
# ADULT PROTECTION COMMITTEE BIENNIAL REPORT 2018 - 2020

## IMPROVEMENT PLAN 2020 -2022

# Content

## Foreword

Welcome to the sixth biennial report by the Independent Convener for Glasgow Adult Support & Protection Committee (ASPC) covering the period 01 April 2018 to 31 March 2020.

Our report reflects on developments since April 2018 but most importantly it outlines the plans and actions we have in place to ensure the continuation of a high quality service through to April 2022.

On 10th December 2019, the Chief Officers Group agreed the committee should change its name from Adult Protection Committee to Adult **Support** and Protection Committee. This is not just a name change but reflects a significant and transformational shift in the committee's approach to structural issues that might exacerbate the risk of harm for already vulnerable adults. We also need to concern ourselves with universal and support services that can mitigate the impact of potential harm.

In particular, the committee had a growing concern regarding the effect of poverty, homelessness and drug abuse on already vulnerable adults. Having received reports concerning the impact of these issues on already vulnerable people, the committee extended its membership and governance role to ensure regular intelligence updates and information on services designed to mitigate harm. We were also keen to look at the effectiveness of universal and more targeted health and social care services, on making that sure otherwise vulnerable adults are supported and empowered to manage risk and stay free from harm.

The importance of health and social care support services is reflected in our latest set of figures which show that where Council Officers are required to undertake a formal "duty to inquire", 69% of individuals are safeguarded by non-statutory Adult Protection services, 26% are able to safeguard themselves and only 5% progress to formal Adult Support and Protection investigations.

We were still working through our strategic context and governance role regarding these structural and support service issues when we were hit by the full impact of the COVID-19 pandemic. It therefore is appropriate that, in this report, we cover our COVID-19 response from the first lockdown through to end October 2020.

The committee quickly adapted to a new way of working and we established a pattern of more focused monthly meetings using technology to establish a “virtual” meetings platform.

We received regular updates and real time data reports from senior managers. The committee was able to record its unequivocal confidence that, despite tremendous and unprecedented challenges, all managers and staff across a range of statutory and voluntary organisations were demonstrating unstinting resilience and were doing their absolute best to meet the needs of Glasgow’s most vulnerable service users and to mitigate the impact of COVID-19.

In just one example, we heard from an area of the city how there had been a 60% reduction in the availability of care at home staff. To mitigate the impact of this, service users were issued with a letter explaining why their services had been affected, including a contact telephone number in order for any escalation of concern to be communicated to the appropriate team for review. The letter included a list of useful resources and contact numbers including Third Sector partners, Care and Repair, Food Train and Good Morning Glasgow.

Care services implemented welfare calls to all suspended service users with the aim of keeping in contact and ensuring that where circumstances had changed, there would be an appropriate and timeous response. A secure referral pathway to third sector partners was developed where a need was identified that could be met by services other than Homecare. In such circumstances, the involvement of community and voluntary organisations was invaluable.

Reports are emerging regarding the performance of statutory and voluntary services during the pandemic. Glasgow’s public protection services already has a strong reputation for using systems theory as a source of learning from case reviews and it is our firm intention that a similar approach should be adopted to disseminating learning from pandemic related service reviews.

COVID-19 will undoubtedly impact on the planning and actions section of this report, but we still need to focus on our core business while at the same time working in collaboration to ensure our services remain resilient, flexible and adaptive to emerging challenges.

Although biennial reports are a statutory requirement that helps us account to the people of Glasgow for our performance, we also produce quarterly newsletters which are “real time” and interactive. In future our newsletters will continue to reflect our ongoing work to build strong links across all aspects of public protection.

Service users play an absolutely key role in developing our vision, policies and strategic plans. At this time in particular, their feedback and engagement with our service response to the challenges of COVID-19 is crucial and valued. Service Users meet regularly as a subgroup but also have an influential role on the Adult Support and Protection Committee. The Service Users Group developed the following vision statement for our Adult Support and Protection Committee:

**By promoting health and well-being we aim to strengthen, safeguard and protect vulnerable people.**

The Adult Support & Protection Committee is the primary strategic planning mechanism for inter-agency adult support and protection work in Glasgow. It is responsible for ensuring that agencies work and act in a co-ordinated way on the prevention, identification and response to abuse and neglect. To fulfil this vision the Adult Support & Protection Committee will work:-

