Edinburgh Adult Protection Committee

Biennial Report 2020 – 2022

Our vision is to work together to support people to be safe from harm.

Our mission is to work with individuals, families, communities and across organisational boundaries, to continually improve the safety and wellbeing of people in Edinburgh.

Background

The Adult Support and Protection Act (Scotland) 2007 aims to protect adults who are unable to safeguard their own interests and are at risk of harm because they are affected by disability, mental disorder, illness or physical or mental infirmity. The Act places duties on councils and other organisations to investigate and, where necessary, act to reduce the harm or risk of harm.

Section 46 of the Act requires the Convenors of Adult Protection Committees to produce a biennial report analysing, reviewing, and commenting on APC functions and activities in the preceding two years.

While these guidance notes recognise the challenge of matching this to local reporting, following the new reporting format provides a way of consistently recording information, key themes and issues that are comparable locally, regionally, and nationally.

Reporting

The purpose of the summary report is to analyse activity and provide a concise overview of the Adult Protection landscape locally and nationally that can be used and cross-referenced, with experiences, challenges, learning, and good practice shared with the intention of improving outcomes.

To support analysis each section of the report should:

- be focussed, concise, with minimum reference to administrative functions
- use clear and consistent language and terminology
- include relevant data wherever possible

We understand the APC biennial report is used to share information with partners, external agencies and the public, and should be accessible and engaging. The page recommendation is included as a way to provide meaningful, manageable information for compiling, and a level of standardisation across each committee for comparison. Images, graphics, and tables containing information and data should be summarised, and so would not be part of the suggested section size. Where you have large amounts of data, please consider highlighting the key points but including as an appendix.

Statutory functions

Previously this has been a separate reporting area, but how the Committees statutory functions have been addressed should always be considered, as it cuts through all ASP work. Please highlight in the relevant section any significant achievements, pressures, developments, complexities or challenges around statutory functions and governance arrangements (particularly those involving cooperation between the council and other public bodies and officials), alongside ways you have addressed them, or suggest potential solutions. You should also provide brief analysis of work that goes beyond legislative requirements - why was this work included, what did you do, and what was the impact?

Template Sections

Each section does not require an exhaustive list of ASP activity over the previous two years. Instead identify key achievements, activities, trends, outcomes, and learning, offer analysis of the work undertaken, what the outcomes were, and the impact following. Where possible, provide case studies, feedback from staff and service users, and transferable learning. This should provide a clearer picture of what the significant themes are across the country.

Reporting and analysis around the support and protection of adults at risk should pay particular attention to areas where there has been:

- significant activity, changing trends, and outcomes
- significant achievements and consistent challenges with management of services, and workforce, practice, and performance
- multi-agency, collaborative practice, communication, and cooperation between agencies
- public information, engagement, and involvement
- training, learning, and staff development

Adult Protection Committee	Edinburgh

Covid-19

The Covid-19 pandemic had significant implications for all areas of Adult Protection activity once the social and physical distancing restrictions were put in place by the Scottish Government on 23 March 2020. Colleagues involved in Adult Support and Protection continued their work during exceptionally difficult circumstances. They showed an impressive level of commitment to supporting and protecting adults at risk despite an overwhelming and traumatic situation. Vacancies throughout the reporting period have increased, which has inevitably led to increased workloads for remaining staff.

At the beginning of the pandemic, the Edinburgh Adult Protection Committee recognised the need for leadership and an immediate response. A Senior Manager's Strategic Oversight Group was put in place and initially met weekly to consider emerging themes and priorities for action in the face of a rapidly changing situation. This group continued to meet throughout the pandemic period and continues to meet monthly. It includes the Chair of the Committee, the Chief Social Work Officer, and the Detective Chief Inspector of the Public Protection Unit and the Chair of the Quality Assurance Subgroup supported by the Lead Officer.

Interim guidance was produced in relation to face to face adult protection work and for the organisation of Adult Protection Case Conferences. The interim guidance has been regularly reviewed in line with guidance produced by the Scottish Government. A significant effort was made to secure fast track access to Microsoft Teams for 54 staff across the EHSCP and Community Justice services who were likely to be responsible for chairing Adult Protection Case Conferences. This worked well and allowed for the continuation of safety planning for adults at risk of harm using the videoconferencing platform. A public communication promoting a 'business as usual' message was disseminated through social media and press release.

All sub-committees continued to meet regularly throughout the period, and Large-Scale Investigations and Initial Case Reviews have continued by using video or teleconferencing. The Committee produced an action log which details the priorities and actions in response to the potential risks to adult protection activity in the light of the pandemic.

One of our key priorities during the covid pandemic was to support the safety and wellbeing of residents living in care homes across the city. Governance arrangements were implemented through the Edinburgh Care Home Oversight Group, chaired by the Chief Officer. Information and data from the care home daily huddle and escalations from the multi-agency strategic group are monitored and used to direct support.

