JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION

Midlothian Partnership - June 2024

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Joint inspection of adult support and protection in the Midlothian partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

Phase two

This programme follows our phase one inspections. We published an overview report which summarised the findings and key themes identified. Phase two is closely linked to the Scottish Government's improvement plan for adult support and protection, and the national implementation groups which support it.

The joint inspection focus

Phase two joint inspections aim to provide national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. We also offer a summary of the partnerships' progress since their inspection in 2017.

Updated codes of practice were published in July 2022. In recognition that adult protection partnerships were at different stages of embedding these, we issued a single question survey to all partnerships in Scotland. This asked respondents to describe their approach to inquiry and investigation work and outline the role of council officers. Twenty-two partnerships responded, and findings showed that practice and adoption across Scotland is variable, with most areas having work to do in this respect. The Midlothian partnership implemented the code of practice in November 2023.

The focus of this inspection was on whether adults at risk of harm in the Midlothian partnership area were safe, protected and supported.

The joint inspection of the Midlothian partnership took place between January 2024 and April 2024. We scrutinised the records of adults at risk of harm for the preceding two-year period, from January 2022 to January 2024.

[1] https://www.careinspectorate.com/images/Adult_Support_and_Protection/1.__Definition_of_adult_protection_partnership.pdf

Quality indicators

Our quality indicators[2] for these joint inspections are on the Care Inspectorate's website.

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.

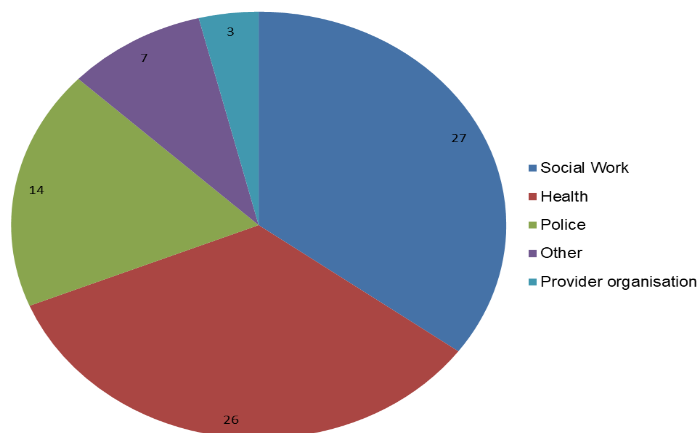
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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. Seventy-seven 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.



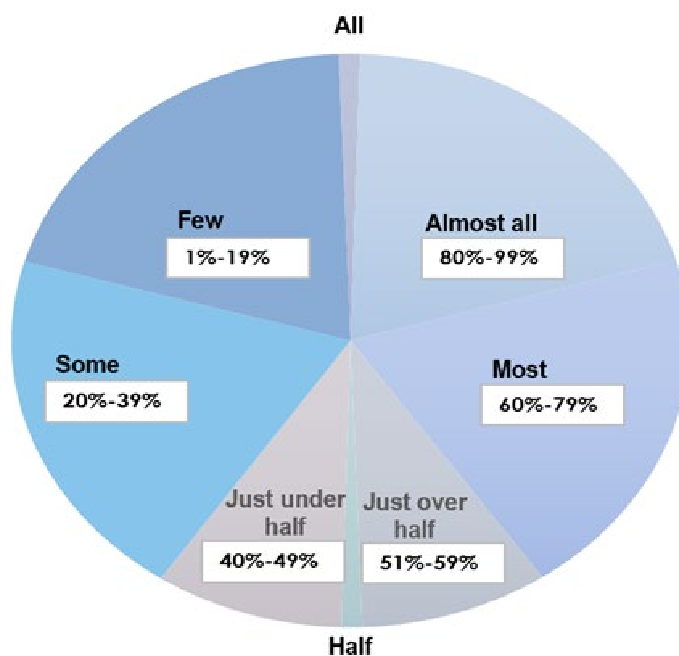
2 https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf

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 require any further adult support and protection intervention beyond the initial 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 for whom inquiries have used investigative powers under sections 7-10 of the 2007 Act. This included cases where adult support and protection activity proceeded beyond the inquiry with investigative powers stage.