- To ensure strategic leadership and ownership of activity in Glasgow to protect adults at risk of harm
- To improve co-operation between agencies in Glasgow in their work to protect adults at risk of harm
- To enhance the development and delivery of services in Glasgow

The report will be produced in formats suitable for a wide range of audiences and will be available on our web site at www.glasgowadultprotection.org.uk

## Glasgow's Priorities

Our aims for adults at risk of harm sit firmly within the vision for Glasgow as a thriving, inclusive and resilient city. It can only be achieved through good partnership working and building relationships with adults at risk of harm, their families and carers in their communities. Our strategic priorities are based on the diverse needs of adults at risk in the city, and are underpinned by the National Health and Wellbeing Outcomes with an emphasis on outcome 7:-

- Outcome 1 – People are able to look after and improve their own health and wellbeing, and live in good health for longer
- Outcome 2 – People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- Outcome 3 – People who use health and social care services have positive experiences of those services, and have their dignity respected
- Outcome 4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Outcome 5 – Health and social care services contribute to reducing health inequalities
- Outcome 6 – People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- **Outcome 7 – People using health and social care services are free from harm**
- Outcome 8 – People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Outcome 9 – Resources are used effectively and efficiently in the provision of health and social care services

[Public Bodies (Joint Working)(National Health and Wellbeing Outcomes)(Scotland) Regulations 2014]

## The Glasgow Context

The most recent estimated population of Scotland is 5,454, 000. Glasgow is the largest city in Scotland and the fourth largest in the UK, with a population of 633, 120. Glasgow is a vibrant and diverse city but is not without its challenges.

The most recent release of the Scottish Index of Multiple Deprivation rankings shows that, out of Glasgow's 746 data zones, 45.4% are in the top 20% in terms of deprivation which is the highest in Scotland. Glasgow's share of the most deprived zones in Scotland is 24.3%, which is again the highest (Scottish Index of Multiple Deprivation, Scottish Government, 2020).

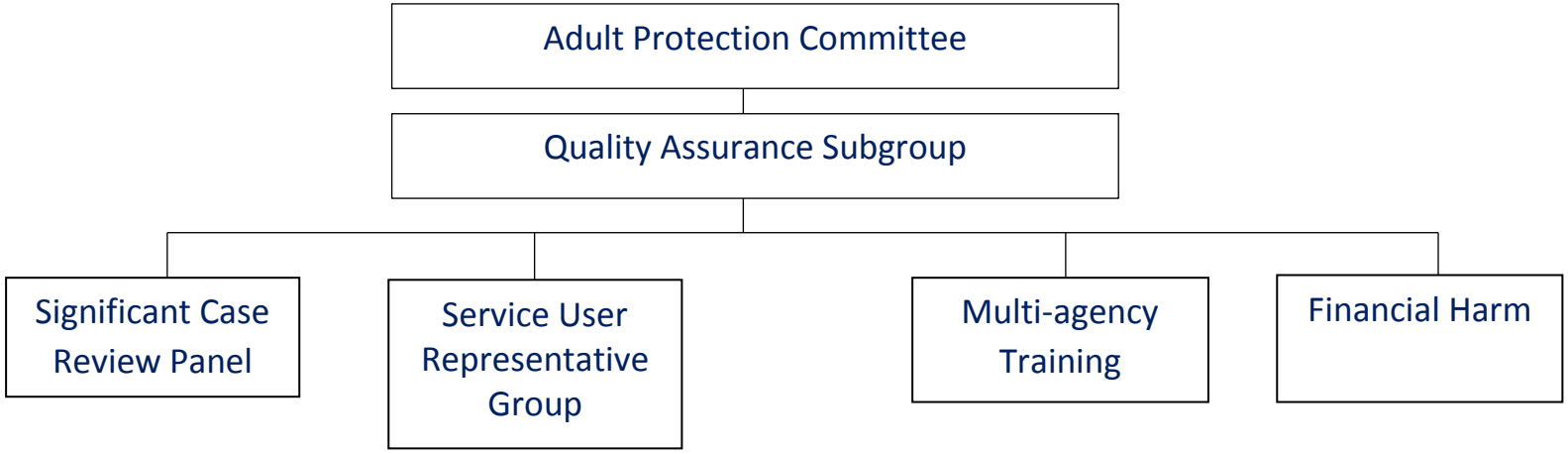
More than 50,000 people claim incapacity benefit benefit/severe disablement allowance/employment and support allowance, representing 9.8% of the 16+ population compared to a Scottish rate of 6.1% (Department of Work and Pensions, May 2016).

