ASP national minimum dataset

Guidance for recording and submission of data

July 2025

Contents

Introduction

This document introduces the national minimum dataset (NMDS) for Adult Support and Protection (ASP)- why it came about, what it's for and how it was created.

It provides helpful information to support each Adult Protection Committee (APC) to collate and report on their data. The ASP NMDS should be understood as a package of support that includes the following:

- 19 indicators (nine of which have two measures; one of which has three)
- A Microsoft Excel workbook to support data submission and collation
- A glossary of terms
- Guidance on how to complete the workbooks, per indicator
- Scrutiny questions

The above can be found on our dedicated webpage. How to access this can be found under 'More information' in this document.

Frequently asked questions

What's the purpose of a National Minimum Dataset?

The NMDS for ASP is a collection of agreed indicators and categories that are quantifiable and collected quarterly each year (April-March). They form part of a package of resources to support collation, analysis and reporting on a core set of data. All of Scotland's 30 Adult Protection Committees are required to return this data to the Scottish Government.

The NMDS aims to create a robust shared understanding of information that works **both** locally and nationally to generate meaningful and comparable data. Its purpose is to inform planning and support the improvement of

services, locally and nationally. It can provide a baseline, map trends and support further scrutiny, reflection and action.

Why we needed to improve on what we had

The Adult Support and Protection National Strategic Forum and Improvement Programme was set up in 2019 to provide a strategic and cross sectoral view of what is needed to improve ASP across Scotland. It was informed by the 2018 thematic inspection by Care Inspectorate & scrutiny partners. Improving data and information in support of better outcomes formed a key strand of the improvement programme.

We knew that there was an opportunity to make data more meaningful, robust and comparable across localities and improve on what the Annual Data returns could tell us. This has meant a shift from annual to quarterly reporting. We also have indicators that tell us more about: the whole ASP journey rather than 'just the start'; the characteristics of adults in the system; the support received eg the uptake of independent advocacy or the number of Adult Support and Protection Plans in place; the extent to which the legislative powers provided by the Adult Support and Protection Act (2007) are used by Council Officers. The NMDS also incorporates data on Large Scale Investigations.

In creating the NMDS we have tried to remove duplication of effort where we can by working with colleagues, to cease collection of ASP data as part of SOLACE returns as part of a managed transition.

How it can be used

Scottish Government colleagues will use the NMDS to inform national improvement strategies and plans and help identify agenda items that can usefully be taken forward at a national level. Data may also contribute to policy developments in Public Protection and areas that interact with ASP.

Locally, the data is for use by multiple-agencies with responsibilities to support and protect adults at risk- to support shared learning, shared accountability and to drive improvement and inform forward planning.

The NMDS should also inform bi-ennial reports submitted by Convenors of APCs to Scottish Ministers every two years, which review and comment upon their activities in the preceding two years.

The strengths, limitations and opportunities provided by the NMDS should be considered, for example:

- It can be considered alongside and combined with other local indicators collected
- It can be combined with different *types* of data, including qualitative and experiential data from adults at risk, and professionals and non-professionals supporting them
- Interpretation of the data should consider local contextual factors, for example the impact of ASP initiatives on data trends or loss of local jobs on the populace
- For the data to be used effectively, sufficient time and space for multidisciplinary stakeholder reflection is needed
- Scrutinising the data in the NMDS should trigger 'deeper dives' to help answer the questions it raises.

At a future point, it is also our hope that extracts of data from the NMDS, can contribute to communications in the public domain to raise the profile of ASP's contribution. Scottish Government colleagues will determine what might be published, dependent upon data quality, and mindful of data protection matters.

How we created the ASP NMDS

We began with a national mapping exercise of indicators frequently collected by Adult Protection Committees (APCs), looking at these appreciatively. Twenty-two APCs contributed to this. This helped us to identify indicators with potential for national roll out.

We also recruited five learning partners to help co-design and test indicators, and develop supporting materials. The five learning partners were: Dumfries and Galloway, East and South Ayrshire, East Dunbartonshire and Renfrewshire, and used a range of MIS systems.

During the project, we also sought feedback on prototype datasets developed by the learning partners from Data Reference Group members - a national group with multi-stakeholder representation, co-chaired by the Scottish Government and Iriss.

Why a phased approach to implementation?

Through dialogue with learning partners and others, we agreed that we needed to roll out the Dataset in a phased way so as not to overwhelm systems. Phase 1 included a sub-set of all the indicators finally rolled out in Phase 2.

Roll out of Phase 1 took place in 2023-24; Phase 2 began at the start of 2024-25.

How is quality assurance supported?

We offer support for implementation in the form of quarterly drop ins. These allow us to provide updates and guidance, but also importantly, listen to and learn from colleagues using and implementing the NMDS locally. These sessions are promoted through the ASP Leads, and are open to anyone with an interest. We encourage attendance from MIS colleagues.

Those submitting the data can also use the commentary boxes in the workbook to highlight where they have been unable to provide data and why. In the first year of roll out forPhase 1 and Phase 2, we have also allowed for retrospective updates to previous quarters as systems and practices adapt to the new NMDS. We will review whether the above supports are helpful beyond 2024-25.

Guidance on sharing data

We know you will be considerate of sharing potentially sensitive information about adults; especially when they may have been harmed and your role is to support and protect them from harm.

In line with Scottish Government data governance practices a Data Protection Impact Assessment (DPIA) has been completed. This outlines how the data will be processed, the purposes of the processing etc. The DPIA was completed with and approved by our data governance colleagues.

