Annual report on significant case reviews and learning reviews for adults 2022-2023

Contents

Introduction

The 2019 Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review designated responsibility to the Care Inspectorate to publicly report on thematic findings from across Scotland. Since November 2020, the Care Inspectorate has acted as the central repository for both initial case reviews and significant case reviews.

The introduction of the new National Guidance for Adult Protection Committees: Undertaking Learning Reviews published in May 2022 replaced initial case reviews (ICRs) and significant case reviews (SCRs) with learning reviews (LRs).

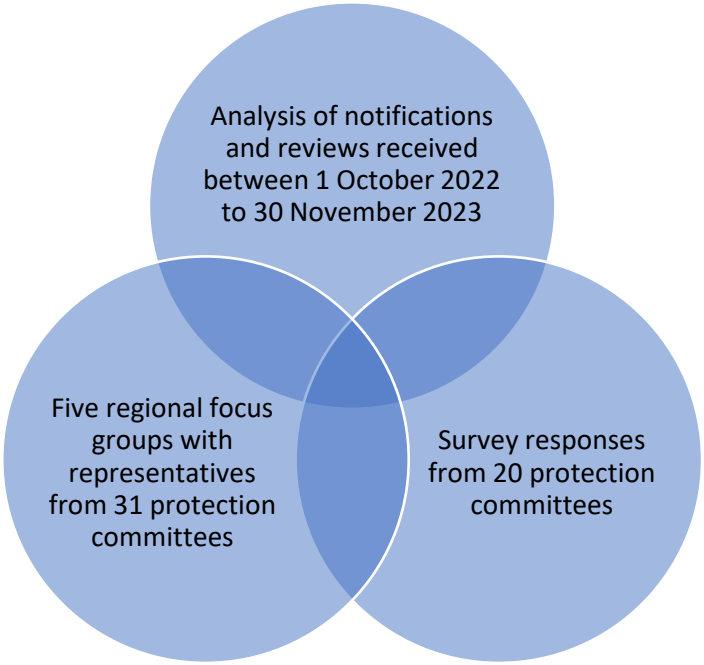
In January 2023, we published our first Triennial Review Report which considered all notifications and completed reviews submitted to the Care Inspectorate between 5 November 2019 and 30 September 2022. Triennial review adult initial case reviews and significant case reviews 2019-22.pdf (careinspectorate.com). Following publication of that review, we have since determined that an annual report cycle would be more advantageous to the sector.

In this, our first annual report, we seek to provide independent public assurance on the quality of reviews undertaken between the 1 October 2022 and the end of November 2023. This reporting period covered 13 months meaning we are now aligned to the publication of children review reports. This calendar year, our children and adult teams intend to review our reporting processes and consider how best to share the learning more collaboratively for the benefit of the wider sector.

In total 31 review notifications were received during this reporting period. These were submitted by 10 adult protection/public protection committees. Of the 31 notifications received, 10 proceeded to learning reviews. In this reporting period only six reviews were completed by committees and submitted to the Care Inspectorate. Four reports have still to be completed and submitted. The small number of submissions limited our ability to identify and comment on widespread themes or trends.

We would like to thank the adult protection and public protection committees across Scotland for their valuable contributions to this report. The voice of the protection committees and their experiences of applying the national guidance to review processes is reflected in this report. This was from information received following the completion of a survey and the participation of 53 adult protection committee members in five focus groups. We would also like to thank the National Adult Support and Protection Co-ordinator for Scotland who co-facilitated the focus groups with the Care Inspectorate.

Report evidence base



Analysis of review notifications
Analysis from all review notifications and case reviews informed the data presented in the overview report.

Regional focus groups
The participation of protection committee members in five regional focus groups provided experiential and perceptual context around the process of undertaking reviews.

