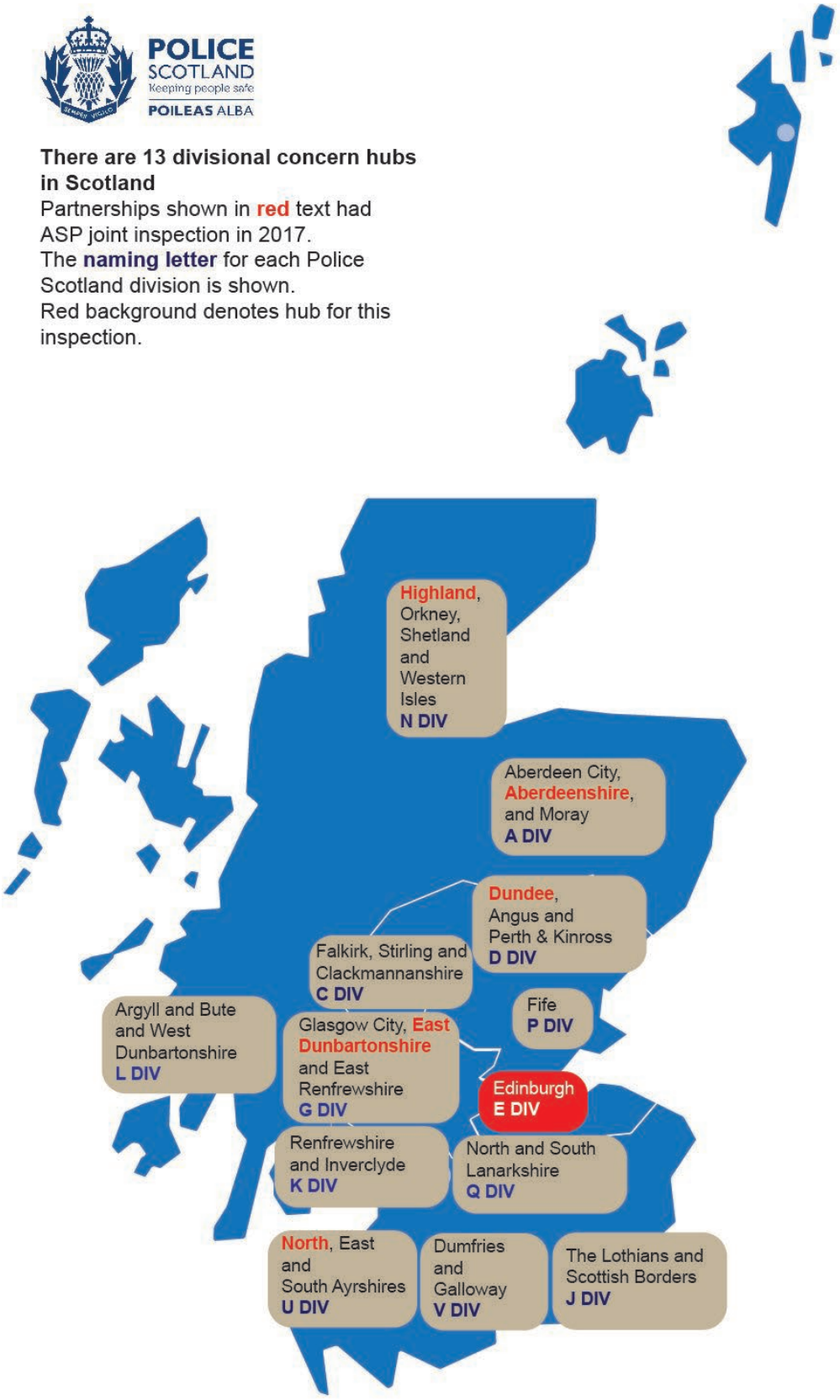
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

City of Edinburgh Partnership February 2023

Contents

Map showing divisional concern hubs



Joint inspection of adult support and protection in the City of Edinburgh 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 City of Edinburgh partnership area were safe, protected and supported.

The joint inspection of the City of Edinburgh partnership took place between November 2022 and February 2023. We scrutinised the records of adults at risk of harm for a two-year period, September 2020 to September 2022. The City of Edinburgh 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 City of Edinburgh 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.