Please note:

- No personal data eg. names, date of birth, postcode etc. have been requested to be shared. Some categorical data has been requested that include a person's attributes e. sex, age group, client group (ie disability), ethnicity etc. but this data has been requested at such a level that it's not specific to an individual eg. age group rather than age. Given that there are more than one person with each attribute in your area, sharing 1s in tables isn't disclosive.
- Each attribute is collected in a separate table and from these tables you can't put more than one together and learn anything new about an individual. For example, if there's one person who had a learning disability and one person had been financially harmed there's no way to tell whether they are the same person or not. If this were to change, and more categories were put together in one table or to reflect one person, we would need to revise the DPIA.
- Iriss are working on behalf of the Scottish Government as their current current designated data Processor and must follow the same governance rules regarding confidentiality and data storage

- Please **do not** include or offer any personal identifiable information, eg names, in the workbook template as we do not want to collect any personal identifiable information.

What will be reported and shared?

The Scottish Government will decide what will or will not be made available in the public domain. The quality of the data received will inform decisions on future publication, and will take into account Data Protection Impact Assessments, considering any risks of identifying individuals within the data.

Will the NMDS evolve over time?

To ensure quality and ongoing relevance, while maintaining consistency, we will need to consider cycles for review and updates. Key dates will be determined by the Scottish Government, with input from those working in the field. Going forward, future iterations of the ASP NMDS will be overseen and supported by the national Data Reference Group.

Indicators at a glance

INVOLVEMENT IN ASP PROCESSES	
INDICATOR 1	ASP REFERRALS SUBMITTED TO ADULT PROTECTION SERVICE (BY SOURCE)
INDICATOR 2	INQUIRIES CONCLUDED WITHOUT THE USE OF INVESTIGATORY POWERS
INDICATOR 3	INQUIRIES USING INVESTIGATORY POWERS
MULTI-AGENCY ADULT SUPPORT AND PROTECTION CONFERENCES (CASE CONFERENCES)	
INDICATOR 4a	INITIAL CASE CONFERENCES
INDICATOR 4b	REVIEW CASE CONFERENCES
INDICATOR 5a	ADULTS INVITED TO ATTEND A CASE CONFERENCE (TOTAL)
INDICATOR 5b	ADULTS INVITED TO ATTEND A CASE CONFERENCE (PERCENTAGE UPTAKE)
INDICATOR 6a	INDEPENDENT ADVOCATES INVITED TO ATTEND A CASE CONFERENCE (TOTAL)
INDICATOR 6b	INDEPENDENT ADVOCATES INVITED TO ATTEND A CASE CONFERENCE (PERCENTAGE UPTAKE)
ADULT SUPPORT AND PROTECTION PLANS AND USE OF POWERS	
INDICATOR 8A	NUMBER OF ADULTS ON ASPPs IN TOTAL AT END OF QUARTER
INDICATOR 8B	NUMBER OF ADULTS WITH NEWLY COMMENCED ASPPs WITHIN QUARTER ONLY
INDICATOR 9A	PROTECTION ORDERS (APPLIED FOR)

INDICATOR 9B	PROTECTION ORDERS (GRANTED)
INDICATOR 10	ACTION TAKEN FOLLOWING INQUIRIES CONCLUDED WITHOUT THE USE OF INVESTIGATORY POWERS
INDICATOR 11	ACTION TAKEN FOLLOWING INQUIRIES USING INVESTIGATORY POWERS
DEMOGRAPHICS AND DESCRIPTIVE DATA	
INDICATOR 13	AGE GROUP AND GENDER (FOR ALL INQUIRIES)
INDICATOR 14	ETHNICITY (FOR ALL INQUIRIES)
INDICATOR 15A	PRIMARY TYPE OF HARM (FOR INQUIRIES CONCLUDED WITHOUT THE USE OF INVESTIGATORY POWERS)
INDICATOR 15B	PRIMARY TYPE OF HARM (FOR INQUIRIES USING INVESTIGATORY POWERS)
INDICATOR 16A	LOCATION OF HARM (FOR INQUIRIES CONCLUDED WITHOUT THE USE OF INVESTIGATORY POWERS
INDICATOR 16B	LOCATION OF HARM (FOR INQUIRIES USING INVESTIGATORY POWERS)
INDICATOR 17A	PRIMARY CLIENT GROUP (FOR INQUIRIES CONCLUDED WITHOUT THE USE OF INVESTIGATORY POWERS
INDICATOR 17B	PRIMARY CLIENT GROUP (FOR INQUIRIES USING INVESTIGATORY POWERS)
INDICATOR 18A	NO. OF INQUIRIES USING INVESTIGATORY POWERS WHERE ADULT HAS CARING RESPONSIBILITIES
INDICATOR 18B	NO. OF INQUIRIES USING INVESTIGATORY POWERS WHERE CHILD WAS PRESENT AT INCIDENT
LARGE SCALE INVESTIGATIONS	
INDICATOR 19A	LARGE SCALE INVESTIGATIONS (BY SERVICE TYPE)
INDICATOR 19B	CARE INSPECTORATE ASSIGNED UNIQUE CS NUMBERS
INDICATOR 19C	NHS HOSPITAL LOCATION CODE (PER INDIVIDUAL LSI)

General notes on the indicators

Numbering

Please note that some indicators have a and b parts.

It should also be noted that there are no indicators 7 or 12. These have been removed based on a period of testing and feedback. To avoid confusion we have opted to keep the original numbering of the remaining indicators.

Changes between Phase 1 and Phase 2

Please note that for indicators 13 (age and gender) and 14 (ethnicity) we are now looking for data on ALL inquiries triggered in a quarter for the current

workbook. For indicators 15 (Principal type of harm), 16 (Location of harm) and 17 (Primary client group) we ask you to distinguish and provide data for: inquiries concluded without the use of investigatory powers; and inquiries using investigatory powers.

The use of the commentary box

We understand that there are different reasons, such as challenges with recording systems or staff absences, that mean data is currently unavailable or will be delayed. We strongly encourage local authorities to still provide the workbook and to use the commentary box to let us know the specific challenges they are experiencing.

If there are any local trends or caveats that you want us to be aware of, please add these as well in the commentary box.

Updating as the year progresses

We fully understand that cases and inquiries often do not neatly fit within one quarter. Because of this, we strongly encourage local authorities to update previous quarters, if needed prior to new submissions. If you have updated something, please indicate this in the commentary box or in the cover email when submitting the workbook.