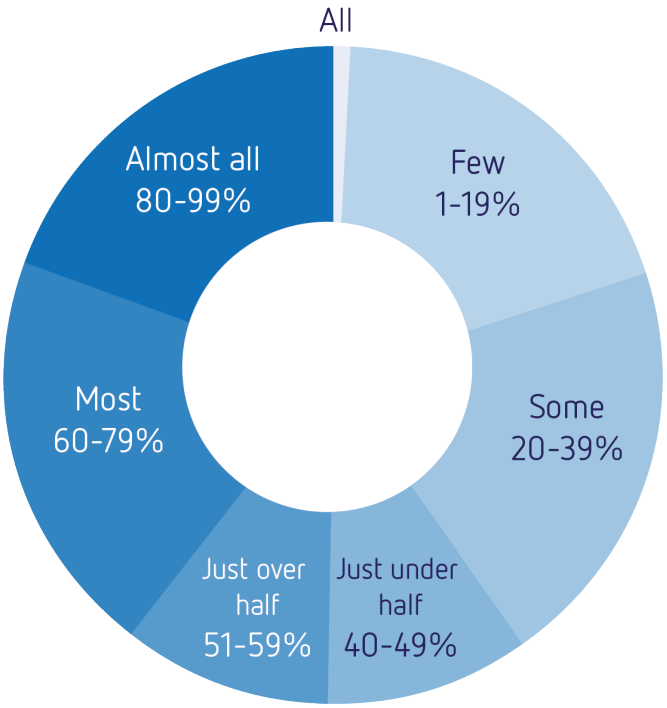
Survey responses
Survey responses provided helpful feedback on the benefits of the national guidance and how it supported adult case review decision making and review activity. It also highlighted some of the challenges faced by protection committees when undertaking reviews.

Definitions and standard terms

For the purposes of the report, the term **protection committee** will be used to reflect both adult protection committees and public protection committees. Throughout this report, we use the term **reviews** to cover all significant case reviews and learning reviews submitted. We detail the specific type of review where relevant.

Standard terms for percentage ranges relating to review notifications only

Data descriptors for percentage scale



Key messages

Review notifications

- Self-neglect, self-harm and neglect were the most prominent primary types of harm.

- Review notifications identified that missed opportunites to protect adults were a significant factor in reviews. Risk identifcation and improved communication remained significant areas for improvement.

- Just over half of review notifications submitted to the Care Inspectorate related to adults aged 65 and over.

- Alcohol, substance misuse, dementia and frailty were the leading service types in review notifications we received. Capacity issues were prevalent within these service types.

- Almost all review notifications related to harm occurring in the adult's own home.

- The spread of review notifications submitted from protection committees remained uneven across the sector.

- Review notifications showed there was robust consideration of what type of review should be undertaken. Where alternatives to learning reviews were completed, they were not consistently submitted to the Care Inspectorate in line with the national guidance.

- Where cases did not proceed to a review, the primary rationale given was that no *new* learning had been identified. How protection committees learned from recurring themes in these circumstances was unclear.

Six review reports and engagement

- Protection committees were in the early stages of adopting trauma-informed practice. Reference to this important area of practice should be strengthened in learning reviews.

- The accessibility of skilled and knowledgeable external reviewers remained a challenge. Capacity and resource issues limited the availability of internal reviewers and chairs.

- Legal literacy around the applicable legislation, particularly adults with incapacity, remained an area protection committees should improve.

- The meaningful involvement of the adult or family/carers was strengthening but more still needed done.

- Good governance overseen by strategic leaders was demonstrated in the reviews submitted.

- Reviews consistently evidenced good multi-agency working.

- Only one review was published. This limited the sectors' ability to cascade and share learning.

- Most review recommendations were not SMART (specific, measurable, achievable, realistic and time bound).

Part 1: Review notification information

Review notification - data summary

Between 1 October 2022 and 30 November 2023, the Care Inspectorate received 31 review notifications from protection committees.