In Scotland, Healthy Life Expectancy at birth is 62.3 years for males and 62.6 years for females whilst in Glasgow it is 57.2 years and 58.9 years respectively. 14% of males and 17% of females report having mental health problems, compared with 18% of males and 24% of females in Glasgow. The national average for psychiatric hospital admissions is 262 per 100,000 population but this rises to 355 per 100,000 in Glasgow. (Glasgow City Health and Social Care Partnership Performance Report 2018 - 2019).

## The Adult Support & Protection Committee

The committee is chaired by an independent chairperson and has representatives from a range of backgrounds and organisations including the Health and Social Care Partnership, Police Scotland, NHS Greater Glasgow & Clyde, Scottish Fire and Rescue Service, Neighbourhoods and Sustainability, People First Scotland, Glasgow Disability Alliance, The Advocacy Project, Trading Standards, Glasgow Life, Registered Social Landlords, the Care Inspectorate and the Scottish Ambulance Service.

The committee has a number of subgroups to progress work on its behalf. Each subgroup has a workplan and reports to the committee on the progress of the plan, via the Quality Assurance Group. The committee reports to the Chief Officers Group.



Improvement Plan 2018 – 2020 Progress

A number of priorities were identified for this period:-

*Undertake a programme of self-evaluation activities*

'Paid Professional' as source of harm in Adult Support and Protection Investigations

In 2018, 312 ASP Investigations were completed, with 'paid professional' recorded as the source of harm in 17% of these cases. Committee members noted that this seemed significant and requested additional information on and interrogation of the data. For this exercise, the investigations completed between July and December 2018 were selected (25 in total) as this would give a representative sample of all cases.

54% of the investigations related to professionals from purchased home care services and 38% from purchased residential care, with the location of harm being recorded as 48% 'own home' and 32% 'residential establishment'. The location of harm figures indicate that an individual's own home carries the highest risk. It is perhaps worth noting that a number of the cases related to situations where one tenancy has multiple occupants all supported by one provider. This is classed as 'own home' but the actual amount of service users living in a single-occupancy or family homes was very small. Regardless, the data for 'own home' and 'care home' were not surprising as the sample is reflective of those with the highest level of needs in our community requiring higher levels of professional services.

Almost three quarters of the investigations were in relation to neglect by others, financial abuse and physical abuse. The 4% (one case) attributed to self-neglect is questionable – the concern was that a member of staff failed to prevent and may have contributed to an act of self-neglect therefore it could be argued that this was mis-categorised.

58% of the concerns reported were fully substantiated, and 21% partially substantiated. 71% of the investigations had harm attributed to an individual's actions, and 43% showed evidence of systemic/organisational issues (solely or in addition to the individual's actions).

Anywhere that there was a clear pattern of an individual or organisation causing harm to more than one service user, Large Scale Investigations were undertaken. For the 71% of cases which did not result in an LSI, there was a wide range of professionals and providers identified as the source of harm with no emergent themes which would suggest that an LSI would have been appropriate. In residential/group living/multiple occupancy settings, it was not so evident that consideration was given to risk and harm to others although a minority of cases had explicit statements within the case recordings.

Overall, there was evidence that risk was assessed for individuals, with the service user's needs and care plans being subject to review where necessary. Concerns were addressed with service providers, and support and guidance was provided to assist in service improvements. It was not always clear that Commissioning Services were involved and the outcomes of notices to Commissioning Services and referrals to Police Scotland were not recorded routinely.

One issue noted in a number of cases was where staff had witnessed or been aware of harmful behaviours and practices by another professional or the organisation, but had been unsure or hesitant about reporting the matter. Case recordings indicate that additional training for staff on recognising harmful practice/systems and understanding agency procedures for reporting such matters was recommended to help mitigate future concerns.

The following actions were recommended –

- Continued provision of multi-agency ASP awareness training, with an emphasis on reporting concerns in relation to colleagues
- Ensure adult services' staff are aware of and have access to the new Adult & Child Protection Committees' learning and development programme
- Case recordings should carry explicit statements regarding the consideration of risk to others by paid professionals
- Case recordings should also include explicit statements regarding referrals to Commissioning Services and Police Scotland, with the outcomes recorded
- The APC and Quality Assurance Subgroup will continue to monitor numbers of cases where 'paid professional' is the source of harm, with the potential to repeat this exercise if necessary

The evaluation also initiated a review of purchased services' whistleblowing policies by Commissioning Services.