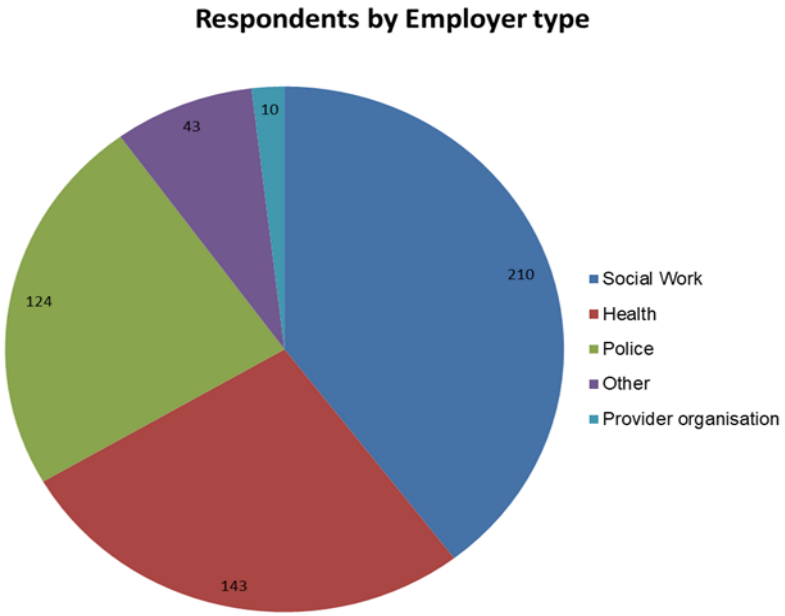
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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 thirty 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.

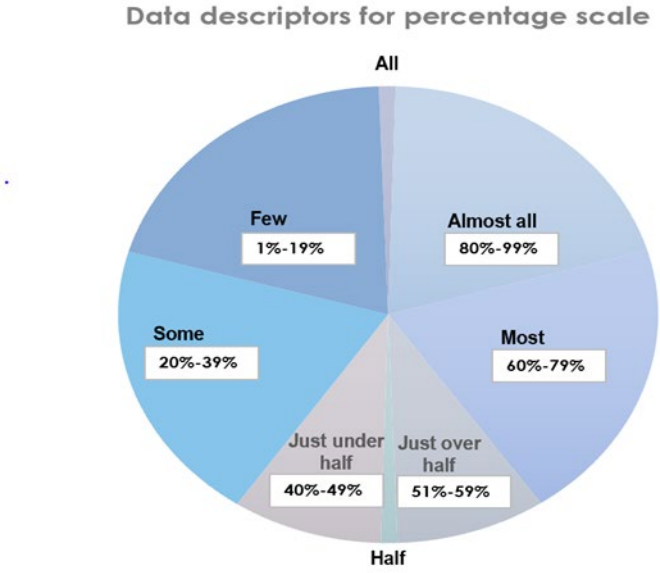


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

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 23 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

- Police Scotland and health staff made an invaluable contribution to identifying adults at risk of harm and worked well with partners to improve their safety and wellbeing.
- The partnership conducted large-scale investigations, collaboratively, competently, and effectively.
- Third and independent sector providers delivered vital support to adults at risk of harm.
- The partnership's strategic leaders effectively oversaw the maintenance of business continuity for adult support and protection during the Covid-19 pandemic.

Priority areas for improvement

- The partnership should improve the quality of chronologies and risk assessments for adults at risk of harm. All adults at risk of harm who require a chronology and a risk assessment should have one.
- The partnership should carry out a prompt adult protection investigation for all adults at risk of harm who require one.
- The partnership should take steps to improve the quality of adult protection case conferences. It had undertaken improvements by creating additional posts for minute takers. It was too early to tell the impact of this.
- Social work services faced the challenge of 30 social worker vacancies in adult services. This impacted adversely on adult support and protection operations, self-evaluation, and quality assurance activity. Social work leaders should work to increase the service's capacity to carry out adult support and protection work promptly, effectively and efficiently.
- The partnership's strategic leaders should ensure there is consistent, competent, effective adult support and protection practice that keeps adults at risk of harm safe and delivers improvements to their health and wellbeing.

