Fife Adult Support & Protection
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# Fife Adult Support & Protection Committee

# Biennial Report 2020-2022

## October 2022

Author: Ronan Burke, Quality & Assurance Officer

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# Foreword

As Independent Chair of Fife Adult Support and Protection Committee I am delighted to introduce this Biennial Report for 2020-2022. The last 24 months has been challenging for people within our community, practitioners, and services.

As a result of the Covid-19 restrictions many people have experienced a range of personal and professional challenges and despite the restrictions on our daily lives, many of us will still know people who became seriously unwell or sadly died during this period.

Within Fife there is a real strength to have so many individuals, practitioners, organisations, and agencies focussed on supporting the wellbeing of others. In these unprecedented times we have seen an extraordinary commitment to support and protect people from across our communities.

The Adult Support and Protection Committee has worked hard to fulfil its functions, as outlined by the Adult Support and Protection (Scotland) Act 2007. Throughout the reporting period, Fife Adult Support and Protection Committee adapted to the pandemic by identifying new ways of working and identifying risks and challenges with new approaches and a renewed dedication to making a difference even in the most difficult of circumstances. Through strong partnership working, commitment and resilience the Committee and Working Group members have; ensured training and development opportunities were delivered virtually to enable the confident application of Adult Support and Protection (Scotland) 2007 legislation across our frontline workers; developed a Committee Covid-19 Recovery Plan ensuring any risks and trends were identified and acted upon at the earliest opportunity; updated and developed policy and procedure including the Interagency Engagement and Escalation protocol and the Herbert Protocol; successfully raised awareness of Financial Harm and strengthened partnership working to identify and report this and initiated a short life working group focussing on hoarding and self-neglect.

Over the course of this reporting period our priorities have been driven and guided by our Strategic Improvement Plan 2019/ 2020 and 2021/2023. The Adult Support and Protection Team work to ensure the effective alignment of local work and priorities with that of the National forum.

The committee continues to work alongside colleagues in the Child Protection Committee, Fife Violence Against Women's Partnership, Fife Alcohol and Drug Partnership, and MAPPA (Multi-agency Public Protection Arrangements) to ensure there are shared learning opportunities and a mutual understanding of protection, harm and responsibility across all partners throughout the life span.

The Adult Support and Protection Committee has continued to drive forward improvement actions despite unprecedented times throughout 2020 – 2022. The contribution of all agencies represented on the Adult Support and Protection Committee who have given their on-going support, dedication, resilience, and creativity has been greatly appreciated.

I would like to offer my sincere thanks and appreciation to all those who have worked tirelessly with resilience and dedication to keep members of our community safe from harm.

Alan Small, Fife Adult Support and Protection Committee Chair

# Introduction

The Adult Support and Protection Committee (ASPC) is a statutory body established under section 42 of the Adult Support and Protection (Scotland) Act 2007 (the 2007 Act) within each council area. The committee is chaired by an independent convenor who is neither a member nor an employee of the Council.

The ASPC is the primary strategic planning mechanism for inter-agency adult support and protection work in Fife. To operate effectively, all office holders and public bodies collaborate on the exercise of functions which relate to the safeguarding of adults at risk in Fife.

The ASPC is made up of senior representatives of key agencies who work together to effectively discharge its obligations in respect of policy and practice in adult support and protection matters. Fife's ASPC reports on its work and progress and is accountable to the Chief Officer of Public Safety (COPS).

The key functions of the ASPC as defined in the 2007 Act are:

- To keep under review the procedures and practices of the public bodies and office holders relating to the safeguarding of adults at risk;
- To give information or advice, or make proposals on the exercise of functions which relate to the safeguarding of adults at risk;
- To make, assist in, or encourage the making of, arrangements for improving the skills and knowledge of officers or employees who have responsibilities relating to the safeguarding of adults at risk; and
- Any other function relating to the safeguarding of adults at risk as the Scottish Ministers may specify.

In performing these functions, the ASPC must have particular regard to improving co-operation between and across each of the public bodies and office holders.

Fife's ASPC has continued to meet on a regular basis throughout the Covid-19 pandemic, moving to 'virtual' online meetings via Microsoft Teams. This has ensured and enabled a continued focus on adults at risk of harm and the timely oversight and identification of any themes and/or trends as they arose. This Biennial Report 2020-22 offers an oversight of how this focus was maintained during this time and shares the resulting outcomes.

## Impact of the COVID-19 Pandemic

At the end of March 2020 Fife Adult Support and Protection Committee, alongside all ASPC's across Scotland, required to quickly adapt to the unknown and regularly changing circumstances surrounding Covid-19. The restrictions and implications linked to COVID-19 meant we had to develop new ways of working. Fife Public Protection Group was set up in order to ensure oversight of the safe and effective delivery of service across the Public Protections. Senior representatives from statutory partners (Social Work, Health and Police) met virtually on a weekly basis to ensure that all partners were supported, that risks or spikes in COVID-19 were identified early and addressed, trends monitored through relevant data analysis, and implications for staff welfare were considered.

All representatives of the ASPC received briefing and awareness raising materials throughout both periods of lockdown to support the continued importance of reporting Adult Protection concerns. Council Officers continued carrying out adult protection related work and visits with the aid of PPE and staff were provided with the appropriate technology and access to virtual meeting systems to allow virtual IRD and Case Conferences to continue.

It is also important to note that despite these unprecedented changes to our ways of working, the strategic work of the sub-committee groups continued, with many of the strategic outcomes being delivered from 2020-22, which the Biennial Report will illustrate.

Finally, it is vitally important to note that the commitment, dedication, creativity and flexibility of our ASPC members were critical in ensuring the support to our service users, patients, communities and workforce continued throughout this period. An integral part of this was the Partnership's Covid Recovery Plan which was first developed in June 2020. This kept, and continues to keep, all processes under review in light of Covid-19 and helps to identify and act on any practice issues raised. The Covid Recovery Plan takes into account ASPC functions, the working groups, learning and development, communication, national networks, working arrangements, service user contact/engagement, data, human rights and identifying harm and hidden harm as a result of the pandemic. This plan has helped ensure that harm continues to be identified and reported and that services and supports are able to reach all those who need it.

## What our data tells us

For the past two years the Committee has been provided with detailed statistical summary reports following the submission of the Scottish Government data return. Reports provide trend analysis, information on types of harm being investigated and demographic details of adults at risk, all of which has helped to inform our local improvement planning discussions for the next reporting period. In addition, it has prompted a number of interagency self-evaluation activities to provide context to emerging trends, for example the annual Adult Support and Protection case file audit, a Mixed Methods Review in relation to care home statistics and future audit of all Large Scale Investigation activity over the last reporting period. A summary of the data is provided below.

### Key Statistics

- 5717 reports of harm were received between 2020-22, representing a percentage increase of 0.70% since the 2018-20 report (5677).

- 835 Investigations were undertaken in the reporting period 2020-22, which is an increase of 15% compared to the 2018-20 Biennial Report (724).

- 223 initial and review case conferences were convened in 2020-22, an increase of 48 in comparison with the previous 2 years. This is a 27% increase in total.

- 17 Large Scale Investigations (LSI) were commenced 2020-22, compared with 4 across 2018-20. This is an overall increase of 325%. This is clearly a notable increase within the reporting period, with audit activity planned within the next reporting period to investigate this further.

- Continuing the trend from previous years, within 2020-2022 the majority of investigations relate to individuals aged 16-65 (64%), compared to 59% for 2018-2020.

- In terms of gender demographics, those identifying as female counted for 59% of total investigations from 2020-22, rising from 56% during the 2018-20 reporting period. For those identifying as male, we see a drop from 44% of total investigations in 2018-20 down to 41% from 2020-22.

- We see an increase from 14% in 2018-20, to 19% in 2020-2022 of total investigations where the adult's client category was recorded as adults with mental ill health. Interestingly, we see a drop of 2% for investigations where the adult's client category was recorded as physical disability (28% in 2018-20, 26% for 2020-22), and a drop of 1% for where it was identified the client category was infirmity due to old age (14% for 2018-20, 13% for 2020-22).

- The main types of harm recorded for cases at Investigation stage for the 2020-22 reporting period were Financial harm (23%), Physical harm (23%) or Self-harm (20%). In comparison, from 2018-20, the main types of harm recorded for cases at investigation stage were Psychological harm (25%), Financial harm (21%) and Physical harm (19%). We see a drop of 6% in reporting periods for Psychological harm. Self-harm statistics continue to rise which is something that has been noted across the adult's social work service for further development in terms of training offerings for frontline workers moving forward.

- Reflecting data in previous years, the 2020-22 reporting period demonstrated that the most likely location of harm investigated continues to be an individual's own home (59%), followed by Not known (10%) and Care home (5%). In comparison, 2018-20 data shows the main locations of harm

were the individual's own home (63%), Not Known (12%) and Care Home (10%). In particular, Fife's Care home statistics are of note. Not only have these numbers halved between the two reporting periods, they are also significantly lower than the 22% national average recorded in 2020. There are actions already in place to investigate reasons for this, including the addition of presentations by the Adult Support and Protection Team to care homes to provide further information on harm and the processes for reporting this.

The available data is reflective of a number of similar trends to that of previous years and identifies a number of areas which may have been impacted upon by Covid-19. The perhaps smaller than expected increase in reports of harm is likely to directly correlate with a reduction in face-to-face contact and engagement with members of the community due to lockdown restrictions at this time in 2020-21 in particular. The ASPC has developed a Stakeholder Engagement Strategy which is particularly relevant and raised the awareness of the continued need of practitioners to remain vigilant to identifying and reporting harm whilst we gradually came out of restrictions. It is not surprising that the most likely location of harm remains a person's own home given the restrictions that were in place for a large part of 2020-2021, however, there remain questions about the low level of investigations being progressed for adults in care homes. A mixed methods review has been taken forward in 2022 and will continue into 2023 to provide exploration and assurances as to the reasons behind this and any supportive action required following.

This report has highlighted that there is a growing number of investigations where the adult is experiencing mental ill health, and a growing number relating to self-harm. There is a possibility that this is reflective of the impact of lockdown restrictions on our individuals and communities. The volume and complexity of Adult Support and Protection work being undertaken across the service, particularly in relation to adults under the age of 65 is apparent. There are a high number of individuals whereby multiple reports of harm are received, and a number of individuals subject to repeat investigations. Existing audit processes will be used to identify learning and ensure that our processes in relation to multiple reports of harm and engagement escalation are sufficiently robust and to ensure that as an ASPC we are finding effective ways to keep people safe from harm.

## Outcomes, achievements and service improvements

A number of different actions have been taken forward across the ASPC within the reporting period for the purpose of improving Adult Support and Protection related services, reducing the risk of harm and improving outcomes for adults at risk of harm.

Within the first 4 weeks of lockdown in March/April 2020, an extensive amount of shielding related work was carried out by Adult and Older Adult Social Work. Within Fife, over 10,000 people had been asked to shield and within this time frame 8,800 of them had been contacted by social work to carry out welfare checks. The remainder were contacted by letter and if this did not trigger contact, then these people were visited. Given the potential for social isolation and loneliness, these actions aimed to reduce the risk of harm for those forced to shield.

An Adult Support and Protection staff survey tool was developed in July 2020 to gather data regarding front-line worker's views on the ASP activity they were carrying out on a day-to-day basis. This included questions regarding confidence in the application of Adult Support and Protection

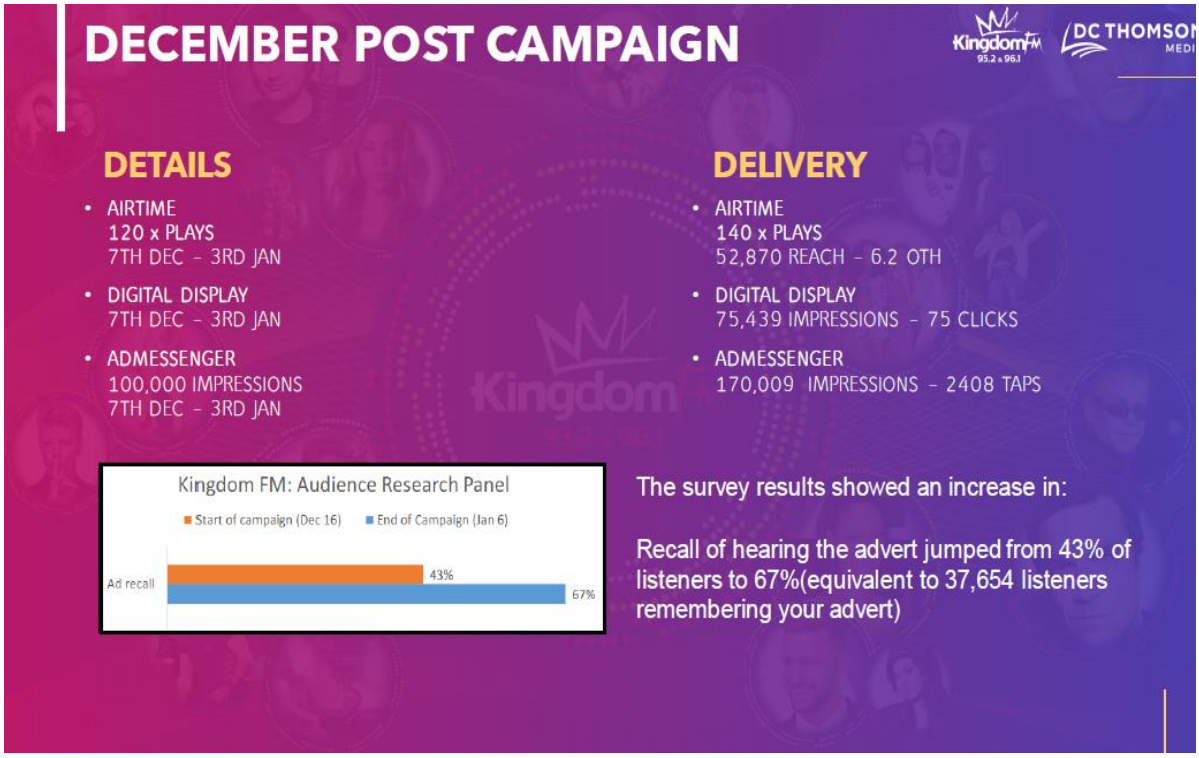
policy and procedures, as well as access to training, support and supervision to ensure ongoing learning and development.

At the same time, a service user feedback tool began development in July 2020 to gain information about how people with lived experience feel about the effectiveness of adult support and protection interventions. It was noted by the Adult Support and Protection Team that previous data focused on the number of investigations, IRDS, Case Conferences for example, but not on the views of those actually involved in these interventions. The aim of this tool was to have a greater understanding of these experiences and to identify gaps and routes for improvement. An initial 6 month review of the tool's effectiveness is planned for December 2022.

In addition, the Adult Support and Protection staff survey tool underwent extensive multi-agency discussion and consultation within the relevant ASPC sub-committee groups throughout the reporting period with first drafts produced. This will be launched within the next reporting period.

Inter-agency Adult Protection policies, procedures and practice guidance have continued to underpin work relating to the support and protection of adults at risk of harm. The overarching Fife Interagency Procedures have been reviewed during the period, to reflect changes and improvements and promote best practice. This has also included individual guidance in relation to important matters such as Financial Harm, Hoarding and Self-Neglect, Domestic Abuse, Multiple Report of Harm, Engagement Escalation protocols and Large Scale Investigation guidance. Each of these updates have been approved by the Committee and went live in June 2022, with reviews due to be carried out within the next reporting period. Also crucial to this has been the development of an inter-agency chronology process which has been an integral service improvement carried out within the reporting period.

Resultant to the identification of an increase in Financial Harm in the previous year, the Financial Harm Working Group continued their campaign to raise awareness of identifying and reporting harm throughout 2020-22. With a concern that Financial Harm may rise due to increased use of technology within homes and loneliness and isolation, the Financial Harm Working Group, supported by the ASPC and The Adult Support and Protection Team, launched its first radio campaign in December 2020 in partnership with Kingdom FM. This campaign aimed to raise awareness of Financial Harm, how to spot it and identify it. Feedback from Kingdom FM analytics identified a very successful campaign with significant reach across the community.




Positively, adverts in relation to the chosen category of harm were played approximately 6 times per day in December and reached a total of 52,870 listeners across the month. Given the population of Fife is approximately 370,000, this means the campaign reached 14% of this population across the month.

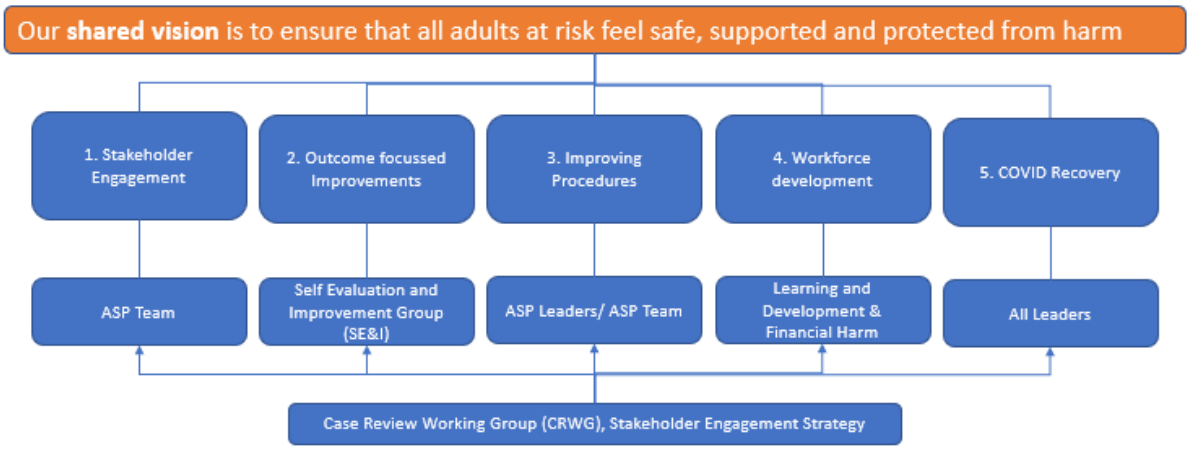
As a result of this, the campaign was run for a second time in February 2021, to align with National Adult Support and Protection Day. January 2021 saw the roll out of 'A Year of Financial Harm Awareness Raising' in the form of monthly SWAY documents, each raising the profile of a different type of scam or finance related harm. This campaign was hugely well received and continued throughout the full year. Linked to this, a pilot project commenced within the same period between Police and Trading Standards, which involved an information-sharing process whereby vulnerable person's database entries related to Financial Harm would be shared with Trading Standards in order to ensure support and preventative action to ensure adults were empowered and supported to remain safe from further harm. This innovative piece of improvement work is now established practice due to the success of the pilot.

We have continued running quarterly radio campaigns throughout the 2021 and 2022 reporting period, both to align with this year's Adult Support and Protection Day but also with different themes each quarter with the goal of raising Adult Support and Protection awareness. These have included Adult Support and Protection and Fire Safety, Adult Support and Protection and Social Media and alcohol and drug awareness. Analytics for each campaign have indicated positive engagement and reach for our topics, evidencing that our innovative strategy for reaching Fife residents has been successful.

In terms of quality assurance and audit activity analysis, this reporting period saw the addition of the Quarterly statistical data report added to the ASPC agenda. Specific indicators were identified to enhance discussion of the major adult support and protection themes affecting Fife and for all

agencies involved to understand more effectively what the data means. This in turn can better identify areas of improvement which are required and ultimately reduce the risk of harm for adults.

The reporting period also saw the introduction and work towards completion of Fife ASPC's Strategic Improvement Plan for 2021-23. The Strategic Improvement Plan set out Fife's vision for ASP and principles, five priority areas for development and subsequent aims and objectives for each. To ensure alignment and shared understanding of our vision, each priority has been driven forward by one of the ASPC sub-groups, the Adult Support and Protection Team or by Adult Support and Protection leads across partner agencies, who are tasked with developing and delivering a strategy or workplan to achieve the aims set out for each priority. The objectives within these plans have been specific, measurable, achievable, relevant and time-bound (SMART). The diagram below shows who has led the delivery of each of the five priorities with the Case Review Working Group (CRWG) feeding into all workplans as appropriate. Similarly, the Stakeholder Engagement Strategy and Performance Framework, which will be discussed later in this report, has actions linked to all priorities. From our vision and principles through to our workplans, this approach aims to be person centred and outcome focused.




Given the pandemic, the introduction of the above tools and methodologies has allowed the Partnership to further adapt to new ways of working which has proved to be a significant achievement.

Finally, a crucial aspect of our Adult Support and Protection outcomes, achievements and service improvements during this reporting period was the Fife Adult Support and Protection Inspection carried out by the Care Inspectorate. The focus of this inspection was on whether adults at risk of harm in the Fife area were safe, protected and supported. The joint inspection of the Fife partnership took place between May 2021 and August 2021.

The methodology for this inspection included four proportionate scrutiny activities. These were the following:

-Analysis of supporting documentary evidence and a position statement submitted by the partnership.

-A staff survey, where staff from across the partnership (738) responded to the Care Inspectorate's adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

-The scrutiny of the health, police, and social work records of adults of risk of harm, which involved the records of 50 adults at risk of harm where their adult protection journey progressed to at least the investigation stage. It also involved the scrutiny of recordings of 40 adult protection initial inquiry episodes where the partnership had taken no further action, in respect of further adult protection activity, beyond the duty to inquire stage.

-Finally, staff focus groups. The Care Inspectorate carried out two focus groups and met with 16 members of staff from across the partnership to discuss the impact of the Covid-19 pandemic on adult support and protection and adults at risk of harm. This also provided them with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Positively, Fife received the following outstanding feedback from the Care Inspectorate.

**Strengths**

• Adults at risk of harm typically experienced improvements to their safety, health and wellbeing due to the collaborative efforts of social workers, health professionals, and police officers.

• The partnership's initial inquiry practice was highly effective, with well documented interagency referral discussions. Partners' participation in these discussions was consistent and purposeful.

• Adults at risk of harm benefitted from sound, well-documented investigative practice, and effective adult protection case conferences and review case conferences.

• Independent advocates ably supported adults at risk of harm throughout their adult protection journey.

• Partnership leaders promoted a collaborative ethos. It led to improved outcomes for adults at risk of harm.

• Adults at risk of harm played a key role on the adult support and protection committee. A third sector body effectively supported their meaningful participation.

• Partnership leaders exercised sound, collaborative leadership for adult support and protection. They initiated constructive quality assurance and self-evaluation work.

In terms of areas of improvement, Fife received the following:

**Priority areas for improvement**

• The partnership should develop standardised templates for adult protection chronologies, risk assessments, and protection plans, and use them consistently.