The use of 'other'

We have included 'other' as a category for many indicators, asking you to specify what 'other' is if you use this. Please ensure that you do not use 'other' where there are relevant pre-existing categories. We will be reviewing the use of 'other' to help identify if there are other key categories that should be added at future review dates. It is our intention that the use of 'other' is minimised or phased out to support quality assurance.

Quality checks before submitting your returns

It is your responsibility to review and check data quality before submitting your data.

Structure of the remaining document

The remaining document sets out the rationale for inclusion of the indicators, detailed information on how to complete the quarterly workbook, a summary of all scrutiny questions across indicators and notes on the interpretation of the data.

More information:

For more information please look on our website: www.iriss.org.uk/aspdataset.

The website contains the latest workbook, deadlines for data returns and how to submit them, as well as FAQs and any updates regarding the national minimum dataset. We encourage you to use this as a resource.

If you need access to this site, but do not have the login details to the page, please contact: ASPData@gov.scot

Rationale for each indicator

Indicator	Rationale for inclusion / exclusion
Indicator 1: ASP referrals submitted to Adult Protection Service (by source)	Tells us how many referrals are submitted across different sources to Adult Protection Services. This helps us understand the overall volume of referrals, as well as identify season or year on year trends including where referrals are coming from. The data will show which stakeholders are contributing – to inform awareness raising, training or learning and development or guidance needs across stakeholder groups on appropriate referral pathways. Locally, totals can be used in combination with Indicators 2 and 3 (inquiries without and with use of investigatory powers) to provide conversion rates.
Indicator 2: Inquiries concluded without the use of investigatory powers	Tells us how many inquiries are conducted without investigatory powers.
Indicator 3: Inquiries using investigatory powers	Tells us how many inquiries are conducted with investigatory powers.
Indicator 4: Case Conferences	a) The number of initial case conferences tells us about levels of activity and resource demands on the workforce; indicator on numbers of 'adults at risk' where further action is anticipated. b) The number of review case conferences tells us about levels of activity and resource demands on the workforce; tells us about due diligence in managing and monitoring individual cases.
Indicator 5: Adults invited to attend a case conference	Tells us where the 'adult at risk' has been involved, as a contributory factor to their views being taken into account.
Indicator 6: Independent Advocates invited to attend a case conference	Indicates that we are meeting our duty to consider advocacy after the decision has been made to intervene, contributing to the views of the adult being taken into account.
Indicator 7	Excluded after discussions with learning partners and piloting.
Indicator 8: Adults on Adult Support and Protection Plans	Tells us about levels of activity and the volume of 'adults at risk' being supported with an Adult Support and Protection Plan in place.
Indicator 9: Protection Orders	Tells us about workforce demands and use of legislative framework as applied to 'adults at risk'.

Indicator 10: Actions taken following inquiries concluded without the use of investigatory powers	Tells us about numbers of vulnerable adults assessed as meeting the three-point criteria, proportion if ongoing ASP work, proportions referred to other non-ASP services, placing work in context. Important in monitoring numbers assessed as meeting the three point criteria over time in a changing context of trauma-informed practice.
Indicator 11: Action taken following inquiries using investigatory powers	Tells us about numbers of vulnerable adults assessed as meeting the three-point criteria, proportion if ongoing ASP work, proportions referred to other non-ASP services, placing work in context. Important in monitoring numbers assessed as meeting the three point criteria over time in a changing context of trauma-informed practice.
Indicator 12	Excluded after discussions with learning partners and piloting.
Indicator 13: Age and Gender	Tells us about the most vulnerable adults in the system - who they are and what types of harm they face and where. The 16-17 age band is to capture data on those in transition from or spanning children and adult services.
Indicator 14: Ethnicity	Tells us about the most vulnerable adults in the system - who they are and what types of harm they face and where. It also allows us to understand if any ethnicities are subject to a disproportionate amount of inquiries. The categories used for ethnicity mirror those used in the last census, 2022: https://www.scotlandscensus.gov.uk/media/fxonlo0d/scotlands-census-2022-question-set-version-v4-0-09-09-2021.pdf
Indicator 15: Primary types of harm	Tells us about the most vulnerable adults in the system - who they are and what types of harm they face and where. Total identifies the number of individuals being referred to and processed by the system.
Indicator 16: Primary location of harm	Tells us about the most vulnerable adults in the system - who they are and what types of harm they face and where. Total identifies the number of individuals being referred to and processed by the system.
Indicator 17: Primary client group	Tells us about the most vulnerable adults in the system - who they are and what types of harm they face and where.

	Total identifies the number of individuals being referred to and processed by the system.
Indicator 18: No. of Inquiries with caring responsibilities	TBC
Indicator 19: Large Scale Investigations	a) Is indicative of demands on the workforce and that large numbers of adults within a service may be at risk. b) Capturing the unique CS number for those registered with the Care Inspectorate will also ensure that we can pinpoint exactly which providers are the focus of an LSI and help those with national oversight make connections across local areas.

Indicator 1: ASP referrals submitted to Adult Protection Service (by source)

Definition

ASP referrals (Glossary term)

ASP referrals are made by different stakeholders to the Health and Social Care Partnership's (HSCP) Adult Protection Service where it is known or believed that an adult is at risk, and that further action may be required to protect the person's well-being, property or financial affairs.

There is a duty on certain public bodies or office holders who know or believe that a person is an adult at risk of harm and that action may need to be taken to protect them, to make an ASP referral. However, ASP referrals may be received from sources in addition to public bodies, including third sector organisations, members of the public, or the person at risk themselves.

Referrers do not need to have evidence that all elements of the three-point criteria, as referred to in the Act, have been met. Good practice would dictate that even if in doubt the referral should be made. This should be counted as an ASP referral by the HSCP's Adult Protection Service receiving it.

Following **receipt** of an ASP referral, if the council knows or believes that the adult is at risk of harm and that it might need to intervene to protect their wellbeing, property or financial affairs, a S4 inquiry must be undertaken.

