were evaluated as good or better, with relevant 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 almost always appropriately considered and properly recorded.

Where adult concerns were referred, officers did so promptly on 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 just over half.

The divisional concern hub shared initial protection concerns with social work in a timely and efficient manner, with the actions/records of the hub staff good or better in most cases. Almost all cases showed a resilience matrix and most had a relevant narrative of police concerns. On a few occasions there was evidence that divisional concern hub practice could have been stronger than it was. Acknowledging the complexity of the cases, greater professional curiosity in exploring the matters under consideration would have brought added value to the policing contribution.

The point at which the police escalation protocol was initiated (following repeat police involvement) was consistent and in line with national practice. What was less apparent was consideration of subsequent alternative interventions in responding to the needs of the adult, and where appropriate minimising continued police involvement. Greater evidence of strategic input from local area police command, may have been expected, particularly in more complex and repeat adult support and protection events.

Interagency referral discussions were a feature in most cases where there was police involvement. Officer contribution was good or better on most occasions, and mostly facilitated by a police supervisor. However, the partnership's approach to referral discussions did not always add clear value to the delivery of ongoing adult support and protection arrangements. Opportunities remained for the core participants to consider the timing, structure, and outcomes of these discussions to ensure that this shared commitment consistently enhanced the response to adult support and protection.

In a few cases officers were not invited to case conferences where involvement may have been expected. Police attended half the case conferences to which they were invited, consistently submitting reports for those cases where officers were not present. Greater police involvement would have further strengthened case conference arrangements.

Third sector and independent sector provider involvement

Provider organisations were encouraged to make referrals and had confidence in the process. Multi-agency training was open to all providers as set out in the learning and development framework. When additional support was required for adults at risk of harm, this was provided responsively by the third or independent sector for most adults. Almost all support provided was rated as good or better and was considered effective in delivering personal outcomes for the adult at risk of harm. There were examples of good provision of support. The health and social care partnership had implemented a system to manage demand and create capacity for more positive work.

Key adult support and protection practices

Information sharing

Timely and appropriate information sharing was evident at inquiry and investigation stage. Engagement and information sharing at case conference stage was less evident. There were missed opportunities for health and police professionals to be involved in this critical process. This was due to social work not routinely inviting key partners to attend and more commonly non-attendance when invited. The partnership operated a multi-agency interagency referral discussion overview group that had the potential to support information sharing around this process. But the inconsistent use of interagency referral discussion practice and quality assurance in this area required improvement.

Social work had established a feedback process, however some referrers, in particular police staff, disagreed.

Management oversight and governance

The standard of social work supervision, record keeping, and management oversight was strong in East Lothian. The health and social care partnership had useful authorisation sections in key templates that included the rationale for decision-making and any delay explanation. Almost all social work and police notes had evidence of governance and oversight. In social work records there were examples of audits completed by service managers to quality assure the protection process with feedback being given to the worker and their direct manager. In police notes there was evidence of a similar approach. However, the same form of wording was repeatedly used in the records regardless of the circumstances undermining confidence in the level of oversight. More meaningful recording by police was required. For relevant health records most had evidence of governance. Almost all staff valued supervision and the support it provided for practice.

Involvement and support for adults at risk of harm

Almost all adults at risk of harm were involved or consulted at inquiry, investigation, and case conference. At the protection planning stage all adults at risk of harm were involved or consulted in the development of their protection plan. Almost all adults had support to be involved throughout the process. The effectiveness of this support was rated good or better for most adults at risk of harm. Unpaid carers were appropriately involved or consulted in almost all cases. There were examples of good practice including council officers being flexible and sensitive in approach. This included identifying family members not involved prior to the concerns and supporting the adult at risk of harm to reconnect.

Independent advocacy

The health and social care partnership commissioned independent advocacy providers for this service. Due to low uptake over recent years the health and social care partnership actively promoted advocacy via focused staff briefings, newsletters to providers and inputs at relevant training.

When required, advocacy was offered to most adults at risk of harm. The service was provided timeously and accepted most of the time. When involved advocacy almost always effectively supported the adult to articulate their views. The health and social care partnership were continuing to progress improvement work around advocacy. They had established a steering group to review service provision. Positively, as part of the developments it had been planned that one of the providers would recruit an advocacy worker to be in post from June 2023. The focus of the new role would be to gather feedback from adults at risk of harm with lived experience and improve operational practice.

Financial harm and alleged perpetrators of all types of harm

The partnership had raised public awareness around financial harm with the 2022 adult support and protection day including input on surviving economic harm. The partnership took appropriate action to address financial harm for almost all adults. For just over half this involved multi-agency working. The quality of intervention was good or better for some adults who were subject to financial harm suggesting further improvement work was required on a multi-agency basis.

For just under half of cases where an alleged perpetrator was identified, almost all were known to the partnership. For just over half of these cases the partnership acted against the perpetrator, with the main action being reporting to the police. Significantly the effectiveness of this action was rated adequate or less for most cases. When appropriate the partnership worked with all alleged perpetrators. That said the quality of this work required improvement.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced good outcomes in relation to safety and protection reflecting a strong staff confidence in this area of practice. This was mostly due to multi-agency working. There were examples of different agencies working together and actively engaging with the adult using a trauma informed approach to deliver good outcomes for the adult at risk. Poor outcomes were identified for a few adults at risk of harm, this was mainly attributed to challenges around the adult engaging with protective measures.