Quality of chronologies

The 2018 tripartite audit of ASP identified that 91% of the casefiles subject to audit contained a chronology. Through discussion at the committee on the meaning of the audit findings and the publication of the Care Inspectorate's Joint Inspection of Adult Support and Protection of six local authorities, it was agreed that there required to be an examination of the contents and quality of the chronologies.

33 cases which had had an ASP investigation carried out were selected. An audit tool was devised using the Care Inspectorate's Practice Guide to Chronologies.

The vast majority of the chronologies were prepared for the purpose of the investigation report and many started from the point of the investigation with no or few historical events entered to provide context or enable identification of patterns of increasing/decreasing risk. A number of service users had ongoing or subsequent involvement but only two had life events added following the conclusion of the investigation. One service user had over 150 life events but these dated from before their transfer from children's services to adult services. In all cases, the chronology was separate and distinct from the case records (the investigation report e-form contains a section with a chronology template).

84% of the chronology entries were in date order, and half were assessed as containing clear and concise information. In over half, the source of the information was not clearly stated but could, in some instances, be inferred from the nature of the information. A significant gap was consideration of the impact of each event on the service user, with only 14% containing any analysis in this regard. The e-form template has four columns for input – date, brief details, those involved and consequences. Whilst the final column was completed routinely, this tended to relate to actions taken or decisions made as a result of the event.

Over half of the chronologies were deemed to be reflective of the case records and there was very little evidence of entries having been copied directly from the records.

The following actions were recommended –

- Increased provision of training on 'Quality in Chronologies' as part of the Adult and Child Protection Committees' learning and development programme
- The 'Quality in Chronologies' training materials are made available to managers to undertake briefings with their own teams
- Review the chronology template contained within the investigation e-form to ensure it facilitates consideration of the impact of events on the service user
- Undertake a repeat of this audit in six months' time
- As part of that audit, convene a focus group with Assistant Service Managers (who chair ASP Case Conferences) regarding their experiences of the use of chronologies in decision-making

Tripartite audit of ASP practice

A tripartite audit was carried out between September and November 2019. A sample of 65 cases which had had an ASP investigation was selected to analyse performance on key ASP processes and outcomes for adults at risk of harm.

The 3-point test was evidenced at every stage of the process, and communication between partner agencies and with service users was apparent. The quality of information captured on risks and concerns was generally clear. Advocacy service involvement was clearly recorded in case conference minutes. Good quality minutes were produced following the case conferences. Overall, service users were supported to be safe from harm.

It was noted that there were difficulties in implementing sanctions against perpetrators due to ongoing relationships with the service user. Some detail was lacking at times in outlining risk, and unpaid carer information was often not recorded appropriately. The involvement of the advocacy service was not well recorded on the e-form, resulting in inaccurate data on the number of referrals and uptake of the service. Service user attendance at case conference was low (40%) with anxiety about the meeting often cited as a barrier.

The following actions were undertaken/recommended –

- Any cases rated as below 'adequate' were passed to the HSCP locality service managers for follow up

- Any cases rated as very good or excellent were passed to the HSCP Learning & Development team for inclusion in training as examples of good practice
- A review of the e-forms is required regarding the recording of advocacy service involvement
- A focus group should be convened to elicit additional and more detailed views from service users on their experiences of ASP
- Further investigation of the barriers which inhibit service user attendance at case conference and actions to mitigate these

*Improve learning from practice*

Significant Case Reviews (SCRs) are a critical part of continuous improvement, and the committee is responsible for the undertaking of reviews, development of action plans based on the findings of reviews, and overseeing implementation of the action plans. The committee reports on SCRs to the Chief Officers' Group and the Care Inspectorate.

Within Glasgow, there is a protocol in place for SCRs based on the national guidance. All referrals are considered by a multi-agency panel, which makes the decision whether to proceed to SCR or not, appoints lead reviewers, monitors the progress of reviews, and reports to the committee on the outcomes.