Rationale for collection

ASP referrals tell us how many referrals are submitted across different sources to Adult Protection Services. This helps us understand the overall volume of referrals, as well as identify seasonal or year on year trends and where referrals are coming from. The data shows us which stakeholders are contributing – to inform awareness raising, training or learning and development or guidance needs across stakeholder groups on appropriate referral pathways.

Locally, totals can be used in combination with Indicator 2 and 3 (inquiries without, and inquiries with- use of investigatory powers) — to provide conversion rates.

Notes on how to count ASP referrals

Whether to count something as an 'ASP referral' or not should always be determined by the act of the sender (not the receiver) *except* in the following two scenarios:

- where a referral is received from a non-professional, such as a concerned member of the public with no knowledge or awareness of ASP and unable to ascertain where to direct their concern OR
- when a welfare concern is escalated to an ASP referral.

In the above two exceptions, the status of the referral and whether it should be recorded as an 'ASP referral' or not would be determined by a worker and not the original source of the referral.

How to interpret ASP referrals

Please note that the number of ASP referrals does not equal the number of adults referred to ASP Services (or subsequent S4 inquiries). These should ***not*** be expected to match. More than one ASP referral can be received for the same individual from different agencies that have come into contact with the adult. This may be for:

- The same individual, same incident, and same type of harm at a singular point in time
- The same individual but separate incidents or different types of harm within a short timescale

Such referrals may or may not generate a separate inquiry. This will depend on local practices and whether different ASP referrals for the same individual are linked in systems.

How to record the source of an ASP referral

This should always be the original source of the referral with the following exception. For welfare concern referrals escalated by a social worker to an ASP referral, the original source of the referral should be recorded. For example, a welfare concern from the police escalated to an ASP referral by a social worker should be counted as an 'ASP referral' with 'police' recorded as the source of the referral.

We have provided standard umbrella categories for ASP referral sources, reflecting **service types**. We recognise that we need something that will work for all 32 Local Authority areas but appreciate that how services are managed (and what professionals are involved in them) will be different in different areas.

The examples provided below are for illustrative purposes to provide guidance and may not be an exact fit with how things are organised in your particular environment.

In determining category selection

Please be guided by the service type

For example, there are Social Work Occupational Therapists (OTs) as well as NHS OTs. The former would be recorded as a social work referral as it is the service, not the job role, which has key importance here. Similarly, workers with the same job title can work in different service types eg a nurse may work in Primary Care, in Acute Services or in Community Health Services.

We appreciate that ASP referrals from integrated teams will be harder to categorise. This will need to be a local decision as to whether there is a broad fit with the categories provided' or if you feel the need to include under 'other' - recording further details and any caveats to highlight data issues going forward.

Please remember that where you are using the 'other category' that you should provide information specifying the referral source. We will review the use of 'other' going forward to minimise its use.

Be guided by the reason for collecting the ASP referral source

Remember that a **key reason** for collecting the source of an ASP referral is to help you understand what local services are contributing to ASP work, and to inform what training, learning and development activities, guidance or awareness raising is required.

To support this, you might want to consider training to ensure the data is captured in a consistent way and take account of how services are organised in your local area, or create a local 'pick list'. And, while not a requirement of the Minimum Dataset, you may choose to provide further sub-categories under the umbrella categories we have provided locally.

Health Source Category

Category	Description / illustrative example
Healthcare Improvement Scotland	
NHS 24	
NHS Primary Care	GPs, dentists, pharmacists, optometrists or District Nurses.
NHS Acute Services	General hospitals including maternity hospitals, some other community hospitals specialising in care such as rehab or long-term care may be included here or could be added to the community health category.
NHS Specialist Drug and Alcohol services	This would cover all NHS drug and alcohol services in-patient and community based. Please note that drug and alcohol services are typically led and managed under mental health services in the NHS.
NHS Community Health Services	Health visitors, school nurses, family nurses, midwives, community hospital staff, Allied Health Professionals (rehab, day services etc); possibly district nursing depending on local service arrangements.

Mental Health Services – hospital and community	This would cover all in-patient and community based mental health services including Learning Disability services, CAMHS, Psychiatric Liaison and crisis. Also psychology services — mostly mental health but may include other service areas depending on local arrangements. It may also include GP based mental health practitioners - again, depending on local arrangements.
Other Health	E.g. Public Health, Private Healthcare, Prison Healthcare
Scottish Ambulance Service	
Care home	This would include care homes from the public, private and third sectors and a mix of professionals.
Housing	This would be inclusive of housing provided by local authorities, private landlords or housing associations and homelessness services.
Children's Services	Eg Children's reporter, CELCIS, Barnardos, Women and Children First.

Recording the source for escalated welfare concerns

For welfare concern referrals escalated by a social worker to an ASP referral, the original source of the referral should be recorded. So for recording purposes, this would be counted as an 'ASP referral' with 'police' as the source of the referral.

Benchmarking options

Data can be benchmarked by converting the number of ASP referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 2 and 3: Inquiries concluded without the use of investigatory powers; inquiries using investigatory powers

Definition

Inquiries and inquiries using investigatory powers

The purpose of an inquiry, with or without use of investigatory powers, is to ascertain whether adults are at risk of harm, and whether the council may need to intervene, provide support, or any other assistance to the adult or any carer. Any use of investigatory powers is triggered through the S4 duty to inquire under the Act.

An inquiry using investigatory powers requires the involvement of a council officer (an individual appointed by a council to perform specific functions under the terms of the Act). It may also require production of a risk assessment if initial inquiries show that further ASP activity is warranted. An inquiry which does not use investigatory powers may or may not require the involvement of a council officer, depending on local arrangements and the nature of the tasks.