- The partnership should prioritise recommencement of multi-agency audits of adult support and protection records, quality assurance, and self-evaluation activities for adult support and protection.

- The adult protection committee should ensure it has direct representation from adults at risk of harm and their unpaid carers. Thus, it would benefit from their lived experience of adult support and protection.

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

Key messages

- Police Scotland officers and heath staff worked well to diligently identify and effectively support adults at risk of harm.
- Third and independent sector providers delivered invaluable support to adults at risk of harm. This enhanced their safety, health, and wellbeing.
- Large-scale investigations delivered improved safety, health, and wellbeing to residents of care homes.
- Inadequate capacity within social work services impacted adversely on the competent, effective, and efficient execution of key processes for adult support and protection. There was recent improvement action, with the creation of senior adult practitioner posts. It was too early to tell the impact of this.
- Management oversight was lacking for initial inquiries into adult protection concerns, as was recording of the application of the three-point criteria.
- Not enough adults at risk of harm had a chronology and a risk assessment that was fit for purpose.
- Social work did not routinely carry out adult protection investigations when it should have.
- Social work did not consistently interview adults at risk of harm about the adult protection concerns raised about them. Other parties, such as paid and unpaid carers and alleged perpetrators were often not interviewed.
- Health professionals' attendance at adult protection case conferences when invited was inconsistent and called for improvement. Social work did not consistently invite police and health to attend adult protection case conferences.

- The quality of adult protection case conferences warranted improvement. Due to problems with business support staff taking minutes, minutes sometimes did not fully reflect the discussion at the meeting. There could be lengthy delays circulating the minutes.

We concluded the partnership's key processes for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns

The social care direct team screened all adult support and protection concerns. It passed them on to one of the four locality social work teams. The partnership recently carried out improvement work on recording application of the three-point criteria at this stage. It was too early to tell how effective this was. Management oversight of screening was an acknowledged area for improvement. This also applied to initial inquiries.

Initial inquiries into concerns about adults at risk of harm

Overall, the partnership handled initial inquiries competently. It had an electronic template to record them. All initial inquiries were in line with the principles of the Adult Support and Protection Scotland Act 2007. Almost all were prompt and evidenced partner's communicating effectively. Most initial inquiries were good or better for quality. Interagency referral discussions, if required, took place after initial inquiry.

Almost all initial inquiries did not record application of the three-point criteria. Most showed no sign of management oversight. This called for improvement. Specific fields in the partnership's initial inquiry template would help.

Investigation and risk management

Chronologies

Chronologies for adults at risk of harm are an essential element of risk assessment and risk management. The partnership's approach to preparation of chronologies for adults at risk of harm was inconsistent. Sometimes it was in the report of the interagency referral discussion, sometimes it was in the safety plan, and sometimes it was in both. Most adults at risk of harm who required a chronology had one. Significantly, some did not. This warranted improvement. Quality of chronologies also needed improvement, with just under half weak or unsatisfactory. They lacked detail of key events, only focused on adult protection events, were not up-to-date, and did not include analysis of patterns of events and the implications for risk to the adult at risk of harm.

Risk assessments

Most of the time a risk assessment was included in the report of the interagency referral discussion. Most adults at risk of harm had a risk assessment. Significantly, some did not have one. This needed improvement. Almost all risk assessments were timely and included partners' views. Quality of risk assessments was uneven, with some weak or unsatisfactory. This warranted improvement. Some risk assessments were sparsely populated, lacked a clear appraisal of the risks and their potential impact on the adult at risk of harm, and did not clearly identify protective factors. A standard risk assessment template for adults at risk of harm would support improvement. For some adults at risk of harm their protection risks were not dealt with adequately. Concerns included no risk assessment when serious risks were present, significant risks not mentioned in risk assessments, no conversation with the adult at risk of harm about their risks, and delayed actions to stop harm.