Staff focus groups. We carried out three focus group and met with 23 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm.

Standard terms for percentage ranges



Summary – strengths and priority areas for improvement

Strengths

- The partnership had a vision for adult support and protection that was widely communicated and well understood.
- Adult support and protection inquiries undertaken by social work complied with the refreshed national code of practice.
- Managerial oversight of council officer activity was commendably strong. It was well recorded and linked to supervision discussions.
- Risk assessments were supported by effective tools and templates that promoted high quality work in this critical area of practice.
- Strategic leaders deployed a governance framework for adult support and protection. Overall, they oversaw the delivery of competent, effective adult support and protection practice. More work needed to be done to strengthen collaborative practice.

Priority areas for improvement

- Quality assurance, self-evaluation and improvement activity was in place. More work needed to be done to ensure this was well embedded and fully linked to improvement activity.
- Interagency referral discussion arrangements were well embedded, but the purpose and process needed to be reviewed to improve their impact on protection planning.
- Where chronologies were completed, they were of a good quality but more needed to be done to improve consistent application in all records. Too many adults at risk of harm did not benefit from having a chronology in place.
- Adult support and protection case conference attendance and information sharing needed to improve. Case conferences should be more person-centred and sensitive to the participatory needs of adults at risk of harm.
- NHS Lothian and Police Scotland needed to strengthen their participation in key elements of practice.
- Adults with lived experience were not engaged in shaping the work of the public protection committee. A plan was needed to address this.

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

Key messages

- Inquiries and investigations were comprehensive, timely and well recorded. Where investigatory powers were enacted, they were undertaken by council officers, in accordance with the adult support and protection code of practice.

- Management oversight of social work records was exemplary. The template used for recording adult support and protection work assisted this process.

- Capacity assessments were promptly sought and undertaken without delay.

- Risk assessments, when completed, were of a high standard. The partnership's framework for managing risk was clear and well understood by staff.

- Where chronologies were completed, most were of a high standard. Too many adults at risk of harm did not have one in their case record.

- Case conferences effectively determined actions to keep the adult safe from harm. But police and health attendance was inconsistent and minutes were not routinely circulated. Review case conferences did not always take place when they should have. Initial and review case conferences needed to be more person centred to ensure the full participation of adults at risk of harm.

- The purpose and function of interagency referral discussions was unclear. They sometimes took place too late in the adult support and protection process to allow for effective joint risk and assessment planning. The e-IRD format did not always support tripartite discussions.

- Governance of police records was often not specific or relevant to individuals. Supervisory oversight needed to be meaningful for all adults at risk of harm.

- Health records did not demonstrate consistent and appropriate recording of adult support and protection. The recently established NHS advisor posts are well placed to support improvement in this important area.

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.

Screening and triaging of adult protection concerns

All adult support and protection referrals and concern reports were recorded on the social work client information system upon receipt. This process was accurately overseen by the business support team. The adult support and protection team leader or delegated depute screened all referrals. A council officer was then allocated to progress the initial inquiry if appropriate. Screening guidance was available and broadly understood by those fulfilling this role. This helped to promote a consistent approach.

In 2024 the partnership reviewed referrals from the previous seven years as the conversion rate for referrals to inquiry when benchmarked was low. Reassuringly, this audit found that the decision not to proceed was correct in almost all cases.

Repeat referrals were reviewed by social work managers to consider whether further interventions under adult support and protection were necessary. This effectively tracked escalating risks.

Initial inquiries into concerns about adults at risk of harm

The partnership adopted the Scottish Government's revised code of practice in November 2023. This meant they were compliant and that all inquiries for adults at risk of harm were carried out by a council officer. The partnership also amended their inquiry template to ensure the use of investigatory powers were accurately recorded where they applied. This promoted confidence amongst staff.

The three-point criteria was well understood across the partnership, consistently recorded and applied. Communication between multi-agency partners at this early stage was collaborative and effective. Strong management oversight of decision making was in place in almost all cases.