A care home support team was established as part of the District Nursing service to support care home staff to implement infection prevention and control measures in line with rapidly changing and evolving national guidance; enhance knowledge and observance of social distancing measures, both for staff and residents; arrange mutual aid to support safe staffing levels; and support the effective use of testing.

As part of the Public Health outbreak response, the care home support team also participated in Problem Assessment Groups (PAGs) and Incident Management Groups (IMTs). Following the PAG or IMT, team visited the care home to support staff with infection control, isolation of residents and 'cohorting' of staff and/ or residents. In addition, the care home support team participated in assurance visits to all care homes for older adults in Edinburgh. This enabled targeted areas of support and training to be delivered.

As part of our assurance and oversight of people in care homes during the covid period we undertook a programme of reviews for all residents. This was undertaken by our specialist Residential Review Team and between April 2021 and April 2022 they carried out 1563 reviews for 1506 people. The RRT continue to support an ongoing programme of reviews.

The pandemic created challenges for the training programme due to social distancing restrictions. However, from May 2020, Level 3 Council Officer training has been successfully delivered using videoconferencing and feedback from participants has been positive. A programme of level 2 multi-agency training recommenced from October 2020 and has continued regularly since.

The City of Edinburgh Council has recently employed a Lead Officer for Trauma Informed Practice who is planning to focus on work to support staff wellbeing in terms of trauma and vicarious trauma. There is work ongoing to address recruitment and retention issues in the Edinburgh Health and Social Care Partnership, which is being led by the Service Director for Strategic Planning. Funding provided by the Scottish Government to

support social work in the recovery period is being used by Edinburgh specifically to resource Adult Support and Protection. A new team is being developed for Social Care Direct which will screen referrals and complete initial ASP inquiries to determine whether the three point test is met and whether further investigation is required. This will provide consistency at the initial stage and will speed up the screening process. Three new full time equivalent Adult Support and Protection Senior Practitioner posts have been created and two new business support posts for the ASP minute taking team. These posts will help to support Adult Support and Protection processes, training, and consistency of practice. Going forward these posts represent a significant increase to Edinburgh's resources, and a commitment to ASP as a continuing priority.

What your data tells you

The tables (A and B) below show the numbers of referrals, IRDS, Initial Case Conferences and those with an outcome to continue to review, along with the conversion rate to the next step. A comparison (table B) between 2018-2020 and 2020-2022 indicates that numbers of referrals have been similar over the two periods. However, there has been an increase in ongoing activity, particularly in relation to numbers of case conferences and reviews. There were **439** Initial Case Conferences in this reporting period and **324** in the previous period. Case Conferences are an important part of the process in Edinburgh and are used to share information between multi-agency partners and to support safety planning. The person will be invited and supported to attend where it is safe and appropriate for them to do so. The increase in Case Conference activity can be viewed as positive engagement with the process of safety planning.

A

	2020 - 2021		2021 - 2022		2020 - 2022		Trend (%)
	Count	Conversion	Count	Conversion	Count	Conversion	Y1 to Y2
Referrals	1868	n/a	1901	n/a	3769	100.0%	**n/a**
IRDs	505	27.0%	481	25.3%	986	26.2%	▼
Initial APCCs	213	42.2%	226	47.0%	439	44.5%	▲
APCC*	247	116.0%	282	124.8%	529	120.5%	▲

*Initial APCC with outcome to continue measures.

B

	2018 - 2020		2020 - 2022		Trend (%)
	Count	Conversion	Count	Conversion	B1 to B2
Referrals	3894	n/a	3769	100.0%	**n/a**
IRDs	833	21.4%	986	26.2%	▲
Initial APCCs	324	38.9%	439	44.5%	▲
APCC*	255	78.7%	529	120.5%	▲

*Initial APCC with outcome to continue measures.

The table below (table C) shows the main types of harm recorded on the adult eIRD form over the reporting period. It shows an increase in categories of 'neglect' and 'self-harm' as well as a slight increase in sexual harm. In 2022 'neglect' became the highest recorded type of harm. The Committee has undertaken focussed work on self-neglect and neglect. This has included emphasis in training and development of a new self -neglect and hoarding protocol. There has been targeted communication to care agencies including a newsletter which has contained articles on self-neglect. It is also noted that there is an increase in substance misuse recorded as a main type of vulnerability (see further table below). There has been emphasis in training of the need to view substance misuse as a vulnerability and to consider the impact of cumulative substance use on an individual's ability to safeguard themselves. There has also been engagement with multi-agency colleagues around the new ASP codes of practice which highlights the need to view substance misuse as a vulnerability. It is difficult to know whether the recorded increase is due to an increase in this type of harm and vulnerability, perhaps due to the pandemic, or an increase in awareness and recognition that adult support and protection processes will apply in cases of self-neglect and self-harm, or a combination of factors.