Full investigations

The partnership's approach and performance for carrying out investigations into adult protection concerns was a major area for improvement. There was no standard template for recording investigations, and one should be instigated quickly. Critically, for some adults at risk of harm there was no investigation when there should have been one. This impacted immensely on these adults at risk of harm as they were not interviewed about the adult protection concerns raised in their name. They might not have been aware they were the subject of the partnership's adult support and protection procedures. When the partnership did conduct an investigation, quality was uneven, with some weak. Almost all investigations effectively determined if the adult was at risk of harm, and they were timely in most cases. But significantly some were delayed, with several substantial delays. The partnership needed to quicky resolve its deficits with investigations and carry them out competently and effectively in all cases.

Interagency referral discussions were fundamental to the partnership's approach to adult support and protection. They were done mainly at the investigation stage. The interagency referral discussion report was often not an account of a person-to-person discussion among core partners. Rather, it was a rolling record of partners' views, often copied and pasted from other documents such as interim vulnerable persons database reports. For three of the four Edinburgh localities, health (a core adult protection partner) was not included in the interagency referral discussion process. Health was included in a test of change initiative in the northwest locality. This had been running for four years. The partnership needed to take prompt decisive action to ensure city-wide direct health inclusion in interagency referral discussions.

Adult protection case conferences

Adult protection case conferences was an area for improvement. The partnership convened an adult protection case conference for almost all adults at risk of harm who required one. For a significant few there was no case conference when there should have been.

Attendance at adult protection case conferences was variable. Health attended just over half they were invited to. Police attendance was better; they attended almost all they were invited to. Social work did not invite police to some case conferences when they should have. They did not invite health to a significant few case conferences when they should have. This called for improvement.

Adults at risk of harm attended just under half of their case conferences when invited. They were supported to participate meaningfully. This was a reasonable performance by the partnership, particularly given the challenges of the Covid-19 pandemic. Commendably, unpaid carers who cared for adults at risk of harm attended almost all adult protection case conferences they were invited to.

Positively, almost all adult protection case conferences were timely and did effectively determine what needed to be done to keep the adult at risk of harm safe, supported, and protected.

There were problems with taking the minutes of adult protection conferences. Often, there were no business support staff available to take minutes. In these situations, social workers had to take the minutes. This could lead to substantial delays in circulating minutes to attendees and others. Case conference minutes could be sparse and not a full, accurate record of the participants' discussion and decisions made. Additional minute taker posts were created recently. It was too early to tell the impact of this. Quality of adult protection case conferences needed to improve significantly, with some weak or unsatisfactory.

Adult protection plans / risk management plans

The partnership completed prompt, collaborative “safety plans” (adult protection plans) for almost all adults at risk of harm who needed one. Some safety plans lacked an accompanying risk assessment. Quality varied, with just under half good or better. This showed room for improvement. Quality issues included not stating clear timescales for actions and who was responsible for carrying them out, and not addressing significant risks.

Adult protection review case conferences

The partnership’s practice on review case conferences was variable. Almost all adults at risk of harm who required one, got one in good time. But some review case conferences did not determine the necessary actions to keep the adult at risk of harm safe.

Implementation / effectiveness of adult protection plans

Most staff surveyed agreed adults at risk of harm got support to remain safe and protected. Effective implementation of safety plans varied. Adults at risk of harm had improvements to their safety, health, and wellbeing because of the partnership’s joint efforts to support them. For others, critical actions were not executed, or vital support services were not delivered quickly enough. Some adults at risk of harm had chaotic lifestyles and were reluctant to accept help.

Large-scale investigations

The partnership competently conducted nine large-scale investigations over a two-year period. Partners, including the Care Inspectorate were appropriately involved. There was a well-constructed large scale investigation procedure. Adults at risk of harm included in a large-scale investigation were safer as a result. The partnership effectively utilised what it learned from large-scale investigations.

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

Overall effectiveness of collaborative working

Almost all staff surveyed thought they were supported to work collaboratively and achieve positive outcomes for adults at risk of harm. Interagency referral discussions did effectively support collaborative working. But the absence of consistent health participation in them was a shortfall.

The partnership had comprehensive, accessible, multi-agency adult support and protection procedures. It had recently updated them to take account of changes to the Scottish Government's adult support and protection code of practice. The procedures were informed by the national health and social care standards.