The recently amended recording template used by social work staff assisted this process. Almost all inquiries reached the right stage in the adult support and protection process and were carried out in line with the principles of the act. The quality of almost all inquiries was good or better, although some were delayed.

More work was needed to ensure that adults at risk of harm were informed of their rights and that they were subject to adult support and protection activity. Reasons why the adult was not engaged needed to be more clearly recorded in the social work records.

Interagency referral discussions

The partnership's guidance clearly set out expectations in respect of inter-agency referral discussions (IRDs). They supported an e-IRD format that could be used at any stage of the adult support and protection process. A well-designed e-IRD template was used to record and collate information and protective actions taken by partners. The police were always involved in e-IRDs, but health participated less frequently. Recently, the partnership sought to improve health representation at e-IRDs by introducing a health staff rota system. It was too early for us to determine if this had improved their participation.

Despite the use of a standard recording template for e-IRDs there was no evidence of follow up discussions between all three partners in records. Frontline staff working with adults at risk of harm were not involved in e-IRDs and did not consistently receive the outcome of these critical meetings. The quality, purposefulness and impact of interagency referral discussions was therefore mixed. Undertaking earlier IRDs and providing access to accurate recordings of outcomes for staff would strengthen the platform for joint risk and assessment planning.

An established interagency referral discussion overview group made up of senior representatives from all relevant partner agencies met monthly. They considered all IRDs, reviewed decision making and identified emerging themes. This group was well placed to oversee the required improvements to the process.

Inquiries including the use of investigatory powers

Chronologies

The partnership's practice in relation to chronologies was informed by the Pan-Lothian chronology working group. This aimed to establish a more consistent approach to chronologies using a standard template. Where chronologies were completed, the quality was good or better in most cases. However, just under half of records that should have contained a chronology did not. Until the recent revision of multi-agency procedures chronologies were completed only when a case progressed to case conference. The revised procedures addressed this and meant chronologies were expected for all adult support and protection interventions. Future staff training workshops focussed on the use of chronologies were planned. The partnership recognised that all adults at risk of harm should benefit from a chronology that laid out significant life events and this was central to their improvement plan. They recognised the benefits of how this promoted a more trauma aware approach.

Risk assessments

In 2022 the partnership introduced the type, imminence, likelihood, and severity (TILS) framework for managing risk. This clearly articulated framework was well understood by staff. The framework was embedded within the recording template and supported ongoing dynamic analysis and comprehensive documentation of risk at each stage of the adult support and protection process. This approach meant there was a risk assessment in most of the records we read. They were timely and almost always informed by multi-agency partners views. The quality of those completed was mostly good or better. However, some adults at risk of harm did not have a completed risk assessment. This is a critical area of practice that should be addressed.

In 2022 the partnership introduced an escalating concerns procedure for those adults who did not meet the three-point criteria, but where significant concerns remained. Escalating concern meetings, chaired by a senior manager, considered whether further actions to mitigate risk could be taken to protect the adult. This promoted a broad and person-centred approach to risk management.

Investigations

The quality of most adult support and protection investigations was good or better and they were always undertaken by council officers. They were comprehensive and recorded to a high standard. They were consistently timely and collaborative. They effectively determined if the adult was at risk of harm and always took account of the adult's views. When second workers were needed, they were almost always deployed. Some investigations did not access a second worker from health when this was appropriate. Consideration of a second worker from health, when necessary, would strengthen the partnership's collaborative approach to adult support and protection. Significant delays to investigations were a feature in a few instances.

Adult protection initial case conferences

Almost all case conferences took place when needed. They were timely, and effectively determined what should be done to ensure the adult at risk of harm was safe, protected and supported. The quality was mostly good or better. Less positively, the attendance of relevant partners was mixed with just under half of those invited attending, including police and health. Non-attendance impacted on the breadth of information shared, collaborative practice and discussion of risk. Staff told us that workload capacity issues impacted on attendance. Some case conference minutes were not held in case records or circulated to attendees. This had the potential to make follow up arrangements unclear, particularly for partners who did not attend. This negatively impacted on outcomes for adults at risk of harm.

