East Ayrshire APC Multi-Agency ASP Self Evaluation

Audit Report – April 2024

Contents

Multi-Agency Audit of Adult Support and Protection

The current Guidance for Adult Protection Committees (July 2022) refers directly to Audit and Quality Assurance activity stating:

“a regular programme of multi-agency audit, self-evaluation and review should be part of the routine work of APCs, directly influencing strategic development and practice improvement.”

This multi-agency self-evaluation forms part of the planned annual commitment to the reestablishment of our East Ayrshire Adult Protection Committee (APC) multi –agency self-evaluation post pandemic. It demonstrates our overall commitment to continuous improvement and implementing the key changes included in the revised Adult Support and Protection (ASP) Code of Practice in July 2022. It both compliments and provides a strong basis for understanding our position that ensures we are well prepared for any external scrutiny as part of national inspection programmes.

The ultimate aim of the Audit is to provide assurance to the APC and therefore Chief Officers (COG) around the effective operation and collaboration in respect of adult support and protection practice standards and service response across and between partners in East Ayrshire that ensure the best outcomes for our citizens.

Involvement of Partners

Those with lived or living experience as well as multi agency staff are considered key partners and as such their views are integral to this multi-agency self-evaluation (The Audit). This is reflected in both the Audit methodology and in the delivery led by the Audit Coordination Group (ACG) who reported directly to the APC Improvement Subgroup on behalf of the APC. The ACG membership was made up of partners from East Ayrshire Health & Social Care Partnership: Adult, Older People’s Services and Community Justice Services. Police Scotland, NHS Ayrshire and Arran, Scottish Fire and Rescue, East Ayrshire Housing Services, East Ayrshire Advocacy and Scottish Care.

The Audit focus

The APC Chairs Biennial Report 2020-2022 was a key driver for identifying local priorities for partners to deliver on. The report highlighted the national and local emerging trends around increased reporting of self-neglect which had become one of the top 3 categories of harm recorded. It was agreed therefore by the APC to take the opportunity to include this theme within the scope of the Audit.

The Audit will provide a current position statement on how well we are delivering on adult support and protection for people aged 16 and over and has a focus on:

- Key adult support and protection processes and practice; **and**
- Understanding responses to people experiencing Self Neglect.

The Audit took place from 11 March – 12 April 2024. We audited the records of adults at risk of harm for the preceding year, 1st January – 31 December 2023.

Quality Outcome Indicators

Our quality Indicators for this audit are detailed below and the question set for all activities have been aligned by colour coding them to one of these areas, for the purposes of collation and analyse. A summary overview of data findings is contained in Appendix 1 of this report which must not be read in isolation but within the context of the main report findings as statistics can be subject to individual interpretation:

Early Intervention – Our policies, procedures and practice are good for people at risk of harm
Prevention – People at risk of harm are safer as a result of our activity (Outcomes)
Protection – The impact and likelihood of repeat episodes of harm have been reduced

Methodology

The APC safeguarding approach to adult support and protection of early intervention, prevention and protection is at the heart of this self-evaluation. At the core of this is to make sure our activity reflects a personal outcomes approach which is why our model of self-evaluation included the following proportionate activities;

The reading of social work and related health and police records of **32** individuals reported as at risk of harm. This represented **9%** of the total annual adult a risk referrals received during the audit timeline and following liaison with Care Inspectorate data analysts was deemed to be a valid sample for the audit purposes.

The sample included the records of **13** Individuals who did not require any further adult support and protection intervention beyond the initial inquiry stage and **19** whom inquiries used investigative powers under sections 7-10 of the 2007 Act. These investigative powers included **11** visits to conduct adult support and protection interviews with adults a risk of harm and statutory requests to access further information from relevant organisations. The Audit also included case conference, core group and protection planning activity as well as post closure review arrangements.

Staff focus groups - We facilitated four focus groups with participation and or responses from **29 frontline staff** and team and service managers from across the partnership. The aim of these focus groups was to have a conversation and gauge staff views on adult support and protection practice. The staff attending were representative of the multi-disciplinary partners included in the audit case record sample. This included administrative staff from the health and social care partnership with a specific role in supporting adult support and protection processes.

Three focus groups were conducted in-person with two of these being made up of multi-disciplinary practitioners and one specific to independent advocacy workers. The fourth focus group specific to managers was held virtually. An additional management survey specific to social work was issued following this focus group in order to ensure a more representative balance across health and social work professionals.

Conversations were independently facilitated by East Ayrshire Advocacy with **30 people** who had lived or living experience of adult support and protection processes (Inquiry, Investigation, Case Conference, Core Groups and Protection Planning). The conversations included 22 individuals who were subject to ASP processes and 8 individuals who were Unpaid Carers and/or family members.

A Rapid Literature Review relating to research around Self Neglect by the Health Improvement Lead, Department of Public Health, NHS Ayrshire and Arran was undertaken. This information was utilised to inform both the training for auditors around risk factors, underlying causes, good practice and challenges affecting good practice as well as inform the development of the audit question set. This ensured the self-neglect aspects of the framework and evaluation was framed by a strong evidence base.

Composition of Audit Files Selected

Age Range & Gender

Age	Male	Female	All Adults
16 - 17	0	0	0
18 - 24	1	2	3
25 - 39	5	1	6
40 - 64	6	7	13
65 - 69	1	1	2
70 - 74	1	0	1
75 - 79	0	0	0
80 - 84	0	3	3
85 +	3	1	4
TOTAL	**17**	**15**	**32**

Client Category

Category	Number for Audit	% for Audit	Number for Year	% for Year
Alcohol or other Substance Misuse	5	15%	57	15.6%
Dementia	4	12%	85	23.2%
End of Life Care	0	0%	4	1%
Frail/OIder	4	12%	29	7.9%
Learning Disability	7	21%	68	18.6%
Mental Health	8	25%	85	23.2%
Physical Disability	5	15%	36	9.8%
Sensory Impairment	0	0%	0	0%
No Client Category Identified	0	0%	1	0.2%
TOTAL	**32**		**365**	**8.77%**

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

Meeting procedural timeframes and responsiveness

The safeguarding of people at risk of harm is not a linear process, it is one that requires a person centred response to the varied and often complex protection needs within a system that acknowledges that flexibility will always be required. The Audit team recognised this and as such the reporting of this data is proportionate and acknowledges the current robust performance reporting and monitoring systems in relation to this standard.

There is the facility to record reasons for delays on the social work information system however within the case file sample audited 45% did not record the reason for delay. The added benefit of this Audit was therefore that we were able to ask file readers to provide information that would offer an explanation to allow us to better understand factors influencing delays and as such be able to identify barriers or gaps and support improvement in this area.

In respect of the 32 cases audited, all of these undertook an ASP Inquiry without the use of Investigatory Powers. Of these 44% (14) were completed within 5 working days and 52% (17) were signed off within 7 working days.

Q9. Considering the delay, was the ASP Inquiry without the use of Investigatory Powers sufficiently responsive to the adults protection needs?

Answer Choices			Response Percent	Response Total
1	Yes		68.75%	11
2	No		31.25%	5

In terms of responding to the individual's protection needs we need to improve in terms of meeting procedural timescales however 69% of the time practice indicates we are responding to the protection needs of the individual and the factors influencing delays are reasonable in the circumstances with the exception of the need for improved recording. An analysis of the reasons for delays and where intervention was less effective related in the main to insufficient recording, time spent reading care planning notes where there had been multiple adult concern reporting or facilitating practical supports. Other factors influencing delays or effectiveness included the need for a further meeting for example an ASP Planning meeting, Care Programme Approach (CPA) meeting date awaited or due to time spent in liaison with psychiatric services to secure inpatient psychiatric assessment for patients who were later detained under the mental health act.

There were 2 anomalies with significant delay which related to situations which were known to managers as part of management performance reports. These relate to situations where inquiries had been passed for completion of an Inquiry or sign off from children and justice services who do not have high demands for these.

Of the 32 cases audited 19 progressed onto an ASP Inquiry with the use of Investigatory Powers. Of these 42% were completed within the 26 working day timescale. In two thirds of cases the reason for delay was not recorded however comments made in the free text suggest presenting factors for social work delays included;

- delays in management sign off rather than completion of the investigation or
- delays due to complexity of risk and multiple service involvement that required analysis of history or time spent by worker arranging supports to facilitate hospital discharge.

The feedback from staff focus groups cite high staff turnover as well as a sense that referrals for adult concerns still at times felt as inappropriate and causing increased demands. The factors influencing this was perceived to be around a need to continue building skills and knowledge around ASP and potential alternative routes and services that may be more in keeping with the needs. Out of Hours services, housing and care homes appear to be three key areas mentioned in relation to this. A further aspect raised was that of feedback mechanisms with a potential need to review this from the start and every stage of the ASP Process as it was considered as a potential barrier at numerous points as well as referral as described below by staff;

"Doesn't feel robust if poor referral form/referral information, then no feedback on meeting the 3 point test to provide referrer….outcome as opportunity to discuss further….lack of feedback can be barrier to raising concerns/submitting referrals."

The Community Learning Disability Team, Police Partners Meetings, Health attending Police Calls were viewed as positive examples by staff of colocation and joined up working. Staff perceived the benefits of these in terms of relationship building, confidence, and communication around ASP activity. Analysis of staff focus group feedback indicates the need for a further focus on the colocation of key services or systems that for example bring housing, care home support teams and front door services together with relevant partners and have an emphasis on diverting adult concern reporting from social work when appropriate. This was viewed as strengthening the culture of a multi-disciplinary team approach, reduce meetings for key services who have a challenge to attend and also find agreed ways of working to divert people to the right resource. The lived experience of an individual sums up the importance of how we work with and for people;

"Yes we all were asked as a family, I kind of took over with information and we were very emotionally involved in my [relative's] care…We felt as a family after the ASP concern team was done then another team from social work became involved, this became confusing for me…As a family we are pleased the ASP concern came

through as it brought things to a head with my [relative] and the positive is that services are involved with his care now, if this process didn't happen then he would still be at risk".

Q42. Was the Inquiry with the use of Investigatory Powers carried out in a timescale that was in keeping with the needs of the Adult at Risk of Harm? If no - please detail why not in box provided				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		80.95%	17
2	No		19.05%	4

In 81% of records read the response was in keeping with the needs of the adult as detailed above and where file readers did not consider this to be the case this mainly appears to be related to quality of recording affecting analysis or reduced contact with relevant professionals as part of information gathering within investigation records.

Of the 32 cases audited 13 progressed to an ASP Initial Case Conference. Of these 85% (11) were completed within the 42 working day timescale. In 73% of cases file readers deemed the timescales were appropriately responsive to the needs of the individual. In 27% of cases where this was not evidenced this was due to the adult passing away or rationale not being recorded.

5 of the 32 cases audited were deemed to be Active Adults at Risk of Harm. Of those 20% (1) had an ASP Core Group completed within the 10 working day standard.

100% (5) had their ASP Review Case Conference held within 3 months of the ASP Initial Case Conference.

Summary

The findings indicate a strength in meeting Inquiry and Initial and Review case conference completion timescales with potential improvement required in investigation completion as well as understanding and tackling delays in core group implementation.

Routine oversight of data in relation to delays is available via monthly management reports from the Protection and Learning Team.

Relevant managers should continue to encourage staff to record reasons for delays on the system which would improve the quality of performance as well as earlier identification and addressing of any emerging trends, gaps or supports for staff.

Delays for anyone experiencing acute mental health crisis or deteriorating wellbeing can have devastating effects in terms of recovery, experiencing trauma or increased risk of suicide. Given reports for people under the category of mental health made up a quarter of case files audited and also convert to the same for annual reporting trends

this is an area worthy of future consideration to ensure robust early intervention and prevention pathways for people experiencing deterioration in their mental wellbeing.

A specific need was identified within staff focus groups for Neighbourhood Coaches to raise further awareness of their support role and focus on sustaining tenancies and not eviction to dispel incorrect perceptions that may remain and be creating unintended barriers to joint working.

The individuals themselves can for many reasons appear to create barriers therefore the need for a culture that seeks to understand these and sticks with people is essential a point summed up by one individual;

"Yes I expressed my views well although they were detrimental…I signed myself out of the xx Hospital without any care arranged, that was not a good idea…Social work were great though and I don't know where we would be without them…Everything was so overwhelming for both of us".

Inquiry without the use of Investigatory Powers

ASP Planning Meetings

An ASP Planning Meeting serves a core and crucial function of bringing multi-agency professionals together where here is complexity to share information, make joint decision around level of risk and decisions that determine whether an adult is at risk of harm and/or in need of intervention which can then be jointly planned and coordinated.

In 57.5% of case files audited there was no ASP Planning meeting held which was considered by the file reader to be the appropriate decision.

ASP Planning Meetings were held for 9% of records audited and were deemed to be effective in meeting the purpose of the meeting in all cases.

In 33% of files read the auditors considered that the criteria for an ASP Planning meeting would have been met and have been beneficial for some of the reasons provided below:

- Involvement of multiple services/agencies for a number of individuals and would have allowed more robust and timeous information sharing to inform decisions
- Allowed opportunity to open up communication with other statutory services thus affording a more joined up approach
- Threshold for escalation due to repeat referrals met but not applied.