• The partnership should adopt the policy that all adults at risk of harm, who require them, should have a chronology, a risk assessment and an accompanying protection plan, whether they have been subject to a case conference or not.

These areas have been addressed by Fife's Inspection Improvement Plan, devised by the Adult Support and Protection Team, again throughout this reporting period. The route for the use of standardised adult protection chronology, risk assessment and protection plan earlier in the ASP journey than previously has been reviewed and agreed at Committee, with clear guidance given to practitioners as part of the overarching updated inter-agency Adult Support and Protection procedures which went live from June 2022 onwards. This will again by reviewed during the next reporting period to assess its effectiveness and ensure these are being used appropriately. To assist with this, Fife's inter-agency case file audit methodology has been reviewed and updated to ensure a focus on the above moving forward.

## Training, learning and development

For a number of months following the initial period of lockdown, there was no Adult Support and Protection Training available. To ensure that there were enough Council Officers available to progress statutory Adult Support and Protection activity, an interim guidance was put in place. By December 2020 all ASPC Training, including Council Officer Training, was launched on Microsoft Teams which allowed practitioners an alternative way of receiving Adult Support and Protection learning and guidance. This focus was necessary given lockdown measures prevented any in-person training taking place. As a result, important Adult Support and Protection training was able to continue in extremely challenging circumstances, positively impacting on both adults at risk of harm and the continued learning and development of Council Officers and practitioners across all services.

We have continued to develop training and learning opportunities for front line staff since then, throughout the reporting period. Priority 4 of Fife's Adult Support and Protection Committee's Strategic Improvement Plan 2021-23 states that the Learning and Development sub-group "will continue to support our workforce, ensuring staff across all agencies are confident, knowledgeable and supported". This has included the development of training opportunities for our Adult Support and Protection training facilitators as well as Adult Support and Protection Senior Manager sessions.

Other essential aspects have included making sure that "training is supported and sustained through active implementation, supervision and coaching and a continued focus on staff wellbeing. This means building in enough time and resources where staff can talk, reflect, and be listened to". The overall aim for priority 4 of the Strategic Improvement Plan has been for all staff across partner agencies to feel supported and confident in identifying and responding to harm and in providing an integrated response to reduce harm. To help achieve this priority the Self Evaluation and Improvement Group launched an Adult Support and Protection post-training questionnaire in September 2021. Another purpose of the questionnaire is to gather data to allow assessment of the effectiveness of the current Adult Support and Protection training offerings across the Partnership.

Training evaluation reports have been completed quarterly and provided to the Learning and Development sub-group to allow discussion to take place at their quarterly Group meetings moving forward, as well as at the wider Committee meetings, also on a quarterly basis. Over 95% of all feedback received across all the Adult Support and Protection training courses since the questionnaire went live has either agreed or strongly agreed that these have resulted in increased Adult Support and Protection knowledge as well as increased confidence in carrying out the Adult

Support and Protection role across the frontline. This is a significant achievement considering the sudden unexpected change to learning via Microsoft Teams as a result of the pandemic at extremely short notice, which emphasises the strength of our Adult Support and Protection training facilitators within the Partnership.

Linked to the above has been the introduction of the frontline Adult Support and Protection Practitioner's Forum. It was a challenge progressing this due to the pandemic. Initially, within the reporting period, the Learning and Development sub-group spent time considering alternative ways in which this could be progressed, including a proposal that this would be held virtually, on a Fife-wide basis. It was proposed that initially the forum would include a representative from each partner agency with the aim of the group identifying themes for the forum for the remainder of 2022. This has allowed representatives of the forum to collate views and questions from colleagues and allowed continued feedback of Adult Support and Protection related information to front-line teams and meant that those front-line workers views could continue to be heard, which was crucial during the pandemic period.

An aide memoir was developed in 2020 by the Learning and Development Group for the accompanying officers (second officers) supporting the progress of Adult Support and Protection investigations. This brought about greater understanding of the role of accompanying officer within Adult Support and Protection interviews/visits and supported staff's confidence to take on this role. This role can be progressed by any appropriate partner, alongside the Council Officer (social worker).

Finally, crucial to the Partnership's ongoing Adult Support and Protection learning and development has been a revamp of our Adult Support and Protection Competency Framework. This is used to focus specifically on ensuring that relevant workers have the competencies, knowledge and skills they need to carry out their roles in supporting and protecting adults at risk of harm. It can also be used to review what the workforce already know and understand, support 'Learning and Development Needs Analysis' and identify ongoing opportunities for this. It should inform and enhance practice for those who need a particular set of skills and can be used as a tool when writing job descriptions.

Adult Support and Protection and workforce development should be seen as an essential part of continuous improvement, and the Framework is designed for use as part of agencies' continued professional learning. The individual learning and development needs of each worker should be considered and reviewed, including Adult Support and Protection where relevant, in how workers and managers will meet the Continued Professional Learning (CPL) requirements of particular roles. The competencies, knowledge and skills can be 'mapped' at an individual level (to any other forms of learning and development that workers take part in).


Each staff member will now read the table above and identify which Group describes their current role. Once this has been established they will be aware of which competencies they need to be able to demonstrate within their own work environment and be able to use this framework in order to evidence them appropriately. See appendix 2 for a full copy of the new framework. The purpose of changing the existing ASP Competency Framework was to simplify the process and provide a document which can be used clearly within frontline worker's supervision sessions with their line manager. It is clear what specific competencies are required for specific roles, prompting a good conversation within supervision as to how gaps of knowledge can be filled to ensure adults continue to be as safe from harm as possible.

## Engagement, involvement, and communication

Continuing to engage with and involve people with lived experience has proved to be challenging within this period due to the lack of face-to-face meeting opportunities caused by lockdown measures. Despite this, the ASPC's Engagement and Participation Coordinators endeavoured to adapt to these changed circumstances as much as possible.

As lockdown measures commenced, a wide range of easy read resources were distributed around the ASPC so these could be shared with a wide range of service users.

The ASPC newsletter continued to be released on a monthly basis with links to sources of support and advice, and updates in relation to legislation. Fife Council's Deaf Communication Service was

involved in making material available in British Sign Language (BSL) to ensure members of our deaf community had access to all of the information needed to confidently identify and report harm.

A hugely important piece of work carried out during this period was the "Staying Safe, Keeping Well" booklet. This was created as a paper resource for those who do not get their information online or from social media. The leaflet contained numbers for emergency support, Council Covid Community helpline, general council numbers related to types of harm including domestic abuse, advice regarding scams, and general hints and tips for getting through the lockdown period. 13,500 were printed and distributed through Fife Voluntary Action Helping Hands volunteers – to people self-isolating, and vulnerable people who may not have had family/friend/neighbour support. Additional distribution was done through Meals on Wheels, Home Care and Community Learning and Development Teams. This demonstrates the effective engagement and joint working across our 3rd sector groups within ASP work and again showed an innovative communication method in challenging times.

Another example of engagement with the community was the ASPC's supermarket campaign carried out in May 2020. All Fife supermarkets were contacted (see appendix 3 for the covering letter which was distributed) and asked to display posters with the Fife Council Contact Centre telephone number and information as to how to make a referral. This was done in response to adults at risk of harm potentially being out of sight at the time due to lockdown measures. Please see below for the poster itself which was displayed.

Fife Adult Support & Protection
www.fife.gov.uk/adultprotection

Fife Child Protection Committee

**Adult and Child Protection means protecting the most vulnerable from harm and neglect.**


**Harm and neglect can be perpetrated by anyone.**
**Harm can be a crime.**

**If you see something, are told something or something doesn't feel right you need to report it.**

**Adult Protection: 01383 602200**

**Child Protection: 03451 55 15 03**

If someone is in immediate danger call **999**

www.fife.gov.uk/adultprotection

www.fifechildprotection.org.uk

The ASPC Engagement and Participation Officers also engaged with community groups as part of Teams/Zoom meetings throughout 2020-21 to continue to better understand the experiences of service users and include them in the co-production of services, policy and procedures as well as offering awareness raising sessions and the space to ask questions. Part of this engagement also included working with the Partnership's Deaf Communication Team so that our ASP policy and procedures could be translated into British Sign Language before being uploaded to Fife Council's Adult Protection information website. This has helped us be as inclusive as possible when raising awareness of ASP within our area.

Finally, an integral part of the Partnership's drive to enhance engagement, involvement, and communication within the reporting period has been the creation of our Communication and Stakeholder Engagement Strategy for 2022.

Section 42 of the Adult Support and Protection (Scotland) Act 2007 states that:

• Any actions undertaken by an Adult Protection Committee must have regard to improving communication and cooperation amongst its members;

• Formal inquiries consistently identify effective communication, information sharing and co-ordination as critical in protecting adults at risk of harm; and

• Adult Protection Committee's will have an opportunity to provide a model of joint working by the way they themselves operate and will require to promote good working relations between agencies and staff working within them.

The overall aims of this Communication and Stakeholder Engagement Strategy, in seeking to ensure achievement of the above, are:

• to set out how appropriate and effective communication will support the achievement of the ASPC's key strategic objectives;

• to promote effective communication in all aspects of adult support and protection; and

• to ensure that key stakeholders are aware of, understand and are engaged in this work.

Communication is a continuous process and the benefits of good communication include:

• Establishing collaboratively, and based on evidence, local priorities and plans which meet local needs;

• Continuous striving to improve outcomes for stakeholders;

• Working together to manage risk at an appropriate level;

• Taking collective responsibility for the achievement of a shared vision; and

• Assisting in the planning and development of more effective services, effective professional practice and stakeholder satisfaction, developing a learning approach across all partner organisations.

Our ASPC has resolved to develop a strong focus on engagement and communication across key stakeholders, including with those at risk of harm and their carers, to ensure the effectiveness of local safeguarding practice.

The ASPC Communication and Stakeholder Engagement Strategy sits within the wider context of the ASPC's Strategic Improvement Plan 2021-23, which sets out the principles and approach to the engaging with individuals, groups and communities in service planning and development to ensure positive outcomes. This plan then evaluates the impact of our activities and allows The Partnership to gain greater insight of the quality of our response to reports of harm, and the lived experience of all stakeholders.

The Action Plan at Appendix 4 has been developed to support the ASPC's Communications and Stakeholder Engagement Strategy. It outlines the communications and engagement activity that will take place over the course of the Strategy to implement and improve the ways in which we communicate with our different audiences. These have taken place within the reporting period, but also cross over into the next. Ultimately, the action plan has detailed how we have and will continue to work together with partners, individuals and in our communities to raise awareness and support the safety of vulnerable people in Fife who may be at risk of harm. Value has been placed on eliciting the voices of people with lived experience of the ASP process to drive outcome focussed improvements to practice.

Progress on delivery of the action plan has and will continue to be reported to the Fife Adult Support and Protection Committee. The development and delivery of this plan is a major achievement for Fife when taking into account the ongoing pandemic and the difficulties in engaging with others on a face-to-face basis during this reporting period.

## Areas for Improvement/Looking forward

The key areas of work and improvement will be driven forward within the next reporting period by the ASPC Strategic Improvement Plan 2023-25. This will be written in the last quarter of 2022 before being approved at committee in January 2023 for the two years to follow.

Our shared vision is to ensure that adults at risk feel safe, supported and protected from harm. This strategic Improvement Plan for Fife will set out the actions we will take over the next reporting period and next two years in total to work towards achieving this vision.

The plan will build on achievements to date, using the previous improvement plan (2021-23) as our foundation and drawing on learning from Single and Interagency Case File Audits, Activity and Performance Data, Stakeholder feedback, and Initial and Significant Case Reviews.

The plan will out the ASPC's vision and principles, priority areas for development and subsequent aims and objectives. We understand particular improvements will be required and contained within strategic planning moving forward. These include an audit of Large Scale Investigations carried out within Fife, annual Initial Case Review reporting, the roll out and embedding of Learning Review guidance, Hoarding and Self-Neglect related guidance work, the creation of a Friends of the

Committee group to further develop our community links within Fife and improve stakeholder engagement further, and also the roll out of the new Liquid Logic case management system.

We need to continue to think differently in how we measure outcomes and move away from a focus on numbers and performance indicators to a more qualitative, deeper understanding of the complexities of people's lives. Underpinning our approach is a focus on transforming the way that we collect and use data to evaluate the impact of our activities and gain greater insight of the quality of our response to reports of harm, and the lived experience of all stakeholders.

A range of outcome focused indicators will be developed to evaluate our success against a number of strategic outcomes.

These will be measured through an outcome focused performance framework which was a fundamental objective of the previous Strategic Improvement Plan. All actions throughout this plan will be linked to the achievement of these outcomes.

## Chairs closing remarks

There has been considerable work undertaken by all partners throughout 2020 – 2022 under the auspices of the Committee. Throughout this time period we were impacted upon by an unprecedented local and national challenge resultant to the sudden impact of COVID-19. The Committee has evidenced dedication, commitment, adaptability, resilience and creativity during this time and has ensured its function has been fulfilled. A robust Strategic Improvement Plan has been created on a foundation of partnership working, continuous improvement and a strive for excellence, where we will endeavour to ensure that learning identified during this time is embedded into practice.

Once again, I would like to offer my sincere thanks and appreciation to individuals, families, carers, practitioners, organisations and agencies within Fife who are involved in preventing harm and supporting those who have been harmed.

This will be my last Fife Adult Support and Protection Biennial report as I intend to stand down as Independent Chair in March 2023. Whilst my time as chair will come to an end I very much look forward to learning of further successes and initiatives undertaken by the Committee to help keep adults safe.

Alan Small, Fife Adult Support and Protection Committee Chair

Appendix 1-Annual Data Reports, 2020-2022

www.fifehealthandsocialcare.org

# Fife Health & Social Care Partnership

## Adult Support & Protection Annual Return 2020-21

## Summary Statistics

May 2021

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

# Contents

## Introduction:

This report summarises the data collated for the annual Scottish Government Adult Support & Protection (ASP) statistical return.

It provides a count of referrals, investigations, Case Conferences and Large-Scale Investigations (LSIs) undertaken between 1st April 2020 and 31st March 2021, an overview of the types and location of harm investigated, and the demographic profile of adults subject to ASP Investigation in the same time frame. Where appropriate, trend or further analysis of the data has been provided. Summary tables are presented in Appendix1which detail the data submitted to the Scottish Government over the past 5 years. It is expected that a new quarterly minimum dataset for ASP will be developed which is intended to replace this return in future years.

Analysis of the data has raised a number of key areas for further exploration and this report highlights a few areas for consideration at Self Evaluation and Improvement Group (SE&I) to agree if they should be integrated into relevant improvement plans.

## Key Statistics

- 2798 reports of harm were received, representing a percentage decrease of 5.7% since the 2019-20 report. Of the 1876 individuals referred, 29% of individuals had multiple reports of harm recorded.

- 460 Investigations were undertaken in the year, whilst this is an increase from the data reported to the Scottish Government last year (385) it must be noted that following a number of data validation exercises in 2020-21, the number of investigations now recorded on the social work system for 2019-20 has risen to 459 therefore there is no significant change noted.

- 126 initial and review case conferences are reported this year, an increase from 2019-20, 73% of these were undertaken in adults teams.

- Two LSIs were started in Quarter 4 of 2020-21, this is a decrease from 3 last year.

- Continuing the trend from previous years, the majority of investigations relate to individuals aged 16-65 (63%), and those identifying as female (58%).

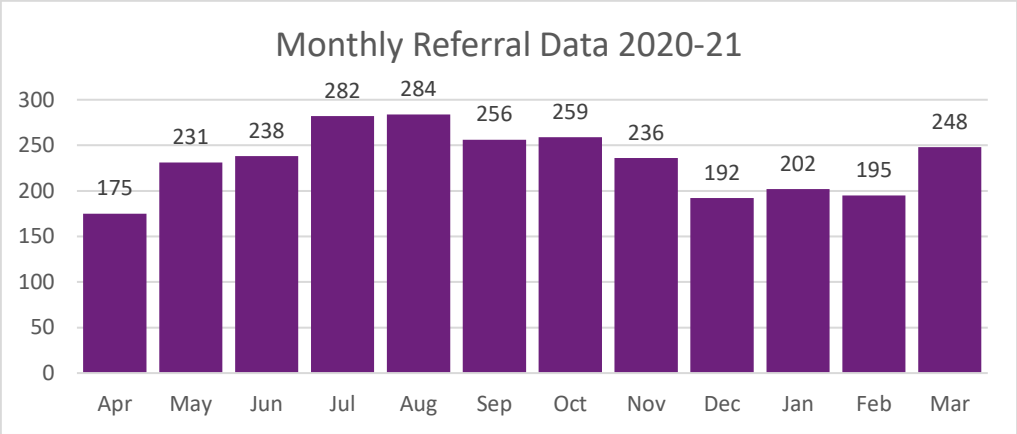
- There has been a 72% increase in investigations relating to adults with mental ill health from 58 last year to 100 in 2020-21.

- The main types of harm recorded for cases at Investigation stage were Financial harm (25%), Physical harm (25%) or Psychological/emotional harm (21%). There has been a notable increase in the number of Investigations relating to self-harm.

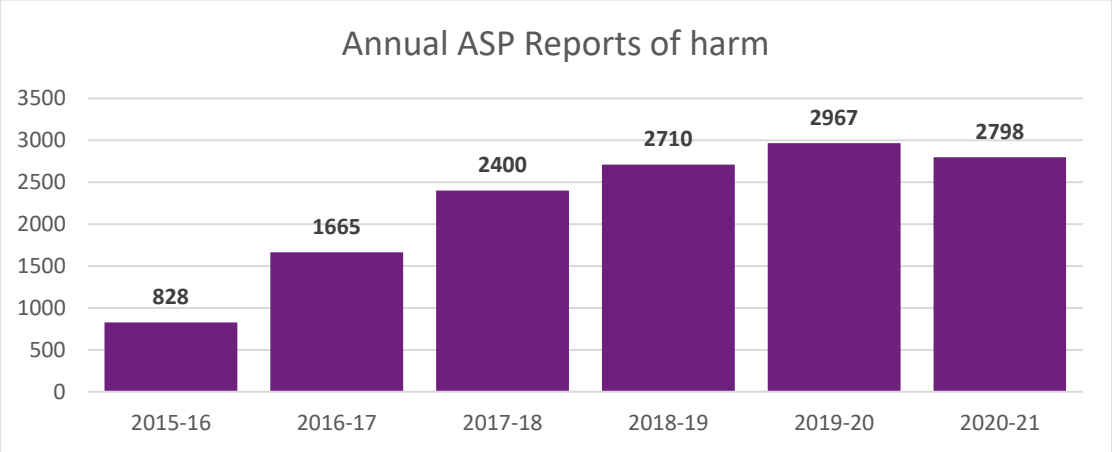
- Reflecting data in previous years, the most likely location of harm investigated was an individual's own home (62%), and very small numbers are recorded within care home settings (5%) when compared to the national average for last year (22%). There are actions already in place to investigate reasons for this.

## Reports of Harm:

In 2020-21, 2798 reports of harm were received, representing a 5.7% decrease since the previous year and reversing the upward trend that we had seen since 2015[1]. It is suspected that this is partly due to the impact of Covid-19 restrictions which meant that some agencies did not have as much contact with individuals as would usually be the case. Monthly referral data shows that there were fewer reports of harm in months with the strictest lockdowns and would therefore support this theory.




In the counts below, an adult at risk of harm can be counted more than once where multiple referrals are made. In 2020-21 there were 2798 reports of harm for 1876 individuals, 551 individuals were referred more than once (29% of individuals had multiple referrals), with 45 people having 5 or more reports of harm recorded in the time period.




*Base: SWIFT AIS- AP Contacts*

*Recommendations:*

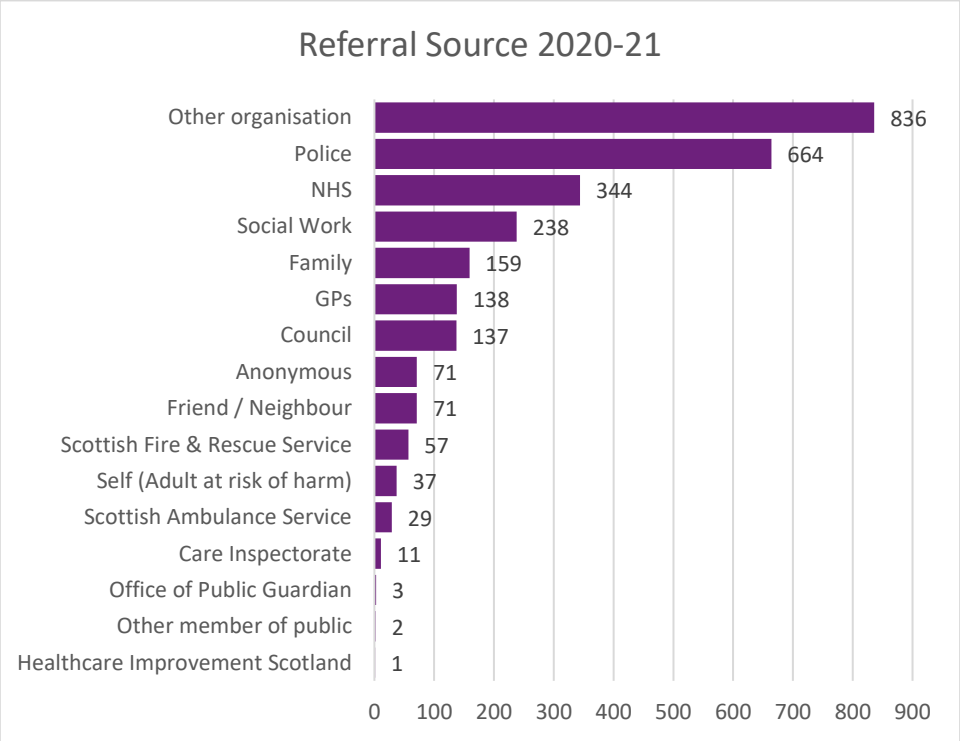
- *Adult Support & Protection Self Evaluation and Improvement Group (SE&I) to consider undertaking an audit of cases where there have been multiple reports of harm to evaluate the quality of the partnership's response to preventing harm and identify any learning or improvement actions.*
- *Social Work to audit 45 cases with 5 or more reports of harm to ensure that the multiple report of harm protocol is being correctly taken forward (and engagement escalation if appropriate), chronologies are in place and there is evidence of defensible decision-making in line with social work recording guidance.*

[1] In Fife, all contacts where 'Adult Protection' is recorded as 'contact reason' are counted as a referral. If reports of harm are later deemed as not appropriate these may be later 'reclassified' and therefore not included in the counts. This may not be the case in all partnership areas and therefore caution must be taken when comparing the data to National data.

