JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Inverclyde Partnership June 2021

Contents

Map showing risk and concern hubs

Joint inspection of adult support and protection in the Inverclyde 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 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 Inverclyde area were safe, protected and supported.

In the face of the emerging Coronavirus (Covid-19) public health emergency, joint inspection partners took the decision on 17 March 2020 to temporarily suspend the adult support and protection inspection programme.

In recognition of the continued significance of this work the Care Inspectorate, Her Majesty's Inspectorate of Constabulary in Scotland and Healthcare Improvement Scotland explored ways to resume the inspection programme that took account of the ongoing pandemic.

During the suspension, the joint inspection team maintained engagement with the Inverclyde local partnership area and developed remote working arrangements that enabled the programme to resume. The joint inspection of the Inverclyde partnership took place between 25 November 2020 and 22 January 2021.

Quality indicators

Our quality indicators[1] for these joint inspections are on the Care Inspectorate's website

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?

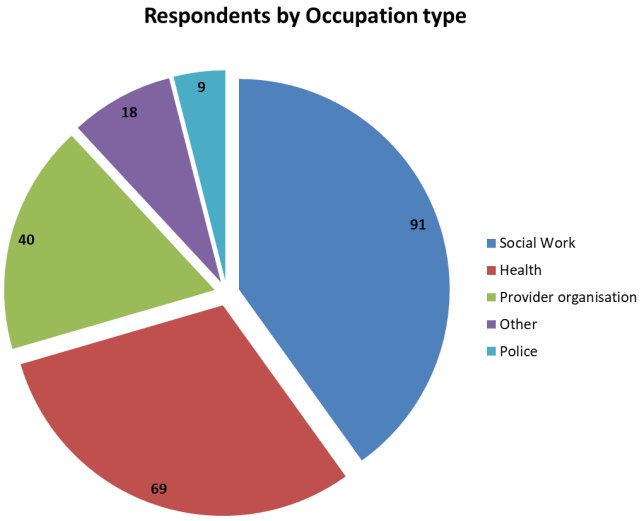
Joint inspection methodology

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. Two hundred and twenty-seven 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.

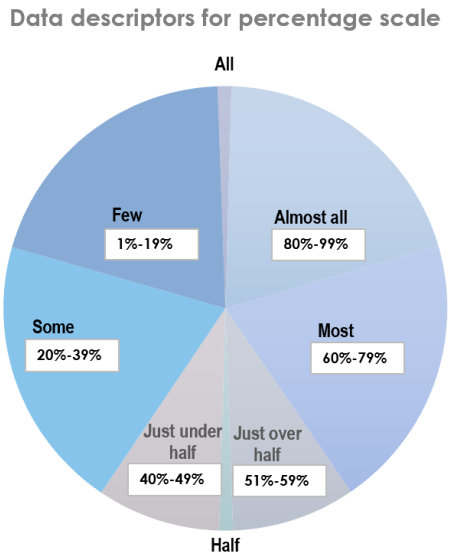
1 https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf



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[2] of 38 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 10 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



[2] We scrutinise the partnership's recording of the initial inquiry episode **not** the adult at risk of harm's records.

Summary – strengths and priority areas for improvement

Strengths

- The partnership had taken positive steps to ensure there was improvements in the lives of adults subject to adult support and protection processes, and that they were safer because of the support and protection they received.
- Effective communication, information sharing, collaboration and joint work were positive features of the partnership's response to adult support and protection work.
- Staff from across the partnership were clear and confident about their responsibilities and protection roles.
- Staff shared a clear and well understood vision for adult support and protection.
- There was a high degree of confidence amongst staff that strategic leaders, including the adult protection committee (APC), provided good leadership for adult support and protection work.

Priority areas for improvement

- The partnership's practice standards and operating procedures need to be revised to ensure service managers apply a more consistent approach to adult support and protection chronology, risk assessment and protection planning work.
- The partnership should review its key processes documentation and ensure it more accurately records the three-point test. The focus should be on screening, inquiry, and investigation activity.
- The partnership's quality assurance performance framework should be further developed and more consistently applied to ensure a better understanding of results and the improvements required.
- The chief officers' group and adult protection committee should scrutinise quality assurance activity more robustly and ensure identified improvement work is carried out.