The Audit findings suggest that there is some assurance that we are starting to see some progress in that when decisions are made not to hold an ASP Planning meeting, these are appropriate and when held they are effective. Equally given that a third of situations were considered to have met the criteria however had not been held and there are situations where escalation standards are not being adhered to this will remain a priority area for improvement.

Feedback from staff attending focus groups indicated a strong sense that ASP Planning Meetings are increasing in use and there is an acknowledgement of the benefit of these. The picture presented was one of variable use by managers across service areas and some need to continue to clarify the definition with and across agencies including police, health and housing. Staff spoken to indicate a standard timescale set and agreed may assist in improvement.

3 Point Criteria Decision Making

Q14. Has the three point criteria been applied correctly in this case?

	Answer Choices	Response Percent	Response Total
1	Yes	63.64%	21
2	No	36.36%	12

Audit findings suggest that there is an understanding in terms of the application of the legal criteria of an adult at risk of harm .The level of variation however indicates this remains an area for improvement for all areas of Social Work who have the lead role in making this determination. This should be considered as a potential area of focus for future social work single agency management audits to identify additional support required to improve across services. Further activity for improvement should also include opportunities to share and learn from over 63% of peers who have shown this as an area of strength.

Current activity supporting the workforce in understanding the legal threshold for ASP which can continue to be built upon has included local implementation of the revised ASP Code of practice resulting in further clarity being provided within the revised Social Work ASP Operational procedures.

The multi-agency ASP Training programme has a clear focus on understanding thresholds at every level. This includes both the mandatory specialist training for Council Officers as well as supports the learning and development for Inquiring Officers who are made up of 90 Social Workers and 40 Support Assistants. Practitioner forums are routinely held to support practitioners to develop skills and knowledge from both research and practice as well as each other. It will be crucial therefore to ensure services support and encourage both attendance and participation as any gaps in learning opportunities may be impacting on this area of practice.

Where workforce capacity is impacting on this managers of teams have an opportunity to work jointly within and across teams when undertaking work to enhance knowledge, skills and confidence through supporting staff to link with those more experienced to shadow and or observe good practice.

Q17. Evaluation of quality of Inquiry without the use of Investigatory Powers				
Answer Choices*note adds to 33 responses as duplicate recording of 1 for adequate or weak as file reader did not save and repeated.			**Response Percent**	**Response Total**
1	Excellent		27.27%	9
2	Very Good		21.21%	7
3	Good		18.18%	6
4	*Adequate		9.09%	3
5	*Weak		9.09%	3
6	Unsatisfactory		15.15%	5

Around 67% of Inquiries without the use of investigative powers was rated Good, Very Good or Excellent. We know from file readers who responded that 40% of files read indicated information from other parallel internal or service investigations were used to inform decisions about whether the 3 point test was met. In 27% of these it was evident from recording that this information had been included in decisions whilst there were 12% of records where this was not evident and therefore performance can be improved through ensuring information from parallel investigations are being routinely recorded.

An analysis of the free text where auditors provided a rationale for their quality rating and a review of file reader concern reports indicate factors that may be impacting on the quality of inquiry practice which are listed below;

- Supporting practice that encourages a culture of joint decision making around risk by ensuring the standards for escalation of repeated adult concern reporting to adult at risk are adhered to and increased use of ASP Planning meetings are more consistently applied
- Supporting a clearer understanding of the impact of alcohol and drugs on an individual's ability to safeguard
- Adult Services and Children and Justice Services to jointly consider effectiveness of having lead role for Inquiries under ASP and include how to improve practice in terms of meeting both procedural timescales and standards of Inquiry
- Improved recording practice with a focus on all information relevant to ASP is contained in the relevant ASP Episode and not across case records which includes information relevant to other agency/service investigatory processes
- Checks with Justice Service that ASP information relevant to Caledonian System recording is recorded in ASP episode on adult services system
- A sense check to consider options to negate the risk of reduced standards on adult at risk recording and decision making that may be due to volume of adult concern reporting affecting workforce capacity.

Inquiries with the use of investigatory Powers

If the outcome of an Inquiry without the use of Investigative Powers records the adult meets the criteria of an adult at risk of harm within the ASP episode there is a requirement to progress directly on to the next stage of Inquiry with Investigative Powers on the social work system.

This process ensures statutory requirements are met as a specially trained ASP Council Officer is designated and that the right worker, with the right skills undertakes the proportionate level of intervention and support to the individual at risk of harm.

In 82% (18) of records audited file readers considered the above standard to have been met and in over 95% of cases a Council Officer was allocated as the investigative lead. The numbers that did not have a Council Officer were those that file readers had already identified as not proceeding to this stage.

The aforementioned standard was not met in 18% (4) of the case records audited.

Following further record checks by the Audit Coordinators across the system and/or escalation to the relevant Audit senior manager it was concluded that there were no situations where an adult or child was considered to remain at risk of harm.

Involvement of multi-agency partners

As at the initial Inquiry stage where an Inquiry moves to the investigation phase contact with and information gathering from relevant multi-agency partners is essential to inform the type and level of risk.

This then informs the decision making of the Council Officer around intervention including whether the threshold for serious harm is met that may warrant consideration of a Protection Order.

A further key role of agencies is to provide their specialist knowledge, skills and resources for example where there may be a clinical perspective or housing need identified or access to relevant supports for the individual or others involved.

59% of records read satisfied auditors that all appropriate agencies had been involved within the investigation phase.

File readers noted that in some instances Independent Advocacy to support engagement and earlier contact with partners from Police and Housing Services to identify information held could have been accessed earlier to inform decisions.

In 40% of records read auditors viewed relevant agencies had not been involved at the investigation stage. This included a number of agencies being mentioned by 3 or more file readers as detailed in the table below:

Housing	**Scottish Fire & Rescue**	**Police Scotland**	**Independent Advocacy**
	Mental Health Services Hospital and Community	**NHS Primary Care**	**Independent Sector**

Secondary Workers

The legislation permits the Council Officer to take anyone deemed appropriate and that would provide benefit. It is expected that the relevant professional (second worker) is identified as part of planning for the visit and interview.

67% of Inquires with the use of Investigatory Powers required a secondary worker.

58% (11) out of 19 inquiries with the use of investigatory powers included a formal investigative interview of the adult at risk of harm. Where a statutory visit and interview of the adult at risk of harm is initiated it is the policy in East Ayrshire to undertake this in pairs and this standard has been met.

90% of secondary workers were sourced from social services.

File readers were asked to consider whether another agency would have been considered more suitable within the circumstances. In the main file readers viewed social services were suitable.

In East Ayrshire all Council Officer training includes understanding the role and function of a second worker. There is also an ongoing course to ensure a wider range of staff have increased confidence in this role. Evidence of this is that of the 90 Social Workers employed 47% have attended second worker training. Of the 40 Support Assistants 67.5 % have attended training with courses delivered to meet demand.

In relation to self-neglect, given the anticipated future increase of this type of harm and the findings around responses in this report it would be prudent to continue to ensure a proportionate section of partners from health and housing receive information and training around this role.

The audit found that second workers were being deployed as necessary and that there is a case for consideration of some continued targeted training for wider multi-agency staff.

Chronologies

The current additional investment in relation to training provision and procedural clarification would appear to be contributing to signs of improvement in that 59% of cases had a single agency chronology proportionate to the stage in the ASP process.

File readers noted some excellent examples of good practice in this area which could be built upon.

68% of chronologies undertaken were rated Good, Very Good or Excellent.

Q28. Please rate the quality of the Chronology				
Answer Choices			**Response Percent**	**Response Total**
1	Excellent		26.32%	5
2	Very Good		15.79%	3
3	Good		26.32%	5
4	Adequate		0.00%	0
5	Weak		10.53%	2
6	Unsatisfactory		21.05%	4

There does remain some variation in quality and in producing chronologies which will require current support around this to continue.

Auditors commented that on occasions chronological information is spread over a number of areas in the ASP process or case notes. Consideration could be given to a template that could also be utilised for multi-agency chronologies and where individuals require to transition from child to adult or other service areas.

The East Dunbartonshire Joint Inspection of ASP has been highlighted as an example of good practice by the Care Inspectorate, They have improved performance through reverting to a template that remains live and moves with the individual and can be attached to the e system and updated. This makes more effective use of worker time by retaining in a central place and as such improving outcomes for those at risk of harm.

<u>Risk Assessments</u>

86% of files read had a risk assessment on file with 89% of those rated Good, Very Good or Excellent. Of those 75% had both an analysis of risk that was appropriate to the protection needs of the adult and had been informed by the views of relevant partners.

The previous pre pandemic self-evaluation had identified that there was little evidence of practitioners providing an AP2 which was the multi-agency risk assessment tool available.

Improvement activity included building the template into the electronic social work ASP episode on Liquid Logic and a number of specialist assessments and checklist around common public protection risks that could be utilised. A Risk Assessment process was included in the revised Social Work Procedures and has been used to inform sessions with Council Officers.

The Audit findings indicate we are starting to see improvement in this area and activity should continue to monitor practice ensuring improvement is both consistent and sustained.

Staff highlighted that in terms of ASP risk “understanding (legal) thresholds getting better”. There was a perceived need for further confidence in how to consider risk to mental health and homicide particularly “how to choose the best pathway, especially when coercive control is present”. Safe & Together training was mentioned as being helpful in supporting this and an area to promote across services.

Q33. How would you rate the quality of the Risk Assessment?				
Answer Choices			**Response Percent**	**Response Total**
1	Excellent		33.33%	6
2	Very Good		50.00%	9
3	Good		5.56%	1
4	Adequate		5.56%	1
5	Weak		0.00%	0
6	Unsatisfactory		5.56%	1

Consideration of Protection Orders and Medical Examinations

In 95% of files read a medical examination was not required. We know from considering delays in timescales that individuals are accessing acute physical and psychiatric clinical care and treatment.

The data in relation to Protection Orders remains below 5 which increases risk of identifiable personal data being relayed. We asked file readers to focus on using the criteria for all protection orders and consider whether the option may have been of benefit as part of Inquiries with Investigative Powers.

In 93% of records read, auditors deemed that protection orders were not a necessary option. In relation to the other 7% these related to the adult passing away after the investigation or a previous Banning Order had been deemed ineffective and therefore of limited or no further benefit.

Q40. Please rate the quality of the full inquiry with the use of investigative powers				
Answer Choices			**Response Percent**	**Response Total**
1	Excellent		30.00%	6
2	Very Good		30.00%	6
3	Good		25.00%	5
4	Adequate		0.00%	0
5	Weak		15.00%	3
6	Unsatisfactory		0.00%	0

85% of Inquiries with the use of investigatory Powers were rated Good, Very Good or excellent.

In the 15% where improvements were required these relate to the two thirds in Q38 below where auditors were unable to determine if the adult continued to meet the 3 point criteria. The free text offered suggests a common factor was the lack of including the views of some partners (care homes), limited consideration of the cumulative impact of alcohol use within previous repeat reports on the individual's ability to safeguard or associated analysis of presenting risk. This is consistent with the findings identified earlier in this report around application of the 3 point criteria, understanding the impact of long term alcohol use and further activity required to improve risk assessment knowledge and skills in specific areas.

Q38. Did the full Inquiry with use of Investigatory Powers effectively determine if the adult continues to meet the 3 point criteria?

	Answer Choices		Response Percent	Response Total
1	Yes		68.42%	13
2	No		31.58%	6

In the majority of cases (68%) of individuals moving to investigation had been deemed to have met the 3 point criteria. This suggests decisions made to intervene were proportionate and in keeping with the revised ASP Codes of Practice.

In a third of the cases where the answer was "No" this was deemed appropriate as file readers commented on reasons for this were the individual had been provided with sufficient supports to reduce the risk and offer protection. This could relate to findings where delays in completion of investigations were due to the time needed for the practitioner to establish practical supports and services,

In relation to local outcomes described later in this report findings suggests that the risk of harm being repeated or sustained has potentially been reduced through proactive intervention which happens when appropriate decisions are made to progress to the investigative stage.

Adult Protection Initial Case Conferences

87% of cases read met the criteria for an Initial Case Conference to be held and records reflect these meetings were held.

13% of cases read met the criteria for an Initial Case Conference to be held and records reflect they were not. Auditors found reasons for this relate to;

- one individual passing away
- a decision made to hold a complex case discussion as an alternative
- Manage risk of harm under care management and review processes
- Include the individual in meetings as part of Large Scale Investigation arrangements.

In 75% of Initial case conferences held, records indicate relevant professionals were invited. Analysis of the free text suggest Police and Mental Health Services were relevant but not invited to the meetings held in respect of 3 or more individuals suggesting this is an area for managers to consider.

The APC know from current activity in respect of Learning Review notifications that the omission of one key agency can have a significant impact on the risk assessment and decision making around whether to intervene. This in turn can lead to a negative outcome in respect of some of our most vulnerable citizens and is why a multi-agency approach is integral to the implementation of ASP Legislation and Code of Practice.