Health involvement in adult support and protection

Health professionals raised the adult support and protection concern for a few cases. They identified concerns appropriately and acted correctly. Positively, where there were relevant recordings, they were almost always good or better in quality.

Health professionals almost always shared information appropriately. There were some instances where the quality of information shared could be improved. Information from health informed interagency referral discussions. However, this information was often inputted into the system by senior social workers rather than directly by health professionals. Health was directly involved in interagency referral discussions only in the northwest locality.

Where adults at risk of harm had repeat emergency department presentations or referrals to community health services, these interventions were almost always good or better. Where adults at risk of harm had emergency readmissions to hospital, interventions to keep adults safe were always good or better. Health made good contributions to outcomes for adults at risk of harm. This was more evident when the adult at risk of harm was already involved with health services. For example, mental health or learning disability services. Most adults at risk of harm who needed a medical examination got one.

Capacity and assessment of capacity

Social work did not request a capacity assessment from health for some adults at risk of harm who required one. This called for improvement. Creditably, health clinicians carried out capacity assessments promptly for almost all adults at risk of harm when requested to do so.

Police involvement in adult support and protection

The police almost always effectively assessed adult protection contacts for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). Just over half of cases had an accurate STORM disposal code (record of incident type).

Initial attending officers' actions were good or better almost all of the time. There was effective practice and meaningful contribution to the multi-agency response. The assessment of risk of harm, vulnerability and wellbeing was accurate and informative in almost all cases. Officers considered and recorded the wishes and feelings of the adult at risk of harm almost all of the time. They recorded adult protection concerns efficiently and promptly on almost all occasions, using the interim vulnerable persons database.

Frontline supervisory input was evident in almost all instances. This was good or better in half of the cases. Evidence of supervisory oversight and support to initial attending officers could be improved through accurate recording of leadership and governance practices.

Divisional concern hub staffs' actions and records were good or better in most cases. There was a resilience matrix and relevant narrative of police concerns recorded in almost all instances. Adults at risk of harm could present with a number of concerns, such as sexual harm and domestic abuse. The divisional concern hub and inquiry officers focused on criminality when a holistic approach to needs and expectations may have supported early and effective prevention and intervention. The divisional concern hub shared all adult protection referrals promptly with partners.

A good practice was to raise a retrospective interim vulnerable persons database following police attendance at interagency referral discussions, in instances where the police was not the initial referrer. This allowed for good information management on partner engagement and informed future assessments about the adult at risk of harm.

Where the criteria for the application of the escalation protocol was met (repeated police involvement), there was an inconsistent approach. In some cases an escalation review was not carried out when it should have been. There were missed opportunities to develop existing local practice, by involving local area command in response or protection planning.

Third sector and independent sector provider involvement

Almost all adults at risk of harm who needed additional health and social care support got it. Most of this support was good or better. Third and independent sector bodies played a vital role supporting adults at risk of harm to realise improvements to their safety, health, and wellbeing.

Key adult support and protection practices

Information sharing

The partnership had effective protocols to support partners sharing of adult support and protection information. All core partners shared information effectively for almost all adults at risk of harm. Just under half of staff surveyed said social work gave them prompt feedback about adult support and protection concerns they raised. Just under half said they got no feedback. This merited improvement.

Management oversight and governance

For just under half of adults at risk of harm the recording, mainly in their social work record, was not in keeping with their needs. There was no record of supervision decisions in some of social work records. This merited improvement. All police records had evidence of governance, as did most social work records. For the health records of adult at risk of harm submitted there was no expectation that there would be evidence of governance.

Involvement and support for adults at risk of harm

Most staff surveyed thought adults at risk of harm got support to participate meaningfully in adult support and protection related decision making. Most adults at risk of harm were supported throughout their adult protection journey. Just over half of support was good or better, which indicated there was room for improvement.

Independent advocacy

The partnership did not offer an independent advocate to just under half of adults at risk of harm who would potentially have benefited from one. This called for improvement. Almost all adults at risk of harm who wanted an advocate got one promptly. Their advocate helped them to articulate their views and understand the adult support and protection processes invoked in their name.

Financial harm and alleged perpetrators of all types of harm

The partnership acted collaboratively and moderately effectively to stop the financial harm for most individuals who suffered financial harm. However, for some adults at risk of harm the partnership's actions to stop the financial abuse were weak or unsatisfactory.