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

Key messages

- The partnership ensured that adults subject to adult support and protection were safer because of the support they received.
- The quality of screening and triage work was good. Referrals were received and processed accurately and in a timely manner.
- Most risk assessment and protection plans completed were timely, reflected a multi-agency approach, and were of a good quality.
- Initial inquiries, investigations, and case conferences effectively considered the concerns about adults at risk of harm.
- Police Scotland and health services effectively collaborated with social work colleagues to keep adults at risk safe from harm.
- The partnership's practice standards and operating procedures were inconsistently applied to critical elements of adult support and protection work including chronologies, risk assessment and protection planning.
- The partnership should amend key documentation to ensure they more accurately record the three-point test in screening, inquiry and investigation activities.
- Police Scotland should look to strengthen its evidence of supervisory oversight of interim vulnerable persons database (iVPD) referrals.

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.

Access 1st was the social work service that provided a single point of contact for adult support and protection referrals and concerns. Almost all respondents to our staff survey agreed that processes for making referrals to social work were clear and understood.

There was well established guidance that assisted access 1st staff to effectively screen, triage and direct referrals to the appropriate officer or team leader. Staff supported our view and were satisfied with the screening and triage arrangements. It is recognised that there were changes to the system in response to Covid-19 which resulted in challenges.

Initial inquiries into concerns about adults at risk of harm

As part of the Inverclyde adult support and protection inspection we read the records of 38 initial inquiry episodes and found that they were all addressed in line with the principles of the Adult Support and Protection (Scotland) Act 2007. Prior to and during the Covid-19 restricted period social work progressed referrals within appropriate timescales. The partnership had more work to do to evidence the outcome of the three-point test which was only recorded in a few duty-to-inquire episodes.

There was evidence of good communication amongst partnership agencies, and this was helping them to effectively determine the stage adult support and protection referrals should reach.

Social work management oversight of referrals was evident in almost all records and the quality of screening and triage work was good or better in most of the episodes. Referrals were handled efficiently and within procedural timescales although some respondents to our staff survey felt better feedback to people making referrals was needed.

It was often difficult to distinguish between the adult support and protection inquiry and investigation stages. In a large number of records, inquiries and investigation reports were recorded on the adult support and protection initial report template, which was confusing. The partnership had already identified this as an issue through self-evaluation activity and planned to refresh local practice standards and operating procedures to reflect the recently updated West of Scotland Guidance. This will help staff to distinguish between the separate key processes.

The partnership carried out inquiries timeously in almost all cases - including during the Covid-19 restricted period. This was commendable. Staff found aspects of working remotely difficult and some felt it was harder to understand the full extent of inquiry situations. Staff said [they were] “not able to get the same feel as when we have personal or visual

contact" and "there can be no replacement for personal contact." Old and inconsistent IT systems also made speedy access to accurate information at the inquiry stage difficult.

Despite the obvious challenges, staff felt well supported by line managers. During the Covid-19 restricted period, it was felt that advice and guidance from social work service managers was not always consistent. Restructuring because of the pandemic included the redeployment of staff at senior level, which impacted on the consistency of support in the short term.

Investigation and risk management

Chronologies

Chronologies of key events were contained in most records, and staff completing our survey appropriately recognised this as an important feature of adult support and protection work. Yet a significant minority (34%) of records of adults at risk of harm did not have a chronology, and the quality was variable. These factors had the potential to undermine the overall strength of the partnership's adult support and protection work. Both the partnership's internal audit activity and position statement recognised that more work was needed to improve this area of practice.

Staff survey findings highlighted a confidence that adult support and protection work was carried out in accordance with partnership guidance. The inspection identified significant variations in practice. A number of staff were using the global risk assessment to record their chronologies. There was also a multi-agency template being rolled out across adult services and other staff simply embedded key dates in the narrative of the investigation report. Previous internal audit work had also recognised these inconsistencies of approach. This variation of practice lacked clarity, particularly service manager's discretion regarding the necessity for chronologies.