83% of relevant parties invited, attended or provided a report and it would appear within the free text that there is no emerging specific trend or pattern.

Of the 17% of those invited who did not attend or send a report received a copy of the minutes of the meeting which was an area of good practice in terms of protection admin support. Where this did not happen there was no minute available in records and it is reasonable to deduce this is related to a recently noted emerging trend of delays in the signing off of minutes by Case Conference Chairs rather than a need for administrative systems to improve.

Leadership from all partners will continue to be required in respect of prioritisation of attendance at ASP meetings or report provision. Social Work Managers and Council Officers should pay particular attention to ensuring the key partners from Police and Mental Health Services are invited where relevant alongside housing colleagues.

<u>Promoting Participation</u>

Q51. Was the adult at risk of harm invited to the Case Conference?

	Answer Choices	Response Percent	Response Total
1	Yes	69.23%	9
2	No	30.77%	4

The ASP Revised Code of Practice reminds us that there should be a basic assumption that the adult known or believed to be at risk of harm will be involved in all meetings about them. Nonattendance should be the exception however it is acknowledged that this may not always be possible particularly as the adult has the right not to attend or participate with any intervention under ASP and should not feel pressured to do so.

The key focus for practitioners therefore is to ensure any barriers to participation are understood and where possible removed and/or any relevant support provided. The current practice standards require reasons for nonattendance to be recorded on the social work information system and on the minute of every ASP Meeting.

The Audit found 69% of individuals at risk of harm had been invited to their Initial Case Conference.

In 31% of cases there was no recorded invite with auditors commenting that potential reasons for this were that the legal proxy for the individual was the invitee or age and frailty or the adult passing away.

An example of good person centred practice was noted with an Independent Advocate liaising with the adult at every stage and providing the adults photograph to focus agencies on who meeting was about.

Of the 69% invited 58% of individuals attended their Case Conference and records reflected the reason for nonattendance were consistent with the reasons for not inviting an individual as described above. Additional factors for nonattendance appear to be that the individual had their independent advocate representing their views or individuals being an inpatient in hospital detained under the mental health act.

There were cases where the reason for non-invite or attendance was not recorded in any of the recording systems where this would have been expected.

71% of adults who attended their Case Conference evaluated as being effectively supported to participate with a further 29% where this was not considered to be the case which highlights this as an area for continued improvement. The need for improvement has been based on comments from auditors which identified on an occasion that the adult appeared to be a “spectator at their own Case Conference”, and on one occasion the alleged harmer was present which is contrary to current local operating procedures. Auditors felt this could have had a direct influence on the adults participation and contributed to their distress during the meeting which was recorded on the Minute of the meeting. It was also noted as a reason the adult and their Unpaid Carer did not attend their follow up Review Case Conference.

This is perhaps an indication that although some trauma awareness is evident there is a need for a more enhanced level of understanding of a trauma informed approach.

Variable practice may also be related to lack of preparation and planning for the meeting which should be in place to anticipate potential distress and offering options to reduce or eradicate the risk of this. This finding could be a reflection of the availability and capacity of managers to support planning for meetings and or provision and quality of professional supervision given these matters were clearly recorded in meeting minutes signed off by Chairs and available in most cases on the information system.

Staff feedback was clear that the ASP procedures were a good framework however stressed importance of confidence, peer reflection and support in developing their skills and knowledge. Staff wellbeing was an area raised by staff who acknowledged that “it can be hard to switch off” as often “can’t just close the door or laptop and forget”.

Staff placed value on peer support, good relationships with each other "knowing each other" and commented there is a culture where it is understood "it is ok, not to be ok". Wellbeing resources and management support was mentioned as a positive in terms of availability and being open to staff raising concerns about practice or an individual. Team meetings and having access to real situations to reflect on was seen as helpful in supporting staff.

100% of Unpaid Carers attended the initial Case Conference and were deemed by file readers to have been supported effectively to contribute although in one instance the Carers perception differed.

The lived experience of family and Carers suggest a common theme around the positive impact of having an advocacy worker.

"Oh yes we had wee [Advocacy worker], she was great and liaised with our landlord and helped with meetings and kept us up to date with what Social work were saying".

61. Did the Case Conference effectively determine what was needed to ensure the adult at risk of harm was safe, protected and supported?

Answer Choices			Response Percent	Response Total
1	Yes		66.67%	8
2	No		33.33%	4

67% of Case Conferences held were considered effective in determining the adult's safety needs.

In 33% of cases where auditors evaluated this was not the case for the individual comments provided below provide some insight into influencing factors which if addressed could promote improvement:

- Time required to secure the provision of specialist emotional or psychological supports; or
- Lack of proactively seeking advice from the Office of the Public Guardian (OPG) at an early stage
- Time required for referral and access to parallel supports for example Care Programme Approach (CPA) or a capacity assessment from health.

The findings suggest the improvements may relate to a systems barrier and indicates considering whether there are fast track pathways that may reduce delays when individuals require psychological supports or alternative risk management processes such as CPA or Capacity Assessments.

75% of case conferences were evaluated as Good, Very Good or Excellent in terms of overall effectiveness with a quarter in need of improvement.

Q64. Please evaluate the quality and effectiveness of the Case Conference • Adequate recorded in error as 8.33% changed to 0%				
Answer Choices			**Response Percent**	**Response Total**
1	Excellent		41.67%	5
2	Very Good		25.00%	3
3	Good		8.33%	1
4	*Adequate error		0%	1
5	Weak		25.00%	3
6	Unsatisfactory		0.00%	0

Free text on a few occasions suggest performance would have evaluated more positively. This relates to some auditors considering there was premature closure of ASP processes before key information or supports required as part of risk management being confirmed as in place.

Areas of good practice noted by auditors were summarised as;

- Facilitation of Chair resulting in all voices heard equally
- Planning of meetings supporting relevant representation
- Awareness by partners of wider statutory roles and risk management systems for example OPG, CPA, Access to Funds

Improvement areas for Initial Case Conferences were summarised as;

- Knowledge of relevant supports from Local Authority or third sector for providing home support or supported employment
- Enhanced knowledge of the role of partners and supports offered for example Housing, District Nursing and Occupational Therapy
- Continued development for Case Conference Chairs that includes a focus on being trauma informed and confidence around conflict management ensuring the adults views and voice do not become lost.

<u>Protection Plans – Implementation and Effectiveness</u>

100% of all active adults at risk of harm had a Protection Plan in place which was up to date with two thirds of those that clearly identify the contributions of multi-agency partners.

A third did not meet the required practice standard and auditors commented that in these cases they were able to ascertain from records that all concerns regarding protection type risk had been addressed.

100% of Protection Plans were evaluated as Good, Very Good with the majority being evaluated as an Excellent Standard (60%). An outcome that demonstrates the effectiveness of protection planning is described below by one Unpaid Carer:

"Well as we said it was like invaders and then things settled, we really did need the support I don't know where we would have been without the support, I don't drink now and we are so looking forward to our new tenancy and garden when it comes. It felt like we both were going over the Niagara Falls to start with and now we are slowly heading for the calm water".

Q71. How would you rate the quality of the Protection Plan?

	Answer Choices	Response Percent	Response Total
1	Excellent	60.00%	3
2	Very Good	20.00%	1
3	Good	20.00%	1
4	Adequate	0.00%	0
5	Weak	0.00%	0
6	Unsatisfactory	0.00%	0

A Protection Plan is the key document recording current and changing risk and mitigating actions as well as ensuring clarity for all agencies in terms of their role therefore arrangements for monitoring, improving and sustaining the current standard is essential.

Social Work managers and Case Conference Chairs have an oversight of Protection Plans and there are practice examples meeting an excellent standard which others can learn from. There should therefore be consideration to ways this learning can be proactively shared not only in this area of practice but across all points of intervention within this audit.

Core Groups

100% of cases moving to a Review Case Conference had a Core Group initiated in line with procedural standards however timescales for these were sometimes variable, Core groups have a key risk management function for situations where there is complexity in relation to ongoing risk and/or multiple service involvement.

Any delays incurred in Core Groups could therefore have a more significant impact on the individual at risk of harm. This should continue to be an area for management performance reporting to ensure early identification and addressing delays is acted upon.

Core Groups were evaluated as being effective in meeting their purpose with comments from auditors suggesting that where this was not the case the factors directly related to the home situation not conducive to managing risk or the individual requiring to remain in hospital pending capacity assessment in order to implement the full community based Protection Plan.

The audit findings suggest there is a better performance in terms of practice standards when formal monitoring under ASP is in place when compared to the earlier stages in the process. This may support the need to explore and really understand both the increasing demands we are aware of in relation to adult concern reporting and the alternative pathways available for earlier community based support for those groups we know are coming to the attention of protective services.

If this is not explored this has the potential to continue to impact on both quality of practice and performance and reduce staff morale which again has implications for workforce retention.

Adult Protection Review Case Conferences

In 71% of cases where a Review Case Conferences was indicated these were held.

In 29% of cases a Review Case Conference was indicated however not held. Auditors commented that the reasons for this were partially related to the adult passing away or a complex case discussion being held as an alternative to the Initial Case Conference stage.

62.5% of the Review Case Conferences held were undertaken within a timescale that was considered appropriate to the adults' protection needs. Where this was not considered the case (37.5%) the factors that influenced this percentage related to meetings that met the case conference criteria being held out with protection processes or auditors not having all available Case Conference Minutes ,due to delay in sign off by the Chair.

80% of all relevant partners attended the Review Case Conference and where this did not happen free text indicates these were not one of the key statutory partners.

60% of adults were not invited to the Review Case Conference and of the 40% that were 25% were supported by services to attend.

Analysis is not fully possible in terms of reasons for nonattendance as recording of this in the minute were variable although appears to relate to an adult passing away and another where the Council Officer considered attendance would be detrimental to the individual due to the level of their perceived anxiety at that time.

This would not be unexpected as the ASP Code of Practice does reinforce that Council Officers consider the impact of processes on individuals and where they do not attend ensure clear arrangements are in place for the adult to be informed of what was to be discussed, arrangements for their views to be represented as well as outcomes of the meeting fed back once concluded.

The numbers of adults attending Review Case Conferences was too low to evaluate factors influencing the effectiveness with any real validity.

In terms of Unpaid Carer involvement low numbers identified at this stage do not make any valid evaluation possible.

In 100% of case records, auditors were able to determine what was needed to keep the adult safe, supported and protected.

The conversations with people with lived experience indicate barriers to engagement are often due to not being aware of referrals made under ASP creating feelings of defensiveness which was compounded by a perception of social work interfering rather than protecting.

40% of minutes of the meeting had been circulated to all however 60% of meeting minutes were not available awaiting sign off by the Chair. This suggests that delay in circulation is not an administrative systems issue rather potentially one of management capacity to sign off minutes to allow distribution.

Q96. Please evaluate the quality and effectiveness of the Case Conference

Answer Choices		Response Percent	Response Total
1	Excellent	50.00%	2
2	Very Good	0.00%	0
3	Good	50.00%	2

The variation in evaluation in this section has been impacted on by factors such as minutes not being available, quality of recording around details of supports offered or key partners not invited which may have contributed to this inconsistency of findings.

Q100. Where it is deemed that the adult is no longer an active adult at risk of harm, but continues to have Social Work involvement, have the minute decisions recorded that a My Life My Plan or My Life My Review should take place within 3 months?

Answer Choices		Response Percent	Response Total
1	Yes	60.00%	3
2	No	40.00%	2

Post protection support is an expectation for individuals who have continued social care needs and may be vulnerable to previous risks returning or further harmful situations arising.

The My Life My Plan/My Life My Review is an important person centred tool to mitigate against this. There is an expectation that any scheduled annual review is fast tracked and held 3 months post closure to ASP to offer assurance that the individual remains safe and supported.

The audit of records found that this standard was met for 60% of individuals and 40% where this was not. Factors that may affect this position could be related to a specific action not being recorded in the minute or decision outcome of the final ASP Case Conference or delays in distribution increasing the risk of drift.

The current ASP performance reporting framework does include monthly performance reports to managers in respect of this standard with an escalation protocol built in where action to address this are not evident. This governance process should ensure early identification of gaps and therefore management intervention to support staff to take any necessary action. This will only be effective however if senior managers accountable for this provide effective leadership.

In terms of the human experience it should be remembered that individuals can be left with feelings of anger and resentment for example if they experience a crisis which results in hospital admission and the possibility of not returning home. It is crucial therefore to ensure individuals have access to continued emotional support as well as independent advocacy perhaps long after the ASP activity closes down which one individual made very clear to us;

"No I was told nothing, I went in to the hospital with a hypo coma and then I was told by a doctor that I was not ready and I couldn't get back home at this time. I was browbeaten in to coming here for two months, then I was forced and pushed to give up my home. Staff kept talking about my capacity but I strongly disagree, I can choose where I want to live and how I live my life…."

Large Scale Investigations (LSI)

The Audit did not include a specific focus on the quality of performance or practice in relation to LSI activity as from the records sampled only 2 of the files included LSI activity.