Adult support and protection training

Responsibility for learning and development for adult protection lay with the East Lothian and Midlothian learning and practice development sub-group. This sub-group developed a learning and development strategy 2021-2023 which outlined the plan and level of training for all agencies involved in adult support and protection. Training was open and delivered to all agencies. Because of the pandemic most training was moved on-line. Initially accessing training on-line was a challenge for some agencies due to the incompatibility of on-line platforms.

The partnership had resolved accessibility issues and re-established training operating a hybrid model of delivery. Most staff reported they had access to training that was appropriate to their needs. The partnership had further developed some training courses to improve the level of skills and knowledge. Notably the council officer course has been developed to take a modular approach over a wider timespan. Almost all council officers reported council officer training effectively supported understanding of duty and roles. This was augmented by facilitating a council officer forum that provided an opportunity for council officers to consolidate learning.

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

Key messages

- The partnership's vision was embedded in the public protection committee improvement plan and was a clear strategic priority.
- The public protection committee was well established with effective multi-agency sub-groups delivering on its strategic goals.
- The critical services oversight group had positively engaged in a self-evaluation process and prioritised improvement activity. This good work was on-going.
- The partnership responded well to the pandemic including increased oversight arrangements and staff welfare support.
- While there was much improvement activity, some identified areas for improvement from single agency audit and self-evaluation had not been effectively progressed. Guidance for staff also needed to be updated. The governance of change needed to be more effective.
- The public protection committee audit programme was limited to a single agency social work approach. A joint multi-agency approach would strengthen quality assurance and improvement activity.
- There was no feedback or strategic engagement with adults at risk of harm or people with lived experience including unpaid carers. This should be addressed in line with the adult support and protection codes of practice.

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.

Vision and strategy

The public protection committee reviewed its vision in June 2022 and communicated it via their quarterly newsletter. It said "Everyone has the right to be safe and protected from harm and abuse. We will protect our children, young people and adults in East Lothian and Midlothian by working together and upholding our values." We saw these core values underpinning the protection work in the community. The vision was well understood, and staff expressed a good level of confidence in the public protection committee.

The delivery of the vision was embedded in the East Lothian adult support and protection improvement plan. The plan was SMART[3] but some fields had not fully been completed. "Keep people safe from harm" had also been made a key objective in the Health and Social Care Strategic Plan (2022-25) thus strengthening the protection agenda across the wider partnership arrangements.

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

Strategic oversight of adult support and protection in East Lothian was overseen by the East Lothian and Midlothian public protection committee. The committee covered all aspects of public protection across both geographical areas. The dual arrangement was well established and supported by four sub-groups with plans for a fifth sub-group that would consider learning reviews for both adults and children. Two sub-groups related directly to adult support and protection, specifically the learning and development sub-group and the performance quality improvement sub-group. Both groups were multi-agency and considered relevant information to progress the delivery of adult support and protection. The work of the public protection committee was supported by a lead officer for adult support and protection who issued a quarterly newsletter. The public protection arrangement encouraged close working across the wider protection agenda.

The chief officers' group, known as the critical services oversight group, had a clear remit and terms of reference. The governance arrangements had been subject to self-evaluation including four planned development sessions. The critical services oversight group had relevant reports from the public protection committee that included performance data and regular updates on the work of the sub-groups. Risk was explicitly considered, and decisions overseen. Other relevant areas were highlighted and considered. The meetings were quorate and well attended. Given the slow progress in some development areas and some gaps in the improvement plan, there was scope for both the public protection committee and critical services oversight group to further strengthen governance. A new chair for

[3] Specific, Measurable, Achievable, Realistic, and Timely

the public protection committee had been appointed. There had been planned changes of personnel in other key posts such as the senior manager responsible for adult support and protection and chief social work officer. The partnership had made plans around this to support business continuity.

In response to the pandemic, the partnership had increased frequency of meetings and they were moved on-line. Within social work a regular internal meeting was commenced with the focus being on managing risk, demand and supporting the workforce. These internal meetings had continued and were useful in supporting improvement action in 2022. There were plans to extend the membership of this group to include other agencies. The partnership continued to prioritise adult support and protection and encouraged office-based duty staff arrangements to promote accessibility and a timely response to concerns.

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

There were no adults with lived experience represented on the public protection committee, nor was there representation from independent advocacy. Feedback from adults at risk of harm or unpaid carers who had been involved in adult support and protection processes was not collected or considered. Strategically there was a lack of engagement with those with lived experience to reflect and influence the adult support and protection strategic agenda and operational practice in East Lothian. The public protection committee recognised the importance of this representative role and had plans to progress work in this area.

While public awareness of adult support and protection was promoted the staff survey indicated that further work in this area would be beneficial.