Risk assessments

While there were risk assessments in most adult at risk of harm records, a significant minority (29%) did not have one. Again, local practice standards and operating procedures afforded little clarity. Critically, it was unclear when risk assessments should be completed, with decisions left to the discretion of individual service managers. This led to an inconsistent approach across adult services.

More positively, where risk assessments were completed, they were collaborative and timely, with most being evaluated as good or better. Staff reported that working remotely as a consequence of Covid-19 provided additional time to reflect, analyse and complete risk assessments and that that this was providing an opportunity to further strengthen this area of practice.

Adult protection plans / risk management plans.

Adult protection plans were evident in just over half of files. Where they were present, almost all were up to date and collaborative with just over half (58%) being good or better. For situations that did not proceed to case conference, council officers used a flexible and proportionate approach that included the use of two templates to record protection plans in their inquiry or investigation work: the global risk assessment and the adult protection initial report.

Protection risks were adequately addressed in most cases but in a significant minority (22%) they were not. Better recording of post-protection plan interventions was an area for improvement.

Large Scale Investigations

We read about one adult at risk of harm appropriately included in a large-scale investigation. The partnership had not adopted the West of Scotland procedures but did apply the guiding principles of these procedures as a framework.

Full investigations

Almost all situations that should have progressed to investigation did so. Council officers appropriately led every investigation, with the assistance of a second worker on most occasions - including health professionals.

In nearly all cases, the investigation report clearly determined if the adult was at risk of harm, were completed on time, and to a high standard. Our survey findings supported this and indicated that staff felt investigation reports supported the presentation of clear evidence to initial case conferences. There were some challenges including that IT systems did not provide universal access across social work services. This made it difficult for staff to piece together the key information. Covid-19 and remote working arrangements had exacerbated this issue. Furthermore, staff in the learning disability team were occasionally using a different adult support and protection tool to that set out in the partnership's standards and operating procedures.

Adult protection case conferences

Commendably, the partnership convened timely initial adult support and protection case conferences on almost all occasions and ensured that other professionals and agencies were invited to attend. Despite offering appropriate invites, attendance by partnership agencies was not as good as it could have been.

Adults at risk of harm should always be at the centre of adult support and protection activity but were only invited to attend in just over half of those situations proceeding to initial case conference. There are often good reasons why some adults at harm might not attend case conferences and the partnership typically reflected this well in minutes of these meetings. Those adults at risk of harm, and unpaid carers, who did attend were well supported to participate.

There was also evidence of appropriate formulation of protection planning at adult support and protection case conferences. Almost all (93%) of initial case conferences effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported.

The partnership delivered training for case conference chairs, in addition to learning materials such as the checklist for chairpersons. This had a positive impact and we evaluated almost all initial case conferences as good or better.

Adult protection review case conferences

Our findings about review case conferences closely mirrored those about the initial case conferences. Even during the pandemic, all review conferences were completed in a timescale in keeping with the needs of the adult and effectively determined what needed to be done to protect them.

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

Overall effectiveness of collaborative working

Collaborative working was also a strong feature among social work, health and Police Scotland for adult support and protection investigations. The majority of staff responding to our survey agreed that they were supported to work collaboratively to achieve positive outcomes for adults at risk of harm. In addition, almost all initial inquiry episodes evidenced timeous and effective communication between partners.

Inverclyde had held multi-agency case file audits together with Renfrewshire's adult protection committee and K-Division of Police Scotland. Supporting evidence also indicated positive joint work with registered social landlords, care home providers and the Scottish Fire and Rescue Service's response to significant events, including fatalities.

There was further evidence of close strategic collaboration across initial case review, learning and development, the adult protection committee and subgroup activities.

Health involvement in adult support and protection

Inverclyde has had integrated and co-located adult community care teams since 2010 with shared management arrangements in place. There was an accompanying multi-agency learning and development strategy which supported health staff to better understand the various roles they played in adult support and protection.

