JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

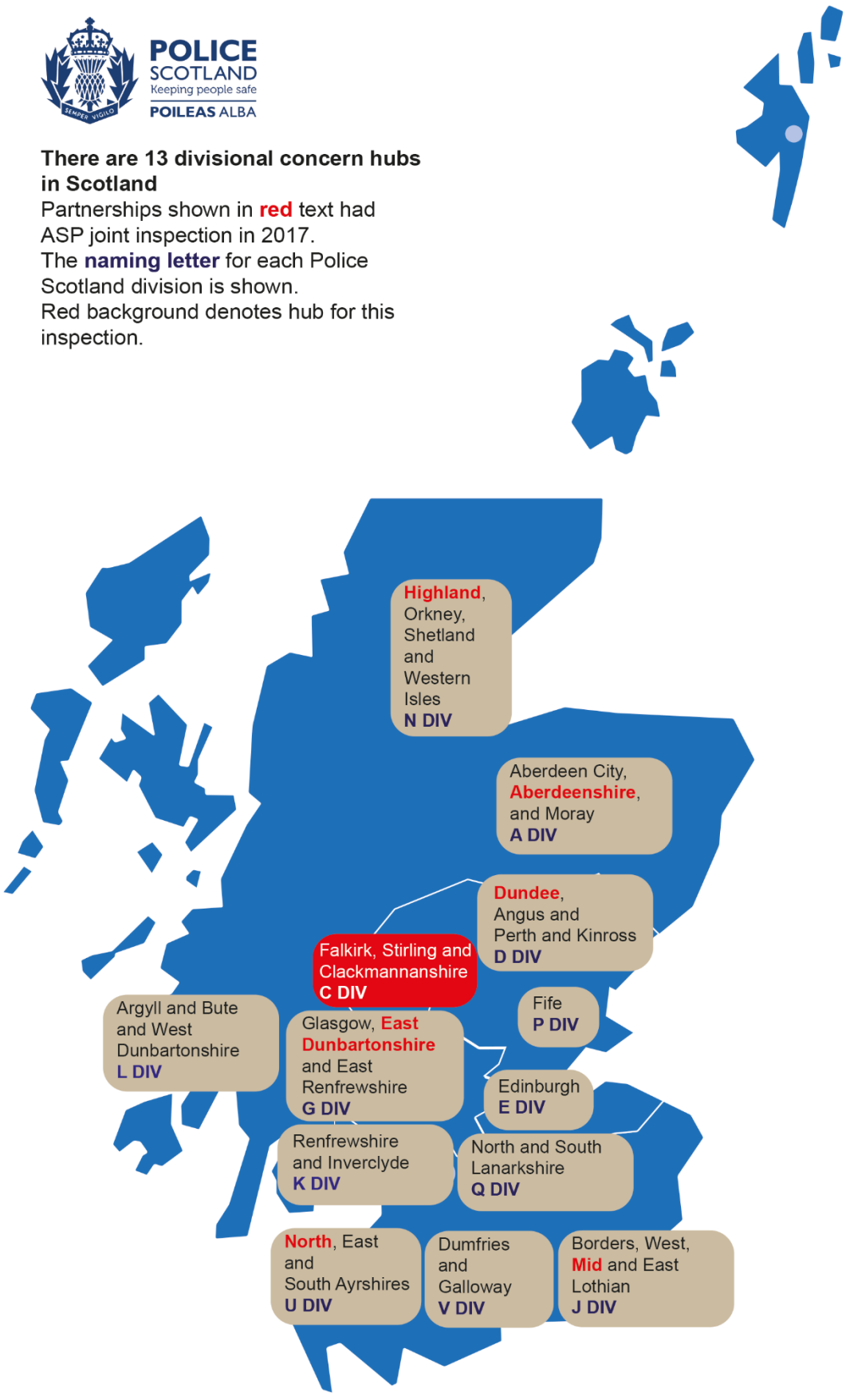
Clackmannanshire Partnership February 2022

Contents

Map showing divisional concern hubs

POLICE SCOTLAND
Keeping people safe
POILEAS ALBA

There are 13 divisional concern hubs in Scotland
Partnerships shown in **red** text had ASP joint inspection in 2017.
The **naming letter** for each Police Scotland division is shown.
Red background denotes hub for this inspection.



Joint inspection of adult support and protection in the Clackmannanshire partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead these joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017-2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the Clackmannanshire area were safe, protected and supported.