Two-part case conferences were a recurring feature. An initial professionals meeting was often held immediately before a case conference. The adult at risk of harm and, where relevant, their carer was only invited to the second part of the meeting. The impact of this approach could cause the adults involved unnecessary discomfort. The venue used was not always conducive to a person-centred approach.

Just under half of case conferences were attended by the adult at risk of harm. Those who did attend were always provided with support to participate but reasons for not inviting the adult to the case conference were not recorded. Carers were always invited, were well supported, and attended every time.

Adult protection plans / risk management plans

Protection plans were completed following initial case or initial review case conferences when protective measures under adult support and protection were required. The partnership’s risk management framework was well implemented by staff and informed production of specific, measurable, realistic and timebound (SMART) risk management plans and interim safety plans. The partnership recognised that more work was needed to fully embed the use of SMART plans and consequently training was planned. Almost all adults at risk of harm had a protection plan when this was needed. The quality overall was good or better. Staff agreed that adults at risk of harm were supported to be safe and protected.

Adult protection review case conferences

Most review case conferences took place when required but some were not convened when they should have been. All review case conferences that were convened took place without delay, and almost all effectively determined actions to keep the adult safe.

Implementation/effectiveness of adult protection plans

Protection plans were always timely and almost always collaborative. They effectively determined what was needed to keep the adult at risk of harm safe. The partnership recently introduced core groups, to strengthen their approach to reviewing dynamic risk and the actions of adult protection plans arising from case conferences. It was too early to evaluate their impact. Staff shared our confidence that intervention under adult support and protection impacted positively on adults at risk of harm.

Large-scale investigations

The partnership followed the multi-agency Pan Lothian Large-Scale Investigation Protocol (2022). No large-scale investigations were conducted during the inspection timeframe.

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

Overall effectiveness of collaborative working

The partnership followed the East Lothian and Midlothian public protection committee multi-agency adult support and protection procedures. These supported close working at almost every stage of the adult protection process. Importantly, the procedures supported staff to be confident working collaboratively. The partnership had progress to make in relation to strengthening collaboration at interagency referral discussions and case conferences.

Health involvement in adult support and protection

NHS Lothian's public protection directorate consisted of dedicated staff with a shared commitment to strengthening integrated arrangements for adult support and protection across Lothian. Two adult protection advisor posts supported both strategic and operational developments.

Health staff made some adult support and protection referrals. Almost all staff knew how to act on concerns about an adult at risk of harm. They were provided with appropriate feedback about their referral most of the time. Almost all health staff contributions to improved safety and protection outcomes for adults at risk of harm were rated good or better. Most health records evidenced a collaborative approach to adult support and protection between health and other key partners. The quality and consistency of adult support and protection record keeping was variable. A few staff told us they were not confident about where to record adult support and protection concerns. There were two separate on-line and paper recording systems for health records. Staff told us they preferred to record adult support and protection activity on paper. Information should be recorded on all relevant systems, including electronic options, to ensure effective sharing. In almost all cases, there was no management oversight of health records evident. There was room for improvement in terms of record keeping and documentation to ensure good governance and to support practitioners in delivering safe and effective care in relation to adult support and protection.

Health staff were invited to case conferences but in most cases did not attend. Health representation at interagency referral discussions also required improvement. The public protection directorate was sighted on these issues and had taken steps to address them. A health rota was established in September 2023 for participation in interagency referral discussions. This positive step supported improved multi-agency working in this area of practice.

Capacity and assessment of capacity

Some adults at risk of harm whose records we read required an assessment of capacity. Almost all were quickly referred to the relevant health professional and received an assessment without delay. This was a strong area of practice.

Police involvement in adult support and protection

Contacts made to the police about adults at risk were almost always effectively assessed for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). Most cases had an accurate STORM Disposal Code (record of incident type) but there was scope to improve recording of STORM Disposal Codes.

In most cases the initial attending officers' actions were good or better, with some evidence of effective practice and meaningful contribution to the multi-agency response. The assessment of risk of harm, vulnerability and wellbeing was accurate and informative in most cases. The wishes and feelings of the adult were appropriately considered and properly recorded in most cases.