NHS Greater Glasgow and Clyde adopted the West of Scotland Interagency Guidance and had a helpful dedicated adult protection webpage for staff. The adult support and protection liaison group brought together key stakeholders from across the health and social care partnership to promote collaboration around shared responsibilities within the context of adult support and protection. These measures had a positive impact in the partnership. Almost all health staff responding to our survey agreed that they understood their role, were confident about where to get advice and were supported to work collaboratively. Importantly, community nurses continued to visit people at home during Covid-19 restrictions and demonstrated a clear commitment to monitoring the welfare of the people they visited.

Health staff interventions contributed to improved outcomes for adults at risk of harm. Health records showed that community health services' responses to episodes of harm were a positive feature. Record keeping was of a good standard and like other agencies, they were effectively sharing information across the partnership's adult services.

Health staff attendance at adult support and protection case conferences and their deployment as second workers was not as consistent as it could have been. There was good evidence of health responding very positively, and in a timely fashion to most requests for capacity assessments.

Police involvement in adult support and protection

In January 2020, Police Scotland introduced the Contact Assessment Model (CAM) in Inverclyde. Calls and contacts to police from people seeking assistance were assessed by service advisors for threat, harm, risk, investigative opportunity, vulnerability, and the engagement required to resolve the issue (THRIVE). This assessment enabled Police Scotland to choose the most appropriate policing response, or signpost to a more appropriate agency.

Incident management records showed consistent and appropriate application of THRIVE, and good practice in the consideration of needs, vulnerability and risk when determining a proportionate policing response.

Police Scotland manages calls and incidents on their System for Tasking and Operational Resource Management (STORM) - command and control. Records showed timely contact between area control rooms and local supervisors to deploy them to ongoing adult protection incident or reports. Officers attending to initial adult at risk of harm calls were conducting accurate assessments of potential harm, vulnerability, and wellbeing. Another positive factor was that officers took account of the adult at risk of harm's wishes and feelings.

In most instances, the quality of the interim vulnerable persons database (iVPD) referrals was good or better, with almost all being progressed without delay. While this was positive, there was a lack of police managerial oversight during the initial operational officers iVPD submission stage, and during triage, screening and referral process within the concern hub.

The Police Scotland divisional concern hub efficiently shared adult concern reports with other agencies. Police Scotland and Inverclyde social work referral processes were electronic and closely aligned. Almost all iVPD referrals submitted to social work included a comprehensive level of detail regarding the source incident. The hub's ability to facilitate Police Scotland's triage process and demonstrate consideration of the three-point test was not as clear as it could be despite a 2019 multi-agency internal audit finding key strengths in both these areas.

Police Scotland's guidance for concern hub staff comprehensively detailed the information to be considered and recorded when completing the Resilience Matrix within the iVPD. This was not reflected in a number of the records, with half failing to meet the required standard. Entries were generic and lacked the rationale to support case prioritisation.

Almost all Police Scotland records contained evidence of good information sharing. Where the identified concerns proceeded to case conference, we learned that officers were mostly invited, and that appropriately experienced and trained staff attended or sent a report where appropriate. Officers who attended were assessed as providing a positive input and evaluated overall as adequate or better.

Third sector and independent sector provider involvement

Provider organisations played a key role in supporting adult support and protection in Inverclyde. Your Voice was the local third sector organisation commissioned to support service user and carer involvement, including adult support and protection proceedings.

Supporting evidence provided by the partnership showed a wide range of providers were accessing level 1 (awareness raising) adult support and protection training courses.

Provider organisations were appropriately initiating adult protection concerns/referrals and were key partners in providing additional support during and after adult support and protection processes. We noted some adult support and protection activity in care homes. While most of the protection work was effective there were occasions where case recording could have been clearer about the role of other agencies involved in protection activity and the outcomes for the adults at risk.

Key adult support and protection practices

Information sharing

Communication was effective and well embedded between partners at the referral stage. This enabled social work staff to make the necessary judgements and consistently determine the right stage to which concerns were escalated. All adult support and protection partners appropriately shared information during inquiry and investigation work, including social work, health and Police Scotland.

Management oversight and governance

There was good evidence of management oversight in social work records that did not progress beyond the initial inquiry stage, but evidence was not as strong in work that progressed to investigation. While front line manager social work oversight was good, there was a lack of clear governance in both the Police Scotland and health records. It is recognised that management oversight in all clinical records is not typical in practice.