- *ASP Leaders to consider audit findings, set up short life working group to review the multiple report of harm protocol and engagement escalation process, updates to coincide with annual interagency procedure review.*

## Referral Source:

The chart below shows the referral source as reported to the Scottish Government for all 2798 reports of harm in 2020-21.

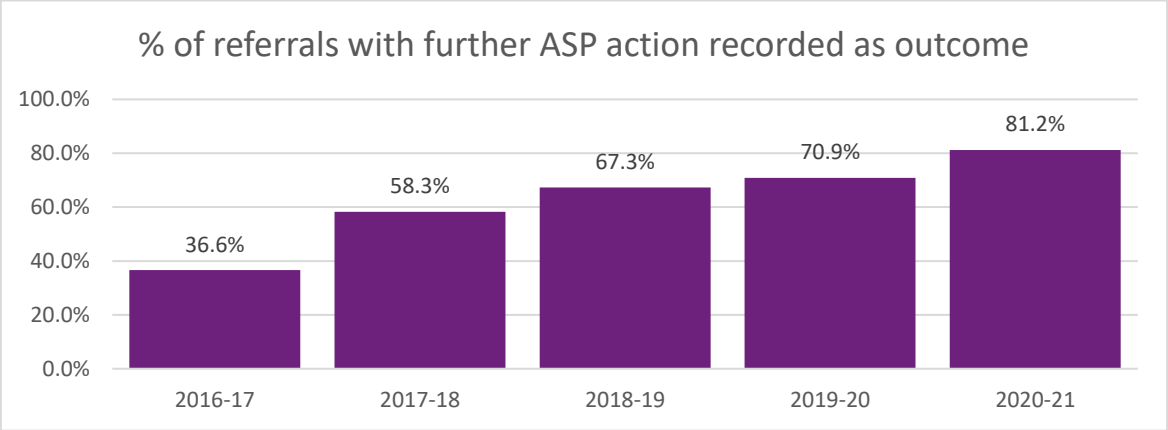



Whilst there has been an overall decrease in referrals this year, this is not consistent across all sources. There has been a significant increase in reports of harm from Police (664 compared to 377 in the previous year), and a notable increase in Scottish Ambulance Service (29 compared to 3 the previous year). Whilst there has been a significant decrease in reports of harm from 'other organisations' the number remains high, potentially indicating that a wide range of agencies are aware of what constitutes harm and how to report it. There has been a decrease in the number of self-referrals this year. As part of the ongoing 2021-23 workplan, the ASP Team will continue to strengthen links with all partners and raise awareness of our key messages throughout 2021-22 through the development and implementation of a stakeholder engagement plan.

The Summary Tables (Appendix1)show the referral source for all reports of harm over the past 5 years. SE& I will continue to monitor referral source on a quarterly basis through quarterly reports.

## Outcome of referral:

In comparison to previous years, a higher proportion of referrals (81.2%) required further Adult Protection action. Whilst this could point to improved practice in relation to the correct identification and reporting of harm, this could also be attributed to an alteration in recording practice at the Social Work Contact Centre (SWCC). There are inconsistencies in how contact reason is currently recorded when a case is reclassified which would also impact on this number. This makes interpretation of referral data difficult. The development of a national minimum data set combined with the procurement of a new case management system (Liquidlogic) for social work brings with it an opportunity to review and clarify recording practices in relation to how reports of harm are captured and reported on in future.




The table below shows the count for each outcome of the report of harm over the last 5 years, the increase in work progressed and the decrease in reports of harm where other non-AP action was required could potentially indicate that practice has strengthened across the partnership with appropriate identification and reporting of harm.

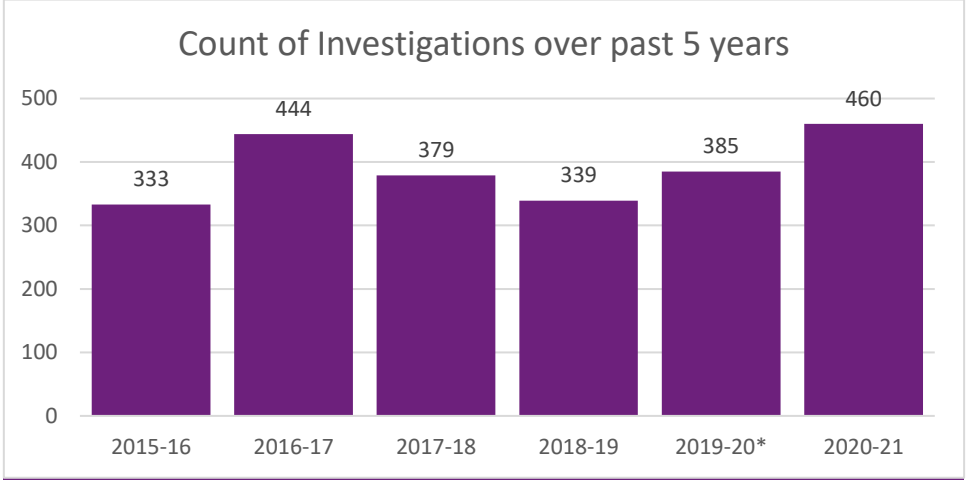
| Outcome | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Further Adult Protection Action | 610 | 1398 | 1825 | 2103 | 2272 |
| Further Non-AP Action | 301 | 332 | 242 | 256 | 130 |
| No further action | 713 | 610 | 560 | 518 | 342 |
| Not recorded | 41 | 60 | 83 | 90 | 54 |
| **Total** | **1665** | **2400** | **2710** | **2967** | **2798** |

*Recommendation:*

- *ASP Team, PIP Team, Social Work and Workforce Development to work with the SWIFT replacement team to ensure that the Liquidlogic system is able to effectively capture and report on count, source and outcome of all reports of harm.*

## Investigations:

In 2020-21 there were 460 ASP Investigations undertaken, whilst this demonstrates an increase from the 385 Investigations reported in the Annual Statutory Return last year, much work has been done with respect to data quality this year which resultantly increased the number of Investigations recorded last year to 459, a similar number to this year. The graph below shows the number of Investigations reported to Scottish Government Annual Return over the past five years.




*This figure has been revised to 459 in the social work performance reports

The number of individuals for whom an investigation has taken place is 428, this is because 29 Individuals have had more than one ASP Investigation undertaken within the time period. A breakdown by age shows that 24 of the 29 individuals who had multiple investigations were aged under 65. Data shows that 9% of all adults aged under 65 are subject to multiple investigations, compared to 3% of those aged over 65.

*Recommendations:*

- *SE&I Interagency Audit to include a sample of cases where there have been multiple investigations with a view to evaluating if the partnership could strengthen its response to harm, particularly in relation to effectively supporting adults aged under 65.*

- *ASP Leaders to review cases and consider procedural implications (if any) where multiple investigations are taking place.*

## Outcome of Investigations:

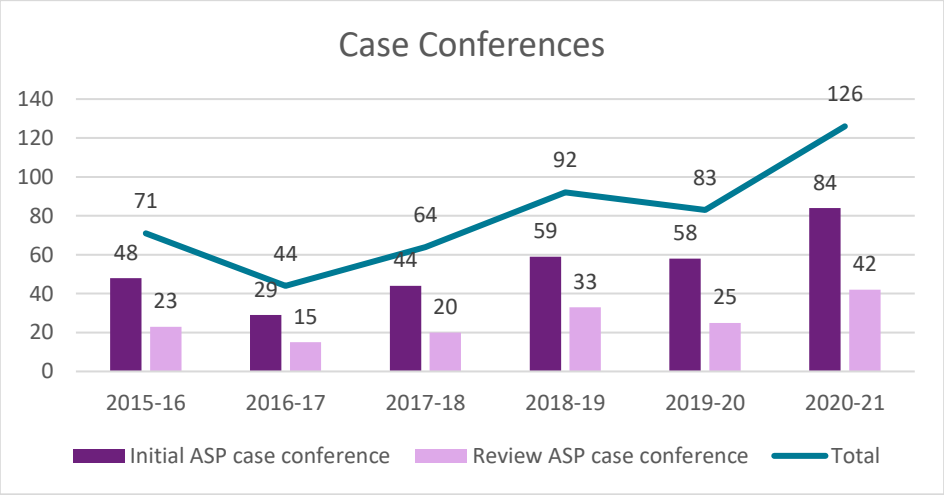
The proportion of cases progressed past investigation stage for further AP action remains similar to previous years.

| Outcome | 2016-17 (444) | 2017-18 (379) | 2018-19 (339) | 2019-20 (385) | 2020-21 (460) |
|---|---|---|---|---|---|
| Further AP action | 16.9% | 12.7% | 10.0% | 11.4% | 12.8% |
| Further non-AP action | 48.2% | 43.8% | 30.1% | 34.0% | 37.4% |
| No further action | 30.9% | 41.4% | 48.7% | 52.2% | 49.3% |
| Not known | 4.1% | 2.1% | 11.2% | 2.3% | 0.4% |

Overall 12.8% of cases were progressed for further ASP action, however of the 59 cases progressed, 44 relate to adults under the age of 65. 15.2% of cases relating to adults under 65 were progressed for further ASP action compared to 8.8% of adults aged over 65. This again points to the complexity of the ASP work being taken forward by Adults teams.

## Case Conferences:

There has been a 52% increase in the overall number of ASP case conferences taking place since last year, of the 126 initial and review case conferences, 92 were undertaken by Adults Teams (73%).




*Recommendation:*

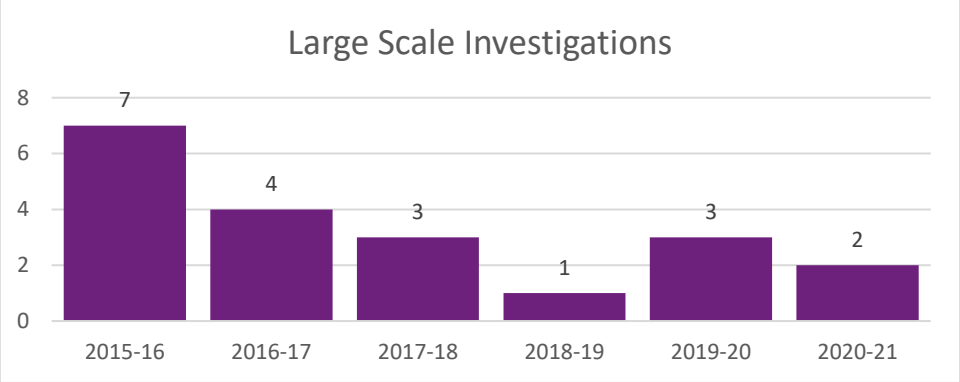
- *Social work service managers to continue to monitor through the Quarterly ASP Performance Process and consider resource implications, specifically as a result of the high number of case conferences undertaken within adults teams.*

## Protection orders:

There were no protection orders granted in 2020-21

## Large Scale Investigations:

There were two Large Scale Investigations undertaken in 2020-21, both commenced in Quarter 4 of the year.

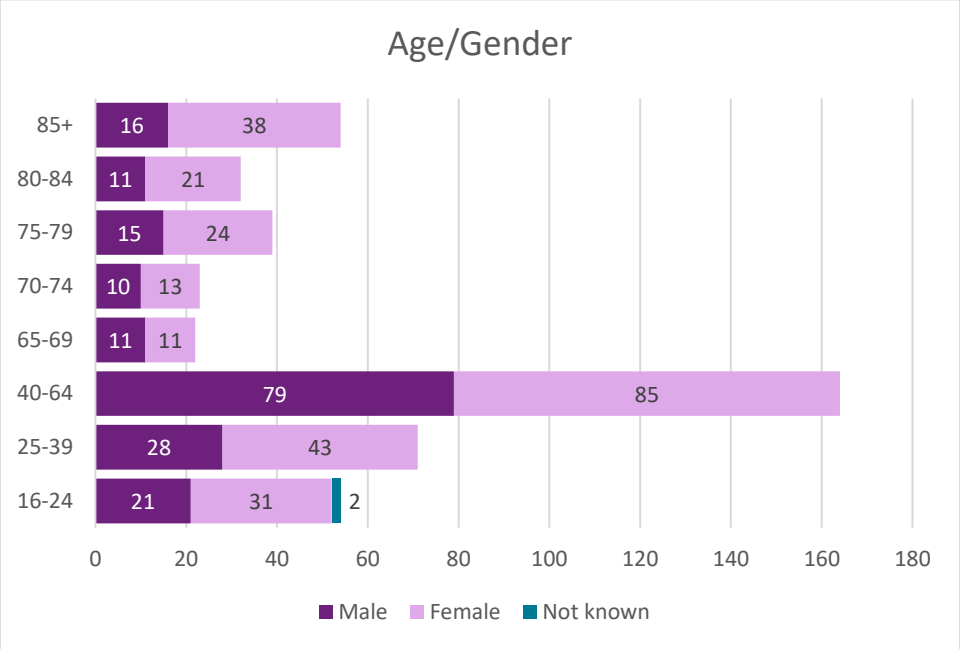


# Demographic Information:

To plan and develop effective pathways and preventative support, it is essential to monitor who is at-risk, what type of harm they are experiencing and where this harm takes place. Nationally, this is reported on at Investigation Stage and this is what is reported on below. Please note an Adult at Risk of harm can be counted more than once in the below counts (where more than one investigation has occurred for an individual in the period). This data is reported to ASPC on a quarterly basis to enable continuous monitoring of any trends.

## Age/Gender

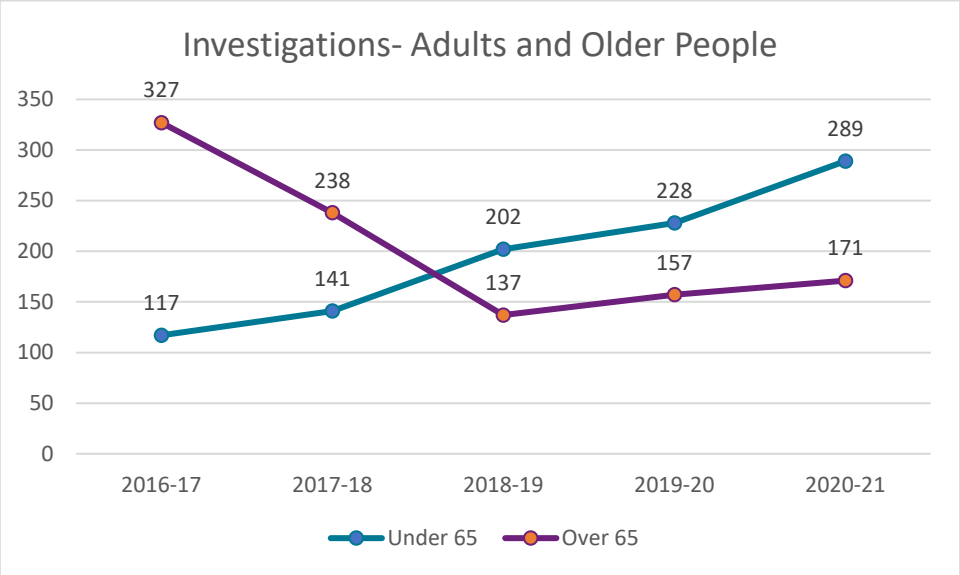
The graph below shows the count of investigations undertaken by gender and age group. Overall, more investigations relate to adults identifying as 'female' and this is the case across all age groups with the exception of the 65-69 group, where there is an equal number of male and female adults. Please note 'not known' relates to two individuals who have chosen not to identify as male or female as opposed to being not recorded.




In 2016-17 26.3% of all investigations related to an adult under 65, compared to 62.8% of investigations this year. A short paper has been produced to summarise the age profile of Adults subject to ASP investigation, the changes over the past 5 years, and to provide a context to this change. (Appendix 2).

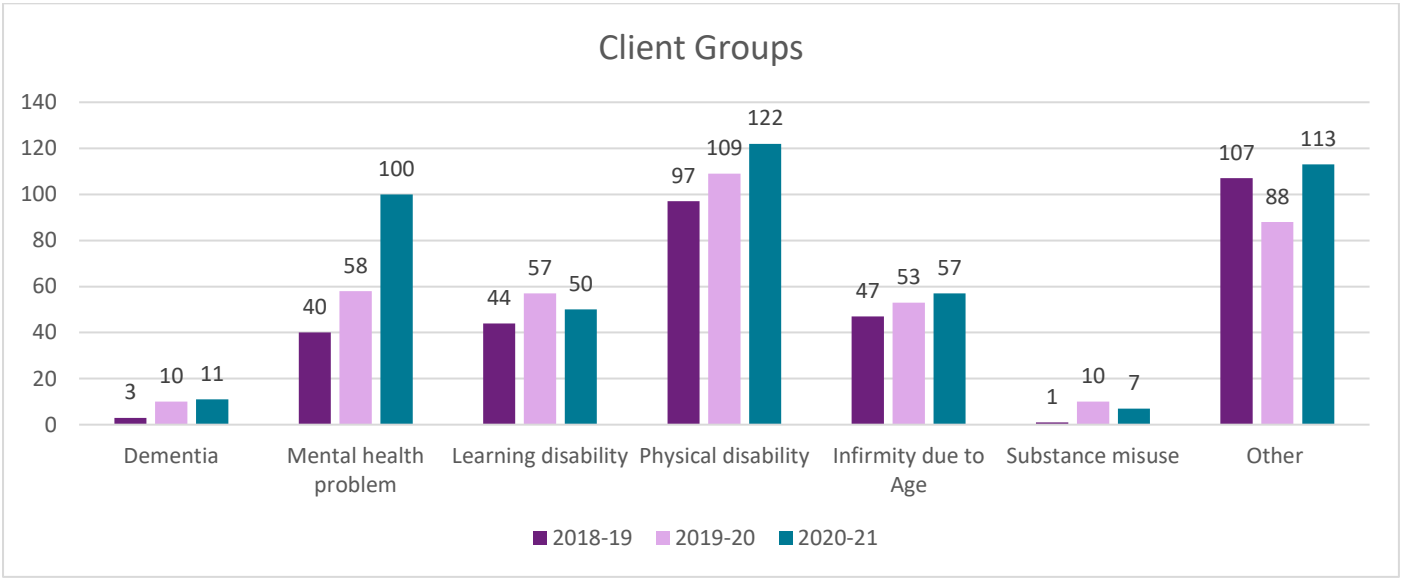
Investigations relating to adults aged under 65 has increased year on year, potentially this could be related to awareness raising and training across Fife to strengthen our approach to identifying and reporting harm. The reduction in reports of harm in older age groups is potentially related to work undertaken to ensure that practitioners are better able to differentiate between significant occurrences and harm and work to reduce the risk of harm occurring in care settings. The number of investigations relating to adults over 65 has been increasing for the past two years but at a slower rate than adults aged under 65.

The chart below shows the number of investigations relating to people under 65 and over 65 since the 2016 return.




### Client Group

A high number of investigations relate to adults with a physical disability (26.5%) however in 2020-21 we have seen a substantial increase in the number of Investigations relating to adults with a mental health problem, with 21.7% of all investigations relating to an individual with mental ill health.



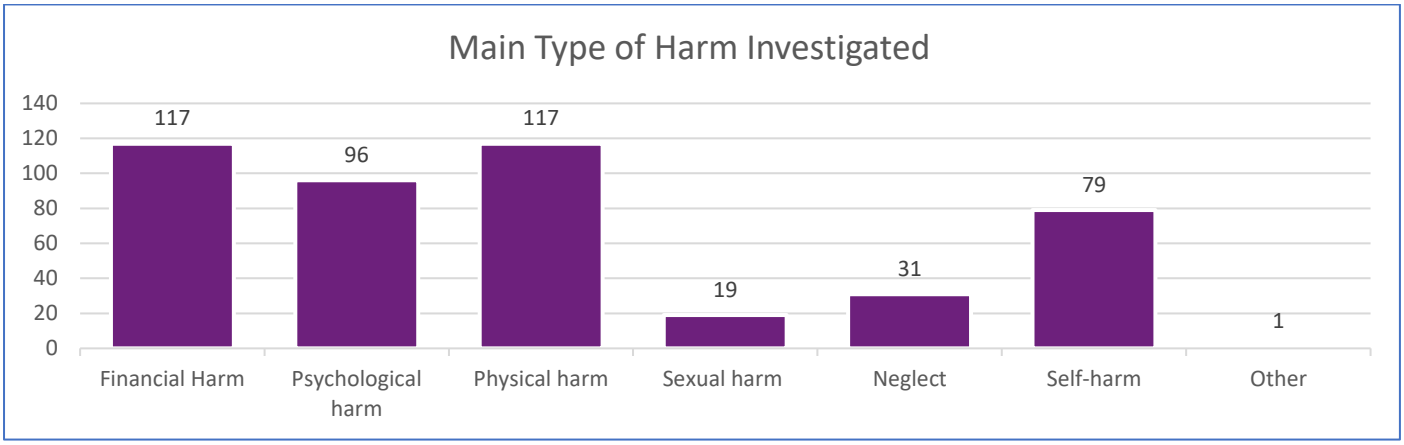

*Recommendations:*

- *Learning and Development to consider the increase in Investigations for adults with Mental ill health, staff confidence working across the acts and links with MH services. Review reach and effectiveness of Crossing the Acts training*

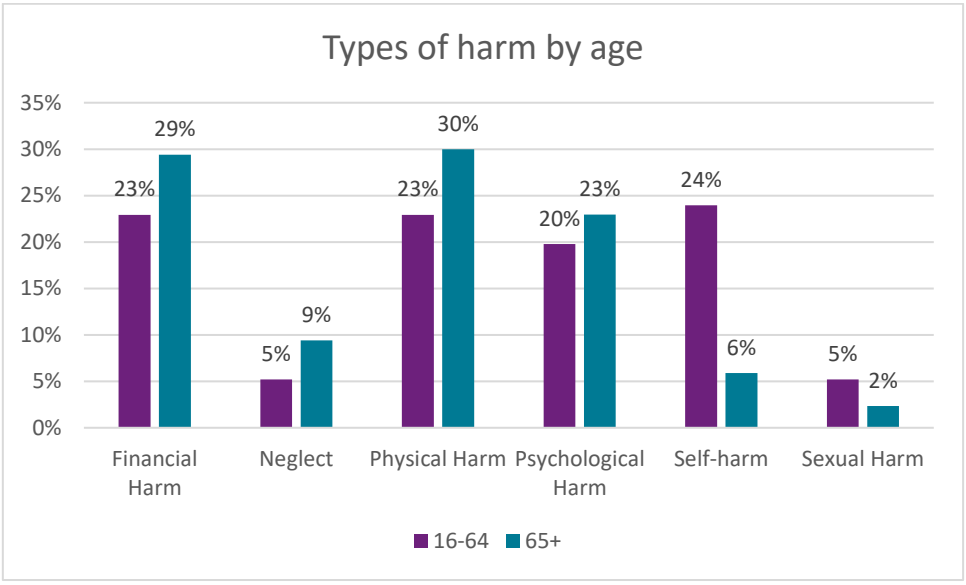
## Incident Information:

### Type of harm

In 2020-21, the most common types of principal harm recorded which resulted in an investigation was Financial (25%) and Physical (25%) harm. High numbers also related to psychological harm (21%) and self-harm (17%). The self-harm category has seen a substantial increase since last year (58% increase reported).