Where adult concerns were recorded, officers did so promptly on almost all occasions, using the interim vulnerable persons database (iVPD).

In most cases frontline supervisory input was evident and was good or better in just over half of cases reviewed. However, records of supervisory oversight and governance were generic and not always relevant and meaningful to the specific episode subject of referral.

Divisional concern hub staff actions and records were good or better in most cases. A resilience matrix and relevant narrative of police concerns was recorded in almost all instances. The resilience matrix research and assessments were comprehensive which led to enhanced informative analysis of police data being shared with partners. This aided timely collaborative approaches to interventions and support for adults at risk of harm. Almost all referrals were shared by the divisional concern hub to partners without delay.

The initiation of an Escalation Protocol Review (instances of repeat police involvement) was inconsistent. Whilst emerging patterns of wellbeing concerns were identified, single agency measures to mitigate harm and reduce demand were not evident. Engagement with and active involvement by the local area commander may improve wellbeing outcomes and reduce significant demands placed on policing in some instances.

The police mostly attended case conferences when invited but, on some occasions, did not. When they attended, the contribution of officers was good or better almost all of the time. There was scope for the police to improve their case conference attendance. A process was in place that enhanced collaboration between the police and case conference chair. This resulted in police frequently sharing reports with the chair prior to the conference but further improvement was needed.

Third sector and independent sector provider involvement

The third and independent sector made appropriate adult support and protection referrals. They provided additional support in a few cases and played a critical supporting role in complex protection activity. Almost all adults at risk of harm who needed additional provision from services received it. This support was comprehensive, effective and met their personal outcomes.

Key adult support and protection practices

Information sharing

Information was almost always shared between partners. All staff agreed that they knew what to do if they were concerned that an adult was at risk of harm, and almost all understood their role. Referrers almost always received feedback in accordance with procedures. The case records we read indicated that good information sharing was core practice within the partnership almost all the time. Information sharing from key partners at case conferences needed to improve.

Management oversight and governance

Commendably, social work managers read almost all adult support and protection records. The template used assisted this process and included supervision decisions. The level of recording was almost always in keeping with the needs of the adult. Governance of police records was mostly evident, but health records demonstrated management oversight on only a few occasions.

Involvement and support for adults at risk of harm

The views of adults at risk of harm were consistently considered through the adult support and protection process but more work was needed at the inquiry stage to ensure that adults were aware of their rights, and their views were considered and accurately recorded. Potential barriers to involvement were effectively addressed, and support for the adult at risk of harm was provided on almost all occasions. The views of unpaid carers were always sought. This was a strength.

Most adults at risk of harm were invited to their case conference and when they attended, they were provided with effective support. However, the two-part process was a barrier to involvement and when adults were not invited the reasons for this were not routinely recorded.

Independent advocacy

Adults at risk of harm were offered advocacy most of the time when it was necessary. On some occasions it was not. When an advocacy service was offered it was always provided timeously and almost always helped the adult at risk of harm's views to be articulated and heard.

Financial harm and alleged perpetrators of all types of harm

A few adults at risk of harm whose records we read experienced financial harm. The partnership took effective multi-agency action to stop this harm in all cases. The partnership acted to strengthen their response to financial harm by having a dedicated practitioner to address investigatory powers under Section 10 of the act. This improved relationships with local banks and trading standards and positively impacted on outcomes for adults at risk of financial harm.

The perpetrator of harm was commonly known to the partnership who undertook supportive work with them most of the time. The quality of work with perpetrators was almost always good or better.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced some improvements to their safety due to the partnership's adult support and protection intervention. Additional support was consistently provided in situations where this was needed. Almost all staff agreed that adults at risk of harm got the support they needed to remain safe and protected. This reflected our findings.

Adult support and protection training

The partnership recently developed a public protection learning and practice development strategy. This aimed to support a comprehensive multi-agency training plan based on priorities developed from national and local data, legislation, policy, learning reviews and inspection reports. A training calendar and the public protection newsletter effectively publicised training events. These measures reflected a sound approach, but the partnership had challenges recruiting to a learning and development post. This limited the partnership's capacity to deploy all the planned training.