In 2018, two reviews were commissioned and it was agreed that the Social Care Institute for Excellence's (SCIE) Learning Together model would be used. A number of senior managers had been trained in the use of the model and SCIE were engaged to provide mentoring and supervision for the reviewers. One review has been completed and the other is nearing completion.

As part of our ongoing work to improve how we learn from practice, a development session for the panel was convened, with the aims of clarifying membership and roles and responsibilities, and agreeing a plan to improve the processes of the panel. The session was supported by the Care Inspectorate, who agreed to act as a 'critical friend' for the process. The following was agreed:-

- Development session will be an annual event
- A pre-panel screening meeting will be set up to ensure all papers are correct and any remedial actions can be taken prior to panel meeting
- The panel will produce an annual review report, incorporating information from ICRs and SCRs, and thematic learning from SCIs Review and refresh panel's terms of reference
- Membership of group requires additional Heads Of Service for adults, older people, and residential care
- The current system of presenting referrals and ICR reports to the panel (agency representative liaises with their staff to prepare) will continue until September 2020, when it will be reviewed
- Panel members should identify a substitute representative in the event of their being unavailable, details to be sent to the lead officer
- Develop process flowchart detailing referral, ICR and SCR processes
- Review and refresh joint SCR protocol
- Provide briefings to staff on the role of the panel, the SCR process, and the links to the committees
- Any MAPPA ICRs/SCRs which are relevant will be shared with the ASPC/CPC SCR panel
- Learning points from ICRs to be summarised/noted and disseminated by relevant Head of Service

A working group has been established to oversee the improvement of learning from practice. One of its tasks is to explore the interface between the SCR and Significant Clinical Incident processes. There will also be activity on the models/ methodologies for learning from practice, how we disseminate and share learning across agencies, learning from positive practice examples, and making the Initial Case Review process more robust.

*Expand learning and development opportunities for the workforce*

Core Adult Support and Protection training continues to be delivered by the HSCP Learning and Development Team, with four standard courses provided to approximately 500 professionals each year – ASP Council Officer, ASP Second Worker, ASP Team Leader, and Multi-agency ASP Awareness. They also offer bespoke ASP sessions for individual agencies and groups.

The Senior Learning & Development Officer assumed responsibility for Multi-Agency Training for the ASPC in August 2018 in line with her existing responsibilities for Child Protection Committee (CPC) Multi-Agency Training. A review was undertaken of existing training and the decision was made to initially approach the planning of training from a thematic perspective, identifying common themes across Adult Support and Protection and Child Protection. This resulted in the creation of four training courses suitable for a joint adults' and children's services audience - Multi-Agency Decision Making, Trauma Informed Practice, Preparation and Practice in Chronologies, and Change and Loss.

These courses were offered to adults' services participants with the training calendar and application process following the same centralised process in place for existing CPC training with representatives of Housing, Home Care Services and Social Work attending on a regular basis. These courses were well received and evaluated with colleagues from adults' services advising they felt the content was appropriate and relevant to their job role. The joint approach to thematic training has strengthened these courses and supported stronger multi-agency working along with participants having a better understanding of the complexities in transition for young people from children's to adults' services.

In 2019, the Senior Learning and Development Officer identified a number of key areas for training around issues specific to adults' services including The Impact of Domestic Abuse on Older Adults (drawing on research undertake by Dewis Choice), Self-neglect and Hoarding, and Hate Crime. There is existing training offered from the HSCP Learning and Development Team in relation to Hate Crime which is offered on a multi-agency basis, the ASPC focus was therefore centred on Domestic Abuse on Older Adults and Self Neglect and Hoarding with a view to delivering these as part of the 2020/21 training calendar. The delivery of training has been significantly impacted by COVID-19 and the relevant restrictions in place, however these courses have now been designed for on-line delivery and will form part of the 2020/21 training calendar as planned, along with the thematic trainings noted above.

*Improve communication and engagement with the workforce and service users*

The committee continues to produce a quarterly newsletter, which is distributed widely across partner agencies and posted on the ASPC website. The newsletters contain a variety of articles from a range of contributors, e.g. help and

support for refugees, drug-related deaths, human trafficking and labour abuse, and suicide prevention. A monthly bulletin has also been established, which provides a summary of relevant articles, research and news in the public protection world. Again, this is sent to all partners and feedback indicates that staff appreciate the opportunity to access new developments and information.