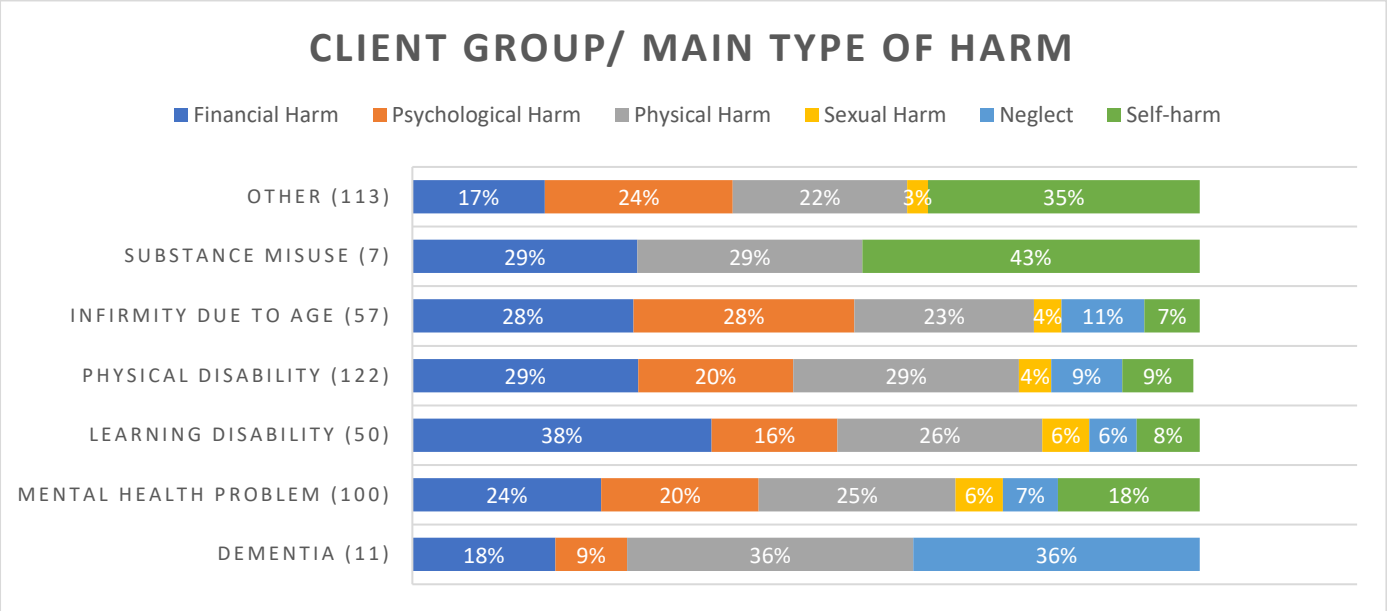

As in previous years, data shows that there is variance in types of harm experienced in different age groups, this is particularly the case with respect to investigations relating to self harm, with 87% of these investigations relating to individuals aged under 65, and accounting for 24% of all investigations where the adult was 16-64 (higher than any other harm type in this age range).




*Recommendations:*

- *Learning & Development to consider the increase in investigations relating to self harm, particularly in 16-65 age range, and the current training and resources in place to support staff to provide effective, timely support*

The type of harm investigated varies between client groups and although caution must be taken as counts broken into client group are small (shown in brackets below), it may be beneficial to consider this information as part of targeted communications campaigns.




*Recommendations:*

*ASP Team to consider the breakdown of client group and types of harm with a view to developing more targeted communications campaigns. For example, looking at increasing information regarding the prevention of financial harm to people with learning disabilities.*

## Location of harm

Where the location of harm is known, the vast majority of harm investigated (62%) took place in an individual's own home. This is universal across age group, gender, primary client group and ethnicity and reflects the data from previous years.

The number of investigations where the location of harm was reported as 'care home' remains low (5.4% compared to 22% national average) and has further reduced in number since last year (25 compared to 37 last year). The planned self-evaluation activity to scrutinise and understand reasons for this is planned in 2021.

## Concluding remarks:

As the data is largely reflective of previous years, the ASPC Strategic Improvement plan and supporting workplans already have a number of actions which are reinforced by the findings in this report, notably the development of a stakeholder engagement strategy which is particularly relevant given the reduction in referrals this year, and the mixed methods review to provide reassurance and explore the reasons behind the low number of Investigations in care homes which has continued this year.

However, this report has highlighted a number of new potential areas for further investigation, namely that there is a growing number of investigations where the adult has mental ill health, and a growing number relating to self-harm. The volume and complexity of ASP work being undertaken across the service, particularly in relation to adults under the age of 65 is apparent. There are a high number of individuals whereby multiple reports of harm are received, and a number of individuals subject to repeat investigations. Existing audit processes could be used to identify learning and ensure that our processes in relation to multiple reports of harm and engagement escalation are fit for purpose and to ensure that as a partnership we are finding effective ways to keep people safe from harm. In response to these findings a small number of actions have been identified to take forward, if agreed, these will be embedded to existing workplans for 2021-23 and are outlined below.

To demonstrate ongoing quality improvement and evidence the work undertaken to progress these identified actions, the ASPC will provide analysis and outcomes of the report recommendations below within the Annual Return 2021/2022.

| 2020-21 Key Findings | Report Recommendations for consideration | Lead | When |
|---|---|---|---|
| Significant number of individuals for whom multiple reports of harm are received | *Adult Support & Protection Self Evaluation and Improvement Group (SE&I) to consider including a sample of cases in the interagency audit where there have been multiple reports of harm to evaluate the quality of the partnership's response to preventing harm/ responding to reports of harm and identify any learning or improvement actions.*<br><br>*Social Work ASP lead to consider audit of 45 cases with 5 or more reports of harm to ensure that the multiple report of harm protocol is being correctly taken forward (and engagement escalation if appropriate), chronologies are in place and there is evidence of defensible decision-making in line with social work recording guidance (include sample within existing case file audit process)*<br><br>*ASP Leaders to consider audit findings, and review the multiple report of harm protocol and engagement escalation process, updates to coincide with annual interagency procedure review.* | SE&I<br><br>ASP SW Lead<br><br>QA Officer/ ASP Leaders | Dec 2021<br><br>Oct 2021<br><br>Jan 22 |
| Difficulty interpreting data relating to the outcome of a report of harm | *ASP Team, PIP Team, Social Work and Workforce Development to work with the SWIFT replacement team to ensure that the Liquidlogic system is able to effectively capture and report on count, source and outcome of all reports of harm.* | SW ASP Lead | Jan 22 |
| Individuals subject to multiple investigations are more likely to be aged under 65 | *SE&I Interagency Audit to include a sample of cases where there have been multiple investigations with a view to evaluating if the partnership could strengthen its response to harm, particularly in relation to adults aged under 65.*<br><br>*ASP Leaders to review cases and consider procedural implications (if any) where multiple investigations are taking place.* | SE&I | Dec 21 |

| | | | |
|---|---|---|---|
| | | ASP Leaders | Jan 22 |
| High volume and complexity of ASP cases coming into adults teams | *Social work service managers to continue to monitor through the Quarterly ASP Performance Process and consider resource implications, specifically due to the high number of case conferences undertaken within adults teams.* | ASP SW Lead | Ongoing |
| Increase in investigations relating to adults with Mental ill health | *Learning and Development to consider the increase in Investigations for adults with Mental ill health, staff confidence working across the acts and links with MH services. Review reach and effectiveness of Crossing the Acts training* | L&D Group | Apr 22 |
| 58% increase in investigations relating to self harm | *Learning & Development to consider this trend (possibly through practitioner forum) and the current training and resources in place to support staff to provide effective, timely support* | L&D Group | Apr 22 |
| Variance in the types of harm investigated by age and client group | *ASP Team to consider the breakdown of client group and types of harm with a view to developing more targeted communications campaigns as part of the stakeholder engagement strategy. For example, looking at increasing information regarding the prevention of financial harm to people with learning disabilities.* | ASP Team | Jan 22 |

Please contact Ronan Burke (Adult Support and Protection Team Quality Assurance and Development Officer) if you have any questions about the content of this report, or if you would like to request further analysis of the data from this return. Ronan.Burke@fife.gov.uk

# Appendix 1

## Summary Tables:

### Section A: Data on referrals

### Q1: Summary of Referrals over the past 5 years

| | | | | | |
|---|---|---|---|---|---|
| | 375 | 510 | 757 | 725 | 644 |
| | 427 | 502 | 659 | 757 | 822 |
| | 410 | 588 | 671 | 730 | 687 |
| | 453 | 800 | 623 | 755 | 645 |
| | **1665** | **2400** | **2710** | **2967** | **2798** |

### Q2: Referrals by Source –over the last 5 years[2]

| Source | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Mental Welfare Commission | 0 | 0 | 0 | 0 | 0 |
| Unpaid carer | 0 | 0 | 0 | 0 | 0 |
| Others | 11 | 7 | 1 | 0 | 0 |
| Healthcare Improvement Scotland | 0 | 0 | 0 | 0 | 1 |
| Other member of public | 7 | 178 | 218 | 122 | 2 |
| Office of Public Guardian | 3 | 2 | 0 | 2 | 3 |
| Care Inspectorate | 15 | 31 | 0 | 7 | 11 |
| Scottish Ambulance Service | 3 | 3 | 0 | 3 | 29 |
| Self (Adult at risk of harm) | 38 | 40 | 49 | 50 | 37 |
| Scottish Fire & Rescue Service | 77 | 74 | 63 | 69 | 57 |
| Friend / Neighbour | 136 | 13 | 0 | 35 | 71 |
| Anonymous | 25 | 33 | 74 | 89 | 71 |
| Council | 272 | 343 | 194 | 193 | 137 |
| GPs | 45 | 64 | 131 | 180 | 138 |
| Family | 39 | 48 | 0 | 117 | 159 |
| Social Work | 216 | 258 | 293 | 310 | 238 |
| NHS | 229 | 365 | 322 | 411 | 344 |
| Police | 87 | 249 | 375 | 377 | 664 |
| Other organisation | 462 | 692 | 990 | 1002 | 836 |
| **Total** | **1665** | **2400** | **2710** | **2967** | **2798** |

### Outcome of referral–over the last 5 years (Section E)

| Outcome | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| **Further Adult Protection Action** | 610 | 1398 | 1825 | 2103 | 2272 |
| **Further Non-AP Action** | 301 | 332 | 242 | 256 | 130 |
| **No further action** | 713 | 610 | 560 | 518 | 342 |
| **Not recorded** | 41 | 60 | 83 | 90 | 54 |
| **Total** | **1665** | **2400** | **2710** | **2967** | **2798** |

### Investigations – over the last 5 years (Section B)

| | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20* | 2020-21 |
|---|---|---|---|---|---|---|
| **Number of Investigations** | 333 | 444 | 379 | 339 | 385 | 460 |

* Following validations this number has been revised to 459 however the number here is what has been reported to SG in 2019-20

[2] Please note that Scottish Ambulance Service and Family are new dropdown categories to enable reports. The decline in 'other member of public' can be attributed to referrals being correctly classified into Friend/ Neighbour or Family in 2019-20

**Investigations by client group - over the last 5 years (Section B)**

| Client groups | 2016-17 | 2017 - 18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| **Dementia** | 157 | 101 | 3 | 10 | 11 |
| **Mental health problem** | 37 | 54 | 40 | 58 | 100 |
| **Learning disability** | 63 | 70 | 44 | 57 | 50 |
| **Physical disability** | 54 | 46 | 97 | 109 | 122 |
| **Infirmity due to Age** | 49 | 48 | 47 | 53 | 57 |
| **Substance misuse** | 19 | 11 | 1 | 10 | 7 |
| **Other** | 65 | 49 | 107 | 88 | 113 |
| **Total** | **444** | **379** | **339** | **385** | **460** |

**Investigations by type of harm - over the last 5 years (Section B)**

| Type of harm | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Financial Harm | 68 | 91 | 52 | 97 | 117 |
| Psychological harm | 46 | 49 | 94 | 84 | 96 |
| Physical harm | 120 | 106 | 43 | 95 | 117 |
| Sexual harm | 20 | 19 | 29 | 17 | 19 |
| Neglect | 104 | 66 | 34 | 36 | 31 |
| Self-harm | 19 | 23 | 85 | 50 | 79 |
| Other | 67 | 25 | 2 | 6 | 1 |
| **Total** | **444** | **379** | **339** | **385** | 460 |

**Investigation by location where principal harm took place - over the last 5 years (Section B)**

| Location of Harm | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Own home | 264 | 246 | 226 | 227 | 285 |
| Other private address | 6 | 13 | 9 | 14 | 14 |
| Care home | 128 | 66 | 33 | 37 | 25 |
| Sheltered housing or other supported accommodation | 17 | 5 | 9 | 7 | 15 |
| Independent Hospital | 1 | 0 | 1 | 3 | 0 |
| NHS | 16 | 19 | 11 | 14 | 10 |
| Day centre | 1 | 5 | 0 | 1 | 0 |
| Public place | 9 | 20 | 27 | 16 | 16 |
| Not known | 2 | 5 | 23 | 66 | 95 |
| **Total** | **444** | **379** | **339** | **385** | **460** |

**Outcome of Investigations - over the last 5 years (Section E)**

| Outcome | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| Further AP action | 75 | 48 | 34 | 44 | 59 |
| Further non-AP action | 214 | 166 | 102 | 131 | 172 |
| No further action | 137 | 157 | 165 | 201 | 227 |
| Not known (ongoing) | 18 | 8 | 38 | 9 | 2 |
| **Total** | **444** | **379** | **339** | **385** | **460** |

**Number of Investigations by Age and Gender - over the last 3 years (Section B)**

| Number of investigations by age and gender | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age Group** | **2018-19** | | | | **2019-20** | | | | **2020-21** | | | |
| | **Male** | **Female** | **Not known** | **All adults** | **Male** | **Female** | **Not known** | **All adults** | **Male** | **Female** | **Not known** | **All adults** |
| 16-24 | 17 | 15 | 0 | **32** | 16 | 22 | 2 | **40** | 21 | 31 | 2 | **54** |
| 25-39 | 28 | 26 | 0 | **54** | 37 | 29 | 0 | **66** | 28 | 43 | 0 | **71** |
| 40-64 | 56 | 60 | 0 | **116** | 55 | 67 | 0 | **122** | 79 | 85 | 0 | **164** |
| 65-69 | 6 | 9 | 0 | **15** | 10 | 8 | 0 | **18** | 11 | 11 | 0 | **22** |
| 70-74 | 9 | 10 | 0 | **19** | 6 | 11 | 0 | **17** | 10 | 13 | 0 | **23** |
| 75-79 | 9 | 13 | 0 | **22** | 9 | 16 | 0 | **25** | 15 | 24 | 0 | **39** |
| 80-84 | 10 | 20 | 0 | **30** | 17 | 27 | 0 | **44** | 11 | 21 | 0 | **32** |
| 85+ | 15 | 36 | 0 | **51** | 17 | 36 | 0 | **53** | 16 | 38 | 0 | **54** |
| Not known | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 1 | 0 | **1** |
| **Total** | 150 | 189 | 0 | **339** | 167 | 216 | 2 | **385** | 191 | 267 | 2 | **460** |

## Number of Investigations by Age and Ethnic Group - over the last 3 years (Section B)

| | 2018-19 | | | | | | | | 2019-20 | | | | | | | | 2020-21 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age Group** | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | **All adults** | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | **All adults** | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | **All adults** |
| 16-24 | 27 | 1 | 0 | 0 | 0 | 1 | 3 | **32** | 37 | 0 | 1 | 0 | 0 | 0 | 2 | **40** | 47 | 0 | 1 | 0 | 0 | 0 | 6 | **54** |
| 25-39 | 48 | 0 | 2 | 0 | 0 | 1 | 3 | **54** | 63 | 0 | 0 | 0 | 0 | 1 | 2 | **66** | 67 | 1 | 1 | 0 | 0 | 0 | 2 | **71** |
| 40-64 | 101 | 0 | 1 | 0 | 0 | 3 | 11 | **116** | 115 | 0 | 0 | 0 | 0 | 0 | 7 | **122** | 152 | 0 | 0 | 0 | 0 | 0 | 12 | **164** |
| 65-69 | 13 | 0 | 0 | 0 | 0 | 0 | 2 | **15** | 15 | 0 | 0 | 0 | 0 | 0 | 3 | **18** | 19 | 0 | 0 | 0 | 0 | 0 | 3 | **22** |
| 70-74 | 16 | 0 | 0 | 0 | 0 | 0 | 3 | **19** | 16 | 0 | 0 | 0 | 0 | 0 | 1 | **17** | 21 | 0 | 0 | 0 | 0 | 1 | 1 | **23** |
| 75-79 | 19 | 0 | 0 | 0 | 0 | 0 | 3 | **22** | 22 | 0 | 0 | 0 | 0 | 0 | 3 | **25** | 35 | 0 | 0 | 0 | 0 | 0 | 4 | **39** |
| 80-84 | 30 | 0 | 0 | 0 | 0 | 0 | 0 | **30** | 36 | 0 | 0 | 0 | 0 | 0 | 8 | **44** | 29 | 0 | 0 | 0 | 0 | 0 | 3 | **32** |
| 85+ | 47 | 0 | 0 | 0 | 0 | 0 | 4 | **51** | 48 | 0 | 1 | 0 | 0 | 0 | 4 | **53** | 52 | 0 | 1 | 0 | 0 | 0 | 1 | **54** |
| Not known | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** |
| **Total** | **301** | **1** | **3** | **0** | **0** | **5** | **29** | 339 | **352** | **0** | **2** | **0** | **0** | **1** | **30** | 385 | **422** | **1** | **3** | **0** | **0** | 1 | 33 | 460 |

**ASP Case Conferences - over the last 5 years (Section C)**

| Type of ASP Case Conference | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| **Initial ASP case conference** | 29 | 44 | 59 | 58 | 84 |
| **Review ASP case conference** | 15 | 20 | 33 | 25 | 42 |
| **ASP case conference*** | 0 | 0 | 0 | 0 | 0 |
| **Total** | **44** | **64** | **92** | **83** | **126** |

**Number of LSI commenced - over the last 5 years (Section D)**

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|---|
| **Total number of LSI** | 4 | 3 | 1 | 3 | 2 |

# Appendix 2
# Fife Adult Support and Protection
## *Summary of age profile of adults subject to ASP Investigation 2020-21*

### Introduction:

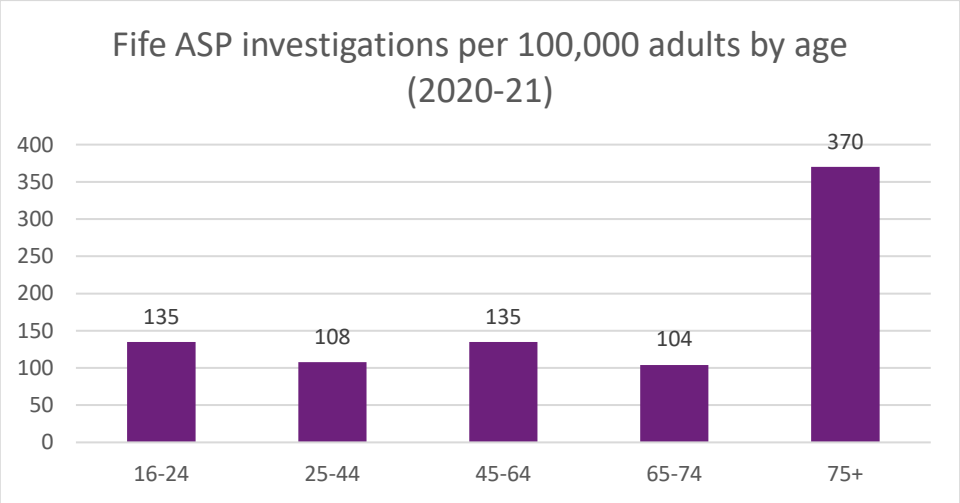
This analysis has been provided to give an overview of the age profile of adults in Fife subject to ASP Investigation. It should be read alongside the Annual Scottish Government Data report for 2020-21 which provides further detail of the data.

### Data Overview:

#### Investigations per 100,000 population

In Fife, the breakdown per 100,000 adults by age group shows that people aged 65 and over are more likely to be subject to an ASP Investigation (225 adults per 100,000) than those of working age (124 adults per 100,000)[3].

When age categories are broken down further, adults aged 75+ are the most likely group to being subject to ASP Investigation (370 per 100,000) as shown in the chart below. This is thought to be broadly reflective of the national picture when compared to available benchmarking data.

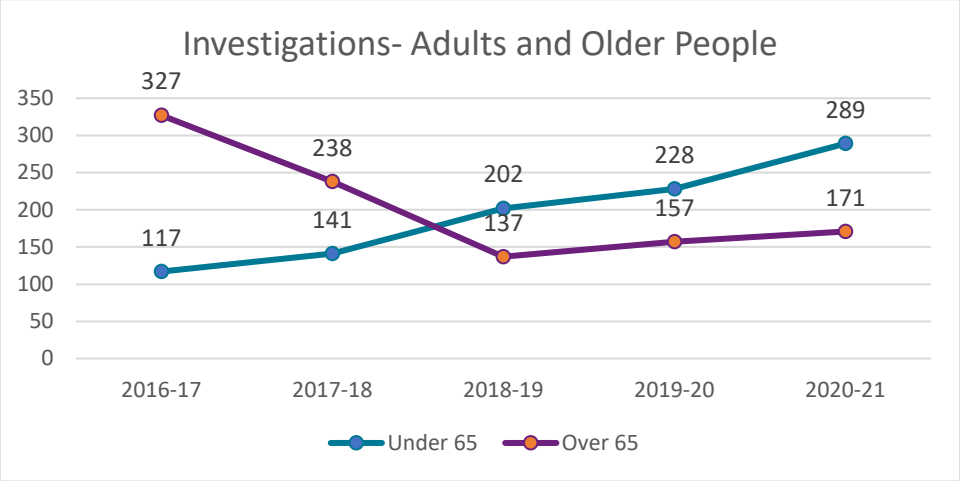



#### Count of Investigations:

Since 2016-17, the number of ASP Investigations relating to adults aged 16-64 has been increasing, 2020-21 data was no exception with figures showing a 27% increase in investigations in this age group since the previous year. Whilst the number of Investigations for Adults aged 65+ has also increased this year, this equates to a 9% increase.