The joint inspection of the Clackmannanshire partnership took place between October 2021 and February 2022. The Clackmannanshire partnership, and all others across Scotland, faced the unprecedented and ongoing challenges of the Covid-19 pandemic. We appreciate the Clackmannanshire partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

Our quality indicators[2] for these joint inspections are on the Care Inspectorate's website.

1 https://www.careinspectorate.com/images/Adult_Support_and_Protection/1.__Definition_of_adult_protection_partnership.pdf

2 https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf

Progress statements

To provide Scottish Ministers with timely high-level information, this joint inspection report includes a statement about the partnership's progress in relation to our two key questions.

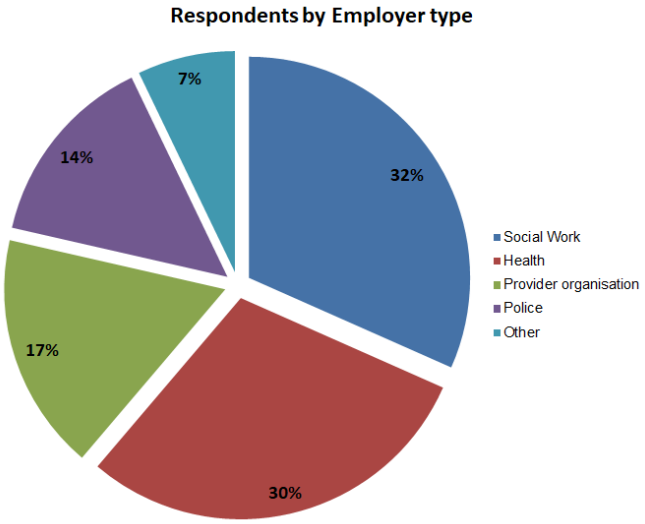
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

Joint inspection methodology

In line with the targeted nature of our inspection programme, the methodology for this inspection included four proportionate scrutiny activities.

The analysis of supporting documentary evidence and a position statement submitted by the partnership.

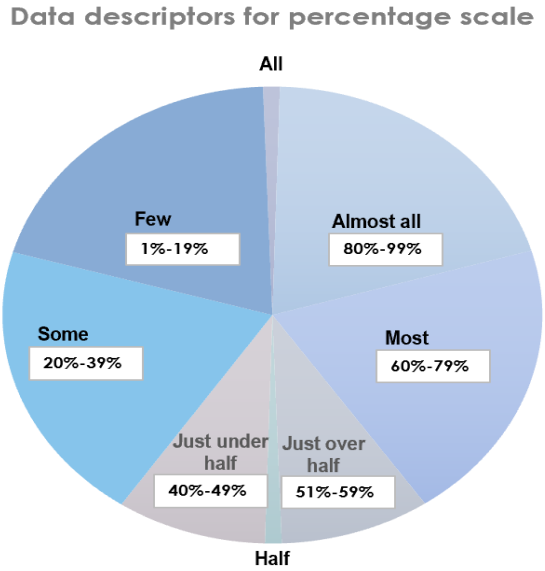
Staff survey. Ninety-eight staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk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



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

Staff focus groups. We carried out two focus groups and met with 25 members of staff from across the partnership to discuss the impact of the Covid-19 pandemic on adult support and protection and adults at risk of harm. This also provided us with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Standard terms for percentage ranges



Additional information

Clackmannanshire and Stirling Health and Social Care Partnership is responsible for all community health and social care services, including adult support and protection. The two local authorities, Clackmannanshire and Stirling, are served by one NHS board (NHS Forth Valley) with one shared Public Protection Committee. Clackmannanshire and Stirling operate separately in terms of adult support and protection practice, albeit the overarching strategic leadership structure remains mostly the same in both areas.

Summary – strengths and priority areas for improvement

Strengths

- Adults at risk of harm experienced improved safety outcomes because of multi-agency collaboration and intervention.
- The partnership consistently carried out all adult support and protection processes in a timely manner. This was in keeping with local procedure and the adult at risk of harm's needs.
- Screening and initial inquiries upheld the principles of the Adult Support and Protection (Scotland) Act 2007 for adults at risk of harm. The three-point test was routinely clearly recorded in the adult at risk of harms' records.
- Police contributed effectively and efficiently to all aspects of the delivery of key process to keep adults at risk of harm safe and protected.
- Early intervention initiatives, such as 'safeguarding through rapid intervention; and the early intervention to welfare concerns initiative' (STRIVE), effectively supported vulnerable individuals.
- Leadership for adult support and protection was effective throughout the Covid-19 pandemic. The partnership maintained critical services to adults at risk of harm.