Work has begun to strengthen the links between the committee and the locality ASP Steering Groups. This has entailed ensuring the correct representation from localities on the committee and the Quality Assurance Subgroup, with steering group updates now a standing item on the QA Subgroup agenda. The steering groups also have responsibility for sharing committee priorities and activity within the locality, and for co-ordinating any tasks required at a local level.

The committee, QA Subgroup and SCR Panel now have annual development sessions, and all partners are encouraged to participate. The committee development session in 2019 focused on membership, responsibilities and preparation for inspection. The QA Subgroup session was held in conjunction with the Child Protection Committee QA Subgroup, where the two groups looked at how they could work together on areas of joint interest and share relevant developments and learning from practice. For the SCR Panel, the priority was identifying ways to improve processes and embed a learning culture across the city.

The Service User Representative Group (SURG) continues to operate as a subgroup of the committee. The subgroup devised their terms of reference during this period, which sets out a clear purpose for the group - seek to influence the Adult Support & Protection Committee, question the committee about policies and procedures, make recommendations, influence practice and have input on training, and commission pieces of research.

SURG held a development session in December 2019, where members undertook a thresholds exercise. This provided an opportunity to focus on and discuss organisational and practice thresholds for access to services, as well as issues around risk and harm. Members provide input to the council officer training, which is seen as invaluable by attendees. The group has identified that additional representation is required, e.g. mental health and older people, and had begun planning an engagement event via other member organisations.

The group has been instrumental in the development of easy read leaflets on adult support and protection, and has noted other issues where these would be useful. Members took part in the ASPC development session, and have contributed information and articles for the newsletter and bulletin. Group members attend the committee, where they raise agenda items and ensure the opinions and experiences of service users are considered.

Individuals who are the subject of ASP investigations and case conferences are invited to complete a questionnaire on their experiences. Return levels are low, and this is an area for improvement. Of those returned, the feedback has been largely positive. 80% reported that they had the concerns leading to the case conference explained to them and that they were provided with a leaflet explaining ASP. All individuals who returned a questionnaire were informed of the advocacy supports available and the benefits this service could provide, and that they had been encouraged to give their views throughout the process. 80% felt that they had been listened to at the case conference and that they had experienced some positives by being involved in the ASP process.

In light of the low number of returns, it was agreed that an attempt would be made to hold a focus group to elicit additional and more in-depth views. Service users who had had an ASP investigation and been supported by the Advocacy Project were approached to participate, and two agreed. They were assisted by Advocacy staff to prepare for and attend the session. Both reported that they knew they needed help and support in relation to the harm they were experiencing, and both stated that the most helpful support was from the Advocacy Project but they were also able to identify other third sector agencies which had been useful. The service users advised that they did feel safer and that their quality of life had improved once the protection plan had been implemented. One of the service users related a number of previous experiences of agency involvement which they felt had had a negative impact on them and they had chosen not to attend their case conference as it would be too intimidating. This person reported that the investigation had involved being asked too many questions, and that they felt judged and not listened to. The other had had a more positive experience, informing that they were treated with dignity, had been listened to, and understood why decisions had been made.

## Adult Support & Protection Activity 2018 – 2020

The majority of AP1 referrals are submitted to Social Care Direct (SCD) which is the initial point of contact for Social Work Services. The total referrals received in 2019/20 were 6926 – a 42% increase from the previous year's total of 4865. The significant rise is due to improvements made to Carefirst 6 (Social Work's information system) to record all AP1s, as requested by the Scottish Govt. The change to the system was implemented in November 2018. However, some referrals will be for the same incident but received from different agencies so will be double counted.

As in previous years, the majority of referrals were from Police Scotland.

The majority of referrals, 89% and 83% respectively, were passed on by SCD to the Social Work duty teams after screening. Under Duty to Inquire, council officers were able to safeguard 69% of individuals by non-ASP actions where they were either signposted to social work for action or to another agency. 26% were no further actioned either because they did not meet the 3 point test and/ or were able to safeguard themselves. The remaining 5% went on to ASP investigation.

In respect of ASP investigations, a higher proportion were for adults with Mental Health (28%) and Learning disability (26%) in 2019/20. The previous year a higher proportion were categorised as 'other' due to data quality issues. There was little change in principal harm data over the two years with a third recorded as neglect. In two thirds of cases, the location of harm was the individual's own home. Over half of the investigations in 2019/20 proceeded to case conference compared to 44% the previous year.