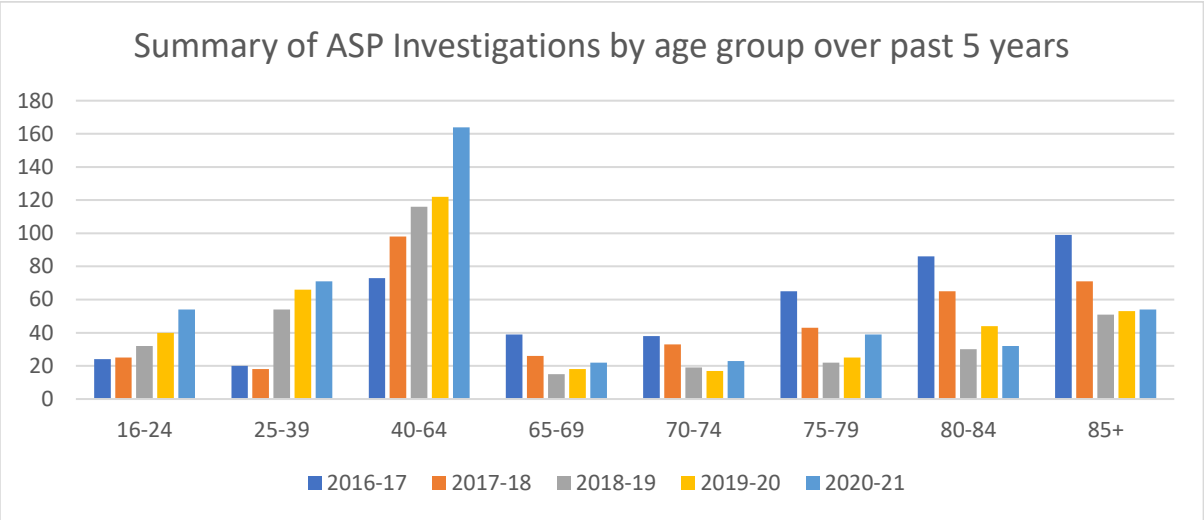
The number of investigations relating to adults aged 16-64 has been higher than those aged 65+ since 2018-19. For adults over 65, there was a sharp decline in Investigations between 2016-17 and 2018-19, followed by small increases over the past two years. The graph below shows the count of Investigations over the past five years by those aged under 65 and those over 65.

[3] For calculation of rates per 100,000, the population data was sourced from National Records of Scotland: https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/fife-council-profile.html#table_pop_est_sex_age




*Source: SG Annual Return Data*

Breaking down the age category further shows that since 2017-18 there are consistently more investigations relating to Adults aged 40-64 when compared to any other age categories. All age categories in the under 65 age group note increases in numbers over the past five years, whilst all age categories over 65 group note a decline between 2016-19, with most categories seeing slight increases over the past two years.




*Source: SG Annual Return Data*

The reduction of Investigations in older age groups between 2016-19, particularly within Care Home settings has been highlighted in previous data reports. It is hypothesised that this decrease is primarily because our workforce is increasingly confident in correctly identifying and reporting harm, preventing harm in care settings and better able to differentiate between significant occurrences and ASP. The decrease may correspond to training launched in 2016 which primarily targeted managers and deputes in care homes, with a focus on 'early indicators' of harm and preventing harm in care settings. Subsequent training and reviews to procedure increasingly support our workforce to be confident in identifying and reporting harm and case file audits would support that improvements have been seen in relation to correct application of the three-point criteria.

It is anticipated that we will find further evidence to support this hypothesis through;

- A mixed methods review of the approach to responding to harm in care home settings (SE&I action)
- A review of the approach to contracts monitoring of Significant Occurrences (ASP Leaders action)
- An interagency staff survey to measure confidence in identifying and reporting harm which will be distributed to Care at home and Care home staff. (SE&I Action)
- Post training questionnaire to measure confidence in recognising and reporting harm following training (SE&I action).

## Conclusions:

Based on the information available at the time of writing, our data reflects the national picture showing that adults over the age of 75 are more likely to be subject of ASP Investigation than those in younger age groups.

Whilst this is the case, in terms of operational management of ASP work it must be noted that the number of Investigations is far higher in Adults Services (16-64) than Older People (65+) and appears to be increasing at a faster rate. In addition, both the Social Work Performance reports and the analysis of the data return has highlighted the complexity of ASP work being undertaken for younger adults, pointing to the numbers progressed for further AP action following investigation, the number of individuals subject to multiple investigations and the different types of harm, specifically self-harm, predominantly experienced in younger age groups.

We are working within our communities to continuously raise awareness of what constitutes harm and how to report it. It is likely that we will continue to see further increases in the number of Investigations undertaken as more people become aware of the signs of harm and how to report it.

www.fifehealthandsocialcare.org

Fife Health & Social Care Partnership

# Adult Support & Protection Annual Return 2021-22

## Summary Statistics

Report Date: August 2022

Report Author: Katie Jones

Fife Adult Support & Protection
www.fifedirect.org.uk/adultprotection

Contents

## 1. Introduction

The following report is a summary of the data collected for the annual Scottish Government Adult Support and Protection (ASP) statistical return. The information gathered includes a count of referrals, IRDs, investigations, case conferences and large-scale investigations (LSIs) recorded between 1st April 2021 and 31st March 2022. An overview of the types and location of harm of investigations and the demographic profile of nominals subject of ASP investigations has also been provided. Summary tables are given in Appendix 1 which shows the data submitted to the Scottish Government for the most recent reporting period and the five previous financial years (2016/17 to 2021/22). Analysis of the 2021/22 data has highlighted key areas for future exploration and this report highlights points for consideration at the Self Evaluation and Improvement Group (SE&I) to agree if they should be integrated into relevant improvement plans. Concluding remarks and an overview of recommendations are provided from pages 16 to 20.

## 2. Key Statistics

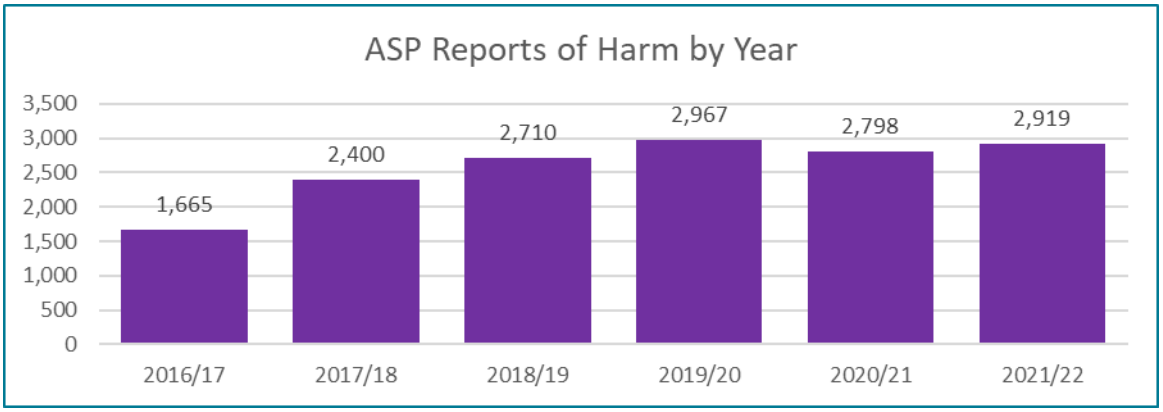
Data for the period 1st April 2021 to 31st March 2022 shows the following:

- There were 2,919 reports of harm received, a 4.3% increase on the 2020/21 report and a reversal of the decrease the previous year, with figures returning to similar levels observed pre-Covid.
- Of the 1,969 individuals referred, 27% had multiple reports of harm recorded (535), a small decrease on the 29% received the previous year but with a greater number of nominals with five or more referrals recorded (45 in 2020/21 and 50 in 2021/22).
- There were notable rises in ASP referrals from the NHS (+30.2%), possibly affected by remobilisation of NHS appointment leading to increased contact with clients in 2021/22. ASP referrals with further AP action continued to rise in 2021/22, marking the fifth consecutive year of increase.
- There were 375 investigations undertaken during 2021/22, which marks an 18.5% decrease on the previous year (460). Data validation exercises should be considered for the 2021/22 figures to ensure that the data is directly comparable.
- There were 97 case conferences reported this year, a 23% reduction on the 2020/21 report (126) and 76.2% of these were undertaken by the Adults team.
- There were 15 LSIs reported by team managers during 2021/22, a notable rise on the year before (2). An audit for LSIs 2020-2022 is currently being conducted to investigate possible reasons for this.
- Continuing the previous trend, the majority of ASP investigations related to nominals aged under the age of 65 (65.1%) and those identifying as female (60.3%).
- There was a notable decrease in investigations involving clients' mental health, which almost halved in 2021/22 (from 100 in 2020/21 to 57) following the rise observed the previous year (58 to 100).
- The main types of harm recorded at the ASP investigation stage were financial harm and psychological harm, consistent with previous trends and each accounting for 20.3% of total

investigations during 2021/22. Following the notable rise in investigations relating to self-harm last year (50 investigations to 79), this figure has increased further during 2021/22 (+5 to 84).

- As observed during previous years, the most likely location of harm investigated was the individual's own home (55.5%). Care home settings have decreased further (from 25 to 18) and remain very low (4.8%) as compared to the previous national average (22%). Actions are ongoing to investigate the reasons behind this.

### 3. ASP Reports of Harm

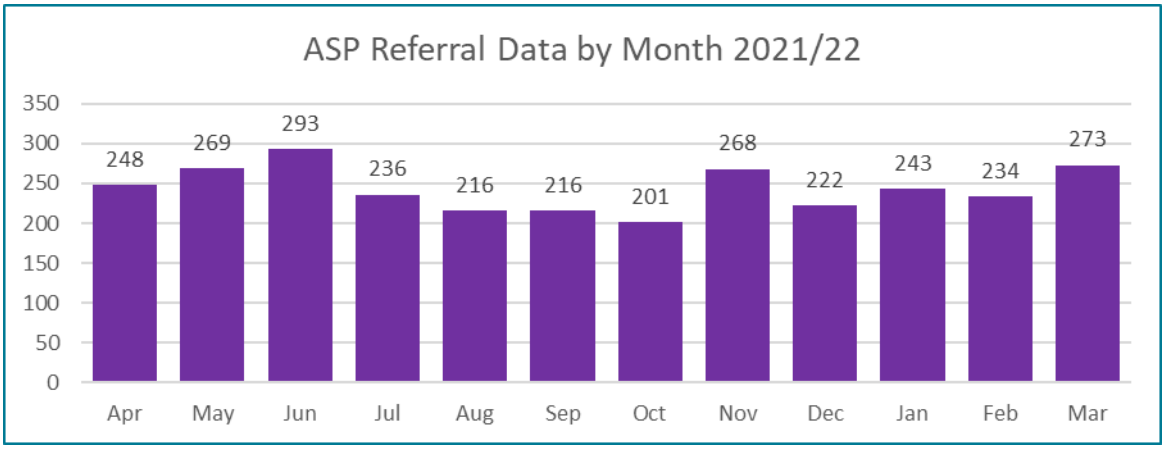



*Source: SWIFT AIS.*

The graph above shows that between 1st April 2021 and 31st March 2022, there were 2,919 ASP reports of harm recorded. This represents a 4.3% increase on 2020/21 (+121, from 2,798) and a return to the upward trend observed in previous years.

These figures reverse the 5.7% decrease observed during 2020/21, which was believed to be affected by Covid-19 restrictions reducing agencies' contact with individuals. This was supported by there being fewer reports of harm recorded in months with the strictest lockdowns (April 2020, December 2021, January 2021 and February 2021).

The graph below shows the number of referrals per month for 2021/22, with volumes ranging from 201 to 293. The total number of referrals in 2021/22 (2,919) have returned to similar levels to pre-Covid (2,967 in 2019/20) as restrictions have eased and services have remobilised.




*Source: SWIFT AIS.*

In relation to referrals, an adult at risk of harm can be counted more than once where multiple reports of harm have been received about the same individual. During 2021/22, there were 2,919 referrals recorded about 1,969 nominals. In total, 27% of individuals had multiple reports of harm (535 of 1,969), with 50 clients having five or more referrals recorded in the time period examined.

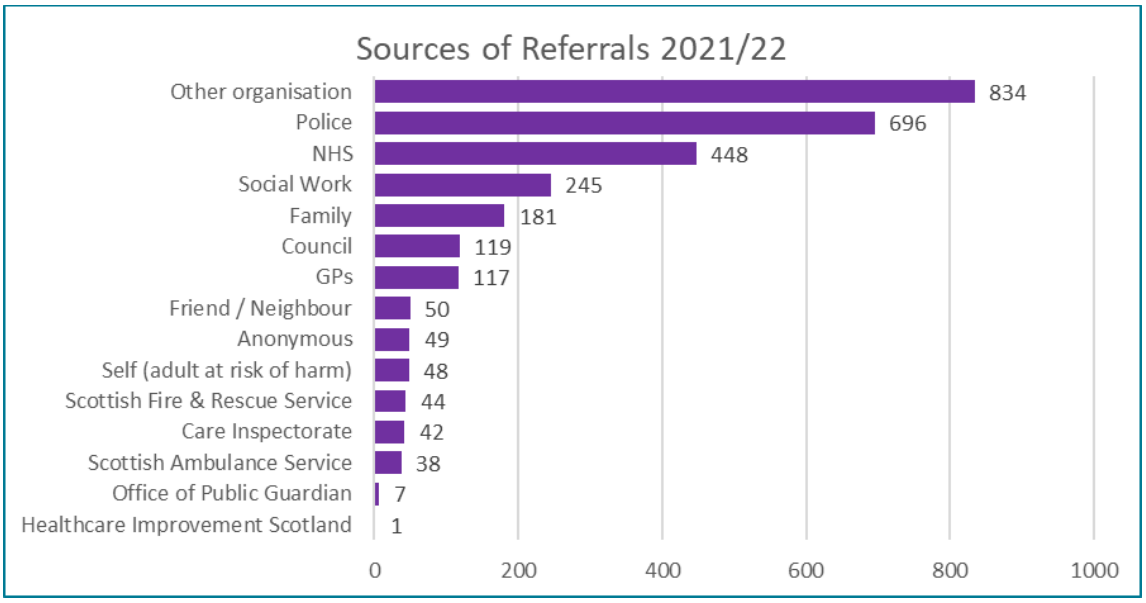
As compared to last year, this is a rise in relation to overall referrals (2,798 to 2,919) but a decrease in individuals with more than one reports of harm (from 29% or 551 to 27% or 535). During 2021/22, there were slightly more nominals with five or more reports of harm recorded (45 last year and 50 this year).

Recommendation 1: Adult Protection Self Evaluation and Improvement Group (SE&I) to consider undertaking an audit of cases where there have been multiple reports of harm (535) and / or an audit of cases with five or more reports of harm (50). This will help ensure that the multiple report of harm protocol is being correctly taken forward and that there is an escalation of engagement (where appropriate). It will also allow an evaluation of the quality of the partnership's response to preventing harm and help identify any learning points or further actions for improvement moving forward. In addition, this would assist with a review of chronologies which will be an action point for the overarching Adult Support and Protection Committee (ASPC) strategic improvement plan for 2023-25 and could be considered for the forthcoming annual ASP audit for 2023. Given the volume of cases involved (535 multiple reports of harm, 50 of which have 5+ referrals), it may be more appropriate to consider a dip sample from both categories to ensure any audit is manageable but as representative as possible of the broader data. The PIP team can provide further data on multiple reports of harm as required.

Recommendation 2: The service aims to complete 85% of inter-agency referral discussions (IRDs) within five working days. However, IRD snapshots may include multiple reports of harm IRDs (MRH) which can lead to delays in the timescale being met due to the time taken to co-ordinate the availability of participants to conduct the face-to-face meetings required. ASP team and PIP to examine the current scale and consider ways in which this can be addressed (such as reviewing MRHs separately, for example).

## 4. Source of ASP Referrals

The graph below illustrates the source of the ASP referral as reported to the Scottish Government for the 2,919 reports of harm recorded during 2021/22.




*Source: SWIFT AIS.*

Overall, there was a 4.3% increase in the total number of referrals recorded during this period (+121, from 2,798 in 2020/21).

The most significant was a 30.2% rise in ASP referrals from the NHS (+104, from 344 to 448). This is likely to have been affected by remobilisation of NHS appointments leading to increased contact with clients in 2021/22. During the previous year, Covid-19 restrictions and subsequent pressures on the service had led to more routine surgeries and treatments being put on hold. Furthermore, the ASP team has reported a greater volume of referrals from NHS24, with analysis evidencing a notable jump this period and a rise year-on-year from 2019/20 (16 referrals to 23 in 2020/21 to 55 in 2021/22). The second most significant rise for the source of ASP referrals was the care inspectorate, with figures almost tripling from 11 in 2020/21 to 42 during 2021/22 (+31).

Increases in ASP referrals were also observed for police (+32, from 664 to 696) and Scottish Ambulance Service (+9, from 29 to 38). Both experienced a notable rise during the last return (referrals from police rose from 377 in 2019/20 to 664 in 2020/21 and reports of harm from SAS from 3 to 29 respectively). Further increases this year show this rise has been not only sustained but exceeded during the return for 2021/22. Other rises of note were evident for the adult's family (+22, from 159 to 181) and self-reporting from the adult (+11, from 37 to 48).

Despite an overall increase in the volume of ASP referrals recorded during 2021/22, not all sources of referral experienced a rise during this period. One of the most significant decreases was in relation to GP referrals (-21, from 138 to 117). This may have been impacted, at least in part, to the reduction in face-to-face appointments in favour of telephone consultations due to Covid-19 restrictions experienced in 2021/22. Other decreases of note included referrals from friends and neighbours (-21, from 71 to 50) and the council (-18, from 137 to 119).

As was observed the previous year, the highest number of ASP reports of harm during 2021/22 were received from other organisations, which accounted for over a quarter (28.6%) of referrals (834 of 2,919). This is comparable with the figure observed during 2020/21 (836) and indicates that a wide range of agencies are aware of what constitutes harm and adults at risk and how to report it.

The summary tables provided in Appendix 1 show the referral source for all reports of harm reported to the Scottish Government during 2021/22 along with the previous five financial years for comparison purposes.

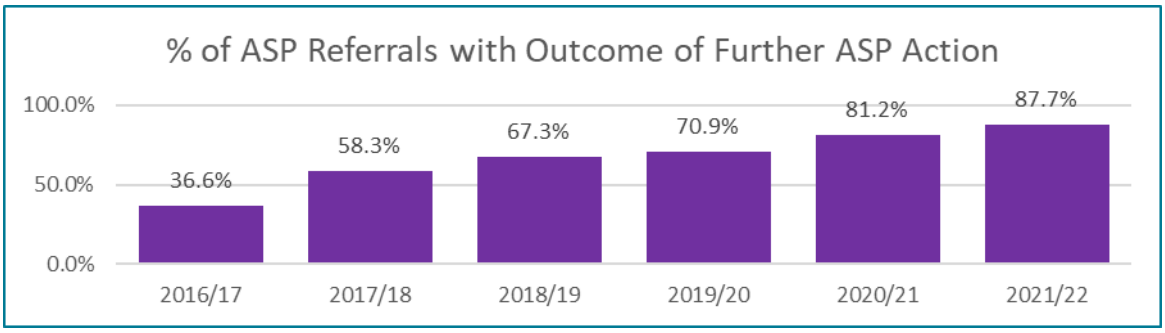
**Recommendation 3:** As per the ongoing 2021-23 ASP workplan, the ASP team will continue to strengthen links with all partners and raise awareness of the key ASP messages during the forthcoming year through development and implementation of a stakeholder engagement plan (planned in early 2023).

**Recommendation 4:** Audit and drug prevention activity from SAS were highlighted at ASPC in August 2022. Work is ongoing to further strengthen ASP links with SAS and reporting of harm moving forward.

**Recommendation 5:** SE&I group to continue to monitor the source of ASP referrals on a quarterly basis via analysis provided by the PIP team in the ASPC quarterly report.

## 5. Outcome of ASP Referrals

The graph below shows the outcome of the ASP referral as reported to the Scottish Government for the 2,919 reports of harm recorded during 2021/22.




*Source: SWIFT AIS.*

The proportion of referrals requiring further Adult Protection action rose by 6.5% during 2021/22 (from 81.2% to 87.7%). This continues the consistent increasing trend seen over six years examined (2016/17 to 2021/22). This may, in part, be a reflection of improved practice in the correct identification and reporting of harm, resulting from increased team knowledge, training opportunities and review at team level. A further contributory factor could be an alteration in recording practices at the Social Work Contact Centre (SWCC).

Further development and refinement of a national minimum dataset alongside the forthcoming new case management system for Social Work will enable review and clarification of recording practices on how reports of harm are collected and recorded. The launch of the new LiquidLogic system has now been rescheduled until mid-2023, allowing additional time for recording practices to be evaluated and refined to facilitate more consistent and robust performance reporting moving forward.

The table below shows the outcomes of ASP reports of harm from 2016/17 to 2021/22. The consistent increase in ASP referrals with further AP action since 2017/18 combined with a decrease in reports where non-AP action was required over the last three financial years indicates a further strengthening of practice across the partnership on the appropriate identification and reporting of harm in relation to adults at risk.

| Referral Outcome | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 610 | 1,398 | 1,825 | 2,103 | 2,272 | 2,560 |
| Further non-AP action | 301 | 332 | 242 | 256 | 130 | 90 |
| No further action | 713 | 610 | 560 | 518 | 342 | 206 |

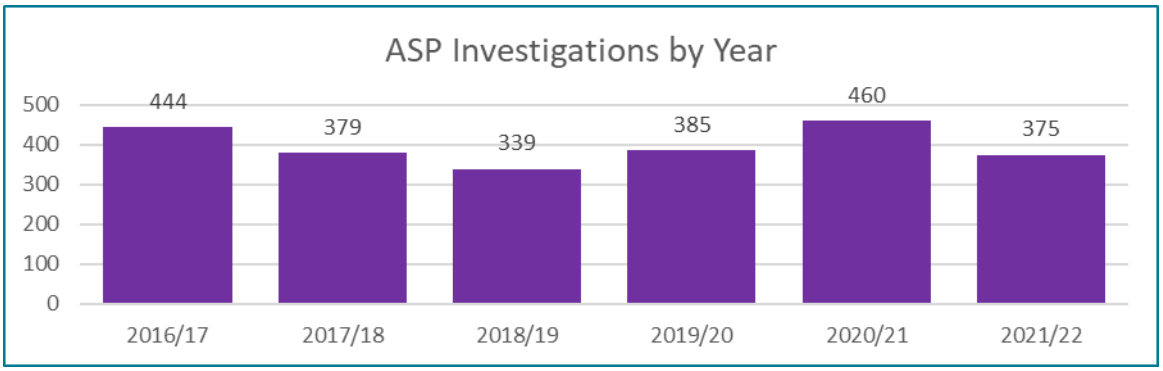
| | | | | | | |
|---|---|---|---|---|---|---|
| Not recorded | 41 | 60 | 83 | 90 | 54 | 63 |
| TOTAL | 1,665 | 2,400 | 2,710 | 2,967 | 2,798 | 2,919 |

*Source: SWIFT AIS.*

**Recommendation 6:** Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, source and outcomes of ASP referrals.

## 6. ASP Investigations

The graph below illustrates the number of ASP investigations as reported to the Scottish Government for the period 1st April 2021 to 31st March 2022.