Priority areas for improvement

- The partnership should remove the 'police only' investigations procedure from its adult support and protection work as a priority.
- Clear chronologies, risk assessments, and protection plans should be done for all adults at risk of harm who require them.
- The partnership should engage with adults at risk of harm and their unpaid carers in adult protection case conferences.
- Managers' expectations of adult protection practice should be in line with published guidance.
- Stages of the adult support and protection process should be clearly defined. This should be supported by templates for recording adult support and protection work.

- The lived experience of adults at risk of harm and their unpaid carers should be represented at the partnership's strategic decision-making forums for adult support and protection.

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

Key messages

- The partnership carried out all adult support and protection key processes in a timely manner in accordance with the adults at risk of harms' needs. It maintained this effectively throughout the Covid-19 pandemic.

- Initial inquiries were carried out effectively and in accordance with the principles of the Adult Support and Protection (Scotland) Act 2007. The three-point test was clearly documented, as was management oversight.

- Police were appropriately and actively involved in key processes for adult support and protection, which contributed to keeping adults at risk of harm safe and protected.

- The distinction between initial inquiries and investigations was not clear. The lack of recording templates for these processes contributed to this lack of clarity for staff and adults at risk of harm.

- The partnership's 'police only' investigations prioritised the criminal investigation, to the detriment of the adult support and protection investigation and the safety and wellbeing of the adult at risk of harm.

- Risk assessments, chronologies and protection plans were not done routinely. They were mainly present only in cases when there was a case conference.

- Case conferences were not always carried out when required. However, when they were, they were effective. No adult at risk of harm attended their case conference.

We concluded the partnership's key processes for adult support and protection were effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns

Adult protection concerns were received into locality teams. A council officer screened them within 24 hours and identified if there was a need for immediate health or police input. Timescales were adhered to consistently. An emergency duty team responded to referrals outwith core hours. They were able to carry out visits if needed or pass to the locality intake teams the next working day for follow up. The partnership screened adult protection concerns effectively.

Initial inquiries into concerns about adults at risk of harm

Overall, the partnership dealt with initial inquiries promptly and effectively. However, the specific activities undertaken as part of initial inquiries were not always clearly recorded. The lack of a standard template for initial inquiries contributed to this lack of clarity. The partnership stated initial inquiries should take place within three working days. It achieved this in almost all cases.

The partnership stated initial inquiries may involve an inter-agency referral discussion (IRD). This took the form of a tripartite discussion between health, police and social work. The function of which was to share relevant information available, make decisions on actions, and promote ownership of adult support and protection. Positively, there was a standardised method for recording these discussions. However, the guidance and threshold for when an IRD should be carried out was not clear. The partnership did not carry out IRDs for initial inquiries. IRDs were carried out where cases progressed to investigation. In some cases, an IRD took place after the initial inquiry. The partnership advised it was implementing an electronic IRD system to develop a more robust IRD process. Forth Valley policing division had dedicated personnel to oversee IRDs.

Importantly, almost all staff were aware of the three-point test and how it applied to the adult at risk of harm. They were aware what constitutes harm under the Adult Support and Protection (Scotland) Act 2007. In almost all duty to inquire episodes, the three-point test was documented clearly and applied correctly. Almost all inquiries were dealt with in accordance with the principles of the Act and had evidence of management oversight.

The partnership developed a document called a ‘ready reckoner’. This supported staff knowledge and skills for the assessment of ‘undue pressure’ on the adult at risk of harm. There was evidence of ‘undue pressure’ in some cases which was recognised by the partnership and acted on appropriately.

In a few episodes we considered the adult support and protection process did not progress far enough in the legislative process, and the 'no further action' decision was incorrect.

Investigation and risk management

Chronologies

A chronology is a key tool in the assessment and management of risk for adults at risk of harm. The partnership used the Forth Valley Adult Support and Protection Multi-Agency Guidance (2018). The risk assessment template included a chronology field. However, it did not include clear direction on completing and using chronologies in practice. This undoubtedly provided a challenge to staff. Most adults at risk of harm who required a chronology did not have one. The presence of chronologies increased where the cases progressed to case conference. Chronologies were weak or unsatisfactory in just under half of cases.

The partnership identified chronologies as an area for improvement. The partnership also recognised chronologies needed to become more multi-agency informed. The staff survey supported this finding. Only just over half of staff agreed all agencies involved in investigations informed chronologies.

Risk assessments

An explicit risk assessment is necessary for the robust management of risk for adults at risk of harm. The partnership used two different risk assessment templates. These were selected by staff based on the complexity of risk. Risk assessment templates were mainly completed when cases progressed beyond investigation, and for this reason were only present in some cases. Where present, the timing of the most recent risk assessment was in keeping with the needs of the adult at risk of harm. In almost all cases, the risk assessment was informed by multi-agency partners. Some risk assessments were good or better in quality. Significantly, an equal proportion of risk assessments were weak in quality.