Local statistical data in relation to the number of Large Scale Investigations is held and reported as part of the national minimum dataset.

Following recent endorsement of the revised West of Scotland LSI Guidance and IRISS Good Practice in Large Scale Investigation, work is progressing on an Ayrshire Guidance to promote consistent practice and application.

In anticipation of this and to offer an opportunity to consider any specific strengths or gaps to inform local implementation , auditors were asked to consider whether the criteria for consideration of an LSI would have been met and if there was evidence of these being ruled in or out.

Q6. Is there written evidence that the option of an LSI has been ruled in or ruled out where appropriate?

Answer Choices			Response Percent	Response Total
1	Yes		13.33%	4
2	No		86.67%	26

76% of files read were not considered to meet the LSI criteria which offers some assurance that LSI activity is not a significant gap.

24% of files read were considered to have potentially met the criteria for consideration.

Taking into account a quarter of these represent those known within the sample this leaves two quarters (6) where the criteria was considered to be met .

The limited recording available to auditors means any valid conclusions around the reason for not being recorded as ruled in or out cannot be made however given the numbers that were deemed to meet criteria for consideration it may suggest a need for increasing awareness and confidence in applying thresholds.

The implementation of the aforementioned Ayrshire LSI guidance will provide an opportunity to promote a clearer understanding around thresholds and increase confidence.

This will require any related communication and briefings have a robust emphasis on these areas and reinforce the expected roles and responsibilities for agencies involved in decision making and the recording standard for those decisions.

The Ayrshire Guidance will include the practice for building in self-evaluation of the process which will complement the recent introduction of sharing learning from LSI, s across the Health and Social Care Partnership and with the APC.

For self-evaluation to be successful there will require to be leadership and a clear arrangement for collation of LSI evaluations to ensure they inform future improvements and/or guidance review.

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

Multi-Agency Involvement and Consultation Overview

Q105. Is there evidence that adult protection partners seek and take into account, where appropriate, the adult at risk of harm's views (either directly or through an appropriate, identified representative) at each stage of the ASP journey? Answer for each of the ASP Stages

Answer Choices	Yes	No	Not Applicable	Response Total
Inquiry without the use of Investigatory Powers	69.70% 23	24.24% 8	6.06% 2	33
Inquiry with the use of Investigatory Powers	50.00% 16	15.63% 5	34.38% 11	32
Adult Protection Initial Case Conference	25.00% 8	12.50% 4	62.50% 20	32
Protection Planning and Implementation and Review	12.50% 4	6.25% 2	81.25% 26	32

Overall there is a degree of variable practice and a need to address some of the practice areas summarised below in respect of improving participation for adults at risk of harm;

- We are good at identifying communication needs but need to get better at recording and /or putting supports in place to address these as well as more consistent application of operational procedures and standards
- Workforce sustainability and capacity have impacted on the ability of workers to take a more proactive approach or to retain the same worker to allow engagement to develop (responding to increasing volumes of adult concerns and crisis means limited time to respond to situations earlier)
- 70% of adults received effective support to remain involved and when we supported them 91% received support deemed to be of Excellent ,Very Good or good quality and effectiveness
- Where support was less effective earlier engagement with independent advocacy would have improved engagement and a more meaningful relationship established with the individual
- We recognise situations where the adult had an Unpaid Carer (31% of cases) and offer support through the adult protection journey with two thirds offered a Carer Support Plan as part of aftercare
- On occasions we don't always recognise situations where the adult at risk is also an Unpaid Carer perhaps related to the focus on crisis intervention rather than a more holistic whole family approach and perhaps partially related to high service demands.
- People do feel safer and have good outcomes even when they may have been afraid of or resisted social work intervention due to preconceived ideas about" interference". Continuing to raise public awareness that promotes the supportive nature of ASP remains a priority to be owned by all partners.
- Anonymous reporting leaves people feeling upset, angry and afraid affecting how they respond to social work. Referrers must ensure they take ownership and where it is safe to do so, they are transparent with individuals and offer explanation of process and supportive nature of ASP.

One individual shared their experience below which highlights an example of local collaboration when it works well.

> "Police Scotland were great with me they came to my home and one of the people who were taking from me came to my door, the police weren't long and getting rid of them and I felt great that day…I know I can pick up the phone any time to [Social worker/Advocacy worker] and the police. I was too scared before but I would now. [Social worker] also told me if I am in town and I am don't feel safe I can walk in to the Bond and ask for her…I could have never solved what was happening on my own".

A crucial resource that can support individuals to move from being involved to actively participating is through access to independent advocacy if this is required.

Q124. Is there evidence that the adult at risk of harm was offered independent support or independent Advocacy?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		63.64%	21
2	No - Not Needed		6.06%	2
3	No - Should have been offered		30.30%	10

Two thirds of individuals are being offered independent advocacy where this is required. This is an area that has been given specific focus over the last 12 months of the Improvement Subgroup and is showing signs of improvement particularly due to the funding of the Lived Experience Project led by East Ayrshire Advocacy Services (EAAS) which has increased the numbers of views being provided.

In the third of cases auditors identified as being appropriate for being offered independent advocacy there were no emerging trends that could be ascertained as case records did not record any rationale. There is the facility to record this data and provide a rationale on the current social work information system and this will continue to be promoted alongside activity to build on the current improving position.

In relation to the uptake of independent advocacy, from the 64% offered accepted this with 11% of those offered declining and 11% offered not accessing.

In 76% of those accepting independent advocacy 76% received this timeously with 24% who did not. There is no standard timescale for accessing advocacy services and the auditors were provide with a number of points in their file reading guidance that would indicate that the response was in keeping with the adults needs rather than a timeframe.

EAAS are an APC member and helpfully share their annual evaluation report with the APC. This provides analysis on advocacy provision and advocacy services may wish to consider providing enhanced information around this area which would alongside social work information provide a more rounded picture for future self-evaluation.

The Advocacy Staff Focus Group findings would indicate referring staff could support improvement by involving advocacy services earlier ensuring adequate time to engage with and prepare the individual as well as having a better understanding of the role for themselves and those they are making referrals for.

It was felt that this could prevent unrealistic expectations which may be affecting the individual's decisions about accepting support from advocacy services.

There was an acknowledgement from advocacy staff that perhaps adding a prompt question on their e referral system that asks a specific question on safety may be helpful in improving in this area.

'I was not offered advocacy but my [relative] was, she is a lovely lady and still supports my [relative] and I. We have had meetings at home and she helps with talking to the bank and social work, she helps my [relative] look after her money safely'. **Source: Family**

Access to Capacity Assessment

Lacking capacity for decision making in relation to your finances, property or welfare does not preclude you from intervention under ASP legislation. The main focus is whether you have the means, skills or opportunity to keep yourself self or consent to participation. Throughout the adults ASP Journey it is crucial to consider their capacity for decision making as where this is impaired alternative legal options may be available under alternative legislation and form part of the safeguarding interventions required.

Q131. Is there evidence of concerns about the adult at risk of harm's capacity, such that an assessment of their capacity is warranted?

Answer Choices			Response Percent	Response Total
1	Yes		40.63%	13
2	No		59.38%	19

41% of cases audited indicated the need for a further assessment of the individual's decision making capacity.

The common reasons for further assessment related to a need to inform a diagnosis of alcohol related brain injury to access appropriate care and treatment or undertake applications under the Adults with Incapacity Act (Power of Attorney, Guardianship, Access to Funds). This would indicate decisions to make requests for further assessment were necessary and proportionate. This offers a positive message that can be shared to offer assurance for clinicians and those who receive these requests.

30% (9) of the 41% where a need was indicated were referred to health for an assessment of their capacity for decision making and all were carried out by the relevant health professional.

Analysis of the free text would suggest that the reasons for individuals not being referred was due to them either being in hospital subject to mental health legislation at the time, referrals pending following a decision that assessment was required at a Case Conference and on one occasion that the impact and distress to the adult warranted a delay.

In 79% of cases the timing of the capacity assessment was in keeping with the adults' needs and where it was not 21% (3) it would be reasonable to conclude that this related to the reasons noted in the above paragraph relating to delays following referral.

Multi-Agency Information Sharing Overview

Q116. Is it evident from the records that the adult protection partners are sharing information?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		84.85%	28
2	No		15.15%	5

An evaluation of 85% is indicative of a culture of information sharing in East Ayrshire across partners which appears led by Council Officers who evaluate the same. Auditors commented there was evidence of good practice.

In the 15% where improvement was indicated the factors relate to the availability and limited recording of key information within adult protection records, reduced ASP Planning Meetings as described earlier in this report or delays in communication being initiated. Information sharing is a strength however acknowledge that we need to continue to foster and build on multi-agency working to address the aforementioned factors.

95% of Police information was appropriately and effectively shared with Social Work and potentially the 5% would relate to when not invited to an ASP Case Conference to share information around history of investigation and criminal charges relevant to the situation.

It should be noted that Police were not in attendance at any Initial Case Conferences and where auditors made an evaluation of quality of contribution or being suitably trained this was in relation to information provided to the Council Officer which was relayed by hem during an Initial Case Conference.

81% of Health information was appropriately shared with Social Work and in the main when this did not happen comments suggest this relates to information awaited following referrals from specialist services and or improving current health systems which is highlighted in the single agency analysis below in the next section.

The perspective from those with lived experience would on the whole support the view of a culture of verbal information sharing and in particular there was a high level of information on what would happen next and a sense of ”feeling listened to” as well as having information on practical supports.

There was an acknowledgement from some that adult support and protection was “difficult to understand” and like “intruders coming in” regardless of having explanations and positive experiences.

There was a sense that individuals felt supported and not blamed which was helped as workers offered person centred explanations of harm and abuse and how it happens to anyone.

A quote from an individual helpfully described this;

'[Social worker] did explain why they were involved, I still don't understand all the long words but she explained that social work were helping to make me safe and to stop other people taking my money'.

A potential barrier emerging from conversations with individuals was related to the difficulties for individuals who were experiencing deteriorating health both physically and mentally and the impact of this on their ability to recall or retain information.

There was evidence of individuals who disagreed with what was being recorded or said about them however respected the participative process as they were able to have their voice heard in a way that was not perceived as confrontational.

This highlights the importance of ownership from all partners and services of understanding the impact of ASP processes on individuals and having a variety of accessible information that can be used to communicate with and reinforce what is happening regularly at points across the individuals ASP journey.

Health Involvement in Adult Support and Protection

The preparation of health information for this multi-agency audit was undertaken by a small team of three from the Public Protection Health Team. This approach supports consistency in professional judgement of what information is shared and how the information is presented.

The systems accessed were; CarePartner, Clinical Portal, Symphony and this provided health information from Mental Health, Learning Disability, Drug and Alcohol, Health Visiting, Family Nurse Partnership, ASP, Community Allied Health Professionals, Emergency Department, Out-patient and In-patient services. GP records were not accessed and some community health services such as District Nursing records were not accessed in full.

Health information considered to not be relevant to ASP was not shared.

Health records were provided in 29 of the 32 cases.

The amount of health information varied significantly with some cases having very little relevant health information and others having a substantial amount of potentially relevant health information.

Table 1. Illustrates the service areas where health information was provided from:

Table 1 - What health record(s) have been made available?				
Answer Choices			**Response Percent**	**Response Total**
1	Adult Mental Health Services		62.07%	18
2	Addiction Services		13.79%	4
3	Learning Disability Services		17.24%	5
4	Older Adult Mental Health Services		20.69%	6
5	Allied Health Professionals (AHP)		13.79%	4
6	District Nursing		3.45%	1
7	Acute In-Patient		17.24%	5
8	Emergency Department		51.72%	15
9	Anticipatory Care Plan		3.45%	1
10	Other (please specify):		34.48%	10

In the 'other' section the Scottish Ambulance Service and the Family Nurse Partnership were noted.

Auditors were asked to record if there was evidence of adult support and protection concerns recorded within the provided health record(s) and positively this was recorded in 22 cases (76%). In 6 cases (20%) there was no evidence of ASP recorded in the records and the question was skipped on 4 occasions. (*Percentages calculated using 29 cases with heath records).*

A number of improvements are in progress in relation to ASP recording, primarily in relation to the CarePartner system. A new ASP chronology has been developed along with a new centre of care for the ASP team, a process is to be developed to receive and add alerts when a referral has progressed to Initial Case Conference stage and a process is being considered for information sharing between NHS 24 and NHS Ayrshire & Arran. The Trakcare system is used in in-patient services to make referrals to a number of services and a revised version of this system has been anticipated for some time. Working with digital services colleagues to include ASP referral has been an identified area for improvement for some time and it is hoped this will progress through 2024.