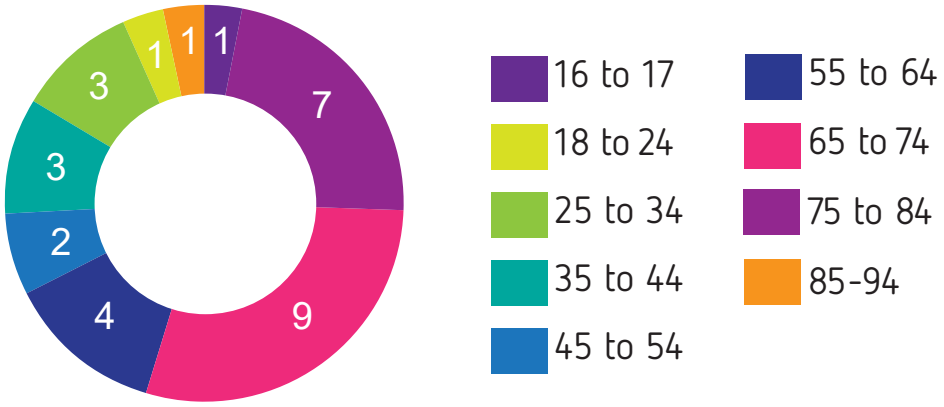
Of these, 10 proceeded to a review**.** A further six completed reviews (one multi-agency review, two SCRs and three learning reviews) were received and analysed during the reporting process.

The data in the tables below relates to all adults for whom a review notification was submitted during the period under review.

Review reporting period covered	Total number of notifications	ICRs not proceeding to SCR/LR	ICR proceeding to SCR/LR	ICR proceeding to further review under a different process
05/11/19 - 30/09/22	90	58	17	15
01/10/22 – 30/11/23	31	17	10	4

Table A: Comparison table - Initial case review and learning review notifications reported on in Triennial Review Report and Annual Review Report

Table 1. Age range



Key observations

- Just over half the notifications received related to adults aged between 65-84.
- There was a small reduction in notifications relating to the 45-64 and the 86+ age categories from our previous report.

Table 2. Primary type of harm

Key observations

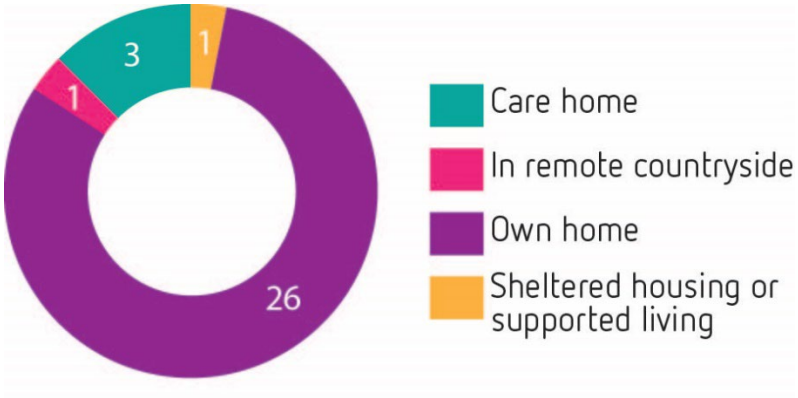
- Self-neglect, neglect and self-harm were the most prominent primary types of harm with cases of self-neglect rising slightly from our previous report.
- Self-neglect was primarily seen in the frail older adult category and numbers were evenly split between males and females in the 65-84 age categories.
- Cases of self-harm have risen slightly from our previous report.
- Twice as many males as females were in the self-harm category with alcohol/substance misuse and mental health issues being the primary case types. Most of these adults were in the 54-64 age category.

Table 3. Other types of harm

Key observations

- Self-neglect, neglect and self-harm were the most prominent 'other form of harm' categories.
- Focus groups confirmed self-neglect remained a significant concern.