C

	2020 - 2021		2021 - 2022		2020 - 2022		Trend (%)
	Count	%	Count	%	Count	%	Y1 to Y2
Financial Harm	102	20.2%	84	17.5%	186	18.9%	▼
Psychological harm	85	16.8%	65	13.5%	150	15.2%	▼
Physical harm	123	24.4%	111	23.1%	234	23.7%	▼
Sexual harm	38	7.5%	39	8.1%	77	7.8%	▲
Neglect	92	18.2%	114	23.7%	206	20.9%	▲
Self-harm	54	10.7%	63	13.1%	117	11.9%	▲
Other	11	2.2%	5	1.0%	16	1.6%	▼
Total	**505**	100.0%	**481**	100.0%	986	100.0%	=

The table below (table D) shows the types of harm in comparison to the previous reporting period. Again, there is indication of increase in self-harm and neglect being recorded as the main types of harm. Psychological harm also shows an increase from 7.6% to 15.2% of the total.

D

	2018 - 2020		2020 - 2022		Trend (%)
	Count	%	Count	%	B1 to B2
Financial Harm	173	20.8%	186	18.9%	▼
Psychological harm	63	7.6%	150	15.2%	▲
Physical harm	242	29.1%	234	23.7%	▼
Sexual harm	113	13.6%	77	7.8%	▼
Neglect	116	13.9%	206	20.9%	▲
Self-harm	64	7.7%	117	11.9%	▲
Other	62	7.4%	16	1.6%	▼
Total	**833**	100.0%	986	100.0%	=

The table blow (table E) shows an increase in the person's own home being recorded as the locus of harm. This is perhaps not surprising given the restrictions in place during the pandemic period.

E

	2018 - 2020		2020 - 2022		Trend (%)
	Count	%	Count	%	B1 to B2
Own home	467	56.1%	660	66.9%	▲
Other private address	68	8.2%	50	5.1%	▼
Care home	126	15.1%	78	7.9%	▼
Sheltered or other supp accommodation	33	4.0%	35	3.5%	▼
Independent Hospital	0	0.0%	0	0.0%	=
NHS	11	1.3%	14	1.4%	▲
Day centre	1	0.1%	1	0.1%	▼
Public place	97	11.6%	81	8.2%	▼
Not known	30	3.6%	67	6.8%	▲
Total	833	100.0%	986	100.0%	=

Table F shows a comparison of recorded ages of adults at risk between the current and previous reporting period. There has been a slight increase in the 25-39 and 40-64 age groups.

F

	2018 - 2020		2020 - 2022		Trend (%)
	Count	%	Count	%	B1 to B2
16-24	116	13.9%	120	12.2%	▼
25-39	138	16.6%	177	18.0%	▲
40-64	248	29.8%	319	32.4%	▲
65-69	44	5.3%	63	6.4%	▲
70-74	58	7.0%	66	6.7%	▼
75-79	62	7.4%	71	7.2%	▼
80-84	61	7.3%	74	7.5%	▲
85+	102	12.2%	87	8.8%	▼
Not known	4	0.5%	9	0.9%	▲
Total	**833**	**100.0%**	**986**	**100.0%**	=

The tables below (G and H) show types of vulnerability recorded. Table G is a comparison of the current and previous biennial reporting periods and table H shows the comparison between the two years within the current period. Dementia has been recently added and there is some work needed to raise awareness with colleagues that this category now exists for recording purposes. Both tables show an increase, as noted above, in substance misuse recorded as a type of vulnerability both over the reporting period and compared to the previous period (2018 – 2020). The category of 'Mental Health Problem' has also shown an increase since the previous period and is the second highest category after 'Infirmity due to Age'. There is further work planned on the theme of self-neglect and neglect, including a development session for colleagues on National Adult Protection Day in February 2023 jointly with East and Mid Lothian Councils.

G

	2018 - 2020		2020 - 2022		Trend (%)
	Count	%	Count	%	B1 to B2
Dementia	2	0.2%	0	0.0%	▼
Mental health problem	201	24.1%	272	27.6%	▲
Learning disability	159	19.1%	128	13.0%	▼
Physical disability	99	11.9%	120	12.2%	▲
Infirmity due to Age	260	31.2%	282	28.6%	▼
Substance misuse	52	6.2%	114	11.6%	▲
Other	60	7.2%	70	7.1%	▼
Total	833	100.0%	986	100.0%	=