## The Next 24 Months

The first few months of 2020 brought us COVID-19, a global event which is having a profound impact on society as a whole, and more severe consequences for the most disadvantaged in our communities. It has exacerbated certain existing risks and is causing new ones to emerge. At this point, it is unclear how long the pandemic will last or exactly what the long-term effects will be. Based on research from previous pandemics and natural disasters, we can predict that there will be increasing numbers of people in need of support and protection. Our data already demonstrates higher incidents of

domestic abuse and a deterioration in mental health. It is therefore crucial that we incorporate this data and research into our analysis of need in the city, and how we adapt policy and practice to respond.

As part of the national response to health and social care provision of services during the COVID-19 pandemic, local authorities were requested to provide weekly data reports to the Scottish Government on a range of data points across adults' and children's services. This has allowed the committees to scrutinise and track patterns and trends almost in real-time, and identify emerging themes and risks.

There have been a number of changes when compared to pre-COVID data, but one of the most significant so far has been in relation to mental health. This is not unsurprising given the general levels of anxiety about the virus across society; enforced isolation, employment insecurity and unemployment; increased financial difficulties and individuals/families being driven into poverty; and experiences of bereavement coupled with organisations having to find new ways of delivering services with safety restrictions in place.

Prior to COVID-19, the weekly average for Mental Health Officer detentions (MHOD) was 20. By week 12 of the lockdown period, this had risen to 24 and by week 21 this had increased to 30. The number of children placed on the Child Protection Register (CPR) with a risk indicator of parental mental health has also increased. During 2018 – 2020, the percentage with this risk indicator was between 14 and 19%. By week 21 of pandemic restrictions, this had reached 30%. The number of Vulnerable Persons reports recorded by Police Scotland has risen by 39% during that period, with anecdotal evidence that much of this is due to people experiencing mental and emotional distress.

These changes were discussed at both the Adult Support & Protection and Child Protection Committees. It was agreed that two thematic reviews would be undertaken into the increases in Mental Health Officer detentions and use of Parental Mental Health as a risk indicator in child protection registration.

The partnership has also embarked on an ambitious programme of work to re-design the city's domestic abuse strategy, supported by Professor Brid Featherstone from Huddersfield University. Strategic and operational groups have been established with the aim of implementing a whole system change, based on local data and evidence and learning from other authorities.

As part of our quest to improve learning from practice, a workstream has been initiated in conjunction with the CPC on the systems, models and methodologies we use. This includes streamlining the interface between our Significant Case Review and Serious Adverse Event (previously Significant Clinical Incident) processes, creating a toolbox of resources for extracting learning, and improving the means by which we disseminate learning across the city.

Another important part of our learning from the pandemic, will be capturing the experiences of service users and practitioners during this crisis, and using it to inform our future policies and service provision.

## Adult Support & Protection Committee Improvement Plan 2020 - 2022

| | Action | Lead | Timescale |
|---|---|---|---|
| Keep adults at risk safe from harm | | | |
| | Improve quality of chronologies in ASP | Locality ASP Steering Groups | March 2021 |
| | Establish annual reporting system on other aspects of public protection, e.g. homelessness, addiction, justice | Committee support team | March 2021 |
| | Improve analysis of available data to identify areas for self-evaluation | Lead Officer/ASPC/Quality Assurance Subgroup | March 2022 |
| | Explore viability of creating a data report based on Child Protection National Minimum Dataset | Lead Officer/Quality Assurance Subgroup | March 2022 |
| | Develop neglect assessment tool | Lead Officer/Neglect Working Group | March 2022 |
| | Improve learning from practice | SCR Panel/SCI-SCR Working Group | March 2022 |
| | Develop long-term strategy on domestic abuse | Domestic Abuse Strategic and Operational Groups | March 2022 |