There are specific indicators from health systems that can suggest when there is potential risk of harm. These are often identified from previous learning from significant case reviews/learning reviews and include;

- Frequent presentations to the Emergency Department
- Repeat referrals for health services

- Failed discharge or repeated hospital presentations
- Poor engagement with health services

Tables 2 – 5 illustrate how often these indicators were present in the audited records

Table 2 - From the health records is there evidence of emergency hospital re-admissions for a health condition which was/may have been related to adult's risk of harm?				
1	Yes		21.43%	6
2	No		78.57%	22

Table 3 - From the health records is there evidence of repeat referrals for community health services for a health condition which was/may have been related to the adult's risk of harm?				
1	Yes		32.14%	9
2	No		67.86%	19

Table 4 - From the health records, is there evidence of frequent presentations to emergency departments (A&E) with a health condition which was/may have been related to the adults' risk of harm?				
1	Yes		22.22%	6
2	No		77.78%	21

Table 5 - Is there evidence of frequent non-attendance at health appointments?				
1	Yes		10.71%	3
2	No		89.29%	25

Although it is not possible in this audit to accurately draw more detailed information from the data, it does provide helpful baseline information which can be used for future comparison. Positively, the follow-up questions in relation to the quality of the interventions offered was mostly favourable;

- 70% of those who answered, rated the intervention(s) offered in hospital in-patient to keep the adult safe and protected as excellent or very good.
- 70% of those who answered, rated the intervention(s) offered by community health services to keep the adult safe and protected as excellent, very good or good.
- 50% of those who answered, rated the intervention(s) offered in ED to keep the adult safe and protected as excellent.

- Notably, the remaining responses were identified as adequate or weak and, of note, no responses considered health interventions as unsatisfactory.

Feedback from health staff about their experience of ASP processes has indicated that a lack of feedback from referrals can discourage them from submitting further referrals. Tables 6 and 7 illustrate how often this was found in health records.

Table 6 - Is there evidence of repeat adult protection concerns submitted by health?

1	Yes		14.29%	4
2	No		85.71%	24

Table 7 - If adult protection concern was initiated by Health is there evidence from the health record of appropriate feedback regarding the outcome of the referral?

1	Yes		38.46%	5
2	No		61.54%	8

Audit and self-evaluation often includes case file scrutiny. The adults file is an obvious source of information and can provide detail of individual practice undertaken and gives insight to the way in which partners work together to support adults at risk of harm to stay safe and protected. Clear, accurate and relevant recordings of assessment, risk and safety planning not only supports audit but also supports good practice. Of those who provided a rating (22) for the recordings and documentation relating to ASP found in health records, 95% were rated good to excellent.

Auditors were provided with an opportunity to make general comments about the health information provided for the audit. All comments were received with thanks and initial learning about the format and use of acronyms is very useful. Below is a selection of comments:

- Evidence of Health liaising with Social Work, CPN and pharmacy, extensive details provided, multiple records created on same day updating as case progresses.
- Health notes have provided a good basis to inform other failures to the ASP stage
- Lots of information on case notes from all aspects of health service.
- No linking back to establish outcome of ASP documented in care partner.
- All relative information relating to DNA appointments has been recorded accurately.
- Emergency department provided information for GP and care home timeously and SALT were active contributors to individuals care and also responded to concerns raised.
- Excellent detail of process and chronology of contact.
- Detailed, MDT working, sharing of information - feedback loop

- Records were detailed and if they had been shared may have prompted ASP moving to investigation or care management.
- Detailed records which highlighted care provided and evidence of multi-agency working and support

It is noted that within the wider audit template that information sharing and collaboration was mostly present but not always. Information sharing was not present in just under 19% of cases and some of the comments offered may provide an insight into this:

- Important partners such as GP and Psychiatry not invited or contacted to case conference. No health records available during inquiry and no mention to whether the adult required GP intervention or support from mental health services re low mood.
- Social Work records cite CMHT referrals & appointments but no trace in NHS files
- Information from Health service was passed to ASP, however this was not acted upon.
- Unclear when health information was requested/shared as not documented in initial inquiry. No NHS records available but notes in Initial Inquiry state referrals made.

Evidence of collaborative working was noted by 72% (18) of those who answered this question. The remaining 28% of respondents did not find evidence of collaborative working. A number of comments provide helpful detail, describing the collaboration evident in the records, below is a small selection:

- There was collaborative working to stop or mitigate the risk of the adult from self-neglecting from partner agencies, however this was not acted on by ASP.
- Social worker and Health liaising and sharing concerns they had regards to self-neglect
- ASP contacted relevant partners, however due to risks within the property could have invited Fire and Housing.
- Health partners appeared to take the concerns of neglect more seriously, keen to discuss at CPA meeting. Social work did not instigate a meeting with other partners regarding frequency or escalation of concern.
- Social Worker, Mental Health officer and Psychiatrist - all worked together to advise and identify self-neglect throughout

<u>Health records summary</u>

There is a clear need for ongoing systems improvement to support staff when documenting ASP related information and this is an identified improvement in the existing Adult Protection Committee Improvement plan.

In addition the feedback from auditors in relation to evidence of professional information sharing and collaboration is very useful and identifies this as an area for further improvement. Areas of focus are feedback for referrers and improved information sharing and collaboration.

Health professionals can be well placed to support ASP processes at both an operational and strategic level. Identified improvements resulting from this multi-agency audit will be supported across NHS Ayrshire & Arran.

Police Scotland involvement in Adult Support and Protection

During East Ayrshire audit 32 individuals were selected, of those, 17 had their details recorded with Police Scotland. None met the escalation criteria of 3 / 6 / 9 concerns forms in a period of 30 days.

The Threat, Harm, Risk, Investigation, Vulnerability and Engagement Model (THRIVE) is applied to all calls for a police service to assess the right initial police response. In all instances where a STORM incident had been created all had THRIVE assessment accurately recorded.

In the majority of cases the initial enquiry officers had submitted iVPD timeously (86.67%) with them taking account of and recording risk, vulnerability, wellbeing (76.92%) and having regard to the wishes and feelings of the adult (85.71%)

In just over 73% of cases the quality of response from enquiry officer was rated good, very good or excellent, however, with almost 27% rated adequate, weak or unsatisfactory, there is opportunity for improvement.

In almost 29% of cases supervisory quality check had not been recorded and of those that had, in almost 37% the quality of their input was rated as adequate or unsatisfactory.

In almost all cases, legal basis for sharing and resilience matrix were recorded, with over 92% of their actions rated good, very good or excellent, with rating of 100% being applied to concern hub supervisors.

Of the records provided by police, due to the nature of sending to Social Work, assessment of three point criteria, escalation protocol and triage assessment were not visible to auditors.

Overall, Police faired well during this audit, with standard being described as ‘excellent and ‘overall good’ which would indicate that current processes and procedures in place are effective.

Areas with potential for improvement being identified in relation to officer and supervisory input which can be addressed by additional training.

A theme repeated in many conversations with those with lived experience was the value they placed on being treated with kindness of which there were many positive references made such as the one below which highlights the role of police being felt beyond their internal processes;

"Social work were very kind along with everyone else who spoke to me…I remember Social work showing me all my bank statements…I remember the police coming to speak with me and showing concern in a nice way, they didn't need to do that".

Outcomes for adults at risk of harm

In 67% of records read file readers concluded that there had been improvements in the adult at risks circumstances in relation to support and protection with the main outcomes being identified below by auditors from a pick list.

Q185. If yes, select all that apply

	Answer Choices	Response Percent	Response Total
1	Better able to protect themselves	45.45%	10
2	Clear have someone to confide ASP concerns	22.73%	5
3	Living as you want	27.27%	6
4	ASP process delivered improved wellbeing	63.64%	14
5	Adult considers partnership's actions least restrictive and upheld human rights	59.09%	13
6	Other (please specify):	45.45%	10

Where other outcomes were provided an analysis identified the common outcomes were;

- Individuals able to be removed to a place of safety (hospital for treatment, care home or a safer alternative accommodation)
- Harm Reduction through access to a needs assessment, review of medication, debt settlement, psychological support and/or Counselling, Police Marker added to Police System

The positive experience of individuals with lived experience was further demonstrated through a number of examples given. When asked if feel safer examples included;

'Yes I feel due to my mental health is now more stable and therefore I feel safer'.

‘Oh Yes, I have my community alarm back and my money has been sorted out so that I have mine and my [relative] gets help to buy my butcher meat and messages in. I also get help to sort my rent arrears out’. **Source: Adult**

‘Oh yes, I haven’t felt safe for a long time, and when I did feel safe there was always the sense that family were telling me what to do. When Covid started I was glad I could close my door and didn’t have to see anyone, that’s when I started to order online for everything, things I didn’t need’.

‘It was a build up to the perfect storm really with my [relative] becoming unwell…however it has had a positive outcome and has been very beneficial. Don’t get us wrong we couldn’t see the wood for the tress to start with but everything is falling in to place now’. **Source: Family**

‘Well I think I am better off now even with all my ailments, but I am starting a wee club at xx next Tuesday to give me more company, I can’t wait, social work arranged all this for me’. **Source: Adult**

‘Aye it’s been good talking about my memories, especially about my husband and losing him to Covid’ **Source: Adult**

Q186. If experiencing poorer outcomes what is contributing to this?

	Answer Choices	Response Percent	Response Total
1	Lack of individuals engagement	33.33%	5
2	Lack of multi-agency working	33.33%	5
3	Lack of social work involvement	26.67%	4
4	Lack of Police involvement	13.33%	2
5	Lack of health involvement	20.00%	3
6	Lack of identified resources available locally (psycology consultant staff shortages)	6.67%	1
7	Lack of identified supports not available locally	0.00%	0
8	Other (please specify):	60.00%	9

In 33% of circumstances where file readers indicated the adult had experienced poorer outcomes the factors that contributed to this are provided below. Although the audit shows collaborative working was evident the main factors identified appear to relate to the need to continue to improve multi-agency working;

Where other factors were provided an analysis identified the common areas as;

- Negative experience of one adult during ASP Process
- Non access to advocacy or voice not heard

'It is so difficult when you are not family and at the heart of [Adult's] support network, I think advocacy would be fabulous to support…to look at what is available for her and to communicate with social work. To fill in the gaps Maggie communication is not good with services and I understand about confidentiality but [Adult] could be so much more active if we as friends knew what is out there regarding things etc.'.

Source: Carer

How well did we respond to people experiencing self-neglect?

Whilst almost a half of partners (48.48%) recognised self-neglect, it was not recognised (18.18%), or only partially recognised (6.06%) in almost a quarter:

Q139. Have partners recognised self-neglect?

	Answer Choices	Response Percent	Response Total
1	Yes	48.48%	16
2	No	18.18%	6
3	Partial	6.06%	2
4	Not Applicable	27.27%	9
		answered	33
		skipped	1

Figure 1

In the majority of cases (61.90%) the partnership has acted to stop or reduce the risk of service refusal. Although this is positive, there was a sizeable proportion (38.10%) where steps were not taken to stop or mitigate the risk of service refusal.

Q140. Has the Partnership acted to stop or mitigate the risk of service refusal?

Answer Choices			Response Percent	Response Total
1	Yes		61.90%	13
2	No		38.10%	8
			answered	21
			skipped	13

Figure 2

In terms of decision making being based on reduced capacity or ability to safeguard, the responses are fairly balanced with just over half (52.38%) indicating decisions relating to capacity were taken into account and just under half (42.86%) not.

Q141. Have any decisions relating to reduced capacity or ability to safeguard taken account of the impact of self-neglect?

Answer Choices			Response Percent	Response Total
1	Yes		52.38%	11
2	No		42.86%	9
3	Partially		4.76%	1

Figure 3

In the majority of cases (72%), collaborative working to stop or mitigate the risk from self-neglect was evident:

142. Was there collaborative working to stop or mitigate the risk of the adult from self-neglecting?

Answer Choices			Response Percent	Response Total
1	Yes		72.00%	18
2	No		28.00%	7
			answered	25
			skipped	9

Figure 4

Free text options identified a range of partners who were identified as being particularly proactive. This included a range of agencies being mentioned:-

Social work	**Fire & Rescue**	**Police**	
Family	**Care at Home**	**SSPCA**	**Helping Hands**
CPN	**CMHT**	**Consultant Psychiatrist**	**Mental Health Officer**
Pharmacy	**Health professionals**	**Addictions**	

Figure 5

Also, in addition to single agencies or professional groups being noted, some examples were given which demonstrated where agencies were particularly proactive:-

"Change of chemist for methadone – addictions. Addictions appointment made at RADAR. Map/details of location provided of chemist (SW). Housing officer cleaned house, organised key safe and arranged for carpets etc. Health – arranged OT assessment to recognise if there were impediments to daily living activities. All worked well to mitigate the risk of non-engagement on discharge".

"Multi-agency supports to mitigate aspects of self-neglect that were identified. Police Scotland applied Rapid Response marker".

"Full transparency across services, all voices heard, services participation timeously, comprehensive chronology of inputs".

"Helping Hands were out in place to ensure that basic needs were met.

Care package in place".

"A MDT meeting was being scheduled".