In a few cases there was good practice with supporting narrative to reflect type and severity of risks, as well as mitigating and protective factors.

Full investigations

A full investigation was carried out in almost all cases where needed. Most investigations involved relevant agencies. The partnership used second workers appropriately in almost all cases. Second workers were health professionals in most cases when they should have been. Most staff agreed second workers could be and were from different agencies.

Almost all investigations were carried out in a timescale in keeping with the adult at risk of harm's needs. The distinction between initial inquiry and investigation stages was not clear. This made it difficult to see what stage an adult protection episode had reached. This was likely to confuse staff and adults at risk of harm.

The quality of investigations was good or better in most cases. However, for some the quality was weak or unsatisfactory. This related to lack of important details of the investigative process, not involving the adult at risk of harm, and designated 'police only' investigations. Recordings of investigations did not clearly outline all the actions undertaken as part of the investigation. For example, if the adult at risk of harm was aware of the investigation, made aware of their rights, or actively involved in the process. Investigations were undertaken by council officers unless it was decided at the IRD discussion that it would be a 'police only' investigation. In these cases, the police progressed with a criminal investigation and active social work involvement paused. Where police officers did not raise any support and protection issues with social work, the episode was closed. The partnership also recognised this resulted in a focus on the criminal activity to the detriment of the adult at risk of harm.

Adult protection case conferences

Adult protection case conferences should be arranged where there is ongoing risk of harm issues. This partnership's procedures state this should occur within 20 days of the initial referral. In almost all cases, the case conference was held in a timeframe suitable to the adults' needs and in line with local procedure. In almost all cases, the relevant agencies were invited and most of the time relevant agencies attended. Health did not attend some case conferences when invited. Since the emergence of Covid-19, all case conferences were held remotely online.

The partnership did not always convene a case conference when it was needed, which affected a few adults at risk of harm. Case conferences were effective at determining what needed to be done to support an adult at risk of harm in almost all cases. It was not always clear whether actions and recommendations from IRDs were followed up at the case conference.

It is vitally important adults at risk of harm are involved, where possible, in case conferences. Significantly, no adults at risk of harm attended any case conferences. Although explained in some circumstances, reasons were not always documented. Unpaid carers were invited in less than half of relevant cases, however, when invited they attended. Again, reasons for non-attendance were only explained in some circumstances.

Adult protection plans / risk management plans

Adults at risk of harm should have a protection plan to co-ordinate multi-agency intervention. In just under half of cases, there was no risk management/protection plan. This was despite there being templates available in the Forth Valley Adult Support and Protection Multi-Agency Guidance (2018). This was a significant omission for the affected individuals. In some instances, the relevant actions were outlined in other documents, but these often lacked the necessary detail. When present, all protection plans were up-to-date and contributions from multi-agency partners were clearly identified. The quality of plans was good or better in half of cases.

Adult protection review case conferences

Positively, adult support and protection review case conferences were convened when required in almost all cases. These were convened within a timescale that was in keeping with the needs of the adult at risk of harm. Case conferences always effectively determined what needed to be done to ensure adults at risk of harm were safe, protected and supported.

Implementation / effectiveness of adult protection plans

Protection plans were not used consistently despite there being two available templates – 'standard' and 'comprehensive'. Guidance specified the function of each template, and they were used effectively in a few cases. The partnership used protection orders effectively to support a few adults at risk of harm as part of a comprehensive support plan.

Large-scale investigations

There were two large-scale investigations in care homes in the past two years. In response to the large-scale investigations and the Covid-19 pandemic, the partnership established a care home practitioners' group. This group increased monitoring in care homes and enabled earlier identification of harm. The group was multi-agency and included commissioning teams, together with the care home assessment and review team (CHART). The response team provided a means for direct engagement with commissioned services in promoting care standards. This initiative was respected and valued by staff and strategic leaders.

Most staff agreed the partnership had a clear procedure for carrying out large-scale investigations and was effective in doing so. The partnership recognised the procedure was overdue for review. Importantly, almost all staff agreed the partnership was effective at safeguarding the adults at risk of harm involved in this process. The partnership involved the Care Inspectorate appropriately in large-scale investigations.