Source: SWIFT AIS. Note: 385 recorded in 2019/20 rose to 459 following data validation exercises.

During 2021/22, the volume of ASP investigations conducted reduced by 18.5% as compared to the previous year (-85, from 460 to 375). The figures for 2021/22 (375) show a return to the levels observed during 2019/20 (385) and are generally consistent with the five-year average (401 per year based on figures from 2016/17 to 2020/21). However, it should be noted that data validations subsequently increased the 2019/20 figures from 385 to 459 (after this had been reported to Scottish Government). Similar actions should be considered for the 2021/22 figures in order to ensure that data is directly comparable.

Whilst 375 ASP investigations were conducted during 2021/22, this was in relation to 358 individuals. The majority of nominals were the subject of only one investigation (342), however 15 individuals had two ASP investigations undertaken and one nominal had three investigations conducted over the time period examined. It should be noted that this is a reduction in the number of individuals with multiple investigations as observed the previous year (29 in 2020/21).

Analysis by age group shows that 11 of the 16 nominals who were the subject of multiple ASP investigations were under 65 years, with five over the age of 65. Proportionally however, the figures are more

comparable, with 4.5% of adults aged under 65 years being the subject of more than one ASP investigation over the period examined (11 of 244) as compared to 3.8% of those aged 65 years and over (5 of 131).

**Recommendation 7:** ASP Team and PIP to investigate what data validation exercises were carried out during 2019/20 given the rise in investigations subsequently observed once this work had been carried out. Consider similar data validations for 2021/22. PIP team can provide data and analysis where appropriate.

**Recommendation 8:** SE&I interagency audit to consider including the 16 nominals who have been subject to multiple investigations during 2021/22 to evaluate if the partnership can strengthen its response to harm, particularly in relation to the support of adults under 65 years.

**Recommendation 9:** ASP team leaders to consider routine review of cases and any procedural implications where multiple investigations are being undertaken.

## 7. Outcome of ASP Investigations

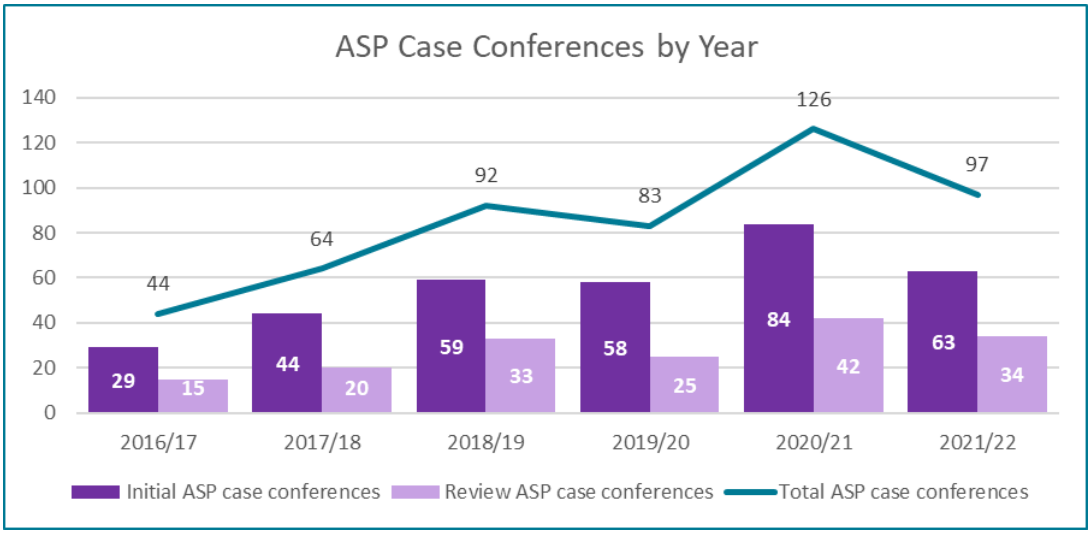
| Investigation Outcome (%) | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 16.9% | 12.7% | 10.0% | 11.4% | 12.8% | 10.1% |
| Further non-AP action | 48.2% | 43.8% | 30.1% | 34.0% | 37.4% | 34.4% |
| No further action | 30.9% | 41.4% | 48.7% | 52.2% | 49.3% | 53.9% |
| Not recorded | 4.1% | 2.1% | 11.2% | 2.3% | 0.4% | 1.6% |

*Source: SWIFT AIS.*

The table above provides the proportion of cases progressed past investigation stage for further ASP action. Overall, the figures observed for 2021/22 remain similar to previous years. Overall, 10.1% of cases were progressed for further AP action. This relates to 38 investigations, a notable reduction on the previous year (59 during 2020/21). Of the 38 cases progressed for further ASP action, 32 related to nominals under 65. Work is ongoing in relation to how this data will be captured on and extracted from LiquidLogic.

**Recommendation 10:** Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, outcomes and nominal demographics from ASP investigations.

## 8. ASP Case Conferences




*Source: Team managers.*

The graph above shows the number of ASP case conferences undertaken during 2021/22 as compared to the previous five financial years. Overall, the volume of ASP case conferences conducted during 2021/22 decreased by 23% (-29, from 126 in 2020/21 to 97). This decrease was evident across both ASP case conference categories, with initial ASP case conferences reducing from 84 to 63 and review case conferences from 42 to 34. This also follows the notable 52% rise observed the previous year (from 83 in 2019/20 to 126 in 2020/21). Of the 97 total ASP case conferences during 2021/22, 76.2% were undertaken by the Adults teams (74). Proportionally, this is broadly comparable with the volume observed during the previous year (73% by Adults Teams).

Recommendation 11: Social work service managers to continue to monitor the distribution of ASP investigations and case conferences and consider the resource implications, particularly in relation to the volume of case conferences undertaken by the Adults teams during 2021/22 (76.2% of total).

Recommendation 12: Data on case conferences is currently gathered from team managers via Microsoft Forms due to difficulties in recording and extracting figures from SWIFT AIS. Ways to enable the consistent and accurate recording and extraction of case conferences on LiquidLogic should be considered as a priority to enable robust and timely data is easily available to facilitate regular performance monitoring and the collation of the statutory Scottish Government annual return.

Recommendation 13: ASP Team and PIP Team to compile concise guidance sheet for use by team managers about which information to record on case conferences for the Scottish Government return. This can be used for training, will facilitate consistency of approach across teams, ensure that data is directly comparable year-on-year and assist with future LiquidLogic discussions. This should be accompanied by a simple table / spreadsheet to capture all data required for internal performance and statutory reporting and saved in a centralised Sharepoint location to allow comparison between periods and facilitate regular updates from team managers. PIP team to compile timetable for completion and send reminders throughout the forthcoming year. Consider for use in the interim pending the launch of LiquidLogic.

## 9. ASP Protection Orders

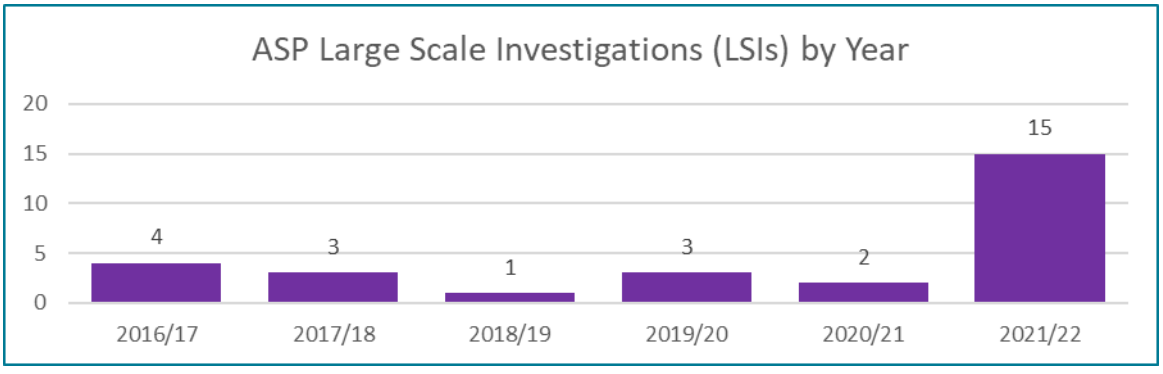
The Scottish Government return for 2021/22 requested information on protection orders granted, namely assessment orders, removal orders, temporary banning orders, banning orders, temporary banning orders with power of arrest and banning orders with power of arrest. There were no ASP protection orders granted in 2021/22 in Fife which is consistent with the previous year. Reporting of protection orders remains very low, and work is ongoing to investigate the reasons behind this. Consideration needs to be given to how information on protection orders will be recorded in and retrieved from the new LiquidLogic system and more streamlined and robust ways to capture the required information in the interim period.

**Recommendation 14:** Data on protection orders is currently gathered manually from team managers via Microsoft Forms due to difficulties extracting this information from SWIFT AIS (this data is currently recorded in profile notes which cannot easily be searched). Ways to enable the consistent and accurate recording and extraction of protection orders on LiquidLogic should be considered as a priority to enable robust and timely extraction to facilitate regular performance monitoring and statutory annual return.

**Recommendation 15:** ASP team and PIP team to compile concise guidance about what information to record on protection orders for the Scottish Government return along with a simple table / spreadsheet to capture all data required. This should be saved in a centralised Sharepoint location and used in the interim pending the launch of LiquidLogic (as per Recommendation 13).

**Recommendation 16:** ASP team to continue work on processes, information gathering and the recording procedure in relation to protection orders due to consistently low figures.

## 10. Large Scale Investigations (LSIs)




*Source: Team managers.*

The graph above shows the number of large-scale investigations (LSIs) reported to the Scottish Government. During 2021/22, there were 15 LSIs undertaken - a notable rise as compared to the previous five years, where the number of annual LSIs ranged from one to four annually. Three of the LSIs were undertaken by the Adults team, with the remaining 12 being conducted by the Older People teams. An LSI audit for the period 2020-2022 is currently being carried out by the ASP co-ordinator and the ASP quality assurance officer to examine reasons for the rise in LSIs experienced this year. LSI cannot be extracted from SWIFT AIS and as such, is currently gathered from team managers. Initial findings suggest that LSI IRD planning meetings may have been included in this year's figures (8) as well as formal full LSIs (6), however this would still constitute a rise in LSIs for 2021/22 as compared to the previous year (from 2 to 6).

Iriss, in partnership with the National Adult Protection Committee, have developed a free online learning resource explaining the role of LSIs within ASP practices in Scotland. This is split over four modules covering key principles, tasks / knowledge, potential practice dilemmas / errors, differences in singular investigations and an LSI and planning / structuring an LSI. The ASP team have been asked to consider this for delivery and training on a multi-agency basis. Iriss is also currently developing a national LSI framework to include learning, evidence and examples to encourage consistency in practice and ensure transparency of approach.

Recommendation 17: Social work service managers to continue to monitor distribution of LSIs and consider resource implications, particularly in relation to the number of LSIs undertaken by OP teams during 2021/22.

Recommendation 18: ASP team and PIP team to compile clear guidance on what LSI information is required for the Scottish Government and a table / spreadsheet to ensure consistency of approach across teams and on previous submissions (as per Recommendation 13). The lead should be taken from the Fife Interagency Guidance and Procedure for Large Scale Investigations of Adults at Risk of Harm (updated December 2021). The LSI review for 2020-22 is ongoing and has been added to the agenda of the next ASP managers meeting.

Recommendation 19: Ways to enable the consistent and accurate recording and extraction of LSIs on LiquidLogic should be considered as a priority to allow robust and timely extraction to facilitate regular performance monitoring and the statutory annual return to the Scottish Government.

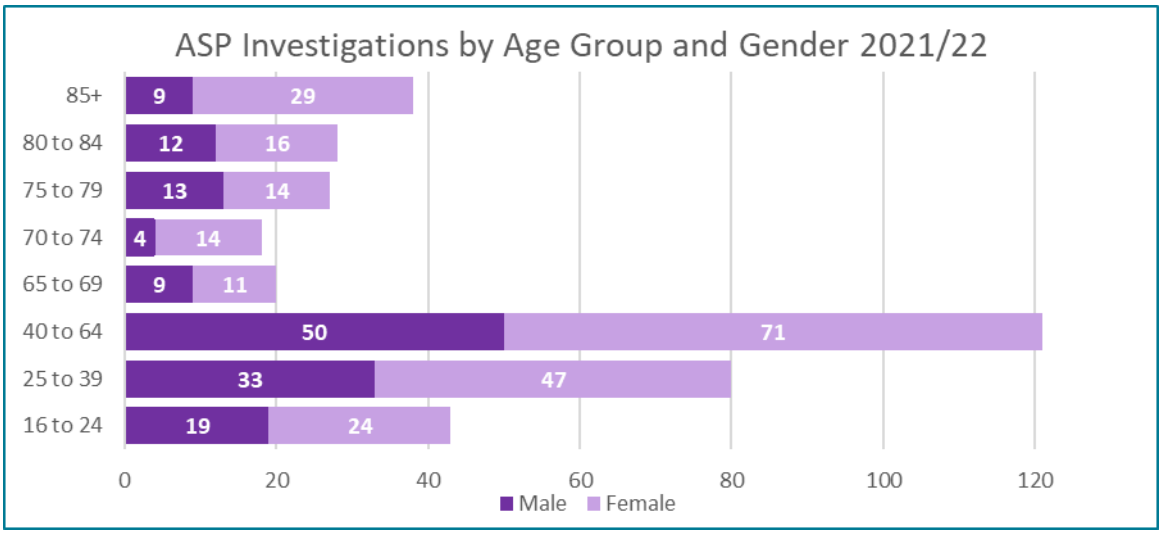
Recommendation 20: ASP are considering the LSI package from Iriss to compile a learning resource for delivery and training on a multi-agency basis.

## 11. Demographic Information

To facilitate planning and development of effective pathways and preventative support, it is essential to monitor details of adults of risk, the types of harm they are experiencing and where this is taking place. Nationally, this is reported on during the investigation stage of an ASP enquiry and analysis of this is

provided below. It should be noted that persons may be counted more than once within the following figures (where more than one investigation has been conducted for that nominal within the time period examined). Demographic data is reported to ASPC on a quarterly basis to enable continuous monitoring and early identification of trends or changes in data.

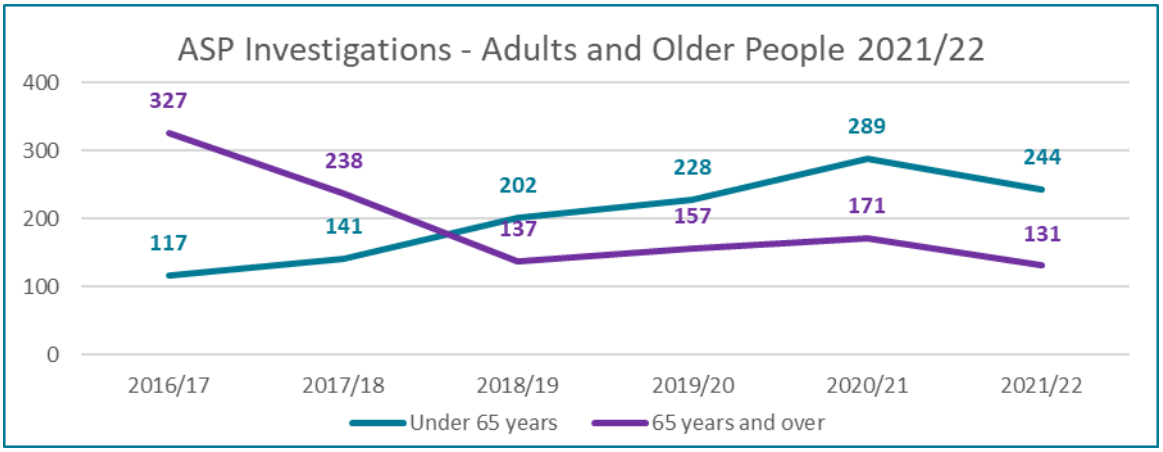
11.1. Age and Gender




*Source: SWIFT AIS.*

The graph above illustrates the count of investigations by gender and age group of the individual concerned.

Overall, a greater proportion (60.3%) of ASP investigations during 2021/22 related to adults identifying as female (226 of 375), which is the case across all age ranges considered. This trend was also observed consistently across all four quarters of the reporting period examined.




*Source: SWIFT AIS.*

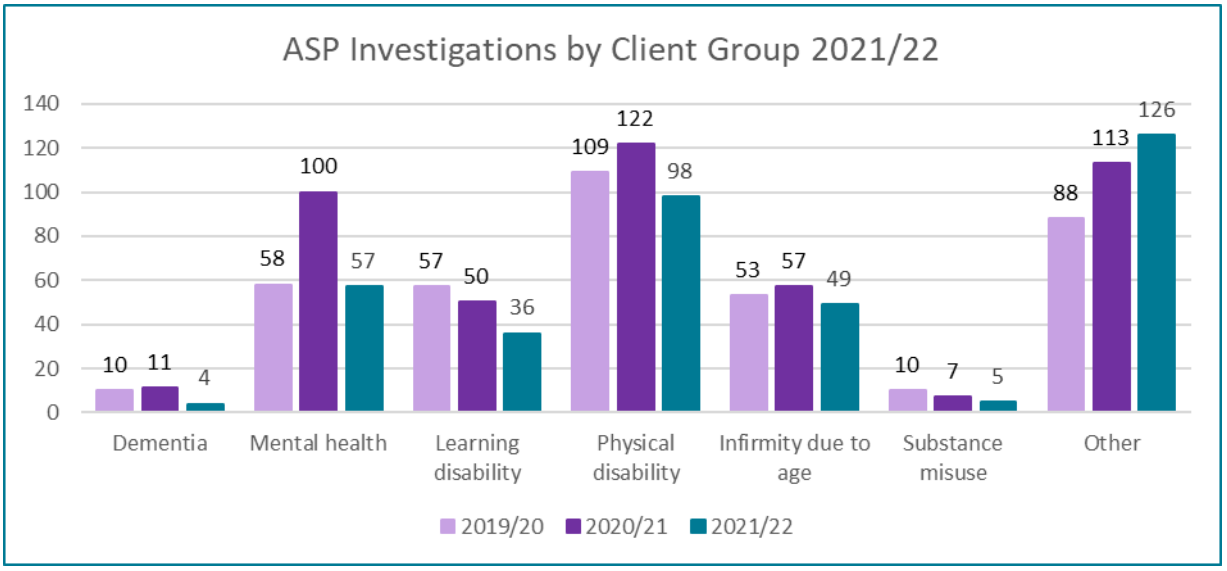
| Age Group (%) | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Under 65 years | 26.4% | 37.2% | 59.6% | 59.2% | 62.8% | 65.1% |
| 65 years and over | 73.6% | 62.8% | 40.4% | 40.8% | 37.2% | 34.9% |

*Source: SWIFT AIS.*

During 2021/22, just under two thirds (65.1%) of investigations conducted involved persons under the age of 65 years (244 of 375). The proportion of investigations for this age group has shown a consistent upward trend since 2016/17 and a year-on-year increase since 2019/20, which may be reflective of awareness raising and training across Fife strengthening our approach to identifying and reporting harm.

The resulting reduction in the proportion of investigations involving older age groups (from 73.6% in 2016/17 to 34.9% in 2021/22) could be related to ongoing work to ensure that practitioners are better able to differentiate between significant occurrences and harm.

11.2. Client Group




*Source: SWIFT AIS.*

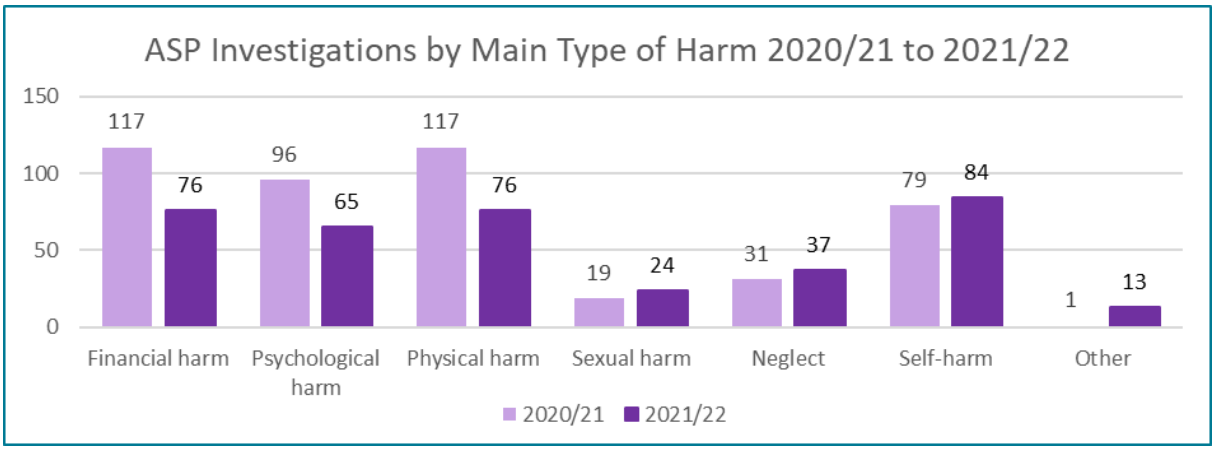
The graph above shows the number of investigations conducted for each client group category during 2021/22. Due to the overall decrease in the volume of investigations carried out over this period (from 460 in 2020/21 to 375 in 2021/22), there has been a resultant reduction in most of the client categories. The most notable is for mental health, which has almost halved in 2021/22 (from 100 to 57) following the rise observed the previous year (from 58 in 2019/20). One possible contributory factor to the rise seen in

2020/21 is the pandemic, with concerns over Covid-19, a reduction in available services and mandatory lockdowns likely to have had impact upon individual's mental health.