The collation and consideration of relevant materials, including consideration of previous records relating to the individual and seeking the views of other agencies and professionals, does not necessarily need to be undertaken by a council officer if these inquiries do not include use of investigatory powers. Investigatory powers will be required, and a council officer involved, where there is a need for a visit and direct contact with the adult for interview or medical examination, or for the examination of record (undertaking activity from Sections 7-10 of the Act).

Inquiries may involve a single agency or more, as relevant to the case.

It should be noted that use of inquiries (with or without use of investigatory powers) supports a move away from talking about inquiries and investigations, and is aligned with the revised Code of Practice (July 2022).

Notes on how to interpret

We do not expect ASP referrals to match the number of inquiries. We know, for example, that multiple agencies can make an ASP referral for the same person- triggered by the same or a different incident.

Neither should we equate the number of inquiries with the number of adults being inquired about. For example, a fresh ASP referral may result in a new inquiry being triggered in a quarter, if the previous inquiry has been closed. If it has not been closed, it would be a continuing inquiry with new information. Equally, if an initial case conference is pending or an adult has an Adult Support and Protection Plan (ASPP) in place, an ASP referral would provide new information, but would not ***necessarily*** trigger a new inquiry.

We are aware that, in certain areas, some ASP referrals are closed to ASP processes before an S4 inquiry has been undertaken (separate from those circumstances described above). These may be passed/signposted to another team or service in the absence of a S4 inquiry. Guidance and clarification has been requested from the Scottish Government on the general duty to make inquiries under S4 of the Act. Any clarifying or best practice information received will contribute to future minimum dataset guidance regarding these particular indicators.

Guidance on completion

It is the trigger point of an inquiry that determines what quarter it should be recorded in. This is pertinent to inquiries that conclude without use of investigatory powers, and to inquiries that use investigatory powers.

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmark options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 4: Case Conferences

Definition

Case conferences

The purpose of case conferences will be defined by local procedures but should include: the sharing of information relating to possible harm; the joint assessment of current and ongoing risk; agreement of a specific and detailed Support and Protection Plan (where required) with timescales for addressing risks and providing services to support and protect the adult. They are sometimes referred to as 'initial' and 'review' case conferences.

Case conferences should be as inclusive of multi-agencies as relevant. There is a presumption that the adults themselves will be in attendance (unless it is considered not to be in their best interests) or the adult freely chooses not to attend with no undue pressure from others.

It will consider actions that may need to be taken under the Adult protection legislation, but may also explore options for protecting people under other legislation – including (but not restricted to) provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Notes on how to interpret

We consider interpretation of 4a and 4b on numbers of initial and review case conferences self-explanatory.

Guidance on completion

Otherwise, we consider this self-explanatory. We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicators 5 and 6: Adults invited to attend a case conference and independent advocates invited to attend a case conference

Definition

The purpose of case conferences will be defined by local procedures but should include: the sharing of information relating to possible harm; the joint assessment of current and ongoing risk; agreement of a specific and detailed Support and Protection Plan (where required) with timescales for addressing risks and providing services to support and protect the adult. They are sometimes referred to as 'initial' and 'review' case conferences.

Case conferences should be as inclusive of multi-agencies as relevant. There is a presumption that the adults themselves will be in attendance (unless it is considered not to be in their best interests) or the adult freely chooses not to attend with no undue pressure from others.

It will consider actions that may need to be taken under the Adult protection legislation, but may also explore options for protecting people under other legislation - including (but not restricted to) provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Guidance on completion

The percentage of those invited to attend a case conference who took up the offer. **Please DO NOT add a percentage symbol (%)** after the value.

We are looking for the cumulative number by end of quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 8: Number of adults on Adult Support and Protection Plans (ASPPs)

Definition

Adult Support and Protection Plans (ASPPs)

An Adult Support and Protection Plan is a set of actions and strategies agreed by relevant agencies (single or multi-agency) and put in place to support and protect 'adults at risk' meeting the three-point criteria. The Plan is designed to eliminate or reduce risk, manage this over time and respond to changing circumstances, overseen through case conference processes. Plans will stay in place until agreed that they are no longer necessary.

Adult Support and Protection Plans should be agreed across all relevant agencies identifying who is responsible for which aspects of the plan, the anticipated timetable, and reporting arrangements. This should include a date for a review meeting - unless it has been agreed that no further actions are required under the terms of the Act. It is also expected that the adult should be supported to contribute to the fullest possible extent and understand the actions in the said Plan.

An Adult Protection Plan can be initiated at any point of the ASP process depending on need or urgency or local processes, but most commonly at a case conference.

Guidance on completion

Indicator 8a

Total number of adults on open plans under ASP at the end of a quarter.

Please note, an ASPP is closed when there is no longer any ASP oversight of support actions.

Indicator 8b

Total ASPPs are those started in a quarter and exclude review plans. An ASPP revised at a review Case Conference is NOT a new ASPP.

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 9: Number of Protection Orders

Definition

Protection Orders

The Act allows for application to a sheriff for a Protection Order. Applications must be made by the council, save for banning orders. Here, the application may also be made by or on behalf of the adult whose well-being or property would be safeguarded by the order, or any other person who is entitled to occupy the place concerned.

Protection Orders may be applied for at any time. Applications can be made for another Protection Order, but not until the expiry date of the one in place.

Assessment Orders

An order granted by a sheriff to help the council decide whether the person is an adult at risk and, if so, whether it needs to do anything to protect the person from harm. These may be to carry out an interview or medical examination of a person and are valid for 7 days.

Removal Orders

An order granted by a sheriff to remove an adult at risk to a specified place to assess and protect them, effective for a maximum of 7 days after the day on which the person is removed, which must take place within 72 hours of the order being granted.

Banning/Temporary Banning Orders

An order granted by a sheriff to ban the person causing, or likely to cause, the harm from being in a specified place. It may have other conditions attached to it, and may last for a period of time not exceeding 6 months. The subject of the order may be a child or adult. Serious harm must be evidenced.

In case of urgency, a council can apply to a justice of the peace of the commission area, as opposed to a sheriff, with different arrangements in place for this.