H	2020 - 2021		2021 - 2022		2020 - 2022		Trend (%)
	Count	%	Count	%	Count	%	Y1 to Y2
Dementia	0	0.0%	0	0.0%	0	0.0%	=
Mental health problem	157	31.1%	115	23.9%	272	27.6%	▼
Learning disability	70	13.9%	58	12.1%	128	13.0%	▼
Physical disability	62	12.3%	58	12.1%	120	12.2%	▼
Infirmity due to Age	140	27.7%	142	29.5%	282	28.6%	▲
Substance misuse	44	8.7%	70	14.6%	114	11.6%	▲
Other	32	6.3%	38	7.9%	70	7.1%	▲
Total	**505**	100.0%	481	100.0%	986	100.0%	=

Outcomes, achievements, and service improvements

In the reporting period the Committee has undertaken a significant piece of self-evaluation activity which has included multi-agency colleague surveys, colleague focus groups, and development sessions for the Committee members. The aim of this activity has been to produce an accurate picture of Adult Support and Protection in Edinburgh and to clearly identify shared priorities for improvement planning across the partnership. This has informed the development of a refreshed improvement plan which addresses the key themes which have been identified. The Committee has also further identified themes and areas for improvement locally through Initial and Significant Case Reviews.

The Committee plan to implement the actions in the redeveloped improvement plan (2022-2024) and outline our priorities for the future. The Committee is undertaking developmental sessions throughout the year with every second Committee session dedicated to improvement and further self-evaluation activity. This will provide robust oversight and focus to drive identified improvement.

The partnership provides a strong commitment to joint working and collaboration by colleagues in Edinburgh across all agencies. The high level of activity, including multi agency Case Conferences and reviews, is indication of the commitment to developing and reviewing safety planning arrangements for adults at risk of harm. Council Officers understand the statutory powers available to them and a strength in Edinburgh is the level of joint work with and support from the Council Solicitors when considering protection orders. There is evidence from feedback from council officers, including some from adults at risk themselves, that the use of banning orders has resulted in keeping people safer.

Domestic Abuse

Domestic abuse is recognised as a cross cutting area with Adult Support and Protection and there are examples of strong partnership working in Edinburgh including:

- MATAC (Multi-Agency Tasking and Co-ordinating): This group consists of representatives across partner agencies and third sector and identifies and manages high tariff and repeat domestic offenders in the community. The aim is to protect vulnerable people at risk of harm through targeting perpetrators.
- MARAC (Multi-Agency Risk Assessment Conference): is victim focussed and provides a partnership forum for sharing information and taking actions that will reduce harm to very high risk victims of domestic abuse, several which have complex vulnerabilities and may also be supported through ASP work. MARAC allows agencies to share information, identify the risk to the victim and produce a multi-agency plan to reduce that risk.
- DALAG (Domestic Abuse Local Action Group): This is a local area multi-agency group allowing information sharing and a clear pathway from domestic abuse incident to service provision based on risk for people who have not yet been subject to a large number of domestic incidents but who are identified by wider risk factors.
- DMF (Decision Making Forum): This is chaired by Police and has representatives from Police, Social Work and Women's Aid. It is a discussion to decide whether to make a disclosure to a person at risk from a DSDAS (Disclosure Scheme for Domestic Abuse Scotland) and has two

main triggers, 'right to ask' and 'power to tell'. The essence of this is giving people the information to empower them to make informed decisions about who they are in a relationship with and has involved several individuals who are also considered as adults at risk in terms of Adult Support and Protection.

Large Scale Investigation, Significant Case Reviews, and Initial Case Reviews

Adult Protection Committees, on behalf of the Chief Officers, are responsible for undertaking Initial Case Reviews (ICRs) and reporting / recommending a Significant Case Review (SCR) when the agreed criteria are met. The Committee uses the learning from ICRs/SCRs to promote good practice, improve practice and contribute to improved outcomes for adults who may be subject to harm, abuse, and exploitation.

During the reporting period 14 Large Scale Investigations were commenced with regard to five care homes, five care at home agencies, one housing support service and three group homes with 24 hour support provided.

There is a Pan Lothian Large Scale Investigation protocol in place which was agreed between the four local authorities in the Lothians and implemented in 2021. This ensures consistency between neighbouring authorities. Edinburgh's Large Scale Investigation Procedure was revised to reflect the protocol, and it is the procedure which colleagues work to in practice. The partnership has progressed 9 Large Scale Investigations between 1 April 2020 and 30 March 2022. Large scale investigations in Edinburgh happen timeously and involve a high level of commitment from multi-agency partners, senior managers, and include representatives from the Care Inspectorate. Improvements in services have been supported due to the multi-agency involvement and some have been evidenced by improved Care Inspectorate grading of the services. Individuals within services have been supported using ASP measures and individual safety planning through IRD and Case Conferences.