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

Overall effectiveness of collaborative working

Overall, the partnership worked collaboratively to keep adults at risk of harm safe, protected and supported. Inter-agency referral discussions enabled an integrated approach where cases were progressing to full adult support and protection investigations. The partnership advised that the planned electronic IRD system which would require tripartite sign off, should promote shared responsibility for adult support and protection across all partners. The standard template for recording IRD discussions was effective.

Documents submitted as part of the partnership's evidence were occasionally badged as health and social care partnership documents and did not always reflect tripartite involvement. This caused confusion about which organisations the documents were relevant to.

Health involvement in adult support and protection

Health professionals had an active role in adult protection key processes. They were confident and knew what to do if they were concerned an adult may be at risk of harm. Almost all staff reported they were encouraged to be professionally curious about risk issues. In addition, staff reported being supported to carry out adult support and protection work. Importantly, almost all health staff were aware of the three-point test and how it applied to an adult at risk of harm. Overall, survey responses from health staff demonstrated they required more support in relation to their involvement and engagement in case conferences.

Relevant health records were submitted in 34 of the 50 records. There was evidence of adult support and protection concerns recorded in just over half of those records. The quality of these recordings was rated as good or better in just over half of cases. One quarter of the referrals in the duty to inquire sample came from a health source, this was positive as health staff were recognising and raising concerns. Significantly, there were a few cases where risk issues were noted in health records, but it was not clear from the information submitted if health staff had acted on these concerns.

Where there were emergency hospital readmissions related to adult protection harm, intervention from hospital services was good or better. This was mirrored across community health services and emergency departments. When a health professional was involved, their contribution to outcomes for adults at risk of harm were good or better most of the time. Where health professionals should have given the adult at risk advice and support about Covid-19, this was done on every occasion.

Police involvement in adult support and protection

Where requests were made to the police about adults at risk of harm, they were almost always effectively assessed by officers and staff for threat of harm, risk, investigative opportunity and vulnerability (THRIVE). Just over half had an accurate STORM disposal code (record of incident type). Police Scotland's national guidance was that adult support and protection incidents should have specific codes, which allow for the recognition and identification of multiple concern types. STORM markers were used effectively to flag potential adult risk of harm concerns.

In the majority of cases, the IRD was the first point of police involvement. Officer assessments of risk of harm, vulnerability and wellbeing were evident in all records where police were involved. Officer responses, including contribution to referral discussions, were almost always good or better. In a few cases the quality of the response was excellent; a similar proportion were weak or unsatisfactory.

Where there was an IRD, the contributing officer consistently recorded relevant detail on the iVPD as part of the police process. This was an effective way of ensuring that police records were accurate, auditable, and aligned to the case information held by partners.

Supervisory oversight was noted as good or better in almost all records, with almost all concern referrals shared timeously.

The divisional concern hub almost always recorded the triage process to prioritise risk, with notes evidencing diligent research, assessment, and input by staff, including the presence of a resilience matrix in all cases. The divisional concern hub actions and records were good or better in almost all cases, and excellent in a few.

Where invited, officers attended all case conferences and officer contribution was good or better in all cases.

Third sector and independent sector provider involvement

The partnership supported the delivery of adult support and protection with a range of third and independent sector services. These services were involved in the delivery of ongoing support and care in almost all cases.

The partnership used the independent advocacy service to carry out a survey with adults at risk of harm, to evaluate their experience of adult support and protection. This was a positive approach to engagement and would benefit from further development.

There were several local initiatives which supported local communities, notably, ‘safeguarding through rapid intervention: the early intervention to welfare concerns initiative’ (STRIVE). Workers from STRIVE raised adult at risk concerns and supported interventions to reduce risk. Interventions from STRIVE workers were described as a positive initiative that benefitted vulnerable individuals and adults at risk of harm in both focus groups.

Key adult support and protection practices

Information sharing

The Forth Valley Adult Support and Protection Multi-Agency Guidance (2018) defined processes, roles, and responsibilities. This supported information sharing among staff. The guidance was due to be reviewed and was included in the partnership's improvement plan. Information sharing was effective. Partners shared information appropriately in all cases.

Management oversight and governance

Overall, the level of recording and management oversight evident in records was inconsistent. In some cases, the level of recording was not in line with the adult at risk's needs. In most cases, there was no evidence of supervision discussions and decisions in the social work records. Line managers periodically read only some records. Positively, most social work records and almost all police records demonstrated governance. Evidence of management oversight is often less apparent in health records. This is not necessarily a deficit due to the types of health records scrutinised. Notably, there was evidence of governance in just over half of the health records submitted.