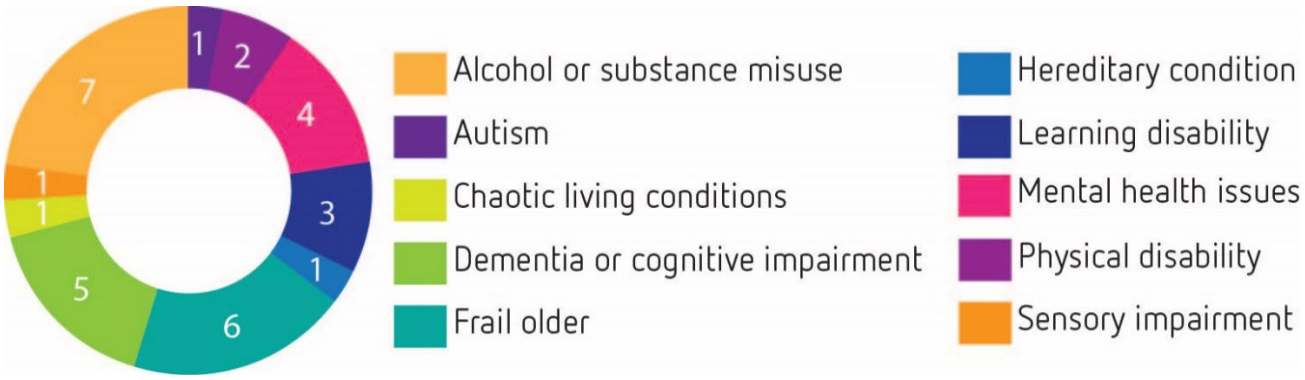
Table 4. Location of harm



Key observations

- For the majority of adults, harm took place at home.

Table 5. Primary case type



Key observations

- Alcohol/substance misuse and dementia continued to be the most prevalent case types, followed by frail elderly.
- There was a small reduction in the number of cases with mental health issues as the primary case type.
- There was a notable increase in issues relating to capacity.

Review notification - summary observations

- The primary reason for consideration of a review was the death of an adult. Of the notifications received, nine adults had died.
- Twenty-two of the 31 total review notifications received were from three partnerships.
- One partnership accounted for 33% of all review notifications we received.
- Robust consideration meetings were held which supported good decision making when determining whether to move to a review. Discussions at the focus groups supported this.
- A proportionate approach to review options was taken by protection committees but the outcomes were not shared with the Care Inspectorate.
- Of the 31 review notifications received, 19 included adults who were subject to adult support and protection under the 2007 Act.
- Fifteen of the 31 notifications received included concerns relating to the adults' decision-making capacity.
- The identification of new learning, learning from missed opportunities and supporting improvement was the most common rationale for undertaking learning reviews used by protection committees.
- Where cases did not proceed to a review, the primary rationale given was that no *new* learning had been identified.
- Four cases progressed to single/multi-agency review or NHS significant adverse event review. The remaining cases implemented single agency improvement actions, multi-agency discussions, or added findings to existing improvement plans to ensure that the learning from the case would be addressed.

Part 2: Review report information

Key review report observations from the six submitted

Decision making
Most review reports demonstrated effective decision-making processes with good governance arrangements supporting this.

Learning
Discussions in focus groups indicated that drawing on learning from previous reviews was carefully and consistently considered when determining whether to progress with reviews. While there was some evidence of this, it needed to be more clearly recorded in review notifications submitted to the Care Inspectorate.

Methodologies used
Various methodologies were used for reviews including SCIE, root cause analysis, systems model, appreciative inquiry, and multi-agency case review approaches. All provided the appropriate rigour needed to undertake a complex review. There were no obvious advantages identified in adopting any particular methodology.

Communication
Ineffective communication remained a significant area for improvement in practice and was a factor in half of the review reports submitted.

Collaboration
Reviews submitted showed strong multi-agency work. There were still some challenges with other partners including general practitioners and Scottish Ambulance Service. Focus groups agreed this contributed to a lack of progression with some recommendations.

Review chairs and protection committees were working hard to ensure opportunities and provide resources that promoted stakeholder engagement and involvement. There was meaningful involvement of the adult and/or family in most, but not all reviews. A range of approaches and resources were used to ensure that this engagement and involvement was effective. Focus groups acknowledged that whilst involving adults and families was improving, work still needed to be done.

Professional curiosity
Professional curiosity needed to be improved. It was not yet fully embedded in practice. Focus groups expressed a will to consider this nationally so that an effective approach could be developed.