Edinburgh has well established Multi-Agency Quality Assurance Groups looking at care service provision and acting as the first point of scrutiny for initiating a Large Scale Investigation. Concerns about services may be raised by practitioners and directly escalated to senior managers if urgent. They may also use 'Care Service Feedback' forms which are a notification system Edinburgh has in place. The forms are screened and collated by Quality Assurance Officers who will escalate as appropriate, including reporting into the Mult-Agency Quality Assurance Groups. The Residential

Review Team is a specialist practice team in Edinburgh working with people who are living in residential care settings, and so it is often practitioners from this team who will note and raise concerns about care homes. This team has developed expertise in adult protection in care home settings. Team representatives attend the Multi-agency Quality Assurance meetings to share relevant information. Multi-agency meetings are used to gather and share information where there are mounting concerns about specific services and a need to consider if the criteria for LSI are met. In circumstances where there is immediate and significant concern, this will be escalated straight to senior managers for a decision to progress to LSI.

The Edinburgh Adult Protection Committee will explore whether anonymised findings, produced as 7-minute briefings, could support shared learning from LSIs, and a thematic review of LSIs will be completed.

Self-evaluation activity identified that there are challenges for colleagues when asked to take part in a Large Scale Investigation when they do not regularly do so. As part of ongoing improvement planning, the partnership will provide clearly accessible guidance on purpose, roles and responsibilities and indicators of concern for practitioners involved in large scale investigation activity.

Outcome Example:

One Large Scale Investigation was in regard to a care at home agency which had been given 'weak' grades by the care inspectorate, and there were significant concerns about the ongoing sustainability of the service. The Large Scale Investigation oversaw an intense level of multi-agency activity and support offered to the service which allowed a regrading by the care inspectorate to adequate grades within an eight week period.

Initial and Significant Case Reviews

The APC progresses Initial and Significant Case Reviews in line with national guidance which are multi-agency in nature**.** A Learning Review protocol covering both Adult and Child Protection has been developed and will be presented to the next Committee meeting in December 2022. There have been **14** ICRs undertaken in the last two years and two of these have progressed to Significant Case Review. Outcome reports are completed and presented to the Adult Protection Committee and submitted to the Care Inspectorate. Identified learning points are overseen by the Quality Assurance sub-committee and has the involvement of multi-agency partners. The learning points have been

organised by theme to better identify recurring issues. It is recognised that further work is required to disseminate and embed learning from Case Reviews, for instance in the form of seven minute briefings. A thematic action plan in relation to Case Reviews has been developed and was presented to the Adult Protection Committee on 24 October 2022. The action plan has identified key areas for improvement. The Committee has agreed to set up a Learning Review/SCR Oversight Group to drive and provide assurance around identified improvements and to oversee ongoing learning reviews to ensure they are completed within timescales.

Various themes have been identified as a result of Case Reviews and improvements implemented as a result. These include:

- Incorporation into level 2 and level 3 training of specific focus on withdrawal and disengagement from services as an indicator of harm.
- Dissemination of key information and learning points to contracted providers through EH&SCP contracts team.
- Use of the newsletter to highlight specific themes such as recognition of the risk and harm of self neglect.
- Improvement in accessibility of the referral pathway for tissue viability service.
- Development of staff briefings in the form of seven minute briefings.

The Committee recognises that further work is required to communicate the learning of such reviews and to improve our processes for monitoring improvement activity generated and share relevant learning from Reviews and Large Scale Investigations with frontline staff. Going forward, staff briefings which have been developed will be evaluated in practice. Self-evaluation has identified a need to increase confidence for colleagues involved in Large Scale Investigation and the Committee is planning to provide a tool kit and accessible guidance.

Interagency Referral Discussion (IRD) and IRD Review Group

The IRD review group meets fortnightly and reviews IRD progress and decision making. The review group is chaired by a senior manager and provides governance and assurance regarding consistency of practice and approach, as well as identifies developing protection themes for learning which can be discussed at IRD workshops or ASP practice network meetings.

Protection Orders

Edinburgh has initiated 52 orders in the reporting period, all of which have been banning orders or temporary banning orders. Self-evaluation activity indicates that advice from Council solicitors is easily available, and colleagues are aware of how and when to access guidance and support from legal colleagues. Training emphasises the need to seek legal advice at the earliest possible opportunity and this is supported by CEC legal team, who have also taken part in facilitation of level three Council Officer training. This relationship between practitioners and legal colleagues is a considerable strength. There is evidence from qualitative feedback from practitioners of good outcomes for people in keeping them safe using banning orders.

Outcome Examples (N.B the following are anonymised examples but in practitioners' own words):

'The banning order appears to be working well for A. The order is to deter three family members from entering her property…A is very frightened of one of the individuals, and whilst she would struggle to call the police if he turned up at her home, I think she would quickly speak to her support workers who see her every day. A lives in a core and cluster type of accommodation. There does not seem to have been any issue around the perpetrators trying to gain access, but I think knowledge of the banning order alone might be deterring this.'