Involvement and support for adults at risk of harm

The partnership had clear and positive guidance in relation to the involvement of adults at risk of harm. Adults at risk of harms' views informed initial inquiries, investigations and protection planning in almost all cases. Most staff confirmed adults' views were taken into consideration as part of investigations. Staff were less confident that unpaid carers were appropriately involved. In most cases, adults were supported to engage in the various processes, however no adults at risk of harm attended their case conference, which was not in line with local guidance.

Independent advocacy

Independent advocacy was offered to adults at risk of harm in just over half of the cases where it should have been. It was accepted by the adult at risk of harm in just under half of those cases. The provision of advocacy was always timely, and almost always helped the adult at risk of harm to articulate their views.

The reasons why advocacy was not offered was not always evidenced or supported by clear and well considered rationales. Just over half of staff agreed that adults had access to advocacy from an appropriate point. The partnership had recently renegotiated the contract with advocacy services, to promote access to the service at all stages of the process.

Capacity and assessment of capacity

There were concerns about the capacity of some adults at risk of harm. In just over half of these cases, social work made a formal request for a capacity assessment. Of the requests made, almost all assessments were undertaken promptly by a health professional.

Social work did not make a request for a capacity assessment in just under half of the instances when they should have. A capacity assessment would have provided a clearer understanding of the individuals' risks and needs.

Financial harm and alleged perpetrators of all types of harm

Financial harm occurred in some of our sample. In almost all cases the partnership acted to stop the financial harm. A multi-agency approach was effective in stopping the harm in almost all cases. A broad range of relevant agencies were effectively involved in this process. The partnership's actions to stop the financial harm was good or better in most instances.

Locally, the financial harm group and neighbourhood watch Scotland alert initiative contributed to increasing awareness and knowledge of financial harm with staff and communities.

The alleged perpetrator of harm was known to the partnership in almost all cases. The quality of the actions taken with and against the alleged perpetrator varied.

Safety outcomes for adults at risk of harm

Almost all the adults at risk of harm experienced improvements in their safety because of adult support and protection processes. This was due to multi-agency working. The contribution of the various adult support and protection partnership agencies was recognised as being key to improved wellbeing in almost all cases where a positive outcome occurred.

Adult support and protection training

The partnership offered training, including multi-agency training. Multi-agency staff attended this. During the Covid-19 pandemic, training moved online to enable some aspects to continue. The partnership adopted creative approaches to deliver training. Examples included seven-minute briefings on case conferences, chronologies and partnership pages, and an adult support and protection podcast. These provided accessible, good quality information.

The partnership had developed a learning and development subcommittee of the public protection committee, to monitor and develop training programmes. Positively, the partnership had also identified learning and development in its improvement plan.

How good was the partnership's strategic leadership for adult support and protection?

Key messages

- Leaders promoted collaboration for adult support and protection across the partnership and in response to the Covid-19 pandemic.
- Leaders understood the strengths and limitations of the partnership's adult support and protection work and evidenced a positive and collaborative approach to improvement moving forward.
- The partnership had effective initiatives such as 'safeguarding through rapid intervention: the early intervention to welfare concerns initiative' (STRIVE), which supported vulnerable groups and early intervention.
- The development of the care home assessment and review team (CHART) to incorporate a focus on care assurance and the early identification of harm was positive.
- The partnership had an improvement plan incorporating actions to monitor and improve adult support and protection, but these were not yet fully implemented.
- There was disconnect between guidance available and the practice expected from managers. This impacted on quality and consistency.
- NHS Forth Valley did not have an adult support and protection lead. The addition of this role would strengthen health strategic leadership for adult support and protection.
- Adults at risk of harm and their unpaid carers were not adequately represented in the improvement of adult support and protection practice.

We concluded the partnership's strategic leadership for adult support and protection was effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

Vision and strategy

The partnership's leadership team significantly changed immediately prior to the onset of Covid-19 pandemic. There had been significant financial investment to bolster the strategic leadership compliment. This was positive for the leadership of adult support and protection. It was evident the impact of the pandemic had stalled development in some areas. Positively, the partnership developed a comprehensive improvement plan and showed insightful awareness of its own strengths and limitations. The plan was approved and overseen by the chief officers' group and laid solid foundations for development but provided only a starting point in some areas. Positively, most staff who offered a view, agreed local leaders provided a clear vision for adult support and protection.

Effectiveness of strategic leadership and governance for adult support and protection across partnership

Of those staff who offered a view, most agreed local leadership of adult support and protection was effective. Staff survey results supported the conclusion that interest, concern and involvement in adult support and protection work was encouraged.