However, a small number of free text comments suggested areas of concern/for improvement and the action was not sufficient (i.e. not long term enough) and in some cases, not responded to/followed up on:-

"Although the subject had been in receipt of support from X, there is no evidence their view had been sought regarding their observations and opinions on the subject's wellbeing and ability to look after himself. It would have been beneficial to see regular reports from them showing how frequently they visited and engaged with him"

"There was collaborative working to stop or mitigate the risk of the adult from self-neglecting from partner agencies, however this was not acted upon by ASP"

"ASP contacted relevant partners, however due to the risks within the property, could have invited Fire and Housing"

"Concluded case conference with no discernible changes for the adult in place at that point to protect her or others".

"Referral done but there was no follow-up"

One free text comment suggests lack of effective record keeping:

"Referrals were made however unable to assess effectiveness in the ASP paperwork"

There was also one specific comment relating to care home which described the challenge in this setting in particular relating to engagement:

"As the adult is in a care home, it has not been documented as self-neglect as such, however there is evidence of the adult being obstructive and aggressive to care home staff as well as a desire not to engage with medical staff and carers".

The majority (72%) of agencies were identified as sharing, and having a developed understanding of the wider legal options available:-

Q144. Did agencies share and have a developed understanding of wider legal options available?

Answer Choices		Response Percent	Response Total
1	Yes	72.00%	18
2	No	24.00%	6
3	Partial	4.00%	1
		answered	25
		skipped	9

Figure 6

Free text options identified a range of actions that could have been considered to help improve outcomes.

Comments made specific mention to partners and/or agencies that could have been involved, as well as making reference to the type of approach that could have helped to improve outcomes.

Comments also mentioned specific assessment/investigations. These are presented as broad themes below:-

Actions that could help improve outcomes Suggested improvements		
Involvement of specific partners/agencies	**Approach**	**Specific assessments/investigations**
CPN CMHT Care at Home Fire Housing	Holistic assessment Involvement of family/relatives Collaboration Communication (by care provider) Multiagency input Prevention work	Home visit Assessment (of LD need) ASP Investigation ASP Planning Meeting AWI legislation to formally gain certificate of capacity Certificate of Power of Attorney

Figure 7

The following quote provides an indication of a situation where there could have been improvements:-

"Take account of chronology to identify patterns of behaviours, and subsequently proceeding to investigation to holistically identify support needed as an MDT. Building the picture of the adult over the period of concerns (6 months) would have possibly resulted in the adult not needing detained and supports put in place. He was repeatedly referred to foodbank by way of list of places to go, advised to buy a phone to contact the services (when he had clear issues with financial accountability and management. There was no meeting which holistically looked at the adults situation. No mention of the Aunts suitability to continue to provide his support (GP in Oct 25th mentioned she would be unlikely to return home).

CPA and detention was done under Mental Health powers. Not ASP.

Information was coming from police, health, CPN, public raised and noted regularly but the actions taken under ASP were inadequate."

The majority of cases were considered to have an excellent (34.78%) or very good (26.09%) partnership response to self-neglect. However, 21.74% were regarded as being weak, and 13.04% as adequate:-

Q146. Please rate the effectiveness of the partnership response to self-neglect				
Answer Choices			**Response Percent**	**Response Total**
1	Excellent		34.78%	8
2	Very Good		26.09%	6
3	Good		4.35%	1
4	Adequate		13.04%	3
5	Weak		21.74%	5
6	Unsatisfactory		0.00%	0

Figure 8

Summary of results

Whilst almost a half of partners (48.48%) recognised self-neglect, it was not recognised (18.18%), or only partially recognised (6.06%) in almost a quarter.

The majority of cases were considered to have an excellent (34.78%) or very good (26.09%) partnership response to self-neglect. However, 21.74% were regarded as being weak, and 13.04% as adequate.

Although in the majority of cases (61.90%), the partnership has acted to stop or reduce the risk of service refusal, there was a sizeable proportion (38.10%) where steps were not taken to stop or mitigate the risk of service refusal.

In terms of decision making being based on reduced capacity or ability to safeguard, the responses are largely similar with just over half (52.38%) indicating decisions relating to capacity were taken into account and just under half (42.86%) not.

In the majority of cases (72%), collaborative working to stop or mitigate the risk from self-neglect was evident. Free text responses also highlighted single agencies/ professional groups as being particularly proactive (as presented at figure 5), and a number of examples were given which demonstrated where agencies were particularly proactive. Additionally, the focus groups highlighted specific agencies who are dealing with referrals, and responding to self-neglect. This includes Scottish Ambulance Service (SAS) and Scottish Fire and Rescue Service (SFRS).

The majority (72%) of agencies were identified as sharing, and having a developed understanding of the wider legal options available however 24% did not have a shared and developed understanding of the options available.

Free text options identified a range of actions that could have been considered to help improve outcomes. Comments made specific mention to partners and/or agencies that could have been involved, as well as made reference to the type of approach and response that could have been implemented including specific assessment/investigations (see figure 7).

A small number of free text comments suggested areas of concern/for improvement where the action was considered to not being sufficient (i.e. not long term enough) and in some cases, not responded to/followed up on (i.e. a referral made which was then not followed-up on). Also, one free text comment from the audit (*"Referrals were made however unable to assess effectiveness in the ASP paperwork")* suggests record keeping could be improved upon.

Findings

The results from the audit highlight areas of good practice. This includes the majority of cases being considered to have an excellent (34.78%) or very good (26%) partnership response to self-neglect, collaborative working to stop or mitigate the risk from self-neglect being evident in the majority of cases (72%) and some single agencies/ professional groups being identified as being particularly proactive. However, the results also highlight areas for improvement including partners recognising self-neglect, as well as taking steps to stop or mitigate the risk of service refusal. This discussion section considers the findings of the audit in conjunction with the current evidence relating to SN and offers suggestions for consideration.

The evidence highlights that self-neglect shows varied presentation along a continuum of severity with behaviours which are hard to define. At its most basic, self-neglect is an inability to care for own basic needs combined with resistance to receiving help, care and support from others. Although a range of definitions of self-neglect have been offered, there is not an agreed standard definition of self-neglect. However, it is widely acknowledged that SN, the causes, consequences and management of it, is complex and challenging and includes health, social, legal and ethical aspects. This, coupled with limited evidence of effective interventions, presents a number of challenges for practitioners and also organisations.

It is recognised that practitioners/professionals supporting people who are experiencing self-neglect face a number of challenges. Lack of, or inadequate knowledge, which can result in SN as an issue being 'overlooked' or 'missed', as well as perceptions and judgements (i.e. SN 'is a lifestyle choice') is cited in the evidence as a barrier .

Taking into account the results from this audit, although it is positive that SN was recognised by partners, the fact it was not recognised or only partially recognised in almost a quarter of cases suggests there is need for awareness raising to support professionals/partners to recognise self-neglect.

Lack of engagement/resistance to support from individuals or family (for example, refusal to accept help/support) which can present in a variety of ways (for example, the person becoming withdrawn, using 'cover-up' techniques in order to refuse help and support and not attending appointments) is also recognised as being a key challenge for professionals/practitioners. Respecting the person's autonomy/ability to make their own decisions whilst fulfilling a duty to protect health and wellbeing is frequently highlighted as an ethical and legal dilemma challenge in the evidence.

Whilst it is positive that the partnership has acted to stop or reduce the risk of service refusal in the majority of cases, there was a sizeable proportion (38.10%) where steps were not taken to stop or mitigate the risk of service refusal. Also, one specific comment relating to the challenge regarding engagement within a care home setting further highlights the need to consider approaches to respond to service refusal. Therefore, in acknowledging the challenge practitioners/professionals face in this area, suggest further action to support in this area is needed.

Although there is little supporting evidence of effective interventions, a number of elements of best practice for an effective approach are included in the evidence. Training and guidance aligned to these areas are recommended. The broad elements of an effective approach include:

- Identifying underlying causes to help address the issue (SN is recognised as a response to trauma and adverse experiences and other causes and risk factors also play a part. Approaches that explore and understand the individual's life history, and its possible connections with patterns of self-neglect, are important).
- Person-centred approaches (this includes exploring the person's wishes, feelings, views, experiences, needs and desired outcomes. Concerned curiosity characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills is important).
- Taking a long-term approach; and regular engagement and gentle persistence (relationships take time to build, and sustained involvement over a long period of time may be needed to build the rapport and trust that can achieve tangible outcomes).
- Multi-agency working.
- Good risk management.

As noted already, management of SN presents a number of challenges to practitioners/professionals which includes ethical and legal issues.

Assessing decision making capacity (informed by knowledge of legislation and procedures), and review of this as necessary is identified as being an essential underpinning to practice. Whilst the results from the audit show a relatively balanced picture relating to decision making being based on reduced capacity or ability to safeguard as the results are fairly equal (52.38% indicating decisions relating to capacity were taken into account and 42.86% not), the challenge relating to capacity, and balancing the need to protect, also emerged from the focus group discussions. Provision of further guidance and support for staff is recommended.

In the majority of cases (72%), collaborative working to stop or mitigate the risk from self-neglect was evident in the majority of cases (72%) and some single agencies/ professional groups have been identified as being particularly proactive (as presented at Figure 5). Since multi-agency working and good risk management are both recognised as elements of an effective approach, actions which seek to maintain and encourage this good practice are suggested.

As discussed already, the management of SN presents ethical and legal challenges. The results of this audit highlight the majority (72%) of agencies were identified as sharing, and having a developed understanding of the wider legal options available, however 24% did not. The sizeable proportion where steps were not taken to stop or mitigate the risk of service refusal, along with the picture relating to decision making being based on reduced capacity or ability to safeguard, does suggest further actions including training and guidance, in particular relating to shared decision making and capacity, to enhance elements of ethical and legal practice is needed.

A range of actions that could have been considered to help improve outcomes were identified via the audit. Comments made specific mention to partners and/or agencies that could have been involved, as well as made reference to the type of approach and response that could have been implemented including specific assessment/investigations (see figure 7). The importance of being person centred, and building a relationship with the person was identified also in the focus groups. As outlined previously, elements of an effective approach have been identified in the evidence (for example, identifying underlying causes of SN, include person centeredness, multi-agency working and good risk management). The actions that could have been considered to help improve outcomes suggested as part of the audit mirror some of the elements of good practice identified via the evidence. Further actions which seek to encourage and enable this practice are suggested.

A small number of free text comments suggested areas of concern/for improvement where the action was considered to not being sufficient (i.e. not long term enough) and in some cases, not responded to/followed up on (i.e. a referral made which was then not followed-up on). Also, one free text comment from the audit (*"Referrals were made however unable to assess effectiveness in the ASP paperwork")* suggests record keeping could be improved upon. Although the number of comments relating to areas of concern/for improvement were small, they should not be disregarded, especially as they do link to elements of effective approaches (i.e. being long term).

It is important to note that the evidence does also highlight workload pressures as being a challenge as well information sharing being a barrier. Some consideration of the role workload pressures may play, as well as challenges relating to information sharing, is recommended.

This discussion has highlighted a number of areas for consideration which relate largely to supporting the practice of practitioners/professionals. It is important to highlight that the evidence also outlines the important role organisations play, in particular in creating the 'correct conditions' therefore these recommendations need to sit within a wider whole system multi-agency response/approach overall. This includes agreed policy and guidance, training, supervision and support (including wellbeing support) for staff dealing with people who are experiencing self-neglect.

Footnote: All literature that inform this section of the report in respect of self-neglect are included in a separate reference list document that is available on request.

Conclusions

Summary Overview –Key Findings, strengths and areas for Improvement

Partnership Response to Adults at Risk of Harm

Key Findings & Messages

- Our practice standards are being more consistently applied from the formal investigation stage when compared to the earlier stages in the process supporting the need to explore and really understand increasing demands and the availability of earlier community based support.
- In relation to ASP Planning Meetings there is some assurance that we are starting to see some progress in increased numbers of these meetings being held and continued promotion across health, housing and police may encourage proactive requests for these.
- A future focus on building a culture of multidisciplinary working within ASP that includes building further skills, knowledge, feedback mechanisms and alternative pathways for responses to increasing adult concern reporting. A particular emphasis was placed on colocation and joined up working with housing, the care home support teams and out of hours services.
- Delays for anyone experiencing acute mental health crisis or deteriorating wellbeing can have devastating effects in terms of recovery, experiencing trauma or increased risk of suicide. People listed as being under the category of mental health made up a quarter of case files audited and also convert to the same for annual reporting trends. This suggests an area worthy of future consideration to ensure robust early intervention and prevention pathways for people experiencing deterioration in their mental wellbeing.