'This banning order has been effective in keeping B safe from risk of physical and financial abuse from her ex-partner. B states she wishes no contact with her ex however I would be concerned for her safety if he was to turn up at her door. B has not disclosed any communication with her ex-partner however I would be concerned if this was no longer in place as I believe he would try to contact B.'

There is also an indication of the views of the adults at risk in the following examples:

'I think the Banning Order has been useful for both C and his neighbours in the sheltered housing complex as his son has been banned from all types of contact with C and banned from attending his address. C feels well supported and protected with the Banning Order in place and we recently put another one in place for a further 6 months.'

'The Banning Order for D has been very successful. She had a very difficult time with her son's behaviour prior to the first Banning Order being put in place and she was struggling with her mental health including anxiety and depression and her tenancy was also at risk due to her son staying there and his behaviours. D's mental health has improved since the first Banning Order was put in place and it has recently been renewed for a further 6 months. We had an APCC Review last week, and D is already requesting a further Banning Order for 6 months' time when the current order runs out. D believes that the situation prior to the first Banning Order would re-occur if there was no Banning Order in place.'

The Herbert Protocol

The Herbert Protocol was implemented in Edinburgh in June 2019. The system provides police with detailed information to help search for people with dementia who are missing, providing a personal description of the individual and information about known routines and habits. The Herbert Protocol can be used for anyone who has a dementia diagnosis and may be at risk of going missing. The protocol offers;

- Information gathering form - encourages carers and families to record vital information. Can be given to police in event of someone going missing.
- Helps police quickly access important information - avoids unnecessary delays in gathering information at a time of crisis.
- Records vital information - where the person grew up, favourite places, former or current hobbies, GP contact details, medication, daily routine, a photograph with consent to share on social media if required

Chronologies

Edinburgh is involved in an ongoing workstream to develop a Pan Lothian Chronology tool and consistency of practice and learning in this area across the Lothians and across service areas. Practice guidance has been incorporated into training.

Training, learning and development

Self-evaluation activity and consultation with colleagues has identified various areas for improvement in learning and development. These include:

- Understanding of roles and responsibilities when undertaking large scale investigations for 'frontline' colleagues in locality teams
- Capacity and decision making
- Emphasis on practice skills
- Self-neglect and hoarding
- Learning from case reviews

Adult Support and Protection training has been reviewed and refreshed and in the reporting period, training continued to be presented to a multi-agency audience online using a videoconferencing platform. For 'Level 2', which is multi-agency training for those working in direct roles with people, a 'training for trainers' model has been developed. An external consultant was commissioned through a tendering process in December 2019 to review Level 1 and Level 2 training and to provide a 'Training for Trainers' course. This was in response to the challenges encountered in providing Level 2 training due to a shortage of trainers. This model trains colleagues to present the content and facilitate the training. This has allowed a level of sustainability and capacity to be built into the system by establishing a cohort of trainers, and this will continue to be reviewed by the ASP Learning and Development Committee. In the reporting period, fourteen City of Edinburgh colleagues and two NHS colleagues (NHS Adult Support and Protection Advisors) have undertaken the Adult Support and Protection Module provided by University of Stirling, and all of these have agreed to present Level 2 training in the forthcoming period. Six further colleagues have been put forward for the course in 2023. Between 1st April 2021 and 30th March 2022, **143** multi-agency colleagues have been trained in Adult Support and Protection at level 2, and **124** at level 3, which is Council Officer level training.

Level 3 Training, which is primarily for Council Officers and others who are working in Adult Support and Protection at a high level, has been reviewed and refreshed in the reporting period. There are further plans to review and move to a more modular model by the end of 2023. Currently the training

consists of two consecutive days of input, but it is recognised that a modular model would give more flexibility and time for reflection upon learning.

Additionally in the reporting period:

- Bespoke training has been provided to various agencies by Adult Protection Senior Practitioners and Lead Officer including to the Public Protection Unit, the University of Edinburgh, and EH&SCP carers support team, and professionals working directly with Ukrainian refugees, amongst others. Training for housing officer will take place in the first quarter of 2023.
- Adult Support and Protection Senior Practitioners have worked with Mental Health Officer Colleagues to develop and provide 'Working Across the Acts' training which explores the interface between the different pieces of mental health legislation and the Adult Support and Protection Act and is aimed at practitioners working directly in Adult Support and Protection.
- Adult Support and Protection leads have instigated work with advocacy providers to develop training for multi-agency colleagues which will raise awareness of different kinds of advocacy and the benefits. Going forward there is a plan to include input from people with lived experience in this training with the support of colleagues who facilitate group advocacy.
- Edinburgh has delivered suicide prevention training throughout the reporting period which has been led by one of the Adult Support and Protection Senior Practitioners. There is recognition that there remains a high degree of stigma around suicide and professionals often lack confidence or sometimes minimise the risk. The aim is to increase staff confidence in identifying and assessing risk of suicide and intervening as appropriate.
- Workshops were held for IRD participants on the theme of human trafficking and self-neglect/hoarding.
- At a national level the Lead Officer and Adult Support and Protection Senior Practitioner have been involved in supporting the development of a learning resource in relation to Adult Protection Case Conferences.