Involvement and support for adults at risk of harm

While more needed to be done to involve adults at risk of harm in case conference meetings, there was evidence that adult protection partners worked closely with adults at risk of harm and took appropriate account of their views at most stages of the adult support and protection process. The quality of this support was good or better in nearly every occasion, reflecting a clear strength within the partnership.

Independent advocacy

Nearly all adults at risk of harm who required independent advocacy were offered it although just under half (45%) actually received this very important service. The reasons for this were not always clear from the records. Importantly, where it was accepted, it was deployed at the right time and helped the adult to articulate their needs on every occasion.

Capacity and assessment of capacity

There was evidence of concerns about the adult at risk of harm's capacity to make informed decisions in over half (62%) of the 50 cases that progressed to the adult support and protection investigation stage. Formal assessments were requested for individuals in just over half of these cases and were undertaken on most occasions. Health services, namely consultants in their specialist fields, completed these in a timescale in keeping with the adult's needs, which undoubtedly helped to achieve better outcomes.

Financial harm and perpetrators of all types of harm

Financial harm to adults at risk of harm was evident in a few (20%) records and there was good multi-agency working in almost all of these situations. The partnership acted to stop financial harm on almost every occasion but success in obstructing the harm was understandably mixed because of the complexities involved. Verbal coercion was the main tactic applied by perpetrators attempting to harm the adults at risk.

Safety outcomes for adults at risk of harm

Significantly, almost all adults at risk of harm experienced improvements in their circumstances in relation to safety and protection. This was primarily because of close multi-agency working. A few adults had less positive outcomes. In the main, this was because those adults were legitimately making independent decisions, out with the protection of applicable legislation, that put themselves at risk of harm despite the best efforts of the partner agencies.

Adult support and protection training

Most (72%) respondents to our staff survey agreed that participation in regular, local, multi-agency training and development opportunities in relation to adults at risk of harm had strengthened their contribution to adult support and protection joint working. Similarly, almost all were confident that the partnership provided the right level of mandatory adult support and protection training for all staff groups. Staff felt that training impacted positively upon their knowledge, skills, and confidence to undertake the protection role required of them. Importantly, council officer training was well embedded and those completing it said it helped their understanding of this critical lead role.

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

Key messages

- There were well embedded strategic governance structures in place across the public protection partnership including adult support and protection.
- There was a clear and well understood vision amongst staff from all agencies for adult support and protection work.
- There was a high degree of confidence amongst staff that strategic leaders, including the adult protection committee, provided good leadership for adult support and protection work.
- The partnership's adult support and protection quality assurance performance framework should be further developed and more consistently applied.
- The partnership should consider how it engages staff more directly in their adult support and protection self-evaluation processes and how it demonstrates the impact of change and improvement activity.
- The chief officers' group and adult protection committee need to govern quality assurance activity more thoroughly to ensure the required change and improvement work is carried out.

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 adult protection committee had renewed its constitution in October 2020. The updated constitution clearly outlined the roles and responsibilities of those involved in the committee. Importantly, most staff agreed that local leaders provided a clear vision and worked hard to raise awareness of adult support and protection work. We saw evidence of the partnership's vision/priorities outlined in both the adult support and protection biennial report and adult support and protection business plan 2018-20, which has since been appropriately updated.

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

The chief officers group provided oversight for all public protection groups in Inverclyde. While the group and the adult protection committee generally functioned well, they should have scrutinised the quality assurance process and outcomes more robustly. The audit framework, tools and templates were appropriately refined from year to year. While this was positive, self-evaluation processes were complex and recommendations for improvement were not always implemented. The Covid-19 pandemic had understandably impacted on progress in these areas.

The adult protection committee was multi-agency and included appropriate statutory and third sector representation. The committee effectively governed most key issues and staff were confident in its leadership. Attendance was often variable, which could have negatively affected the performance of this group.

The work of the committee was supported by the quality and policy subgroup, which progressed improvement work and the committee's training plan. While this group had a wide range of members, most actions were attributed to the council's adult support and protection lead officer.

The independent convenor's biennial report 2018-20 appropriately referenced the development of an adult protection recovery plan which took account of Covid-19. This plan focused on building resilience and took a human rights approach.