| | | | |
|---|---|---|---|
| | Learning from impact of COVID-19 to identify strengths and areas for change | Quality Assurance Subgroup/Locality ASP Steering Groups | March 2022 |
| Learning and Development | | | |
| | Adapt existing programme for online delivery | Senior Learning & Development Officer | October 2020 |
| | Develop ASP-specific singe agency training courses | Senior Learning & Development Officer/Multi-agency Training Subgroup | October 2021 |
| | Create Learning Network to expand capacity for training delivery | Senior Learning & Development Officer/Multi-agency Training Subgroup | December 2021 |
| | Improve dissemination of learning from practice | SCR Panel/SCI-SCR Working Group/Multi-agency Training Subgroup | March 2022 |
| Communication and Engagement | | | |
| | Continue to produce newsletter and bulletin | Lead Officer/Development Officer | March 2022 |
| | Review of ASPC website | Lead Officer/Development Officer | March 2022 |
| Service User Engagement | | | |
| | Continue to support Service User Representative Group operations | ASPC/Committee Support Team | March 2022 |
| | Increase membership of Service User Representative Subgroup | SURG | March 2022 |

| | | | |
|---|---|---|---|
| | Provide learning and development opportunities for the Service User Representative Subgroup | SURG/Committee Support Team | March 2022 |
| | Capture service users' experiences of COVID-19 | SURG/ Locality ASP Steering Groups/Quality Assurance Subgroup | March 2022 |
| | Improve opportunities for service users to provide feedback on experiences of ASP | SURG/QA Subgroup/Advocacy Project | March 2022 |

## Appendix i - Adult Support and Protection in Glasgow

**Table 1**

Adult Support and Protection Referrals – Source

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **4865** | **6929** |
| Police Scotland | 26% | 40% |
| Other organisation | 26% | 18% |
| Council | 0% | 11% |
| NHS | 16% | 11% |
| Social Work | 19% | 8% |
| Scottish Fire and Rescue Service | 2% | 4% |
| Family | 2% | 1% |
| Other | 7% | 4% |
| GP | 1% | 1% |
| Care Inspectorate | 1% | 0% |
| Self | 0% | 0% |
| Friend/neighbour | 0% | 0% |
| Anonymous | 0% | 0% |
| Office of the Public Guardian | 0% | 0 |
| Scottish Ambulance Service | 0% | 0% |
| Mental Welfare Commission | 0 | 0 |
| Health Improvement Scotland | 0 | 0 |
| Unpaid carer | 0 | 0 |
| Other member of the public | 0 | 0 |

**Table 2**

Adult Support and Protection Referrals – Outcome

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **4865** | **6929** |
| Further ASP action | 89% | 83% |
| Further non-ASP action | 11% | 12% |
| No further action | 0% | 6% |
| Not Known | 0 | 0% |

**Table 3**

Adult Support and Protection Investigations - Gender

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| Female | 50% | 58% |
| Male | 50% | 44% |

**Table 4**

Adult Support and Protection Investigations – Age

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| 16 - 24 years | 7% | 9% |
| 25 – 39 years | 17% | 19% |
| 40 – 64 years | 36% | 36% |
| 65 – 69 years | 9% | 5% |
| 70 – 74 years | 8% | 8% |
| 75 – 79 years | 8% | 10% |
| 80 – 84 years | 6% | 7% |
| 85 years + | 8% | 7% |

**Table 5**

Adult Support and Protection Investigations – Primary Client Group

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| Infirmity due to age | 1% | 2% |
| Mental Health | 6% | 26% |
| Learning Disability | 19% | 22% |
| Other | 80% | 7% |
| Substance Misuse | 4% | 11% |
| Physical Disability | 3% | 12% |
| Dementia | 1% | 15% |

**Table 6**

Adult Support and Protection Investigations – Type of Harm

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| Neglect | 30% | 35% |
| Psychological | 16% | 16% |
| Financial | 20% | 14% |
| Physical | 13% | 14% |
| Self-harm | 7% | 9% |
| Sexual | 4% | 4% |
| Other | 10% | 8% |

**Table 7**

Adult Support and Protection Investigations – Place of harm

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| Own home | 63% | 62% |
| Other | 10% | 9% |
| Care home | 11% | 14% |
| Other private address | 7% | 4% |
| Public place | 5% | 7% |
| Sheltered or supported accommodation | 1% | 1% |
| NHS | 2% | 3% |
| Independent hospital | 0 | 0 |
| Day centre | 1% | 1% |

**Table 8**

Adult Support and Protection Investigations – Outcome

| | 1st April 2018 – 31st March 2019 | 1st April 2019 – 31st March 2020 |
|---|---|---|
| | **307** | **320** |
| Further ASP action | 44% | 55% |
| Further non-ASP action | 47% | 38% |
| No further action | 9% | 6% |
| Not known | 0 | 1% |