Learning and Development Subcommittees

A new Public Protection Sub Committee has commenced and is meeting quarterly, chaired jointly by Lead Officers for Adult Protection, Child Protection, and the Equally Safe Committee. This Sub Committee has multi-agency representation and aims to identify and develop cross cutting areas in learning and development, encouraging joint approaches to shared areas of work and to avoid duplication. The Sub Committee is currently developing a terms of reference and strategic plan.

The Adult Protection Learning and Development Sub Committee will continue to meet quarterly in order to oversee and develop learning pertinent to Adult Support and Protection. The Sub Committee has a multi-agency membership including the voluntary and independent sectors.

Engagement, involvement, and communication

There is representation of advocacy organisations on the Adult Protection Committee in Edinburgh and on the Learning and Development sub group and there is a commitment to focus on this as a key area for improvement. Edinburgh has a strategic plan for commissioning independent advocacy services for Adult Support and Protection. Data from advocacy partners indicates a 76% increase in annual rates of referral for independent advocacy since 2018. It recognised that it is often hard to give advocacy services enough time prior to the initial Adult Support and Protection Case Conference for them to meet with the adult. Ways to prompt practitioners to consider advocacy referral earlier in the process are being considered as part of the Committee's improvement plan. Specific advocacy training is being developed with advocacy partners and the involvement of people with lived experience in the training is being scoped. An online session on predatory marriage presented by an unpaid carer with lived experience was commissioned and attended by Edinburgh colleagues.

Through self-evaluation activity including staff survey, audit and focus groups Edinburgh has identified improvement actions to better involve adults at risk of harm and their unpaid carers where appropriate in adult support and protection activity, whether this is individual or wider strategic processes. This is a key area of the Edinburgh Adult Protection Committee improvement plan for 2022-2024.

The Edinburgh Adult Protection Committee is multi-agency and includes both statutory and voluntary sector representatives. The Committee's improvement plan has been informed by consultation with frontline colleagues including those from advocacy and third sector organisations and includes an action to improve involvement of the voluntary sector in Committee work.

A quarterly newsletter has been produced since December 2021 which promotes e and communicates Committee activity and improvements. The newsletter has contained articles on financial scams, self-neglect, the cost of living crisis and the revised codes of practice. The Committee's web presence has also been built up over the past 12 months and will be further developed in the next year. A communication plan is in development which will aim to better link the governance arrangements, workplans and associated activities to the direct work of colleagues involved in adult protection, and promotion of the APC strategic activities with those delivering ASP services to ensure awareness and linkages between the APC and daily activity in ASP work. There will be further development and promotion of work through the existing newsletter and website. The work of the Committee has been presented to a frontline practitioner forum in August 2022 and further forums are planned. There have been communications through press release and social media in the period on specific issues such as the cost of living crisis, cuckooing and county lines, the latter being reported in multiple national newspapers.

During the reporting period Suicide Prevention has been led by one of the Adult Support and Protection Senior Practitioners, which carries overall responsibility for managing Edinburgh's actions in relation to Every Life Matters programme in Scotland. Over the period this has included public awareness raising events, provision of training and other strategic work which has involved people with lived experience and bereaved relatives in the planning and implementation of the work.

Outcome Example: in this example the individual and their family have been involved in the process which helped to overcome challenges and provide a positive outcome.

An older woman was admitted to hospital with significant pressure sores and delirium. She lived with family, but concerns arose about the family's understanding of their mother's needs and that there had been a reluctance to accept support. Adult Support and Protection Case Conference and reviews provided an opportunity for the family to be involved in multidisciplinary discussions. They agreed that to accept support in the form of a package of care, visits from district nurses and emergency contact

numbers. The main carer was referred for a carers assessment and supports. At Case Conference review the woman and her family expressed to professionals that were very appreciative of the support in place and how this enabled them to care for their mother.

Outcome example: In this example a rights based approach has been taken, and the woman has been involved and supported with decisions to achieve a positive outcome.

A young woman with learning disabilities had moved to her own flat with minimal support. An individual she identified as a friend was taking significant sums of money from her and was also setting up loans and phone contracts in her name, which led to debt. The Adult Support and Protection Case Conference identified the need for more supported accommodation with access to assistance with her finances. A suitable resource was identified, and support with finances arranged. Initially, the woman was concerned that a move to supported accommodation was a step back for her, but she was supported to make decisions. At the subsequent review, she was able to identify the opportunities the support provided. She stated that her finances were protected, she was involved in positive activities, and she had made some very positive friendships.