For all known alleged perpetrators of harm, the partnership took some action against most of them. Significantly, it successfully secured a banning order for some of them. The quality and effectiveness of the partnership's actions against known alleged perpetrators had room for improvement, with some weak or unsatisfactory.

Safety outcomes for adults at risk of harm

Most staff surveyed thought adults at risk of harm realised a safer quality of life because of the support they got from the partnership. For almost all adults at risk of harm there was some improvement to their safety. This was mainly due to effective multi-agency working. Significantly, a few adults at risk of harm experienced poor outcomes. The predominant reason for this was lack of social work involvement.

Adult support and protection training

The partnership's performance on delivering effective good quality adult support and protection training was mixed. Almost all staff surveyed thought their adult support and protection training equipped them for their role in adult support and protection. However, only just over half of staff considered they participated in regular, local multi-agency adult protection training, some said they had not had this training. The partnership suspended face-to-face adult support and protection training during the Covid-19 pandemic. It was reinstating this. It effectively continued virtual adult support and protection training during the pandemic. It successfully delivered online council officer adult support and protection training to 275 officers. Creditably, almost all council officers thought their specialised adult support and protection training equipped them well for their role.

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

Key messages

- The partnership and its strategic leaders effectively maintained business continuity for adult support and protection during the Covid-19 pandemic.
- Strategic leadership did not deliver consistent, competent, effective adult support and protection practice that ensured adults at risk of harm were safe, supported, and protected.
- Social work services lacked capacity to carry out adult support and protection work promptly, effectively, and efficiently.
- The partnership had not carried out any significant audit, or self-evaluation of adult support and protection for over three years. It acknowledged that this was on hold due to capacity deficits. The Covid-19 pandemic also affected this.
- A vital improvement initiative to secure city-wide direct health involvement in interagency referral discussions had not delivered the target improvements after four years. The partnership reported progress. Direct health input to the system was available – in the southeast and southwest localities – from January 2023.

We concluded the partnership's strategic leadership for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Vision and strategy

The partnership recently developed a vision statement for adult support and protection. The adult support and protection improvement plan (2022-2024) did not address critical issues such as necessary improvements to adult protection investigations and the recording thereof. Several improvement actions in the previous improvement plan (2020) were not implemented or put on hold due to the pandemic and "capacity issues". It did not mention improvement required to health involvement in interagency referral discussions. It was not obviously linked to the last audit of adult protection records done in 2019.

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

All our staff survey results on strategic leadership for adult support and protection showed under half of respondents held positive views about this. Some staff thought leaders ensured there was enough capacity to carry out adult support and protection work, and thought leaders knew about the quality of operational adult protection work. Our staff survey results showed strategic leadership for adult support and protection warranted improvement.

From our staff survey results and our frontline staff focus group, lack of capacity to carry out adult support and protection work emerged as a critical issue. The health and social care partnership's adult services had 30 vacancies for main grade social workers. This adversely affected the capacity to carry out adult support and protection work promptly, effectively, and efficiently. More positively, it recently created three senior practitioner posts for adult support and protection, and two business support posts for taking the minutes of adult protection case conferences. It was too early to tell the impact of this.

The partnership's adult protection committee was well attended. It had representatives from across the adult support and protection community. It did not have an independent convener, contrary to the Scottish Government guidance for adult protection committees. In December 2022, the partnership decided to recruit an independent convener. This was a positive development.

Given the existing key process deficits for adult support and protection, the governance for social work adult support and protection practice, in particular, needed improvement. The adult protection committee did not have effective mechanisms to inform it about the existing critical adult protection key processes deficits. Consequentially, the chief officers group was not informed about them.

The adult protection committee initiated some developments in adult support and protection training, such as staff guidance on hoarding and clutter.

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

The adult protection committee did not have a delegate who was an adult at risk of harm. Thus, it did not benefit from the direct lived experience of an adult at risk of harm. It did not have an unpaid carer who cared for an adult at risk of harm as a delegate. These were important areas for improvement. A representative from independent advocacy was on the adult protection committee.