- There remains a variation in the application of the ASP Legal criteria which includes 63% of peers showing strengths in this area. This suggests the current workforce activity addressing this can be built upon with a focus on opportunities for peer reflection and through observation.
- Two thirds of individuals are being offered independent advocacy where this is required. This is an area given specific focus over the last 12 months of the Improvement Subgroup and is showing signs of improvement particularly due to the funding of the Lived Experience Project led by East Ayrshire Advocacy Services (EAAS) which has increased the numbers of views being provided.
- ASP Workforce learning and development and staff support is positively impacting on practice improvements with workforce capacity remaining a challenge in terms of capacity to attend training. We are meeting our legal requirements in terms of deploying specialist Council Officers when required.
- The current additional investment in relation to training provision, procedural clarification and management focus around the use of chronologies and risk assessment would appear to be contributing to signs of improvement with further good practice examples available to consider.
- In 95% of files read a medical examination was not required. We know from considering delays in timescales that individuals are accessing acute physical and psychiatric clinical care and treatment.
- Requests for further assessment of an individual's decision making capacity were deemed necessary and proportionate. This offers a positive message that can be shared to offer assurance for clinicians and those who receive these requests.
- Health professionals can be well placed to support ASP processes at both an operational and strategic level. Identified improvements resulting from this multi-agency audit will be supported across NHS Ayrshire & Arran.
- This Audit shows that Police practice was either "excellent" or "good'" which would indicate that current processes and procedures in place are effective.
- Indication that the risk of harm being repeated or sustained has potentially been reduced through proactive intervention and we demonstrate appropriate decisions are being made to progress to the investigative stage.
- Partnership response to self-neglect including collaborative working as well as some agencies/professional groups being particularly proactive.
- Staff placed value on peer support, good relationships with each other "knowing each other" and commented there is a culture where it is understood "it is ok, not to be ok". Wellbeing resources and management support mentioned as a positive in terms of availability and being open to staff raising concerns. Team meetings and having access to real situations to reflect on was seen as helpful in supporting staff.
- People with lived experience support the view of a culture of information sharing and in particular there was a high level of information on what would happen next and a sense of "feeling listened to" as well as having information on practical supports.

Strengths to build on

- A strength in meeting Inquiry and Initial and Review case conference completion timescales with potential improvement required in investigation completion as well as understanding and tackling some delays in core group implementation.
- Staff relay a strong sense that ASP Planning Meetings are increasing in use and that the benefit of these are better understood by social work.
- 67% of Inquiries without use of investigatory powers were rated Excellent, Very Good or Good with 75% of case conferences meeting a Good to Excellent standard in terms of effectiveness.
- 85% of Inquiries with the use of investigatory Powers were rated Good, Very Good or excellent.
- 100% of individuals had their ASP Review Case Conference held within 3 months of the ASP Initial Case Conference.
- 68% of chronologies undertaken were rated Good, Very Good or Excellent.
- 86% of files read had a risk assessment on file with 89% of those rated Good, Very Good or Excellent. Of those 75% had both an analysis of risk that was appropriate to the protection needs of the adult and had been informed by the views of relevant partners.
- 69% of individuals at risk of harm had been invited to their Initial Case Conference. An example of good person centred practice was noted with an Independent Advocate providing the adults photograph to focus agencies on who meeting was about.
- 100% of Unpaid Carers attended the initial Case Conference and were deemed by file readers to have been supported effectively to contribute although in one instance the Carers perception differed.
- 100% of Protection Plans were evaluated as Good, Very Good with the majority being evaluated as an Excellent Standard (60%).
- Our protection admin processes are robust with minutes and decisions being circulated effectively and where they are not this is due to delays in management sign off.
- 81% of Health information was appropriately shared with Social Work and in the main when this did not happen comments suggest this relates to information awaited following referrals from specialist services and or improving current health systems.
- 95% of Police information was appropriately and effectively shared with Social Work and potentially the 5% would relate to when not invited to an ASP Case Conference to share information
- In 67% of records read file readers concluded that there had been improvements in the adult at risks circumstances in relation to support and protection with records able to identify these .

- The ASP training programme and practitioner learning forums are in place with monitoring to ensure key ASP decision makers are meeting agreed training standard. Leadership in promoting and prioritising these for staff will enhance confidence.
- Protection Team Admin received comments as some viewed as extremely conscientious in checking referrals have been received by Advocacy
- People do feel safer and have good outcomes even when they may have been afraid of or resisted social work intervention due to preconceived ideas about" interference". Continuing to raise public awareness that promotes the supportive nature of ASP remains a priority to be owned by all partners.

Priority areas for Improvement

- **Recording Standards** - relevant managers to meet both timescales for sign off of investigations and encourage staff to record all relevant information on ASP episode on system including reasons for delays in ASP process. This will improve the quality of performance thus ensuring data reports provide earlier identification and addressing of any emerging trends, gaps or supports for staff.
- **Chronologies** - chronological information is spread over a number of areas in the ASP process or case notes. Consideration could be given to a template that could also be utilised for multi-agency chronologies and where individuals require to transition from child to adult or other service areas
- **Consistent application of escalation standard for ASP Planning Meetings** -a third of situations meeting the criteria for an ASP Planning Meeting were not been held with some evidence that escalation standards for triggering these not always being consistently applied
- **ASP Planning Meeting benefits to be better understood** and role for partners in making proactive requests in particular Police, Health and Housing.
- **ASP Inquiry with the use of Investigatory Powers completed within the 26 working day timescale** (42%) - two thirds not recording reason for delay so cannot evaluate fully, appears to match delays in managers signing off investigation rather than lack of completion in some cases.
- **Promotion of Neighbourhood Coaches support role** - raise further awareness across agencies of role in sustaining tenancies and not eviction to dispel incorrect perceptions that may remain and be creating unintended barriers.
- **Adult Services and Children and Justice Services to jointly consider effectiveness** of having lead role for Inquiries under ASP and include how to improve practice in terms of meeting both procedural timescales and standards of Inquiry .
- **Learning and Development** for multi-agency managers to consider and make better use of opportunities for joint working and to learn from peers across the ASP landscape who demonstrate excellence in standards. There should also be a focus on ways to support a clearer understanding of the long term impact of alcohol and drugs on the ability to safeguard across partners.

- **Earlier access to Independent Advocacy** - to support engagement
- **Early and consistent** contact with partners from Police and Housing to identify information held could have improved outcomes of decision making and for the individual.
- **Adult's participation** - 71% of adults who attended their Case Conference evaluated as being effectively supported to participate with a further 29% where this was not considered to be the case.
- **Case Conference Chairs Development**- joint work with partners to enhance knowledge of the role of partners and supports offered for example Housing, District Nursing and Occupational Therapy. A focus on being trauma informed with confidence around conflict management ensuring the adults views and voice do not become lost.
- **Views of Partners**- continued activity required to increase likelihood of staff consideration of the views of some partners (care homes), the cumulative impact of long term alcohol use within previous repeat reports on the individual's ability to safeguard or associated analysis of presenting risk to improve risk assessment practice.
- **Consideration of fast track pathways** that may reduce delays when individuals require psychological supports or alternative risk management processes such as CPA or Capacity Assessments.
- **Police single agency areas with potential for improvement** being identified in relation to officer and supervisory input which can be addressed by additional training.
- **Health single agency themes-**include clear need for ongoing systems improvements to support staff when documenting ASP related information.
- **Consideration of the emerging themes to identify any further systems gaps** where the adult experienced poorer outcomes would support future improvement work.
- **Support for the multi-agency workforce** that include key partners from health, housing and SFRS to build confidence in response to service refusal and seeks to foster supportive relationships that encourage engagement.
- **Moving from Trauma Aware to Informed –** e learning viewed as positive however there is an indication of the need to promote a more enhanced level that includes face to face learning.
- **Anonymous reporting** leaves people feeling upset, angry and afraid affecting how they respond to social work. Referrers must ensure they take ownership and where it is safe to do so, they are transparent with individuals and offer explanation of process and supportive nature of ASP.

Conclusion

Partnership Response to Self-Neglect

Key Findings

- Although in the majority of cases (61.90%), the **partnership has acted to stop or reduce the risk of service refusal**, there was a sizeable proportion (38.10%) where steps were not taken to stop or mitigate the risk of service refusal.
- In terms of decision making being based on reduced capacity or ability to safeguard, just over half (52.38%) indicated **decisions relating to capacity were taken into account** and just under half (42.86%) not.
- The challenge relating to capacity, and balancing autonomy with the need to protect, also emerged from the focus group discussions.

Strengths

- Almost a half of partners (48.48%) recognised self-neglect.

- The majority of cases (34.78%) being considered to have an **excellent** (34.78 %) or very good (26%) **partnership response to self-neglect**, **collaborative working to stop or mitigate the risk** from self-neglect being evident in the majority of cases (72%) and **some single agencies/ professional groups being identified as being particularly proactive including SFRS and Housing** (focus group data also highlighted specific agencies who are responding to SN).

Priority areas for Improvement

- Further workforce support for all agencies to recognise self-neglect in ways that proactively respond to service refusal and promote engagement

- Utilise best practice evidence from literature review to improve supporting evidence of effective interventions with further training and guidance aligned to these areas

- A sizeable proportion where steps were not taken to stop or mitigate the risk of service refusal, along with the picture relating to decision making being based on reduced capacity or ability to safeguard, does suggest further actions including training and guidance, in particular relating to shared decision making and capacity, to enhance elements of ethical and legal practice is needed.

Trauma Informed Practice

The ASP Code of Practice revised July 2022 introduced further substantive amendments which included a more detailed consideration of Trauma as a particular circumstance that can impact on an individual's decision making when exposed to this.

The Ayrshire Trauma Advisory Board has begun to support the promotion of Trauma informed approaches and in East Ayrshire a Trauma Lead Officer appointed to develop the local strategy and implementation of the National Trauma Training programme. In response to this the East Ayrshire Social Work ASP Operating Procedures October 2023 were revised to integrate all COP amendments and provided additional information on how the five key principles of trauma informed practice might relate to the ASP context and within processes and responses.

The Audit Coordination Group viewed the current self-evaluation activity as an opportunity to gauge a sense of how a trauma informed approach was being adopted within the adult support and protection processes. Adopting a trauma informed approach means doing the opposite of what occurs when trauma is experienced and building a trusting relationship based on the five trauma informed principles.

In order to provide us with a baseline position to inform future improvement activity an exercise will be undertaken to cross check the Audit Template question set against the five key principles of trauma informed practice Safety, Collaboration, Trust, Empowerment and Choice as they may apply to ASP Practice . The audit findings will be collated to provide a high level analysis of our current position which will be reported to a future APC in August 2024 to afford further discussion. There are indications from staff focus groups that access to e learning has supported some trauma awareness that can be built on and therefore embedding a more trauma informed approach within ASP practice.

The Staff focus groups indicated the knowledge of the meeting Chair impacted on the level and degree of a trauma informed approach for example one meeting lasting for over 2 hours and the individual not asked to give their views until last and others where the Chair stopped the meeting to allow comfort breaks.

There was an indication that improvement include the need for continued development for Case Conference Chairs that includes a focus on being trauma informed with confidence around conflict management ensuring the adults views and voice do not become lost.

An advocacy worker offers an insight which supports this conclusion;

"Cannabis use can be a coping mechanism for some people and although staff are aware it's not ideal often for people who have been through significant trauma they can't cope with their trauma or begin to process it without their cannabis use. Services demanding they stop their cannabis use before the engage or support them is unhelpful. How can they engage/process deal with trauma without their coping

mechanism which is cannabis? But they can't engage whilst using cannabis, chicken and the egg situation."

Learning from the self-evaluation process

To reflect the learning culture integral to the work of the APC the Audit Coordination Group (ACG) ensured arrangements were in place that afforded the opportunity to share learning around the ACG arrangements, application of the newly revised multi-agency audit guidance, audit templates and training offered to auditors.

An overview of learning points for the ACG are currently being collated and will be reported to the APC Improvement Subgroup with any actions taken to improve these in preparation for the next self-evaluation in 2025.

The Multi-Agency Case File Audit Training was delivered over two days with the outcomes for participants to:

- gain knowledge in self-evaluation and their role within the case file audit
- understand self-neglect to enable them to identify good practice and areas for improvement
- learn about the audit tool and guidance and become familiar using these

The course participants were asked to complete a pre-course questionnaire. This identified most auditors were reluctant to be part of the audit. They were unsure how it could benefit their practice and were hesitant regarding identifying areas for improvement, thinking this would mean criticising colleagues work.

On completion of the training and following the audit, the auditors were asked to complete a post course and audit evaluation. There was a clear contrast in views from the pre to the post course questionnaire. It identified that following the training the auditors concerns identified above were addressed and they felt "well prepared" for conducting the audit. Following the audit the evaluation reflected that despite most auditors feeling "nervous, apprehensive, reluctant" prior to the audit, on completion they were able to "see the benefit", and they "found it interesting and would be happy to participate in future audits".

All auditors that completed their evaluation identified the benefit in seeing the whole process via social work, health and police records which gave them a better understanding of the multi-disciplinary team around the adult and their roles.

All Multi agency partners referenced the benefit in understanding the whole social work process. Multi agency partners also felt being partnered with a social worker was of benefit to support understanding of the process, complex cases and the sensitive/emotional nature of the notes. They felt the multi-disciplinary pairing aided good discussion around evaluation, rating and assessment of the information for audit purposes.

Areas for improvement that were noted by the auditors were the wifi, location, larger screens, training to include health and police record examples. Auditors recognised the experience as being "emotional, intellectually tiring and triggering". There was

acknowledgement of this and wellbeing support available however It would be of benefit to consider supports around this for future audits for all agencies.

Some of the learning that auditors advised they would take into their own practice was “the benefit of chronologies, better understanding of the process, the importance of the voice of the adult and listening to the adult’s right to make choices”.