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 10 and 11: Action taken following inquiries with and without the use of investigatory powers

Definition

Inquiries and inquiries using investigatory powers

The purpose of an inquiry, with or without use of investigatory powers, is to ascertain whether adults are at risk of harm, and whether the council may need to intervene, provide support, or any other assistance to the adult or any carer. Any use of investigatory powers is triggered through the S4 duty to inquire under the Act.

An inquiry using investigatory powers requires the involvement of a council officer (an individual appointed by a council to perform specific functions under the terms of the Act). It will also require production of a full risk assessment. An inquiry which does not use investigatory powers may or may not require the involvement of a council officer, depending on local arrangements and the nature of the tasks.

The collation and consideration of relevant materials, including consideration of previous records relating to the individual and seeking the views of other agencies and professionals, does not necessarily need to be undertaken by a council officer if these inquiries do not include use of investigatory powers. Investigatory powers will be required, and a council officer involved, where there is a need for a visit and direct contact with the adult for interview or medical examination, or for the examination of record.

Inquiries may involve a single agency or more, as relevant, to the case.

It should be noted that use of inquiries (with or without use of investigatory powers) supports a move away from talking about inquiries and investigations, and is aligned with the revised Code of Practice (July 2022).

Guidance on how to count

For both indicators 10 and 11 please count all inquiries triggered in a quarter and record actions taken where these are known. Actions can be tracked up to the submission date you have been provided with for each quarterly data return.

To illustrate:

If 100 inquiries were begun in Quarter 1 (1 April - 30 June inclusive) we ask you to record what actions were taken, tracking these up to August 12th, the Scottish Government submission date for returns. Please select the action taken from the list of categories provided.

We understand that there may be delays that result in actions taken being recorded as pending/unknown. We ask you to provide commentary in the free box on the reasons for delays eg. delay in receipt of financial records requested of other agencies as part of an inquiry.

In determining category selection

We offer the following notes to help you determine category selection for indicators 10 and 11.

Does not meet three-point criteria — NFA

This is where the adult does not meet the three point criteria, there is no requirement for any social work involvement and no requirement to refer to another agency ie. NFA.

Meets three-point criteria — non-ASP support provided or offered

Every time we intervene in a person' s life we can only do so under a legislative framework. We might determine during an inquiry that the adult is an adult at risk (as defined under the ASPA) but it is not of benefit or it is the least restrictive option to continue that intervention under a different statute i.e. Social Work (Scotland) Act 1968.

Illustrations

This might include scenarios where:

- the inquiry identifies that the person is better suited to support under the Adults with Incapacity (Scotland) Act 2000 by the statutory mental health team (MHOs), or
- a new adult care assessment under self-directed support is agreed to complement support for the adult to manage risk, or
- existing care management plans are deemed sufficient or can be supplemented with, for example, additional 1-1 support for an adult in a care home in increasing distress.

In these situations, it would be closed to ASP and not managed by its processes despite meeting the three point criteria.

However, we recognise that practice in this area varies, and in some areas the case would remain under ASP - either as ongoing ASP work with the case proceeding to a case conference, or in situations where a person has died, it would be recorded as 'no opportunity for further ASP intervention'.

Meets three-point criteria — no opportunity for further ASP intervention

For 'Meets 3 point criteria- no opportunity for further ASP intervention. This should be selected in instances where there is no opportunity for further ASP intervention, for example where the adult has died during the ASP process and there is no opportunity to complete an inquiry.

If the adult has moved to another area and their case has been transferred ie. via a transfer case conference, this should be recorded under Category 3 'Meets 3 point criteria- ongoing ASP work'.

For all of the above, we are looking for the cumulative number by end of quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 13: Age group and gender

Definition

This indicator collects age group and gender of clients across all inquiries.It includes men, women, trans and non-binary and prefer not to say category to provide an inclusive overview of gender. The age groups aim to provide comparability to other data sets, as well as having a distinct category for 17 and 18 years old to capture data specifically on individuals transferring from children's to adult protection services. Based on feedback received from ASP stakeholders, we recently reviewed the current age bandings within the ASP National Minimum Dataset (NMDS). The new categories are more aligned with health data set to allow for easier comparison.

Notes on completion

To be captured for all inquiries, irrespective of whether investigatory powers are used or not.

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 14: Ethnicity

Definition

This indicator collects the ethnicity of all clients based on ethnicity. The ethnicity categories are based on the census categories to ensure comparability to census data.

Notes on completion

To be captured for all inquiries, irrespective of whether investigatory powers are used or not.

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 15: Primary type of harm

Definitions

This indicator has the purpose of collecting the primary type of harm for each inquiry. This does not mean that other types of harm are not present in the relevant inquiry but for the purpose of the minimum dataset, we only collect the primary harm.

Physical harm

Can include hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.

Sexual harm

Can include rape and sexual assault or sexual acts to which the adult at risk has not consented, could not consent or was pressured into consenting.

Psychological/emotional harm

Can include emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or Material harm

Can include theft, fraud, exploitation, pressure in connection with wills, property, inheritance, financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and Acts of Omission

Can include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition or heating.

Discriminatory harm

Includes actions (or omissions) and / or remarks of a prejudicial nature focusing on a person's age, gender, disability, race, colour, sexual or religious orientation.

Self-harm

When an individual, knowingly or unknowingly, behaves in a way that directly or indirectly, causes serious harm to their physical, psychological or social well-being. Self-harm is complex and can vary widely from individual to individual. It can serve a variety of functions including but not limited to, a way of coping with distress or trauma, a way to regulate emotions, communicate feelings, gain control, as a form of self-punishment or as a way to feel present and alive Self-Harm may manifest in various forms such as self-injury (eg. cutting or burning oneself), self-poisoning (such as taking an overdose of drugs, medication or other substances), but it can also include other health harming behaviours such as having an eating disorder, problematic use of alcohol, drugs, or gambling, or simply not looking after their emotional or physical needs.