Legal literacy
The lack of knowledge around adult support and protection legislation, policies and procedures were evident in three of the six reports submitted. Discussions at focus groups reinforced the need for continued training and evaluation of operational staff's knowledge of adult support and protection legislation.

Focus groups discussed the need for protection committees to review how they applied relevant legislation and the role of legal services when undertaking reviews. Where good legal advice was provided this strengthened decision making in review processes.

Staff
Several of the recommendations in the reviews focused on the training needs of operational staff. There was a clear link between staff training recommendations and a requirement for better legal literacy. Across the sector, regular adult support and protection legislation training was in place. Protection committees recognised the need for the evaluation of training better linked to supervision and practice.

Review recommendations
Whilst recommendations appropriately addressed areas for improvements, most were not SMART. The number of recommendations made in reviews were proportionate and manageable. The style of recommendations varied considerably depending on the methodology applied. Focus groups agreed there could be more consistency in how recommendations were reflected and recorded in reviews.

Some recommendations identified learning worthy of national dissemination. However, due to most reports not being published, this limited their impact. Where national recommendations had been made in published reviews, it was not clear what discussions had been made with the sector, including the Scottish Government, in advance of publication.

Timescales
Identifying an external reviewer from a limited pool was challenging. Committees often waited until an external reviewer was free to take on the role which contributed to delays and timescales being extended.

Identifying internal lead reviewers with the appropriate skills and knowledge remained a significant challenge for protection committees. Those identified often had little workload capacity. This was particularly difficult for smaller authorities. Difficulties were also identified in getting the right people to join the review/support teams that were set up, especially with reviews becoming increasingly complex. There was also recognition that there was a lack of accredited training available to support reviewers.

Undertaking learning reviews also had an impact on capacity within already pressurised systems. The demands on staff involved in the review process were significant for busy managers and senior practitioners in the longer term. There was some concern in focus groups about the sustainability of this approach.

Procurement frameworks had to be considered by protection committees when appointing external reviewers. This involved the development of contracts making it a lengthy process for some areas. Focus groups agreed that a standard contract applied nationally would be helpful to all protection committees.

Parallel criminal proceedings were often a common cause of review delays. A lack of consistency, including advice given from the Crown Office compounded this issue.

Other parallel processes caused difficulty for example, accessing health clinicians who lacked capacity to contribute due to being involved in concurrent reviews. It was acknowledged that review activity was a cluttered landscape across the agencies and that this had to be made more streamlined whilst ensuring that the appropriate review approach was taken.

Trauma-informed practice
Focus group discussions identified that the principles of trauma-informed practice were being applied in practice and informed review processes. There was a recognition that this was not fully embedded. As a result, there was limited consideration of trauma-informed approaches within reviews.

Focus groups agreed that there was a need to implement trauma-informed practice in a structured way. Many thought that full implementation would require transformational change and careful joint planning across the sector to implement effectively.

Strategic leadership and governance
Reviews reflected strong strategic leadership and support from the protection committees and chief officers' groups. Focus groups agreed there was a high level of interest and prioritisation of the review process. There was regular oversight of progress of reviews, and a willingness to provide support particularly where barriers were identified. This helped to resolve any issues quickly.

Review report information - summary observations

- Review process provided clarity of roles and responsibilities and governance arrangements.
- Governance arrangements in place were operating effectively in almost all review reports submitted.
- The methodology used in reviews was almost always clearly outlined.
- There was evidence of appropriate multi-agency representation within the review teams supporting the lead reviewer.
- Staff were meaningfully involved in the review process. In most reviews, this was particularly evident in the early engagement of front-line practitioners.
- Only one out of the six review reports were published. This was a missed opportunity to share the learning from the reviews.

Part 3: Impact of reviews on practice – questionnaire and focus group feedback.

Review reports do not provide information on the impact of recommendations and findings on practice improvement. To understand the impact from identified improvements, we asked protection committees to complete a questionnaire and invited them to discuss the findings within focus groups. These opportunities to share learning encouraged and supported discussion about challenges and best practice.