Key health and social care partnership strategic leaders undertook a range of staff engagement sessions to increase visibility and obtain staff feedback. Although this work was not specific to adult support and protection, it showed a positive and proactive approach to leadership, particularly considering the significant changes, including personnel in leadership roles. Staff, including those undertaking adult protection work welcomed these sessions and found them valuable.

The public protection committee was formed from the adult protection committee and child protection committee. The terms of reference had been updated accordingly. The committee had a newly appointed chairperson after a considerable period of vacancy with interim rotating chair arrangements. The combined remit remained under review. Of those staff who offered an opinion, most agreed the public protection committee offered effective leadership.

NHS Forth Valley did not have a designated adult support and protection lead and it was clear this was an omission. There was a proposal for how this role may be filled. The partnership was awaiting the outcome of this inspection report to finalise the job description, banding, and initiate recruitment.

Delivery of competent, effective and collaborative adult support and protection practice

There was a disconnect between procedure, guidance and adult protection practice, meaning expectations were not always clearly set out. For example, despite the partnership using the Forth Valley Adult Support and Protection Multi-Agency Guidance (2018), it did not expect staff to use all the embedded templates. This was confusing for staff and led to inconsistencies in practice. The partnership had robust standalone guidance for case conferences, and this was a supportive tool in the delivery of case conferences.

Where there was clear guidance, the impact of this was not always evident. For example, the partnership had clear and positive guidance in relation to the involvement of adults at risk of harm in case conferences, but no adults attended their case conference.

Quality assurance, self-evaluation and improvement activity

The partnership had not undertaken any audit or quality assurance activity in the past two years. This was due to the impact of the Covid-19 pandemic on services. Despite this, the partnership had identified a range of necessary areas for improvement, which was commendable. There was a performance and quality subgroup to the public protection committee. Its remit and implementation were impacted by out-of-date terms of reference for the group.

The partnership had devised a detailed and thorough self-evaluation programme. This was a positive step, as only some staff agreed they were involved in evaluation that informed improvement activity. However, it had not yet been implemented.

The partnership said adults at risk of harm and unpaid carers' views were represented in the public protection committee by advocacy, however, there was insufficient evidence this was a satisfactory substitute.

Initial case reviews and significant case reviews

The health and social care partnership was responsible for completing significant case reviews (SCR) and initial case reviews (ICR). There was one concluded ICR in the past two years. Learning from the ICR was incorporated in the improvement plan, but it was too early to assess if the learning had been implemented.

There were no SCRs in the past two years.

Impact of Covid-19

Covid-19 and the impact on services and communities was an immediate and challenging situation for the newly formed leadership team but proved to be a formative opportunity for collaboration. There was evidence this collaboration was effective at prioritising and focusing work for the partnership. It was a catalyst that sped up the implementation of some initiatives, including early intervention and care assurance work.

The partnership established a good understanding of local at-risk groups and vulnerable groups, through the local resilience partnership and the caring for people subgroup.

The health and social care partnership established a rota for duty staff, which ensured there was no shortfall of staff to cover essential services, including adult support and protection. This was supported by our analysis of the case sample and initial inquires. There were no significant delays noted that were attributed to the impact of the Covid-19 pandemic. Staff continued to deliver face-to-face contact, as required, for essential work. This ensured adults at risk of harms' needs were fully assessed. There was evidence of appropriate face-to-face visits in several cases. Most staff agreed adults at risk of harm were safe and protected during the restricted period.

Staff were confident about their role protecting adults at risk of harm during the Covid-19 pandemic. Most staff felt they were safe and appropriately supported. Staff benefitted from regular contact with team leaders. Electronic applications, such as 'same chat', supported increased communication and enabled peer support.

Summary

Adults at risk of harm experienced improved safety outcomes because of timely, multi-agency collaboration and intervention. The health and social care partnership was still in an 'emergency response phase' of service delivery, resulting from the Covid-19 pandemic. Despite this, early intervention initiatives effectively supported vulnerable individuals.

Leadership for adult support and protection was effective throughout the Covid-19 pandemic and staff felt supported and confident in their roles.

The partnership had a comprehensive adult support and protection improvement plan, awaiting full implementation. Quality monitoring and improvement planning was integral to this plan.

There was evidence of inconsistencies between guidance and expected practice, leading to variation in practice. Although the partnership had robust self-evaluation, preparation of clear procedures and guidance in line with expectations should be a priority.

The partnership's practice of 'police only' investigations resulted in a focus on criminality to the detriment of adult support and protection. Specific elements of delivery, including the recording of information, management of risk, and protection planning, required improvement. The presence and quality of risk assessments, protection plans, and chronologies improved where cases progressed to case conference. The partnership did not convene an adult protection case conference for all adults at risk of harm who required one. Adults at risk of harm were not sufficiently involved in their own case conferences or at a strategic level. These were areas for improvement.