Council officer training was extended to other local authority areas which facilitated exchange of learning and practice. Attendance and evaluation of training was reported to the public protection committee learning and practice sub-group.

Training that was undertaken was viewed very positively by staff who agreed it provided them with the skills, confidence and training to undertake their roles and duties. It also strengthened their understanding of risk within the adult support and protection context.

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

Key messages

- The partnership had a clear vision for adult support and protection that was widely communicated and well understood by staff across the partnership.
- Overall, strategic leaders oversaw the delivery of competent and effective adult support and protection practice. More collaboration was needed to improve in key areas such as interagency referral discussions and case conferences.
- Strategic leaders had a well-structured public protection framework in place. They needed to capitalise on this framework and strengthen governance of key processes.
- Quality assurance, self-evaluation and improvement activity was routinely undertaken. A multi-agency framework and revised improvement plan would strengthen the partnership's approach.
- Adults with lived experience of adult support and protection were not involved in shaping the work of the public protection committee. There was no plan to include adults in this crucial area of work.

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 East Lothian and Midlothian public protection committee (EMPPC) had a clear vision statement. The vision and core values were regularly communicated via the quarterly public protection committee newsletter distributed to staff and services across the partnership and at training events. These steps strengthened key messages for staff with most expressing confidence about clarity of the adult support and protection vision provided by strategic leaders.

The partnership promoted development sessions to strengthen communication of their public protection vision. This included presentations by EMPPC members. This supported a shared vision for public protection partners across wider community planning and protection strategic partnerships.

The partnership acknowledged that their vision could be communicated more widely to the public and planned to achieve this through the launch of a new public protection office website later in 2024.

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

The partnership benefitted from a long-standing shared services approach to public protection across East Lothian and Midlothian. The two areas shared a critical services oversight group, public protection committee, public protection office and public protection lead officers. The critical services oversight group was the chief officers' group that oversaw public protection, including adult support and protection in the partnership. Other strands of public protection activity were well inter-connected. A 2023 review of governance streamlined reporting, governance, and decision-making processes. Following this, the chairs of critical services oversight group attended the public protection committee development session to reinforce their support and express clear expectations for the committee.

The public protection committee had good multi-agency representation including the Scottish Fire and Rescue Service, education and the third sector. There was no advocacy included in the core membership. The committee had three sub-groups that worked across the public protection agenda. Public protection committee development work led to the creation of two further sub-groups for adult protection and child protection to allow for more in-depth discussion and a greater focus on these areas of public protection. These sub-groups were planned to start later in 2024 for a trial period of 18 months. The committee appointed an independent convener in 2023 who will chair both new sub-groups. As the groups had not yet been implemented it was too early to determine if these steps had a strengthening effect.

The partnership benefitted from their shared approach to public protection through the East Lothian and Midlothian public protection office where lead officers for adult and child protection worked alongside the coordinator for protecting women and girls against violence. This arrangement provided significant opportunities for collaboration across the whole public protection agenda and allowed for shared procedures, guidance, and resources. These were positive steps that ensured most staff were confident in the leadership for adult support and protection work.

Social work had strong governance in place for its staff. Strategic leaders ensured there were supportive arrangements in place for staff working with complex protection cases. The partnership prioritised staff support and appointed a well-being lead and set up projects to support them to remain safe and well at work.

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

The partnership recognised that overall engagement with adults at risk of harm and their carers needed improvement. There was no opportunity for them to contribute to adult protection policy formation and planning. Adults and carers were also not represented on the public protection committee or sub-groups. The committee acknowledged the views of adults with lived experience needed to be better represented but there were no clear plans to address this.

Further work was planned to enhance engagement with adults who were subject to adult support and protection processes. This included the development of accessible written information and supported by multi-media videos and animation.

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

The partnership's strategic leaders were responsive and encouraged innovative practice. They oversaw the delivery of the implementation of the revised code of practice in November 2023. Consequently, all inquiries using investigatory powers were undertaken by a council officer. Multi-agency adult support and protection procedures were updated to align and launched simultaneously with supportive briefings attended by over 170 staff, suggesting a strong commitment from all stakeholders.