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

The partnership effectively collaborated in most key areas. There was good multi-agency working at committee level and within sub-groups to deliver the key strategic aims. There was scope to develop this further particularly operationally at case conferences and in audit and self-evaluation of operational practice. While the interagency referral discussion system and overview group had operated for many years input and quality varied. In December 2022 a rota for heath staff was introduced to support the health contribution to these processes. Further reflection of what was being focused on would improve governance around this process.

Performance reporting for adult support and protection was presented at each committee meeting. The helpful report had key indicators with breakdown for each geographical area. This was focused on the social work delivery of key processes and when discussed at committee performance and involvement of the key partners was not explored.

Due to the remit of the committee, the membership was wide and usefully included representation from housing and Scottish Fire and Rescue. There were opportunities to involve wider representation in the strategic agenda such as trading standards, particularly as improvement in operational practice in financial harm was required.

In response to the pandemic, as well as having increased frequency of meetings of the committee, the partnership also took additional measures. In line with Scottish Government guidance the health and social care partnership convened care home oversight groups that included care at home. The aim of this was to provide support and have oversight of risk. The health and social care partnership also recognised the importance of the well-being of the workforce. In response, they commissioned an external organisation to facilitate a debrief session with staff who had been involved in responding to the challenges and associated risks within commissioned social care services.

Quality assurance, self-evaluation, and improvement activity

The public protection committee commenced a programme of self-evaluation in October 2021 which consisted of a staff survey including the health and social care partnership and Police Scotland, and workshops for managers. Operational delivery and governance had since been allocated to the general manager for adult services and a specific service manager. This new arrangement supported the improvement of the delivery of key processes.

In November 2021 and August 2022 there were single agency audits. The findings of which were reported to the relevant sub-group and public protection committee. These audits would have benefitted from a wider focus that involved multi-agency partners. Some of the areas for improvement identified in the audits were similar to our inspection findings, specifically the risk assessment, protection planning and the use of chronologies. The partnership had made some progress in these areas, particularly around risk assessment but the pace of change needed accelerated. There was a regular interagency referral discussion oversight group which included representation from health, police, and social work. The findings from inspection suggest a review of the approach of this group would be beneficial.

The partnership had implemented a new quality assurance programme in 2023 consisting of performance indicators, monthly focused audits, and peer review. To support improvement action there was a monthly social work adult support and protection oversight meeting where findings were discussed, and action agreed. Other than the interagency referral discussion oversight group and work around the critical services oversight group, there was no planned multi-agency approach to self-evaluation or audit. While it was too early in the implementation stage to measure the impact of this programme just over half of staff agreed that changes were well managed. Only some agreed they had been involved in evaluating the impact of adult support and protection practice.

Initial case reviews and significant case reviews

In the past two years there had been one initial case review completed and one learning review referral that did not proceed further. Both processes were conducted in line with the relevant guidance resulting in learning and improvement actions. To embed the Learning Review Guidance for Adults (2022) the partnership planned to establish a mandated sub-group. This would oversee all action in relation to learning reviews for children and adults.

The partnership also reflected on available case reviews and thematic reports from other areas. Learning from these had been used and disseminated via the use of seven-minute briefings.

Summary

It was evident that the partnership was on a positive improvement journey and that while considerable progress had been made, much was ongoing or planned. Consolidation of work with updated procedures would support the planned future developments.

The partnership response to referrals and inquiries was very effective. Overall, the partnership's delivery of investigations and case conferences were effective but demonstrated some key areas for improvement. The inclusion of the Type, Imminence, Likelihood and Severity (TILS) framework in all key documents resulted in a more structured focus on risk. This approach had the potential to significantly improve standards, but the changes were still being embedded. It was too soon to evidence the full impact of this approach. Risk management and protection planning was often impacted by the lack of involvement of key partners and was particularly evident at case conference. So, while risk was considered and protection plans implemented, the robustness of the plan and discharging of decisions sometimes lacked clarity. The quality of chronologies and use in practice were areas for improvement.

Person-centred practice was strong in this partnership and there were good examples of sensitive, trauma informed practice in effectively engaging with adults at risk of harm and their unpaid carers. When involved, independent advocacy supported this further. Social work case recording, oversight, and management support was effective and valued by the workforce.

The partnership had a clear vision with established governance and oversight, although there was scope to develop this further. The critical services oversight group had completed a self-evaluation exercise and planned further developments to enhance their governance processes. The remit of the public protection committee was wide, but it fostered links across the protection agenda. This was supported by well-established sub-groups for the delivery of the strategic agenda.

There were opportunities to improve collaboration and audit by adopting a multi-agency approach that included increased involvement by all practitioners. While feedback and strategic engagement with adults at risk of harm with lived experience was planned this was not yet in place. It was important that this be progressed so strategic improvement work could be shaped by this important group.

Overall, the partnership had demonstrated the capacity to deliver improvement actions. This should continue and include embedding change and implementing outstanding actions from previous audits.

Next steps

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

Appendix 1 – core data set

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

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

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

Chronologies

Police involvement in adult support and protection

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

Information sharing

Safety and additional support outcomes

Staff survey results about strategic leadership