Overall, the partnership's strategic leadership and delivery of key processes for adult support and protection were effective with areas for improvement.

Next steps

We ask the Clackmannanshire partnership to prepare an improvement plan to address the priority areas for improvement (see priority areas for improvement we identify). The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and HMICS will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key process 1

Initial inquiries into concerns about adults at risk of harm scrutiny recordings of initial inquiries

- 95% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 95% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 98% of episodes where the three-point test was applied correctly by the HSCP
- 95% of episodes were progressed timeously by the HSCP
- Of those that were delayed, two cases, 50% less than one week, 50% two weeks to one month,
- 95% of episodes evidenced management oversight of decision making
- 76% of episodes were rated good or better.

Staff survey results on initial inquiries

- 63% concur that the partnership accurately screens initial adult at risk of harm concerns, 30% did not concur, 7% didn't know
- 90% concur they are aware of the three-point test and how it applies to adults at risk of harm, 7% did not concur, 3% didn't know
- 80% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 11% did not concur, 9% didn't know
- 67% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 29% did not concur, 4% didn't know

Information sharing among partners for initial inquiries

- 98% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm, staff survey results (purple)

Chronologies

- 32% of adults at risk of harm had a chronology
- 36% of chronologies were rated good or better, 63% adequate or worse
- 74% concur chronologies form an important feature of ASP investigation reports, 14% did not concur, 12% didn't know

Risk assessment and adult protection plans

- 38% of adults at risk of harm had a risk assessment
- 44% of risk assessments were rated good or better
- 34% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 50% of protection plans were rated good or better, 50% were rated adequate or worse
- 67% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors. 17% did not concur, 17% didn't know

Full investigations

- 82% of investigations effectively determined if an adult was at risk of harm
- 92% of investigations were carried out timeously
- 53% of investigations were rated good or better

Adult protection case conferences

- 75% were convened when required
- 92% were convened timeously
- 0% were attended by the adult at risk of harm (when invited)
- Police attended 90%, health 73% (when invited)
- 74% of case conferences were rated good or better for quality
- 92% effectively determined actions to keep the adult safe
- 45% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences, 39% did not concur 16% didn't know

Adult protection review case conferences

- 86% of review case conferences were convened when required
- 100% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 97% of adult protection concerns were sent to the HSCP in a timely manner
- 92% of inquiry officers' actions were rated good or better
- 95% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 74% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 52% good or better rating for the quality of ASP recording in health records
- 73% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 50 adults at risk of harm and staff survey results (purple)

Information sharing

- 100% of cases evidenced partners sharing information
- 90% of those cases local authority staff shared information appropriately and effectively
- 92% of those cases police shared information appropriately and effectively
- 98% of those cases health staff shared information effectively

Management oversight and governance

- 30% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 67%, police 86%, health 90%

Involvement and support for adults at risk of harm

- 77% of adults at risk of harm had support throughout their adult protection journey
- 67% were rated good or better for overall quality of support to adult at risk of harm
- 73% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 19% did not concur, 8% didn't know

Independent advocacy

- 52% of adults at risk of harm were offered independent advocacy
- 45% of those offered, accepted and received advocacy
- 100% of adults at risk of harm who received advocacy got it timeously.
- 57% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy, 19% did not concur, 24% didn't know

Capacity and assessments of capacity

- 54% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 86% of these adults had their capacity assessed by health
- 100% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 26% of adults at risk of harm were subject to financial harm
- 77% of partners' actions to stop financial harm were rated good or better
- 44% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 86% of adults at risk of harm had some improvement for safety and protection
- 90% of adults at risk of harm who needed additional support received it
- 68% concur adults subject to ASP, experience safer quality of life from the support they receive, 17% did not concur, 14% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 50% concur local leaders provide staff with clear vision for their adult support and protection work. 26% did not concur, 24% didn't know

Effectiveness of leadership and governance for adult support and protection across partnership

- 49% concur local leadership of ASP across partnership is effective, 19% did not concur, 32% didn't know
- 48% concur I feel confident there is effective leadership from adult protection committee, 15% did not concur, 37% didn't know
- 35% concur local leaders work effectively to raise public awareness of ASP, 24% did not concur, 41% didn't know

Quality assurance, self-evaluation, and improvement activity

- 40% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 21% did not concur, 39% didn't know
- 39% concur ASP changes and developments are integrated and well managed across partnership, 27% did not concur, 35% didn't know