Strategic leaders ensured good practice in relation to the quality of interventions using investigatory powers, high standard risk assessments, risk management plans and protection plans.

There was a strong ambition for collaboration across the partnership with initiatives such as the interagency referral discussion (IRD) overview group, IRD health rota, and escalating concern procedure.

Some key areas of practice required attention including consistent use of chronologies, case conferences and attendance at case conferences by police and health. There was a lack of evidence that minutes were circulated for one-third of case conferences. This had the potential to negatively impact on adults at risk of harm. The partnership planned quality assurance work around the strength of its case conference procedures.

Interagency referral discussions (IRDs) were long established and followed an e-IRD format. While leaders oversaw this was a well embedded approach the positive impact of these key meetings was limited and more needed done to promote their effectiveness.

Quality assurance, self-evaluation and improvement activity

Performance information was reported to the public protection committee performance and quality information sub-group at each quarterly meeting throughout the year. The adult support and protection lead officer and team managers recently undertook work to improve accuracy and quality of reporting. This informed themes for further quality assurance activity and were overseen by the critical services oversight group.

The partnership undertook a multi-agency audit of chronologies and risk assessment that identified areas of improvement around analysis and management of risk and recording. Key improvement findings from the audits were incorporated into the revisions of multi-agency procedures and the adult support and protection training framework. Furthermore, quarterly single-agency audits were carried out by the lead officer, adult support and protection team leader and council officers focussed on adult support and protection referrals that did not progress to inquiry. These provided assurance to the public protection committee about decision making during the adult support and protection screening process.

NHS Lothian adult support and protection advisory team also undertook an audit of health records. This was identified as an area for improvement following previous inspections of adult support and protection across Lothian partnerships. For Midlothian, this led to changes in the adult support and protection training programme including record keeping, attendance and prioritisation of case conferences and guidance for reports, chronologies, and duty to cooperate.

The partnership recognised that their approach to multi-agency quality assurance required strengthening. Development of a programme of multi-agency audit was included in the adult support and protection improvement plan. The public protection committee had more work to do to share the learning from self-evaluation and audit work. More should be done to encourage staff involvement in audit and self-evaluation activity and to show that the partnership evaluated the impact of adult support and protection work and that this informed improvement activity.

The adult support and protection improvement plan was discussed at each public protection committee meeting. The plan was incomplete and lacked detail. Improvement actions were not always linked to policy drivers or audit actions. Further development of the improvement plan would assist the partnership to monitor and evaluate improvement activity.

Learning reviews

The East Lothian and Midlothian public protection committee had a dedicated learning review sub-group to provide oversight of the process of learning reviews and action plans and facilitate dissemination of learning. The partnership had not undertaken any learning reviews during the timeframe of the inspection. Learning points were addressed from two initial case reviews that were undertaken.

Summary

Key processes

Overall, the Midlothian partnership delivered adult support and protection processes that protected and supported adults at risk of harm. There were some strong areas of practice particularly management oversight of council officer practice, the risk assessment framework and the quality of chronologies and risk assessments when completed. Some areas required further improvement.

The 2017 joint inspection of adult support and protection in Midlothian highlighted timeous progression of adult support and protection referrals and completion of chronologies as areas for improvement. While some progress was being made, more was needed. A significant number of adults did not have a completed chronology in 2017. While the quality of completed chronologies had since improved, their presence in records had reduced.

The partnership's approach to risk assessment was strong. A robust framework was in place that promoted a dynamic review of risk throughout the adult support and protection process. As a result, the quality of risk assessments had improved since 2017, although their presence in records had reduced. A more consistent deployment of the tool would further strengthen this area of practice.

Since 2017 the partnership had worked to positively change practice and ensure that timely advocacy was offered to adults at risk of harm. A range of ongoing measures were put in place to promote advocacy to staff such as briefings, training and the public protection committee newsletter. Staff were guided by procedure to offer advocacy at first contact. Advocacy attendance at case conferences was monitored and reported to the performance and quality improvement sub-group. These measures meant that advocacy was now offered to most adults at risk of harm and always provided without delay.