The only rise in client group during 2021/22 was in relation to the Other category (from 113 in 2020/21 to 126). The highest number of investigations were for Offenders (32) and Other Vulnerable People (30). It should be noted that for 19% of this category, the client group was listed as Not Recorded (24 of 126).

## 12. Incident Information

### 12.1. Type of Harm

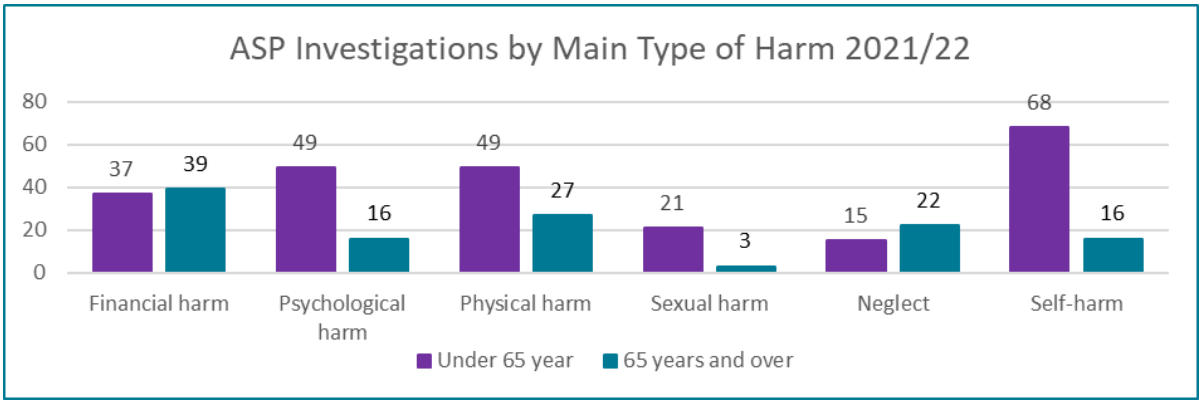



*Source: SWIFT AIS.*

The graph above shows the number of ASP investigations by main type of harm recorded. During 2021/22, the most common types of principal harm leading to an ASP investigation were financial harm and psychological harm, consistent with the previous year. Each accounted for 20.3% each of total investigations during 2021/22 (76 each of 375), a reduction in the proportions seen the year before (25% each in 2020/21).

Despite an overall decrease in the volume of ASP investigations carried out in 2021/22 (from 460 to 375), there were small rises in the volume and proportion of investigations involving sexual harm (+5, from 19 or 4.1% in 2020/21 to 24 or 6.4% in 2021/22; 18 nominals to 23), neglect (+6, from 31 or 6.7% to 37 or 9.9%; 31 nominals to 35) and self-harm (+5, from 79 or 17.2% to 84 or 22.4%; 75 nominals to 83). It is notable that the rise in investigations involving self-harm last year (from 50 to 79) has continued in 2021/22 (+5 to 84).

The graph below shows the main type of harm recorded in the ASP investigation by client age group for 2021/22. As in previous years, this demonstrates the variance in types of harm experienced over the different age groups. Consistent with the findings from 2020/21, the most notable is for investigations involving self-harm, with 80.9% of these involving under 65s (68 of 84) and accounting for 27.9% of all investigations involving adults aged 16 to 64 (68 of 244, higher than any other harm type for this age range).




*Source: SWIFT AIS.*

The type of harm investigated varies between client groups and it may be beneficial to consider this information to advise targeted communications campaigns. The highest count and percentage has been shown in red for each category in the table below for ease of reference. Caution must be taken when analysing the findings as counts for each can be small (given in the TOTAL column).

| | | Main Type of Harm | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Client Group** | | Financial harm | Psychological harm | Physical harm | Sexual harm | Neglect | Self-harm | Other | TOTAL |
| Dementia | Count | 0 | 0 | **2** | 0 | **2** | 0 | 0 | 4 |
| | % | 0.0% | 0.0% | **50.0%** | 0.0% | **50.0%** | 0.0% | 0.0% | 100.0% |
| Mental health | Count | **14** | **12** | 7 | 5 | 3 | **16** | 0 | 57 |
| | % | **24.6%** | **21.1%** | 12.3% | 8.8% | 5.3% | **28.1%** | 0.0% | 100.0% |
| Learning disability | Count | 7 | 7 | **11** | 3 | 2 | 5 | 1 | 36 |
| | % | 19.4% | 19.4% | **30.6%** | 8.3% | 5.6% | 13.9% | 2.8% | 100.0% |
| Physical disability | Count | **20** | 12 | **20** | 5 | 19 | 18 | 4 | 98 |
| | % | **20.4%** | 12.2% | **20.4%** | 5.1% | 19.4% | 18.4% | 4.1% | 100.0% |
| Infirmity due to age | Count | **17** | 4 | **14** | 1 | 4 | 4 | 5 | 49 |
| | % | **34.7%** | 8.2% | **28.6%** | 2.0% | 8.2% | 8.2% | 10.2% | 100.0% |
| Substance misuse | Count | **2** | **2** | 1 | 0 | 0 | 0 | 0 | 5 |
| | % | **40.0%** | **40.0%** | 20.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% |
| Other | Count | 16 | **27** | 20 | 10 | 7 | **41** | 5 | 126 |
| | % | 12.7% | **21.4%** | 15.9% | 7.9% | 5.6% | **32.5%** | 4.0% | 100.0% |

*Source: SWIFT AIS.*

**Recommendation 21:** Learning and Development to consider the continued increase in investigations relating to self-harm and the current training and resources in place to support staff in providing effective and timely support.

**Recommendation 22:** ASP team to consider the breakdown of client group and types of harm with a view to developing more targeted communication campaigns based on the analysis above.

12.2. Location of Harm

The most frequent location of harm continues to be the individual's own home, accounting for over half (55.5%) of the ASP investigations during 2021/22 (208 of 375). This is a small decrease on the proportion observed the previous year (62%) but has remained universal across age group, gender, primary client group and ethnicity and is consistent with data from previous years. The number of investigations where the location of harm was reported as a care home has further decreased in 2021/22 (from 25 in 2020/21 to 18) and is very low (4.8%) as compared to the previous national average (22%).

**Recommendation 23:** Self-evaluation activity to scrutinise / investigate reasons for difference between number of investigations where location is a care home as compared to national average (ongoing).

## 13. Concluding Remarks

As has been observed previously, the data for 2021/22 is broadly consistent with the findings from past returns. As such, the ASPC Strategic Improvement Plan, updates and supporting workplans already contain ongoing actions which are further reinforced by the findings of this report. National statistics in relation to the Scottish Government returns for 2021/22 have not yet been published, but a comparison paper in relation to Fife statistics will be produced once this data becomes available.

Current work includes the development of a stakeholder engagement strategy and a mixed methods review to investigate the low number of investigations involving care homes as compared to the national average of 22% (volume in Fife decreased further in 2021/22, from 25 to 18 or from 5.4% to 4.8%).

Ongoing trends from previous years which have continued during 2021/22 include:

- Rising reports of harm from police (664 to 696) and Scottish Ambulance Service (29 to 38).
- Continued reduction in referrals from GPs (180 in 2019/20 to 138 in 2020/21 to 117 in 2021/22).
- Further increase in investigations involving self-harm, majority of which (80.9%) involve under 65's.

New potential areas for further investigation highlighted by the findings from this 2021/22 report include:

- Notable increase in referrals from NHS (from 344 to 448) – possibly due to greater service contact / involvement following easing of lockdown restrictions. Specific rise from NHS24 (from 23 to 55).
- Notable rise in ASP referrals from care inspectorate (from 11 to 42).
- Significant increase in the number of LSIs reported (from 2 to 15).

Overall, the volume and complexity of ASP work undertaken across the service, particularly in relation to those aged under 65 years, continues to increase. There has been a small reduction in the number of individuals for whom multiple reports of harm are received (551 to 535) but a rise in nominals with five or more referrals (from 45 to 50). The proportion of referrals requiring further adult protection action rose again 2021/22, marking the fifth consecutive year of increase. The proportion of ASP investigations involving those under 65 years of age has grown further (from 62.8% in 2020/21 to 65.1%).

Existing audit processes can be used to identify learning points and review and refine our processes regarding multiple reports of harm and escalation of involvement and engagement. This will help to ensure that we continue to move forward as a partnership in finding effective ways to keep people safe from harm. The tables overleaf provide an overview of the recommendations made from the findings in this report. If agreed to be taken forward, these can be embedded in the existing workplans for 2021-23 and the stakeholder engagement plans (as appropriate).

Recommendation 24: PIP team to produce a report on Fife ASP return for 2021/22 as compared to national statistics for Scotland once data becomes available from the Scottish Government (anticipated late 2022).

Please contact Katie Jones (Performance Improvement and Planning Officer) if you have any questions about the contents of this report or would like to request further analysis of the data from this return.

Email: Katie.Jones@fife.gov.uk

| Key Finding and Report Section | Report Recommendation for Consideration | Lead | Required |
|---|---|---|---|
| Small decrease in nominals with multiple reports of harm (from 29% or 551 to 27% or 535) but a rise in the number of individuals with five or more referrals recorded (from 45 to 50).<br><br>*(Section 3. ASP Reports of Harm)* | Recommendation 1: SE&I to consider undertaking an audit of cases where there have been multiple reports of harm (535) and / or an audit of cases with five or more reports of harm (50). This will help ensure that the multiple report of harm protocol is being correctly taken forward and that there is an escalation of engagement (where appropriate). It will also allow an evaluation of the quality of the partnership's response to preventing harm and help identify any learning points or further actions for improvement moving forward. In addition, this would assist with a review of chronologies which will be an action point for the overarching Adult Support and Protection Committee (ASPC) strategic improvement plan for 2023-25 and could be considered for the forthcoming annual ASP audit for 2023. Given the volume of cases involved (535 multiple reports of harm, 50 of which have 5+ referrals), it may be more appropriate to consider a dip sample from both categories to ensure any audit is manageable but as representative as possible of the broader data. The PIP team can provide further data on multiple reports of harm as required. | SE&I<br><br>ASP team | 2023 |
| | Recommendation 2: The service aims to complete 85% of inter-agency referral discussions (IRDs) within five working days. However, IRD snapshots may include multiple reports of harm IRDs (MRH) which can lead to delays in the timescale being met due to the time taken to co-ordinate the availability of participants to conduct the face-to-face meetings required. ASP team and PIP to examine the current scale and consider ways in which this can be addressed (such as reviewing MRHs separately, for example). | SE&I<br><br>ASP team | 2023 |
| Changes in referral trends in 2021/22 include a 30.2% rise in ASP referrals from NHS (+104), a notable increase from care inspectorate (+31) and continued rises from police and SAS.<br><br>*(Section 4. Source of Referrals)* | Recommendation 3: As per ongoing 2021-23 ASP workplan, the ASP team will continue to strengthen links with all partners and raise awareness of the key ASP messages during the forthcoming year through development / implementation of a stakeholder engagement plan. | ASP team | Early 2023 |
| | Recommendation 4: Audit and drug prevention activity from SAS were highlighted at ASPC in August 2022. Work is ongoing to further strengthen ASP links with SAS and reporting of harm. | ASP team<br><br>SAS | 2023 |

| | | | |
|---|---|---|---|
| | Recommendation 5: SE&I group to continue to monitor the source of ASP referrals on a quarterly basis via analysis provided by the PIP team in the ASPC quarterly report. | SE&I<br>PIP team | Quarterly |
| Later launch of LiquidLogic allows additional time for ROH recording practices to be evaluated / refined for more consistent / robust performance reporting moving forward.<br>*(Section 5. Outcome of ASP Referrals)* | Recommendation 6: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement team to ensure that the LiquidLogic system can effectively record and report on counts, source and outcomes of ASP referrals. | ASP team<br>PIP team<br>SWIFT replacement team | As required |

| Key Finding and Report Section | Report Recommendation for Consideration | Lead | Required |
|---|---|---|---|
| Investigations reduced on last year to 375, similar to 2019/20 (385), which rose to 459 following data validation exercises.<br>*(Section 6: ASP Investigations)* | Recommendation 7: ASP Team and PIP to investigate what data validation exercises were carried out during 2019/20 given the rise in investigations subsequently observed once this work had been carried out. Consider similar data validations for 2021/22. PIP team can provide data and analysis where appropriate. | ASP team<br>PIP team | 2023 |
| 16 nominals were the subject of multiple ASP investigations during 2021/22 (albeit decrease on last year).<br>*(Section 6: ASP Investigations)* | Recommendation 8: SE&I interagency audit to consider including the 16 nominals who have been subject to multiple investigations during 2021/22 to evaluate if the partnership can strengthen its response to harm, particularly in relation to the support of adults under 65 years. | SE&I | 2023 |
| | Recommendation 9: ASP team leaders to consider routine review of cases and any procedural implications where multiple investigations are being undertaken. | ASP team | 2023 |
| The recording and extraction of ASP investigation data from LiquidLogic. | Recommendation 10: Continuation of working group and regular meetings between ASP team, PIP team, Social Work, Workforce Development and SWIFT replacement | ASP team<br>PIP team | As required |

| | | | |
|---|---|---|---|
| *(Section 7: Outcome of ASP Investigations)* | team to ensure that the LiquidLogic system can effectively record and report on counts, outcomes and nominal demographics from ASP investigations. | SWIFT replacement team | |
| 76.2% of case conferences completed by Adults teams in 2021/22 (74 of 97).<br>*(Section 8: ASP Case Conferences)* | Recommendation 11: Social work service managers to continue to monitor the distribution of ASP investigations and case conferences and consider the resource implications, particularly in relation to the volume of case conferences undertaken by the Adults teams during 2021/22. | SW teams | 2023 |
| Recording of case conference information on Liquid Logic and for Scottish Government return and internal monitoring and reporting purposes.<br>*(Section 8. ASP Case Conferences)* | Recommendation 12: Data on case conferences is currently gathered from team managers via Microsoft Forms due to difficulties in recording and extracting figures from SWIFT AIS. Ways to enable the consistent and accurate recording and extraction of case conferences on LiquidLogic should be considered as a priority to enable robust and timely data is easily available to facilitate regular performance monitoring and collation of statutory SG return. | ASP team<br>PIP team<br>SWIFT replacement team | 2023 |
| | Recommendation 13: ASP Team and PIP Team to compile concise guidance sheet for use by team managers about which information to record about case conferences for SG return. This can be used for training, will facilitate consistency of approach across teams, ensure data is directly comparable year-on-year and assist with LiquidLogic discussions. This should be accompanied by a simple table / spreadsheet to capture data required for internal performance and statutory reporting and saved in a centralised Sharepoint location to allow comparison between periods and facilitate regular updates from team managers. PIP team to compile timetable for completion and send reminders throughout the forthcoming year. Consider for use in the interim pending the launch of LiquidLogic. | ASP team<br>PIP team | 2023 |

| Key Finding and Report Section | Report Recommendation for Consideration | Lead | Required |
|---|---|---|---|
| Recording of ASP Protection Orders.<br><br>*(Section 9. ASP Protection Orders)* | Recommendation 14: Data on protection orders is currently gathered manually from team managers via Microsoft Forms due to difficulties extracting this information from SWIFT AIS (this data is currently recorded in profile notes which cannot easily be searched). Ways to enable the consistent and accurate recording and extraction of protection orders on LiquidLogic should be considered as a priority to enable robust and timely extraction to facilitate regular performance monitoring and statutory annual return. | ASP team<br><br>PIP team<br><br>SWIFT replacement team | 2023 |
| | Recommendation 15: ASP team and PIP team to compile concise guidance about what information to record on protection orders for the Scottish Government return along with a simple table / spreadsheet to capture all data required. This should be saved in a centralised Sharepoint location and used in the interim pending the launch of LiquidLogic (as per Recommendation 13). | ASP team<br><br>PIP team | 2023 |
| | Recommendation 16: ASP team to continue work on processes, information gathering and the recording procedure in relation to protection orders due to consistently low figures. | ASP team | 2023 |
| Increase in volume of LSIs during 2021/22.<br><br>*(Section 10. Large Scale Investigations (LSIs))* | Recommendation 17: Social work service managers to continue to monitor distribution of LSIs and consider resource implications, particularly in relation to the number of LSIs undertaken by OP teams during 2021/22. | ASP team | 2023 |
| Recording of LSIs.<br><br>*(Section 10. Large Scale Investigations (LSIs))* | Recommendation 18: ASP team and PIP team to compile clear guidance on what LSI information is required for the Scottish Government and a table / spreadsheet to ensure consistency of approach across teams and on previous submissions (as per Recommendation 13). The lead should be taken from the Fife Interagency Guidance and Procedure for Large Scale Investigations of Adults at Risk of Harm (updated December 2021). The LSI review for 2020-22 is ongoing and has been added to the agenda of the next ASP managers meeting. | ASP team<br><br>PIP team | 2023 |

| | | | |
|---|---|---|---|
| | Recommendation 19: Ways to enable the consistent and accurate recording and extraction of LSIs on LiquidLogic should be considered as a priority to allow robust and timely extraction to facilitate regular performance monitoring and statutory annual return to Scottish Government. | ASP team<br>PIP team<br>SWIFT replacement | 2023 |
| | Recommendation 20: ASP are considering the LSI package from Iriss to compile a learning resource for delivery and training on a multi-agency basis. | ASP team | 2023 |

| Key Finding and Report Section | Report Recommendation for Consideration | Lead | Required |
|---|---|---|---|
| Continued rise in the number of ASP investigations for self-harm (50 in 2019/20, 79 in 2020/21 to 84 in 2021/22).<br>*(Section 12. Incident Information*<br>*Section 12.1. Type of Harm)* | Recommendation 21: Learning and Development to consider the continued increase in investigations relating to self-harm and the current training and resources in place to support staff in providing effective and timely support. | L&D Group | 2023 |
| Variance in the types of harm investigated by age and client group.<br>*(Section 12. Incident Information* | Recommendation 22: ASP team to consider the breakdown of client group and types of harm with a view to developing more targeted communication campaigns based on the analysis above. | ASP team | 2023 |

| | | | |
|---|---|---|---|
| *Section 12.1. Type of Harm)* | | | |
| Number of investigations where the location of harm was reported as a care home has further decreased and is very low as compared to the national average.<br><br>*(Section 12. Incident Information*<br><br>*Section 12.2. Location of Harm)* | Recommendation 23: Self-evaluation activity to scrutinise / investigate reasons for difference between number of investigations where location is a care home as compared to national average (ongoing). | ASP team | 2023 |
| Analysis of Fife annual ASP return for 2021/22 and other statistics for Scotland to provide comparison on national basis.<br><br>*(Section 13. Concluding Remarks)* | Recommendation 24: PIP team to produce a report on Fife ASP return for 2021/22 as compared to national statistics for Scotland once data becomes available from the Scottish Government (anticipated late 2022). | PIP team | Late 2022 / early 2023 |

## 14. Reference Documents

This report should be considered in conjunction with the following additional reference documents, which outline strategies for the forthcoming period as well as ongoing workplans and partnership information (press Ctrl and right click on the link to access the documents).

### Adult Support and Protection Committee Strategic Improvement Plan 2021-23

https://www.fife.gov.uk/__data/assets/word_doc/0031/176908/ASPC-Strategic-Improvement-Plan-2021-23-FINAL.docx

Adult Support and Protection Improvement Plan 2021-23

https://www.fife.gov.uk/__data/assets/pdf_file/0031/188086/ASPC-Vision-and-priorities-2021-23-1.pdf

## Appendix 1: Summary Tables

Section A: Data on ASP Referrals

Question 1: Number of ASP referrals received

| Summary of ASP Referrals | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Q1 (Apr to Jun) | 375 | 510 | 757 | 725 | 644 | 810 |
| Q2 (Jul to Sep) | 427 | 502 | 659 | 757 | 822 | 668 |
| Q3 (Oct to Dec) | 410 | 588 | 671 | 730 | 687 | 691 |
| Q4 (Jan to Mar) | 453 | 800 | 623 | 755 | 645 | 750 |
| **TOTAL** | **1,665** | **2,400** | **2,710** | **2,967** | **2,798** | **2,919** |

Question 2: Source of principal referral

| Source of ASP Referrals | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Mental Welfare Commission | 0 | 0 | 0 | 0 | 0 | 0 |
| Unpaid carer | 0 | 0 | 0 | 0 | 0 | 0 |
| Others | 11 | 7 | 1 | 0 | 0 | 0 |
| Healthcare Improvement Scotland | 0 | 0 | 0 | 0 | 1 | 1 |
| Other member of public | 7 | 178 | 218 | 122 | 2 | 0 |
| Office of Public Guardian | 3 | 2 | 0 | 2 | 3 | 7 |
| Care Inspectorate | 15 | 31 | 0 | 7 | 11 | 42 |
| Scottish Ambulance Service | 3 | 3 | 0 | 3 | 29 | 38 |
| Self (adult at risk of harm) | 38 | 40 | 49 | 50 | 37 | 48 |
| Scottish Fire & Rescue Service | 77 | 74 | 63 | 69 | 57 | 44 |
| Friend / neighbour | 136 | 13 | 0 | 35 | 71 | 50 |
| Anonymous | 25 | 33 | 74 | 89 | 71 | 49 |
| Council | 272 | 343 | 194 | 193 | 137 | 119 |
| GPs | 45 | 64 | 131 | 180 | 138 | 117 |
| Family | 39 | 48 | 0 | 117 | 159 | 181 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Social Work | 216 | 258 | 293 | 310 | 238 | 245 |
| NHS | 229 | 365 | 322 | 411 | 344 | 448 |
| Police | 87 | 249 | 375 | 377 | 664 | 696 |
| Other organisation | 462 | 692 | 990 | 1,002 | 836 | 834 |
| **TOTAL** | **1,665** | **2,400** | **2,710** | **2,967** | **2,798** | **2,919** |

Section B: Data on Investigations

Question 3: Number of investigations commenced under the ASP Act

| ASP Investigations | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Number of investigations | 444 | 379 | 339 | 385 | 460 | 375 |