The biggest learning point for all auditors who fed back was that of multi-agency working.

Summary

The training was well received by the auditors. There are some considerations identified for future audit training. The resources provided by way of guidance and templates was of benefit to the auditors.

The audit experience was of benefit to all auditors and they felt they had a better understanding of the multi-disciplinary team around the adult. Auditors felt being involved in this process was of benefit to them, their practice and the adult’s they support, despite most being nervous or reluctant prior to embarking on the process. Auditors felt they would be happy to be involved in future audits and would encourage colleagues to take opportunities alike.

The annual Ayrshire APCs joint seminar “Self Neglect as a Public Health Issue” is being hosted by East Ayrshire APC on 20 June 2024 and is a way we will use to build on the learning and work to date to help inform early intervention and prevention in relation to self-neglect.

Next Steps

The Audit findings will be shared with all the APC Improvement Subgroup and ACG Members on 07 May 2024 with invites extended to all file auditors, staff attending focus groups and adults and families who shared their experience.

The APC will be presented with the report on 21 May 2024 and to Chief Officers thereafter on 25 June 2024 with arrangements in place to confirm how these will be further communicated across partners to support wider dissemination of learning.

Arrangements will be made to review the current APC ASP Improvement Plan in light of these findings and ensure we are focussed on the right areas for 2024-2026.

Appendix 1 – Core Data Set

Audit of recording findings- not to be interpreted in isolation refer to main report for context.

Large Scale Investigation
• 24% of case records would have met the criteria for a Large Scale Investigation • 13% of case records had written evidence that the option of a Large Scale Investigation had been ruled in or ruled out.
Inquiry without the use of Investigatory Powers
• 97% of ASP Referrals had an Inquiry without the use of Investigatory Powers undertaken • 45% of Inquiries without the use of Investigatory Powers were not completed within the 5 working day timescale • 69% of Inquiries without the use of Investigatory Powers were sufficiently responsive to the needs of the adult • 33% of Inquiries without the use of Investigatory Powers should have held an ASP Planning Meeting • 50% of ASP Planning Meetings held were chaired by a Team Manager or above • 12.5% of Inquiries without the use of Investigatory Powers had evidence of a care provider or party other than the local authority carrying out an internal investigative process • 64% of Inquiries without the use of Investigatory Powers had the three point test applied correctly • 27% of Inquiries without the use of Investigatory Powers were informed by the outcome of any internal investigative process undertaken that was reflected in the decision around the three point criteria • 66% of ASP Inquiries without the use of Investigatory Powers were rated good or better
Inquiry with the use of Investigatory Powers
• 81% of Inquiries without the use of Investigatory Powers that met the three point test progressed onto Inquiry with the use of Investigatory Powers • 59% of Inquiries with the use of Investigatory Powers involved all appropriate parties • 95% of Inquiries with the use of Investigatory Powers had a Council Officer as the designated lead • 67% of Inquiries with the use of Investigatory Powers required the deployment of a Secondary Worker • 95% of Inquiries with the use of Investigatory Powers did not require a medical assessment under s9 of the ASP Act to be undertaken. • 68% of the Inquiry with the use of Investigatory Powers effectively determined that the adult met the three point criteria

- 45% of Inquiries with the use of Investigatory Powers did not record the reason for the procedural delay
- 81% of Inquiries with the use of Investigatory Powers were carried out in a timescale that was in keeping with the needs of the adult
- 85% of Inquiries with the use of Investigatory Powers were rated good or better

Chronology

- 59% of Chronologies met the practice standards when considered at the Inquiry with the use of Investigatory Powers stage
- 68% of Chronologies were rated good or better

Risk Assessment

- 85% of Inquiries with the use of Investigatory Powers had a risk assessment on file
- 75% of these risk assessments were appropriate to the risks identified
- 75% of risk assessments evidenced that relevant multi-agency partners views have informed the risk assessments
- 89% of risk assessments were rated good or better

Protection Order

- 93% of cases audited did not make use of a Protection Order

ASP Initial Case Conference

- 100% of cases that undertook an Inquiry with the use of Investigatory Powers **should** have convened an ASP Initial Case Conference
- 13% of cases that undertook an Inquiry with the use of Investigatory Powers **did not** convene an ASP Initial Case Conference
- 73% of ASP Initial Case Conferences were convened in a timescale appropriate to the needs of the adult
- 75% of ASP Initial Case Conferences had all relevant professionals invited
- 67% of ASP Initial Case Conferences had all relevant parties attend or provide a report
- 69% of ASP Initial Case Conferences had the adult invited to attend
- 60% of ASP Initial Case Conferences recorded the reason for not inviting the adult clearly within the minute
- 58% of adults invited to attend the ASP Initial Case Conference attended
- 71% of adults in attendance at the ASP Initial Case Conference were effectively supported to participate
- 30%, where applicable, of Unpaid Carers were invited to attend the ASP Initial Case Conference
- 42% of Unpaid Carers attended the ASP Initial Case Conference
- 100% of Unpaid Carers in attendance at the ASP Initial Case Conference were effectively supported to participate
- 50% of Police Scotland's contribution to the ASP Initial Case Conference was rated as very good
- 67% of ASP Initial Case Conferences effectively determined what was needed to ensure the adult at risk of harm was safe, protected and supported
- 77% of ASP Initial Case Conference minutes were circulated to all attendees and invitees

- 15% of Police Scotland attendees did not discharge any actions arising from the ASP Initial Case Conference
- 75% of ASP Initial Case Conferences were rated good or better

Protection Plan

- 100% of adults deemed to be an Active Adult at Risk of Harm had a Protection Plan on file
- 100% of Protection Plans were up to date
- 80% of Protection Plans clearly identified the contributions of other multi-agency partners where appropriate
- 100% of all concerns regarding protection type risk have been dealt with
- 100% of Protection Plans were rated good or better

ASP Core Groups

- 80% of ASP Core Groups held were effective in meeting the purpose

ASP Review Case Conference

- 100% of cases that where an ASP Initial Case Conference was held **should** have convened an ASP Review Case Conference
- 100% of ASP Review Case Conferences were convened in a timescale appropriate to the needs of the adult
- 100% of ASP Review Case Conferences had all relevant professionals invited
- 80% of ASP Review Case Conferences had all relevant parties attend or provide a report
- 40% of ASP Review Case Conferences had the adult invited to attend
- 20% of ASP Review Case Conferences recorded the reason for not inviting the adult clearly within the minute
- 20% of adults invited to attend the ASP Review Case Conference attended
- 20% of adults in attendance at the ASP Review Case Conference were effectively supported to participate
- 100%, where applicable, of Unpaid Carers were invited to attend the ASP Review Case Conference
- 0% of Unpaid Carers attended the ASP Review Case Conference
- 100% of Police Scotland's contribution to the ASP Review Case Conference was rated as good
- 80% of ASP Review Case Conferences effectively determined what was needed to ensure the adult at risk of harm was safe, protected and supported
- 40% of ASP Review Case Conference minutes were circulated to all attendees and invitees
- 75% of ASP Review Case Conferences were rated good

My Life My Plan

- 60% of ASP Review Case Conference minutes recorded that at the end of the adult being an Active Adult at Risk of Harm who continues to have social work involvement should have a My Life My Plan/Review completed within 3 months

- 40% of adults no longer deemed to be an Active Adult at Risk of Harm who continues to have social work involvement had a My Life My Plan/Review completed within 3 months

Appropriate Adult

- 19% of Adults required an Appropriate Adult during their ASP Journey
- 22% of Adults who required an Appropriate Adult had one deployed

Adult Protection Involvement and Consultation

- 70% of the adult at risk of harm, and partners views were sought and taken into account during the Inquiry without the use of Investigatory Powers
- 50% of the adult at risk of harm, and partners views were sought and taken into account during the Inquiry with the use of Investigatory Powers
- 25% of the adult at risk of harm, and partners views were sought and taken into account during the ASP Initial Case Conference
- 80% of the adult at risk of harm, and partners views were sought and taken into account during ASP Review Case Conference
- 80% of the adult at risk of harm, and partners views were sought and taken into account during the Protection Planning, Implementation and Review
- 56% of cases evidence that all dealing with the adult at risk of harm have adequately addressed all potential barriers
- 70% of cases evidence support for the adult at risk of harm to be involved throughout the ASP process
- 91% of cases rated the effectiveness of support provided to the adult at risk of harm in respect of involvement and consultation to be good or above

Unpaid Carer

- 6% of adults at risk of harm who were also an unpaid carer did not have a carers support plan
- 31% of adults had an unpaid carer who provided support to them
- 29% of unpaid carers were appropriately involved and consulted
- 19% of unpaid carers had a carers support plan offered or in place

Multi-Agency Collaboration

- 85% of records evidence that adult protection partners are sharing information
- 85% of records evidence that local authority staff are sharing information appropriately and effectively
- 81% of health staff are sharing information appropriately and effectively
- 95% of police staff are sharing information appropriately and effectively
- 77% of ASP Information Sharing and Collaboration was rated good or better

Capacity and Independent Advocacy

- 64% of cases evidence that the adult was offered independent support or Independent Advocacy
- 53% of adults at risk of harm accepted and received Independent Advocacy Support
- 76% of adults at risk of harm received an Independent Advocate timeously
- 52% of cases evidence that Independent Advocacy has helped the adult at risk of harm articulate their views
- 19% of adults had a POA
- 44% of adults had capacity

- 40% of cases evidence concerns about the adult at risk of harms capacity, such that an assessment of their capacity is warranted
- 30% of adults had a request for a formal capacity assessment made to Health
- 33% of health professionals carried out a capacity assessment
- 79% of capacity assessments were carried out in a timescale in keeping with the needs of the adult at risk of harm

Self-Neglect

- 48% of partners recognised self-neglect
- 62% of cases acted to stop or mitigate the risk of service refusal
- 52% of cases where there were decisions relating to reduced capacity or ability to safeguard took account of the impact of self-neglect
- 72% of cases evidenced collaborative working to stop or mitigate the risk of the adult from self-neglecting
- 72% of agencies shared and had a developed understanding of wider legal options available
- 65% of cases rated the effectiveness of the partnership response to self-neglect as good or better

Police Scotland

- 82% of records submitted by Police Scotland for Audit were relevant to the matter under consideration
- 92% of STORM Command and Control records incidents have been accurately coded
- 92% of STORM Command and Control records have thrive assessments accurately recorded
- 77% of iVPD assessment of risk, vulnerability and wellbeing have been conducted and recorded by the Initial Inquiry Officer
- 86% of iVPD evidence that the submitting officer had regard for the wishes and feelings of the adult
- 87% of iVPD's were submitted timeously
- 73% of Inquiring Officers responses were rated good or better
- 71% of records evidence supervisory officer quality check conducted and recorded
- 64% of Supervising Officers quality of information recorded was rated good or better
- 93% of Police records evidence the legal basis for information sharing in adherence to GDPR
- 69% of iVPD's evidence that the risk and concern hub has applied the three point criteria to their assessment
- 85% of resilience matrices include a narrative showing due consideration of adversity, vulnerability and protective factors
- 92% of Risk and Concern Hub Officers actions were rated good or better
- 50% of Risk and Concern Hub escalation protocol has been undertaken and recorded (with none meeting escalation threshold)
- 46% of Police Bundle evidences the application of a "Triage Assessed Risk Priority"
- 79% of Risk and Concern Hub have referred iVPD to the partnership timeously

- 100% of the risk and concern hub supervisors actions and record have been rated good or better
- 57% of Police records selected included a crime management report
- 88% of Crime Management Reports were rated good or better
- 10% of Police Scotland attendees at ASP Initial Case Conference were known to be appropriately experienced and suitably trained to attend
  (NB this last evaluation point is based on provision of information from police via an information request included in Council Officer Investigation at ASP Initial Case Conference. No Police attended an Case Conference)

NHS Ayrshire and Arran

- 94% of relevant health records were submitted
- 79% of health records evidenced adult support and protection concerns were recorded in health records provided
- 21% of health records evidenced emergency hospital re-admissions for a health condition which was/may have been related to the adult's risk of harm
- 70% of intervention from hospital services to help keep the adult safe and protected was rated good or better
- 32% of health records evidenced repeat referrals for community health services for a health condition which was/may have been related to the adult's risk of harm
- 70% of intervention from Community Health Services to help keep the adult safe and protected was rated good or better
- 22% of health records evidenced frequent presentations to emergency departments with a health condition which was/may have been related to the adult's risk of harm
- 50% of intervention from Emergency Department to help keep the adult safe and protection was rated good or better
- 11% of adults evidenced frequent non-attendance at health appointments
- 14% of health records evidenced repeat adult protection concerns submitted by Health
- 38% of health records evidenced appropriate feedback regarding the outcome of the referral
- 95% of health records quality of record keeping and documentation relating to ASP recorded by health records has been rated good or better

Adult Protection Outcomes

- 67% of cases indicate improvement in the adult at risk of harm's circumstances in relation to safety and protection that match what you would reasonably expect to see