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

The partnership had some fundamental deficits in aspects of adult support and protection key processes. These were, not always conducting investigations when required, poor quality adult protection case conferences, limited health involvement in all interagency referral discussions, and insufficient social work capacity to carry out adult support and protection work. Improvements in these and other areas were needed quickly.

The partnership's strategic leaders supported partners working collaboratively to deliver positive, safety, health, and wellbeing outcomes for adults at risk of harm. Police Scotland worked well with other partners in all aspects of supporting adults at risk of harm and their unpaid carers.

The Scottish Fire and Rescue Service made a vital, progressive contribution to the safety and wellbeing of adults at risk of harm. It was involved at a strategic level (on the adult protection committee) and operationally by identifying and convincingly supporting adults at risk of harm. Housing services was appropriately involved in adult support and protection at a strategic and operational level.

Overall, the partnership and its strategic leaders maintained business continuity for adult support and protection during the Covid-19 pandemic. It supported staff to deal with the challenges of working with adults at risk of harm during the pandemic's restricted period. It prioritised adult support and protection work. It developed the use of digital platforms, for staff communication and for communication with adults at risk of harm and their unpaid carers.

The partnership established a care home support team within the district nursing service. It purposefully supported care home staff to deal with all the exigencies of the pandemic. Progressively, the partnership carried out an extensive audit of all hospital discharges to care homes during the pandemic. It was committed to taking forward the findings and the learning from this work.

In December 2022, the partnership was dealing with the considerable challenges from the "long tail" of Covid – continued hospitalisations due to Covid, and the backlog of work emanating from the pandemic.

Quality assurance, self-evaluation and improvement activity

Our staff survey results on strategic leadership showed scope for improvement on strategic leaders purposefully evaluating adult support and protection practice. Some staff thought leaders evaluated adult support and protection practice and this informed improvement. A few considered they had been involved evaluating the impact of adult support and protection practice.

The partnership conducted a multi-agency audit of adult support and protection records in 2019. This was the last audit the partnership conducted. Audits and other quality assurance and self-evaluation activity were suspended due to "capacity issues". The partnership acknowledged this was a significant gap.

The 2019 audit comprehensively reported its findings by adult service area or adult service team. There were important gaps in the audit's methodology. It did not mention preparation of chronologies for adults at risk of harm. It was very sparse on the critical domain of the management of risk for adults at risk of harm. It did not identify the problems with adult protection investigations we later found.

The partnership did not carry out any activity with adults at risk of harm or their unpaid carers to ascertain their perception of the outcomes adult support and protection activity realised for them. Thereby, the lived experience of adults at risk of harm and their unpaid carers did not inform improvement activity for adult support and protection. This merited improvement.

The partnership carried out some successful improvement work for adult support and protection. For example, the systems it developed to disseminate and implement the learning from significant and initial case review and large-scale investigations. However, its improvement efforts to deliver city-wide direct inclusion of health in interagency referral discussion had taken too long. The partnership reported progress. Direct health input to the system was available – in the southeast and southwest localities – from January 2023.

Initial case reviews and significant case reviews

The partnership conducted two significant case reviews and 14 initial case reviews in the last two years. It had a comprehensive, well-crafted multi-agency procedure for carrying out significant case reviews and initial case reviews. The partnership developed a thematic action plan on taking forward what it learned from the reviews. The quality assurance sub-committee of the adult protection committee disseminated and promoted the learning from these reviews. Learning from these reviews was purposefully incorporated into staff training.

Summary

The partnership conducted initial inquiries into adult protection concerns competently. Management oversight and recording application of the three-point criteria needed to improve.

The quality of chronologies for adults at risk of harm called for improvement, as did, to a lesser extent, the quality of risk assessments. While most adults at risk of harm who required a chronology and a risk assessment had one, there was a significant number who did not.

The partnership's approach to conducting investigations into concerns about adults at risk of harm warranted substantial improvement. Some adults at risk of harm were not interviewed when they clearly should have been.

Interagency referral discussions were mainly a dated list of information from partners. Health professionals city-wide could not contribute directly to interagency referral discussions. The partnership reported progress. Direct health input to the system was available – in the southeast and southwest localities – from January 2023.