Participants indicated that it was too early to demonstrate the impact of improvement activity following learning reviews although they had started to explore how this could be measured and evaluated. Review recommendations often led to audit and evaluation activity with most focussed on auditing quantity over quality improvement. There was a strong appetite to develop a consistent approach to quality improvement measurement at a national level.

Participants said that some learning reviews were conducted in isolation and were not embedded in wider self-evaluation activity being undertaken, for example, by a health and social care partnership.

Feedback confirmed that the involvement of staff in review processes was critical. More reviewers actively engaged practitioners and took a 'bottom-up approach' throughout the review process. Positively, this approach increased understanding amongst practitioners about the rationale for change to support practice improvement.

Many valued the involvement of practitioners in the development of improvement plans. This approach promoted awareness of the recommendations and supported implementation of the identified improvements. Most protection committees created capacity for staff to engage in reflection, dissemination of learning and consideration of the impact of improvement activities. Critically, the new guidance was successfully shifting the culture of learning reviews towards identifying learning to drive continuous improvement and away from blame. The learning review approach provided staff with a more positive and enabling experience in difficult circumstances. It also helped to reduce some of the anxieties held by staff who contributed to the process.

The close alignment of the new national learning review guidance relating to children and young people's services was seen as a positive step and there was an appetite across the sector to develop this connection further. Several partnerships had implemented joint review guidance, linked to the national review guidance for children and adults. There were many perceived benefits to this approach including efficiencies, increased capacity, shared learning, and stronger public protection approaches. Focus groups said that the national guidance provided more flexibility and supported proportionate decisions to be made by protection committees. Decision making about whether to proceed to a review had matured since the implementation of the guidance as had the knowledge and experience of those contributing. This resulted appropriately in fewer cases progressing to a full learning review.

Part 4: Next steps and recommendations

In March 2023 the then Minister for Mental Wellbeing and Social Care, hosted a roundtable event to consider key themes identified in the Care Inspectorate's Triennial Review Report of initial case reviews and significant case reviews for adults (2019-2022)

Since the event, Scottish Government adult and child protection colleagues have worked together to progress learning reviews at national level. Joint work between them and the child protection learning review liaison group and community of practice is underway. This promotes links to wider work being taken forward at national level across adults, children, and justice. This work is exploring how relevant stakeholders might work more collaboratively on key areas of 'public protection' and give greater scope for supporting joined up strategic discussions, planning, and re-design.

Next step: Stakeholders should ensure a SMART implementation plan and governance framework is put in place to support the aims, objectives and intended outcomes of this joint work. This will support timely and effective implementation of the change and improvement needed**.**

The refreshed (July 2022) code of practice puts trauma informed practice at the heart of adult support and protection work. The primary type of harm we present in this, and last year's report confirm this is necessary. Learning reviews need to better evidence their consideration of trauma informed practice. Overall**,** protection committees are at the early stage of implementation across the sector with most having strategic development frameworks in place to advance this work. Nevertheless, adoption and progression of this approach requires support to implement it fully.

Next step: There should be a national discussion that supports the use of the : Roadmap for Creating Trauma-Informed and Responsive Change: Guidance for Organisations, Systems and Workforces in Scotland. This should be aimed at supporting organisations to implement and embed trauma informed practice across Scotland and review chairs who should strengthen reference to this in their reports.

Some adult protection committees undertook alternative adult case reviews that met the criteria for a learning review but did not submit these to the Care Inspectorate. This is a long-standing issue that is compounded by the small number of published reviews. These factors limit opportunities for national learning.

Next step: The adult support and protection sector, including protection committees and the Care Inspectorate should jointly consider how they engage in the future to improve review report submissions. These meetings should include how the Care Inspectorate can support more timely reporting linked to national improvement activity.

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com

This publication is available in alternative formats on request.

© Care Inspectorate 2024 | Published by: Communications | COMMS-0124-476

@careinspect careinspectorate