Question 4a: Number of investigations commenced by age and gender

| Age Group | 2019/20 | | | | 2020/21 | | | | 2021/22 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Not Known | TOTAL | Male | Female | Not Known | TOTAL | Male | Female | Not Known | TOTAL |
| 16 to 24 | 16 | 22 | 2 | 40 | 21 | 31 | 2 | 54 | 19 | 24 | 0 | 43 |
| 25 to 39 | 37 | 29 | 0 | 66 | 28 | 43 | 0 | 71 | 33 | 47 | 0 | 80 |
| 40 to 64 | 55 | 67 | 0 | 122 | 79 | 85 | 0 | 164 | 50 | 71 | 0 | 121 |
| 65 to 69 | 10 | 8 | 0 | 18 | 11 | 11 | 0 | 22 | 9 | 11 | 0 | 20 |
| 70 to 74 | 6 | 11 | 0 | 17 | 10 | 13 | 0 | 23 | 4 | 14 | 0 | 18 |
| 75 to 79 | 9 | 16 | 0 | 25 | 15 | 24 | 0 | 39 | 13 | 14 | 0 | 27 |
| 80 to 84 | 17 | 27 | 0 | 44 | 11 | 21 | 0 | 32 | 12 | 16 | 0 | 28 |
| 85+ | 17 | 36 | 0 | 53 | 16 | 38 | 0 | 54 | 9 | 29 | 0 | 38 |
| Not known | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| TOTAL | 167 | 216 | 2 | 385 | 191 | 267 | 2 | 460 | 149 | 226 | 0 | 375 |

Question 4b: Number of investigations commenced by age and ethnic group

| Age Group | 2019/20 | | | | | | | | 2020/21 | | | | | | | | 2021/22 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | TOTAL | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | TOTAL | White | Mixed or multiple ethnic groups | Asian, Asian Scottish or Asian British | African | Caribbean or Black | Other ethnic group | Not known | TOTAL |
| 16 to 24 | 37 | 0 | 1 | 0 | 0 | 0 | 2 | **40** | 47 | 0 | 1 | 0 | 0 | 0 | 6 | **54** | 40 | 0 | 0 | 0 | 0 | 0 | 3 | **43** |
| 25 to 39 | 63 | 0 | 0 | 0 | 0 | 1 | 2 | **66** | 67 | 1 | 1 | 0 | 0 | 0 | 2 | **71** | 74 | 0 | 1 | 0 | 0 | 1 | 4 | **80** |
| 40 to 64 | 115 | 0 | 0 | 0 | 0 | 0 | 7 | **122** | 152 | 0 | 0 | 0 | 0 | 0 | 12 | **164** | 105 | 2 | 2 | 0 | 0 | 0 | 12 | **121** |
| 65 to 69 | 15 | 0 | 0 | 0 | 0 | 0 | 3 | **18** | 19 | 0 | 0 | 0 | 0 | 0 | 3 | **22** | 20 | 0 | 0 | 0 | 0 | 0 | 0 | **20** |
| 70 to 74 | 16 | 0 | 0 | 0 | 0 | 0 | 1 | **17** | 21 | 0 | 0 | 0 | 0 | 1 | 1 | **23** | 18 | 0 | 0 | 0 | 0 | 0 | 0 | **18** |
| 75 to 79 | 22 | 0 | 0 | 0 | 0 | 0 | 3 | **25** | 35 | 0 | 0 | 0 | 0 | 0 | 4 | **39** | 26 | 0 | 0 | 0 | 0 | 0 | 1 | **27** |
| 80 to 84 | 36 | 0 | 0 | 0 | 0 | 0 | 8 | **44** | 29 | 0 | 0 | 0 | 0 | 0 | 3 | **32** | 27 | 0 | 0 | 0 | 0 | 0 | 1 | **28** |
| 85+ | 48 | 0 | 1 | 0 | 0 | 0 | 4 | **53** | 52 | 0 | 1 | 0 | 0 | 0 | 1 | **54** | 33 | 0 | 0 | 0 | 0 | 0 | 5 | **38** |
| Not known | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **TOTAL** | **352** | **0** | **2** | **0** | **0** | **1** | **30** | **385** | **422** | **1** | **3** | **0** | **0** | **1** | **33** | **460** | **343** | **2** | **3** | **0** | **0** | **1** | **26** | **375** |

Question 5: Number of investigations commenced by primary main client group

| ASP Investigations by Client Group | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Dementia | 157 | 101 | 3 | 10 | 11 | 4 |
| Mental health problem | 37 | 54 | 40 | 58 | 100 | 57 |
| Learning disability | 63 | 70 | 44 | 57 | 50 | 36 |
| Physical disability | 54 | 46 | 97 | 109 | 122 | 98 |
| Infirmity due to age | 49 | 48 | 47 | 53 | 57 | 49 |
| Substance misuse | 19 | 11 | 1 | 10 | 7 | 5 |
| Other | 65 | 49 | 107 | 88 | 113 | 126 |
| **TOTAL** | **444** | **379** | **339** | **385** | **460** | **375** |

Question 6: Type of principal harm which resulted in an investigation (as defined under the ASP Act)

| ASP Investigations by Type of Harm | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Financial harm | 68 | 91 | 52 | 97 | 117 | 76 |
| Psychological harm | 46 | 49 | 94 | 84 | 96 | 65 |
| Physical harm | 120 | 106 | 43 | 95 | 117 | 76 |
| Sexual harm | 20 | 19 | 29 | 17 | 19 | 24 |
| Neglect | 104 | 66 | 34 | 36 | 31 | 37 |
| Self-harm | 19 | 23 | 85 | 50 | 79 | 84 |
| Other | 67 | 25 | 2 | 6 | 1 | 13 |
| **TOTAL** | **444** | **379** | **339** | **385** | **460** | **375** |

Question 7: Location of principal harm which resulted in an investigation (as defined under the ASP Act)

| ASP Investigations by Location of Harm | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Own home | 264 | 246 | 226 | 227 | 285 | 208 |
| Other private address | 6 | 13 | 9 | 14 | 14 | 17 |
| Care home | 128 | 66 | 33 | 37 | 25 | 18 |
| Sheltered / supported accommodation | 17 | 5 | 9 | 7 | 15 | 4 |
| Independent hospital | 1 | 0 | 1 | 3 | 0 | 0 |
| NHS | 16 | 19 | 11 | 14 | 10 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Day centre | 1 | 5 | 0 | 1 | 0 | 1 |
| Public place | 9 | 20 | 27 | 16 | 16 | 23 |
| Not known | 2 | 5 | 23 | 66 | 95 | 99 |
| **TOTAL** | **444** | **379** | **339** | **385** | **460** | **375** |

Section C: Data on ASP Case Conferences and Protection Orders

Question 8: Number of cases subject to an ASP case conference

| Type of ASP Case Conference | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Initial ASP case conference | 29 | 44 | 59 | 58 | 84 | 63 |
| Review ASP case conference | 15 | 20 | 33 | 25 | 42 | 34 |
| **TOTAL** | **44** | **64** | **92** | **83** | **126** | **97** |

Question 9: Number of protection orders granted

No protection orders were granted between 1st April 2021 and 31st March 2022.

Section D: Data on ASP Large Scale Investigations (LSIs)

Question 10: Number of LSIs commenced

| ASP Large Scale Investigations (LSIs) | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Number of LSIs | 4 | 3 | 1 | 3 | 2 | 15 |

Section E: Data on Outcomes

Question 11: What happened to referrals received

| Outcome of ASP Referrals | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 610 | 1,398 | 1,825 | 2,103 | 2,272 | 2,560 |
| Further non-AP action | 301 | 332 | 242 | 256 | 130 | 90 |

| | | | | | | |
|---|---|---|---|---|---|---|
| No further action | 713 | 610 | 560 | 518 | 342 | 206 |
| Not recorded | 41 | 60 | 83 | 90 | 54 | 63 |
| TOTAL | 1,665 | 2,400 | 2,710 | 2,967 | 2,798 | 2,919 |

| Outcome of ASP Referrals (%) | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 36.6% | 58.3% | 67.3% | 70.9% | 81.2% | 87.7% |
| Further non-AP action | 18.1% | 13.8% | 8.9% | 8.6% | 4.6% | 3.1% |
| No further action | 42.8% | 25.4% | 20.7% | 17.5% | 12.2% | 7.1% |
| Not recorded | 2.5% | 2.5% | 3.1% | 3.0% | 1.9% | 2.2% |

Question 12: What happened to investigations received

| Outcome of ASP Investigations | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 75 | 48 | 34 | 44 | 59 | 38 |
| Further non-AP action | 214 | 166 | 102 | 131 | 172 | 129 |
| No further action | 137 | 157 | 165 | 201 | 227 | 202 |
| Not known / ongoing | 18 | 8 | 38 | 9 | 2 | 6 |
| TOTAL | 444 | 379 | 339 | 385 | 460 | 375 |

| Outcome of ASP Investigations (%) | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|
| Further Adult Protection action | 16.9% | 12.7% | 10.0% | 11.4% | 12.8% | 10.1% |
| Further non-AP action | 48.2% | 43.8% | 30.1% | 34.0% | 37.4% | 34.4% |
| No further action | 30.9% | 41.4% | 48.7% | 52.2% | 49.3% | 53.9% |
| Not known / ongoing | 4.1% | 2.1% | 11.2% | 2.3% | 0.4% | 1.6% |

# Appendix 2-Updated Adult Support and Protection Competency Framework

**Group A – Competences 1-5**

Members of this group have a responsibility to contribute to Adult Support and Protection, but do not have specific organisational responsibility or statutory authority to intervene.

- All Support Staff in Health and Social Care
- Day service Staff
- Housing Staff
- Council Based Office Staff
- HR Staff
- Elected Members
- Volunteers
- Befrienders
- Charity Trustees
- Drivers, other transport staff

**Staff Group B - Competences 1-12**

This group have considerable professional and organisational responsibility for Adult Support and Protection. They have to be able to act on concerns and contribute appropriately to local and national policies, legislation and procedures. This group needs to work within an inter or multi-agency context.

- Social Workers
- Nurses
- Frontline Managers
- Team Managers
- Health and Social Care Providers Service Managers
- Senior Support Workers

**Staff Group C - Competences 1-16**

This Group is responsible for ensuring the management and delivery of Adult Support and Protection Services is effective and efficient. In addition they will have oversight of the development of systems, policies and procedures within their own organisations to facilitate good working partnerships with allied agencies to ensure consistency in approach and quality services.

- Operational Managers
- Senior Management
- Heads of Assessment and Care Managers
- Service Managers
- Senior Social Workers

**Staff Group D - Competences 1-5 and 16-20**

This Group is responsible in ensuring their organisation is, at all levels, fully committed to Safeguarding Adults and have in place appropriate systems and resources to support this work in an intra- and inter-agency context.

- Senior Leadership Team
- Chief Executive

**Demonstrating Competence**

To demonstrate competence staff should present a combination of evidence to their line managers. This could include formal training, completion of vocational/professional awards and work products. The line managers may wish to carry out a professional discussion, question / answer session with you in order to ensure competency in a specific area. A full list of suggested evidence can be found at the end of this document (appendix 2)

If you are required to demonstrate more than one set of competences, for example your current role is within both B and C - you may want to look at both of these competences as you should be able to cross reference your evidence for competences in other groups.

**Staff Group A**

**All Staff to complete this section:**

| Competencies 1-5 | Description | Evidence or Demonstration of Competence/Confidence in this area | Any development Required? | Review Date (minimum of 12 monthly) |
|---|---|---|---|---|
| 1. | I understand that *"adult support and protection is everyone's business"* | | | |
| 2. | I am able to recognise an adult potentially in need of Adult Support and Protection intervention and take action. | | | |
| 3. | I understand how to make an ASP referral. | | | |
| 4. | I understand dignity and respect when working with individuals. | | | |
| 5. | I have knowledge of Fife Health and | | | |

| | | | | |
|---|---|---|---|---|
| | Social Care Partnership's multi-agency ASP Procedures. | | | |

Staff Signature …… Line Managers Signature ……..

Date ……....

**Staff Group B & C to complete this section**

**Competence in working with people and delivering Safeguarding Services Competence**

| Competencies 6-12 | Description | Evidence or Demonstration of Competence/Confidence in this area | Any development Required? | Review Date (minimum of 12 monthly) |
|---|---|---|---|---|
| 6. | I have the required knowledge and skills to contribute fully to the Adult Support and Protection process. | | | |
| 7. | I am aware of and can apply local policy and procedural frameworks when undertaking Adult Support and Protection Activity. | | | |
| 8. | I ensure service users/carer's are supported appropriately to understand Adult Support and Protection issues. | | | |
| 9. | I am able to distinguish between observation, facts, information and | | | |

| | | | | |
|---|---|---|---|---|
| | opinion gained from others in gathering evidence with regard to ASP issues | | | |
| 10. | I know and understand the legislative context of Adult Support and Protection i.e. Adults with Incapacity (Scotland) Act 2000 and Mental Health Care and Treatment (Scotland) Act 2003 | | | |
| 11. | I maintain accurate, complete and up to date records. | | | |
| 12. | I am able to demonstrate the required level of skills and knowledge to undertake an Adult Support and Protection Investigation. | | | |

Staff Signature …….. Line Managers Signature ……..

Date ……..

**Staff Group C (Need to complete B & A also)**

**Competence in Strategic Management and Leadership of Safeguarding Services**

| Competencies 13-16 | Description | Evidence or Demonstration of Competence/Confidence in this area | Any development Required? | Review Date (minimum of 12 monthly) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 13. | I actively engage in supporting a positive multi-agency approach to Adult Support and Protection work. | | | |
| 14. | I support the development of robust internal systems to provide consistent, high quality Adult Support and Protection service. | | | |
| 15. | I chair Adult Support and Protection meetings such as IRD discussions OR Case Conferences.<br><br>(This only applies to Senior Practitioners or Team Managers who role involves chairing ASP meetings) | | | |
| 16. | I ensure record systems are robust and fit for purpose. | | | |

Staff Signature …….. Line Managers Signature ……..

Date ……..

**Staff Group D (need to complete A also)**

**Competence in Strategic Management and Leadership of Safeguarding Services**

| Competencies 17-20 | Description | Evidence or Demonstration of Competence/Confidence in this area | Any development Required? | Review Date (minimum of 12 monthly) |
|---|---|---|---|---|
| 17. | I lead the development of effective policy and procedures for Adult Support and Protection services in my organisation. | | | |
| 18. | I ensure plans and targets for Adult Support and Protection are embedded at a strategic level across the organisation. | | | |
| 19. | I promote awareness of Adult Support and Protections systems within and outside my organisation. | | | |
| 20. | I develop and maintain systems to ensure the involvement of service users in developing Adult Support and Protection services. | | | |

**Development of Competence-Appendix 1**

Please make notes of how any competences that have not been demonstrated, can be evidenced in the foreseeable future and dates to when this will be assessed.

| Competence: | Actions: | Target Date: |
|---|---|---|
| For example, I have knowledge of Fife's Health and Social Care Partnership's inter-agency ASP procedures | CB requires to broaden his understanding of Council Officer training. To attend CO training. | Within next 6 months. |
| | | |
| | | |
| | | |
| | | |
| | | |

**Examples of Evidence to Support Competence Level-Appendix 2**

<u>Suggested Evidence Group A</u>

- Clear understanding of their role in making an alert and an Adult Support and Protection referral.
- Clear understanding of their organisation's policy and procedures.
- Understand limits to confidentiality.
- Be able to define 'adult at risk of harm'.
- Know the different types of abuse and how to recognise indicators/signs.
- Contact emergency services where appropriate.
- Know how to make an alert and a referral.
- Know how to record appropriately.
- Value individuality and be non-judgmental.

- Be aware of how own values and attitudes influence understanding of situations.
- Understand how to 'whistleblow' using Local procedures.

Suggested Evidence Group B

- Responds to referrals within specified timescales.
- Identify and reduce potential and actual risks after an allegation of abuse has been made.
- Convene relevant ASP meetings such as IRD or Case Conference meetings as appropriate within specified time scales.
- Contribute effectively to all information sharing.
- Develop protective strategies for those who refuse services.
- Show a clear understanding of the thresholds and pathways for investigating in response to an Adult Support and Protection referral.
- Describe the purpose of a IRD Meeting and Case Conference.
- Describe the purpose of a Protection Plan.
- Use of appropriate forms and recording systems.
- Understand the use of legislation within Adult Support and Protection work including:-
  -Adult Support and Protection (Scotland) Act 2007
  -Mental Health Care and Treatment (Scotland) Act 2003
  -Adults with Incapacity (Scotland) Act 2000
- Recognise service users' rights to freedom of choice.
- Understand the impact that abuse can have on individuals.
- Provide information on local support services that may provide support.
- Provide written and verbal information on Adult Support and Protection processes.
- Demonstrate knowledge of gathering, evaluating and preserving evidence.

Suggested Evidence Group C

- Evidence of protection planning.
- Evidence of report writing.
- Evidence of multi-agency working.
- Explicit understanding of confidentiality and data protection issues
- Demonstrate a thorough knowledge and application of purpose, duties, tasks involved in Adult Support and Protection investigations.
- Plan and carry our agreed strategy to protect an adult from harm during and following an investigation.
- Understand the different roles and responsibilities of the different agencies involved in investigating allegations of harm.
- Demonstrate a clear understanding of Fife Health and Social Care Partnership multiagency policy and procedures.
- Ensure supervision is carried out regularly to support safeguarding activity.
- Ensure effective performance management systems are in place and implemented when poor Adult Support and Protection practice is identified.
- Ensure the workforce has the necessary skills and knowledge to carry our effective safeguarding activity.
- Chair relevant Adult Support and Protection meetings and conferences in line with local policy and procedures.
- Demonstrate effective systems are in place to maintain records including investigation reports, minutes and protection plans.

Suggested Evidence Group D

- Have a strategic understanding of the scope of Adult Support and Protection services across the organisation.
- Work in partnership with a range of key agencies to promote Adult Support and Protection Services.
- Promote the Fife Health and Social Care Partnership's Adult Support and Protection Committee work plan and key priorities.
- Effectively communicates a proactive approach to Adult Support and Protection within your organisation.
- Be able to account for your organisations Adult Support and Protection practice
- Ensure that internal audit systems are robust and meet the requirements for external scrutiny.
- Have a comprehensive knowledge of Care Inspectorate inspection findings and how these will be implemented to support service development in your organisation.
- Be aware of the findings from serious case reviews and any Adult Support and Protection implications for service delivery in your organisation.
- Identify systems and structures in place used to raise awareness of Adult Support and Protection locally.
- Evidence that service users, patients and carers are supported and involved in all aspects of activity, and that their feedback impacts upon service planning and delivery.

# Appendix 3-Covering Letter as part of the ASPC's COVID Supermarket campaign

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Fife Adult Support & Protection Committee

*Child and Adult Protection Committee Support Team*

*Police Headquarters*

*Detroit Road*

*Glenrothes*

*KY6 2RJ*

Fife Child Protection Committee

**Fife Child Protection Committee**

To the Shop Manager

Dear Sir/Madam

I write to ask for your assistance to help Fife Child and Adult Protection Committees keep children and adults safe from harm during the current crisis.

The COVID- 19 outbreak and the current lockdown presents a variety of challenges to support children, young people and adults at risk of harm. The closure of schools and nurseries, day and drop-in centers, community hubs, libraries, banks and shops has resulted in people being behind closed doors, away from the people and services who might normally spot problems. We are asking everyone to keep their eyes and ears open for children and adults who may be at risk of harm, abuse or neglect during the COVID-19 crisis. During lockdown it's more important than ever to speak up if you see or hear something worrying about an adult or a child. This includes your staff, customers and delivery drivers, who can all have a part to play.

As part of our ongoing efforts to ensure that people know what harm is and how to report it, we have created the attached poster which details this information and shows the numbers to contact to talk about any concern you may have for both adult and child protection.

It would be appreciated if this poster can be displayed on your community noticeboard or near your shop entrance, so that we can continue to raise awareness of reporting methods and keep our communities safe from harm. I have enclosed an additional poster for display in staff areas and request that you make staff aware that any concerns they may see or hear about can be reported using the phonelines. If you are operating a delivery service, I would ask that you make your drivers aware.

If your staff, either within the shop environment or during deliveries see anything that gives them cause for concern, please assure them that it can be reported, confidentially if preferred, and that all concerns will be dealt with by Social Work and/or Police, handled sensitively and support provided if required.

I appreciate your assistance in this matter.

Yours faithfully

Alan Small

Independent Chair

Fife Child Protection Committee

**Chair** Alan Small **Lead Officer** Amanda Law

*"child protection is everyone's job ….it's our job"*

www.fifechildprotection.org.uk

# Appendix 4- Communication and Stakeholder Engagement Action Plan

| How will we communicate and engage with stakeholders? | Timescale | Responsibility | Measuring Impact |
|---|---|---|---|
| Seasonal ASPC SWAYs (one for the public, another for professionals) Winter 2022 SWAY will focus on "Staying Safe and Keeping Well" | Quarterly | ASPC | Feedback received (annual survey and ongoing) re the bulletin, and items for inclusion |
| Evaluate ASPC Webpage, and make any necessary recommendations for improvement | January 2022 | ASP Team | Website analytics/Visits to site |
| Harm Awareness Raising Campaigns via SWAY to be provided for joint audience of public and professionals. | Monthly | Learning and Development Group | Increased referrals from members of the public<br><br>Number of visits to SWAY page |
| Radio Campaigns | Quarterly | ASP Team, Kingdom FM Radio | Post Campaign Analysis fed back each quarter |
| Annual Adult Support and Protection Day | February | ASPC | Increased referrals from members of the public |
| Easy Read Resources/ Review resources for carers and families of adults at risk of harm, produce glossary of resources | March 2022 | ASP Team | Feedback received from public and professionals |
| Inter-agency Guidance and Protocols<br><br>- This is targeted work to strengthen links and ensure effective pathways of support for a workforce confident in ASP practices. | January 2022, to be updated as necessary | ASP Team | Feedback received from partner agencies as part of annual review of inter-agency guidance and protocol. |
| Professional updates to be provided relating to what the ASPC has achieved over the last quarter and will work towards over the next quarter | Quarterly | ASPC | ASPC to respond to this feedback in order to improve practice. |
| Practitioners Forum events | Quarterly | ASP, Learning and Development Group | Appropriate response – as measured by SE+I |

| | | | |
|---|---|---|---|
| | | | Group Performance Framework<br><br>Numbers in attendance |
| ASP Bitesize Awareness Sessions | Last quarter of 2022 | ASP Team, Engagement and Participation Co-Ordinator | Feedback from those involved |
| Service User Engagement Sessions<br>- Consideration to be given to engaging with minority groups and those with specific language requirements, for example, BSL. | Ongoing | ASP Team, QA Officer, SW Teams | Feedback from those affected<br><br>– Collected by front-line staff, Advocacy (including via website), QA Officer (Post-intervention questionnaire), wider partners, etc |
| Care Home Awareness Raising Sessions | Annual programme of engagement opportunities to be developed to help improve staff awareness:<br><br>- Awareness-raising sessions<br>with specific care home partners (via Teams or in person)<br><br>- Multi agency awareness-raising sessions, eg with third sector partners (via Teams or in person) | ASP Team, Learning and Development Group | Appropriate response – as measured by Performance Framework,<br><br>Numbers attending sessions across partners |