Police Scotland identified adults at risk of harm competently and promptly. Additionally, they, alongside health professionals, made a vital contribution to keeping adults at risk of harm safe and enhancing their health, and wellbeing.

Adult protection case conferences were a noteworthy area for improvement. Social work did not always invite police and health. Health professionals did not always attend when invited. Case conference quality merited improvement.

The adult protection committee did not benefit from the lived experience of adults at risk of harm and their unpaid carers. It should work to change this.

Social work services did not have the capacity to carry out all adult support and protection work promptly, efficiently, and effectively. This lack of capacity also had an adverse impact on audits, quality assurance, and self-evaluation of adult support and protection.

The partnership effectively maintained business continuity for adult support and protection during the Covid-19 pandemic. It supported its staff to carry out priority work with adults at risk of harm.

Overall, there were a number of critical areas for improvement identified for the partnerships key processes for adult support and protection, and its strategic leadership for adult support and protection. Thereby, both key processes for adult support and protection, and strategic leadership for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm.

Next steps

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

Appendix 1 – core data set

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

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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 8% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 85% of episodes where the three-point criteria was applied correctly by the HSCP
- 85% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% one to two weeks, 50% one to three months
- 40% of episodes evidenced management oversight of decision making
- 68% of episodes were rated good or better.

Staff survey results on initial inquiries

- 86% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 10% did not concur, 4% didn't know
- 70% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 10% did not concur, 20% didn't know
- 64% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 19% did not concur, 17% 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

- 78% of adults at risk of harm had a chronology
- 26% of chronologies were rated good or better, 75% adequate or worse

Risk assessment and adult protection plans

- 78% of adults at risk of harm had a risk assessment
- 36% of risk assessments were rated good or better
- 81% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 44% of protection plans were rated good or better, 56% were rated adequate or worse

Full investigations

- 91% of investigations effectively determined if an adult was at risk of harm
- 76% of investigations were carried out timeously
- 36% of investigations were rated good or better

Adult protection case conferences

- 81% were convened when required
- 86% were convened timeously
- 43% were attended by the adult at risk of harm (when invited)
- Police attended 83%, health 58% (when invited)
- 31% of case conferences were rated good or better for quality
- 83% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 90% of review case conferences were convened when required
- 67% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 98% of adult protection concerns were sent to the HSCP in a timely manner
- 81% of inquiry officers' actions were rated good or better
- 71% 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
- 82% good or better rating for the quality of ASP recording in health records
- 79% 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

- 92% of cases evidenced partners sharing information
- 98% of those cases local authority staff shared information appropriately and effectively
- 98% of those cases police shared information appropriately and effectively
- 98% of those cases health staff shared information effectively

Management oversight and governance

- 72% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 75%, police 100%, health 0%

Involvement and support for adults at risk of harm

- 75% of adults at risk of harm had support throughout their adult protection journey
- 57% were rated good or better for overall quality of support to adult at risk of harm
- 75% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 11% did not concur, 14% didn't know

Independent advocacy

- 51% of adults at risk of harm were offered independent advocacy
- 58% of those offered, accepted and received advocacy
- 82% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 62% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 88% of these adults had their capacity assessed by health
- 71% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 22% of adults at risk of harm were subject to financial harm
- 36% of partners' actions to stop financial harm were rated good or better
- 0% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 84% of adults at risk of harm had some improvement for safety and protection
- 97% of adults at risk of harm who needed additional support received it
- 65% concur adults subject to ASP, experience safer quality of life from the support they receive, 13% did not concur, 22% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 45% concur local leaders provide staff with clear vision for their adult support and protection work. 25% did not concur, 29% didn't know

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

- 43% concur local leadership of ASP across partnership is effective, 22% did not concur, 35% didn't know
- 42% concur I feel confident there is effective leadership from adult protection committee, 19% did not concur, 39% didn't know
- 26% concur local leaders work effectively to raise public awareness of ASP, 29% did not concur, 45% didn't know

Quality assurance, self-evaluation, and improvement activity

- 34% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 21% did not concur, 46% didn't know
- 35% concur ASP changes and developments are integrated and well managed across partnership, 23% did not concur, 42% didn't know