Strategic leadership

The 2017 joint inspection found that leadership within the partnership had major strengths. This inspection found that overall, strategic leaders ensured the delivery of competent and effective adult support and protection practice. Strategic leaders' vision for adult support and protection was strong and well understood by staff to ensure effective governance. The partnership's ambition for collaboration had not been fully realised. Further improvement was needed in key adult support and protection processes such as interagency referral discussions and case conferences to expand progress.

The key areas identified for improvement in 2017 had not been fully achieved. The partnership had the components of a sound approach but needed to do more to strengthen collaboration and oversight in some key areas of adult support and protection practice.

Next steps

We asked the Midlothian partnership to prepare an improvement plan to address the priority areas for improvement we identify. The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland will monitor progress implementing this plan.

Appendix 1 – core data set – We will minimally amend this when we see data for first partnership inspected in phase 2

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

- 98% 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
- 85% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 95% of episodes where the three-point criteria was applied correctly by the HSCP
- 80% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 13% less than one week, 38% one to two weeks, 50% two weeks to one month
- 93% of episodes evidenced management oversight of decision making
- 78% of episodes were rated good or better.
- 53% of initial inquiries used investigative powers, 100% of initial inquiries done by a council officer

Staff survey results on initial inquiries

- 92% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 4% did not concur, 4% didn't know
- 88% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 5% did not concur, 6% didn't know
- 94% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 2% did not concur, 4% didn't know

Information sharing among partners for initial inquiries

- 95% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm

Chronologies

- 58% of adults at risk of harm had a chronology
- 69% of chronologies were rated good or better, 32% adequate or worse

Risk assessment and adult protection plans

- 78% of adults at risk of harm had a risk assessment
- 77% of risk assessments were rated good or better
- 97% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 75% of protection plans were rated good or better, 25% were rated adequate or worse

Full investigations

- 96% of investigations effectively determined if an adult was at risk of harm
- 88% of investigations were carried out timeously
- 79% of investigations were rated good or better

Adult protection case conferences

- 83% were convened when required
- 89% were convened timeously
- 47% were attended by the adult at risk of harm (when invited)
- Police attended 61%, health 58% (when invited)
- 79% of case conferences were rated good or better for quality
- 95% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 67% of review case conferences were convened when required
- 92% of review case conferences determined the required actions to keep the adult safe

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

Information sharing

- 96% of cases evidenced partners sharing information
- 98% of those cases local authority staff shared information appropriately and effectively
- 92% of those cases police shared information appropriately and effectively
- 92% of those cases health staff shared information effectively

Management oversight and governance

- 94% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 94%, police 74%, health 5%

Involvement and support for adults at risk of harm

- 83% of adults at risk of harm had support throughout their adult protection journey
- 92% were rated good or better for overall quality of support to adult at risk of harm
- 88% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 3% did not concur, 9% didn't know

Independent advocacy

- 73% of adults at risk of harm were offered independent advocacy
- 50% of those offered, accepted and received advocacy
- 100% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 90% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 89% of these adults had their capacity assessed by health
- 100% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 14% of adults at risk of harm were subject to financial harm
- 100% of partners' actions to stop financial harm were rated good or better
- 84% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 98% of adults at risk of harm had some improvement for safety and protection
- 91% of adults at risk of harm who needed additional support received it
- 86% concur adults subject to ASP, experience safer quality of life from the support they receive, 5% did not concur, 9% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 70% concur local leaders provide staff with clear vision for their adult support and protection work. 12% did not concur, 18% didn't know

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

- 77% concur local leadership of ASP across partnership is effective, 6% did not concur, 17% didn't know
- 66% concur I feel confident there is effective leadership from adult protection committee, 9% did not concur, 25% didn't know
- 53% concur local leaders work effectively to raise public awareness of ASP, 10% did not concur, 36% didn't know

- 62% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 8% did not concur, 30% didn't know
- 68% concur ASP changes and developments are integrated and well managed across partnership, 6% did not concur, 26% didn't know