Self neglect

The inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community. (Gibbons et al., 2006)

Self-neglect can include:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs

- Inability or unwillingness to manage one's personal affairs

Domestic abuse

Domestic abuse can be any form of physical, verbal, sexual, psychological or financial abuse which takes place within the context of a relationship. The relationship may be between partners (married, cohabiting, civil partnership or otherwise) or ex-partners. The abuse may be committed in the home or elsewhere including online.

Examples of domestic abuse include:

- Being threatened or name calling
- Controlling what you do, where you go and who you speak to
- Threatening your children
- Not being allowed see friends and family
- Sharing - or threatening to share - intimate images of you with family, friends or work colleagues
- Being hit, kicked, punched, or have objects thrown at you
- Rape, being forced into sexual acts.

Human trafficking and/or Exploitation

Human trafficking and exploitation are complex and hidden crimes and involve perpetrators treating people as commodities and exploiting them for their personal profit or gain. Victims can sometimes appear to be criminals themselves.

The many purposes for which people are exploited - including commercial sexual exploitation, labour exploitation, criminal exploitation (for example benefit fraud and forced drugs cultivation and cuckooing), domestic servitude or compulsory labour, sham marriages and organ trafficking – are continually evolving. Victims can sometimes appear to be criminals themselves when forced into criminal exploitation.

Human trafficking involves the recruitment, transportation or transfer, harbouring or receiving or exchange or transfer of control of another person

for the purposes of exploiting them. It is irrelevant if the victim 'consented' to any part of the action, neither does it require the victim to have been moved for this to be considered an offence. People can be trafficked within Scotland and the UK as well as across international borders.

This might include:

Criminal Exploitation

This is when an adult is coerced, controlled or manipulated into involvement in criminal activity for the financial or other advantage of the exploiter. It can involve force, threats or deception, taking advantage of a power imbalance.

These activities can include and combine (and are not an exhaustive list):

- cuckooing, i.e. taking over the home/property of a vulnerable person in order to establish a base for illegal drug dealing
- county lines drug networks and cannabis cultivation
- pick pocketing and forced shoplifting
- financial abuse and benefit fraud
- forced begging and busking

Labour exploitation

This is when a person is forced to work for little or no pay, or has access to their wages controlled or limited by another party. It can involve threats, intimidation and violence in order to force the person to work long hours in poor conditions. The person may also be forced to work without appropriate equipment in potentially dangerous situations. It is also important to recognise that labour exploitation can occur within legitimate business, with wages and/or bank accounts controlled by a perpetrator.

Common industries prone to labour exploitation are car washes, nail bars, construction, seafood/fishing, delivery drivers, and hospitality but it can also occur in private homes including activities such as painting and decorating, window cleaning, gardening and other domestic duties (domestic servitude).

Sexual exploitation

Sexual exploitation is the sexual abuse of an adult in exchange for attention, affection, food, drugs, shelter, protection, other basic necessities and/or money, and could be part of a seemingly consensual relationship. It involves someone taking advantage of an adult, sexually, for their own benefit and could be carried out by threats, bribes, deceit and violence. It doesn't have to be physical contact, it can also occur online.

Adults can be sexually exploited in many ways. Examples include:

- Grooming
- Rape and sexual assault
- Being trafficked into, or around the UK for the purpose of commercial sexual exploitation (e.g. prostitution, lap dancing, stripping, pornography)
- Sextortion, i.e. when a person being forced into paying money or meeting another financial demand after an offender has threatened to release nude or semi-nude photos of the person

Organ harvesting

Organ harvesting involves the removal of one or more organs from a person by means of coercion, abduction, deception, fraud, or abuse of power.

Notes on completion

Primary type of harm only. To be captured for all inquiries where investigatory powers are not used, those where they are used, and for all those with ASPPs in place.

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 16: Location of harm

Definition

This indicator has the purpose of collecting the primary location of harm for each inquiry. This does not mean that other types of location are not present in the relevant inquiry but for the purpose of the minimum dataset, we only collect the primary location.

Notes on completion

Primary location of harm only. To be captured for all inquiries where investigatory powers are not used, those where they are used, and for all those with ASPPs in place.

We are looking for the cumulative number by end of quarter (eg January to March 2023)

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 17: Primary client group

Definitions

This indicator has the purpose of collecting the primary client group for each inquiry. This does not mean that individuals might not fit or belong to another client group but for the purpose of the minimum dataset, we only collect the primary client group.

Palliative care

Palliative care is for people with serious health conditions to relieve suffering and enable them to live as well as possible. There is a move away from talking about 'end of life' or 'end of life care' and a life expectancy approach. It is not possible to predict and make judgements with any validity on when a person will die (nor should this be the basis for planning or offering support). This guidance will be reviewed/refreshed as necessary following publication of the Scottish Government's incoming strategy on palliative care.

Notes on completion

Primary client group only. To be captured for all inquiries where investigatory powers are not used, those where they are used, and for all those with ASPPs in place.

We are looking for the cumulative number by end of quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 18a and 18b: No. of inquiries using investigatory powers where adult has caring responsibilities and No. of inquiries using investigatory powers where a child was present at the incident

Definitions

Adult has child care responsibilities

A dependent child is any person aged 0 to 15 in a household (whether or not in a family) or a person aged 16 to 18 who's in full-time education and living in a family with his or her parent(s) or grandparent(s). It does not include any people aged 16 to 18 who have a spouse, partner or child living in the household.

A family is defined as a group of people who are:

- A married, same-sex civil partnership, or cohabiting couple, with or without child(ren),
- A lone parent with child(ren),
- A married, same-sex civil partnership, or cohabiting couple with grandchild(ren) but with no children present from the intervening generation, or
- A single grandparent with grandchild(ren) but no children present from the intervening generation.

Children in couple families need not belong to both members of the couple.

For single or couple grandparents with grandchildren present, the children of the grandparent(s) may also be present if they are not the parents or grandparents of the youngest generation present.