Challenges and areas for improvement

Edinburgh recognises that there is need to streamline some of its processes and procedures to provide a clearer order of process for practitioners. It has been identified through self-evaluation activity that the difference between inquiry and investigation requires clarification in line with the new ASP codes of practice. Planned procedural changes will provide clarity around these processes for practitioners which will increase confidence in decision making and support the best outcomes for adults at risk of harm.

The Act provides a means to intervene where individuals meet the legal definition of an “adult at risk of harm”, known as the “three-point test” and now known as the ‘three point criteria’. In Edinburgh the Committee has identified that a rigid adherence to this definition can act as a barrier to responding to situations which equally require inquiry and intervention. There is a strong emphasis in training on recognising harm, regardless of the cause, and recognising that adverse life experiences can directly affect an individual’s abilities to make decisions about safety and wellbeing. It is a continuing challenge to ensure that practitioners embed this approach in their practice. However, looking forward the Committee is aiming to develop further training input on application of the three point criteria, which will emphasise that a broad, trauma informed approach should be taken. There has been training input to a Practitioner Forum on the application of the criteria and written guidance has been produced and disseminated.

An area highlighted for improvement through self-evaluation is staff confidence in undertaking Large Scale Investigations. This area of work presents challenges as it is not a regular occurrence for colleagues, so they do not have opportunity to gain experience. New national training has been developed and the Committee has highlighted and disseminated this, but it is also recognised that there is a need for local practice guidance to be produced and this forms part of the Committee’s improvement plan.

An identified theme from Initial and Significant Case Reviews as well as an analysis of recorded types of harm has highlighted the need for focussed work around neglect and self-neglect. A hoarding and self-neglect protocol has been launched and training developed for staff. A themed development session on the subject is planned for February 2023 and the Committee will discuss and develop further improvement actions through the Quality Assurance Sub Committee and the Learning Review Oversight Group.

The Adult Support and Protection Partnership in Edinburgh, like many other areas of Scotland, has been affected by a reduction in key post holders, and connected recruitment challenges. An overall increase in Council Officer vacancies, primarily in social work, have had an eventual impact upon the capacity of the service. Tied to this is an ever increasing pressure to respond to other crises and need arising from supporting people in the community through care packages and support, as well as pressures associated with people leaving hospital back into the community. As a result, teams struggle

with the competing demands of such work, and this has led to challenges in allocating key tasks to appropriately qualified colleagues in the expected timeframe.

A further challenge for Edinburgh has been to maintain consistency of practice across the city and across different teams, Edinburgh is a large area, and the Health and Social Care Partnership has four locality teams and various specialist teams. Each locality team have their own improvement plan and reviews of these are ongoing. Specific improvements have been put into place with regard to areas with the most outlying data connected to training and development, improvement, culture, and assurance. Improvements to recognition and management of risk have already been identified following the implementation of the plan.

Resource and capacity issues are likely to continue to present challenges. There are various service developments planned for the forthcoming period which aim to improve delivery through promotion of consistency of practice. There has been an increase to the Adult Support and Protection Senior Practitioner resource and agreement for three further full time equivalent posts. This will provide increased capacity for development of training and consistency of practice across service areas. A change to Social Care Direct, which is City of Edinburgh contact centre where the majority of ASP referrals are received, is being progressed. This will promote consistency of screening and initial inquiry to determine if further ASP work and intervention is required. There is a proposal in the police strategic workforce plan which has been agreed by senior management, to create an adult protection team. This will compose of a Detective Sergeant and six Detective Constables. This team will provide some consistency of ownership around adult protection investigations, where currently some inquiries sit with uniformed officers and some with Detectives. It would also provide better coverage of Adult Support and Protection Case Conferences' and other partnership processes and increased specialist knowledge in a very complex area. Due to a number of challenges around demand, finance, and resources, for example the pandemic and COP-26, it has not yet been possible to secure the resources for this team. It remains as a commitment, which would improve outcomes for vulnerable adults and partnership working.

Looking forward

In the next reporting period, the Adult Protection Committee will regularly undertake a review of progress against areas of improvement identified within the APC Improvement Plan for 2022-2024 and will continue with development sessions to focus improvement work. Some key improvement areas are as follows:

- Consider ways to improve the involvement of people with lived experience in the work of the Committee and in Adult Support and Protection processes and the work of the Committee.
- Progress with development of health professional's participation in IRDs;
- Continue to develop IRD workshops and frontline practitioner forums;
- Continue to develop and evaluate ways to disseminate learning from Case Reviews including use of seven minute briefings;
- Review of training and development of training focussed on practical skills, risk assessment, investigation skills and professional decision making;
- Improvements to key processes and recording, including application and recording of the three point criteria;
- Improve the visibility of the work of the Committee to colleagues and the public, including dissemination of the vision statement, continuing with regular newsletters, and further development of web presence.