Source definition:
https://www.scotlandscensus.gov.uk/metadata/dependent-children-in-family/

Adult has care responsibilities

TBC

Notes on completion

TBC

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking.

Indicator 19: Large Scale Investigations

Definitions

Large Scale Investigations

An LSI is conducted when it is suspected that more than one adult in a given service may be at risk of harm. This may relate to adult residents in a care home, supported accommodation, an NHS hospital or other facility, or those who receive services in their own home. The risk of harm may be due to another resident, a member of staff, some failing or deficit in the management regime or in the environment of the establishment or service.

Decisions about whether to proceed to an LSI or not, are expected to take place in a multi-agency meeting and for these meetings to be chaired by a senior officer of the council at Head of Service level or above.

There is a duty to "alert and involve" relevant bodies of LSIs as set out in the ASP Code of Practice including the Care Inspectorate. To ensure this, there is a single point of contact available on the Care Inspectorate's website where you can notify them about LSI i) commencement and ii) conclusion of the LSI. Where services are registered with the Care Inspectorate, you should involve them in the investigation itself where appropriate.

Notes on completion

Indicator 19b

The first two categories care homes and support services will be registered with the Care Inspectorate and will have a unique care service (CS) number which should be recorded in the spaces available above.

Indicator 19c

For LSIs taking place in a hospital setting, please record the relevant national hospital code found in this list of 'Current NHS Hospitals in Scotland' [https://bit.ly/447JK40] — the code to be entered is found in column two, 'Location'). Please note that these national codes are different to local NHS Board ones. If the hospital in question is not on this national list, please record 'not on the national list.'

We are looking for the cumulative number by the end of the quarter (eg January to March 2023).

Benchmarking options

Data can be benchmarked by converting the number of referrals into a rate per 100,000 adults aged 16+ (which can be found at National Records of Scotland Mid-Year Population Estimates). The resulting total per 100k can then be compared with other areas.

There currently is no local area to national data available for benchmarking

List of Scrutiny Questions

The national minimum dataset is a minimum number of indicators which are feasible to collect across all local authorities in Scotland. However, we encourage local authorities to analyse, interpret and collect additional data based on the following scrutiny questions. We hope that these questions will allow local authorities and their partners to further discuss and analyse the data and identify local trends and potential for further data work.

Indicator Number	Scrutiny Questions
Indicator 1	1. What do the sources of ASP referrals tell us, or the conversion rates of ASP referrals to inquiries or inquiries using investigatory powers? Are there any awareness raising or learning and development implications for us or multi-agency partners? 2. What does data on re-referrals tell us about the number of ASP referrals relating to the same or different incident/concern? 3. Have there been any unexpected increases or spikes in ASP referrals, inquiries (without or with use of investigatory powers)? What are the reasons for this? 4. How many adults have been referred to ASP services, as opposed to the number of ASP referrals received, and if a disparity exists, what might that tell you?' 5. Locally, do we have any data on re-referrals to ASP services? a. Does this indicate that we previously missed or mis-directed adults to non-ASP services? Or that help should have been provided earlier? b. Does it indicate that adults who have left the ASP system are returning to it? If so, how can we find out the reasons for this?
Indicator 2 and 3	6. What proportion of inquiries proceed to further inquiries using investigatory powers, and what does this tell us?
Indicator 4	7. Are we meeting local timescales for review case conferences to take place, and what are the reasons for this?

	8. To what extent are case conferences attended by all relevant multi-agency partners - and what are the reasons for this?
Indicator 5	9. Are we working as effectively as we can with the adult and/or their family/friend representatives - to promote supported decision-making, ensure the adult's wishes and views are heard and that they are able to participate as fully as possible? 10. To what extent are the adults and / or their representatives active contributors to the meeting – ie what is the quality of their participation?
Indicator 6	11. Are we working as effectively as we can with independent advocacy to promote and support its uptake (where useful)- to promote supported decision-making, ensure the adult's wishes and views are heard,and that they are able to participate as fully as possible?
Indicator 8	12. Adult Support and Protection Plans: How long are these plans in place for? How good are our review processes?
Indicator 9	13. What proportion of Protection Orders were applied for but not granted? What were the reasons for them not being granted? 14. What powers under the Adult Support and Protection (Scotland) Act 2007 are most used and helpful? Are there any that are not working for us, and does this have implications for local or national policies and practice? (See glossary for list of powers).
Indicator 10 and 11	15. Are there changes to the non-ASP services we are referring onto; what does this tell us about a) our local partnerships b) changing demand or context of ASP work? 16. Is our application of the three-point criteria changing due to trauma-informed approaches, and resulting in changes to numbers supported through ASP processes or referred to non-ASP services?
Indicator 13	No scrutiny question
Indicator 14	No scrutiny question
Indicator 15	17. Is there any changes in reporting certain categories of risk (e.g. increase in self-neglect, domestic abuse)? If so, is that linked with local initiatives (eg awareness campaigns or new local guidelines) or due to wider environmental factors?

Indicator 16	No scrutiny question
Indicator 17	No scrutiny question
Indicator 18	18. How well are services working together to support adults with caring responsibilities? 19. Are we effectively identifying other adults or children at risk and making these known to relevant services?
Indicator 19	20. How is learning from LSIs being taken forward and shared?

Notes for data interpretation

While the ambition is to have a minimum data set which provides a national picture for Adult Support and Protection across Scotland, we must still be careful with the interpretation of the data.

- **Differences in recording across local authorities:** All local authorities have individual recording systems, categories and practices. While there is work being undertaken to assimilate these, it will be some time before data is fully comparable.
- **Local context:** Where appropriate, we adapt the numbers per 100,000 population. However, even with those adjustments it is important to take into account differences across local authorities. For example, recruitment, geographic and demographic challenges might influence the numbers across the different local authorities.
- **Scottish average:** As we are working towards a fully comparable and complete national minimum data set, the national average is an indication of the national picture but it needs to be interpreted with caution, as the aforementioned challenges with the dataset might skew the average slightly.