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

Much of the adult support and protection practice was sound and underpinned by good leadership. Responses to concerns were timely, collaboration was effective, and the quality of work being carried out in many aspects of the key processes was good. Most staff also agreed that leaders ensured there was capacity in the system to undertake protection work even through the Covid-19 restricted period.

There were a few key areas for improvement that the committee was already aware of through its own self-evaluation activity. These included social work practice standards and operating procedures that were not explicit enough, resulting in significant variation of practice across chronology, risk assessment and protection planning activity. Closer monitoring of improvement work was an area for improvement.

Frontline management support for adult support and protection practice during the pandemic was of a good standard. The high volume of information provided to workers, coupled with necessary structural and procedural changes made conditions challenging for staff. Despite this, staff we met had adapted well over time and were subsequently more comfortable with the changes that were made.

Quality assurance, self-evaluation and improvement activity

The partnership had delivered a comprehensive multi-agency training plan targeted at individual adult support and protection roles, which staff welcomed. The partnership also hosted a wide range of thematic events that raised awareness of adult support and protection practice across agencies.

The partnership carried out self-evaluation activity in 2018 and again in 2019. While these approaches were applied differently, the outcomes were broadly similar. Identified areas for improvement were not fully embedded and Covid-19 had further impacted progress, with most staff feeling steps could be taken to engage them more effectively in the self-evaluation process. Others were uncertain about the impact of this work and its ability to drive forward integrated change and improvement. The last two biennial reports provided strong and welcome statements of commitment to ongoing self-evaluation and improvement. The adult protection committee also committed to this in its business plan and aimed to implement a more robust quality assurance performance framework.

Initial case reviews and significant case reviews

Over the last two years, there were four cases referred to the adult protection committee for consideration. Three initial case reviews (ICRs) had taken place with one proceeding to significant case review (SCR). One SCR was completed in 2018 and another SCR was due to start. The findings of all three ICRs and the completed SCR were presented to the chief officers' group and the adult protection committee for action on the key learning points. As a result, appropriate improvement work and targeted training were undertaken by the partnership. Transition work between the Inverclyde significant case review process and the adoption of Scottish Government's adult protection significant case reviews interim framework was ongoing.

Impact of Covid-19

Screening and triage of adult support and protection referrals before and during Covid-19 restrictions was of a good standard. Well-established referral processes between agencies were in place and were effective. There had been a restructuring of the social work duty system model in response to the pandemic, which caused some uncertainty among staff in the early stages although this had lessened over time. Understandably, some staff expressed challenges about working remotely, including feeling isolated and the ability to gather information. Reassuringly, visits to adults at risk of harm were still being carried out in the most critical instances.

Where the adult at risk of harm's journey progressed to the investigation stage, similar challenges were identified and largely resolved. Staff across the partnership were well supported but the impact of re-organisation was felt by social work more acutely. Health staff acknowledged some additional pressure and felt that quite often they were the only agency still visiting adults in their own home. Health staff appropriately recognised the need for increased vigilance. Information sharing is a critical element of protection activity and while this was clearly demonstrated, the partnership's IT systems were not as effective as they could have been. This exacerbated communication and information sharing challenges for staff.

The partnership's strategic leadership team appropriately mitigated risks to adult support and protection delivery and was at an appropriate stage of recovery planning.

Summary

The Inverclyde partnership took a proactive and positive approach to inspection at a time when Covid-19 was significantly impacting on how support was provided to adults at risk of harm. Restrictions caused by the pandemic had complicated how services were delivered, placing significant pressure on both front-line staff and strategic leaders to change and adapt.

There was a well understood vision across the partnership. This helped them to respond to adults at risk of harm effectively and jointly. This ensured adults at risk of harm experienced good outcomes and improvements in their circumstances. Interventions were timely and staff were confident in their adult protection roles. Communication, collaboration, and information sharing between the various statutory and provider organisations was a strength of the partnership.

A more consistent approach to chronologies, risk assessments and protection plans is required. Central to this should be a review of the partnership's practice standards and operating procedures. The partnership should also improve how it implements change and improvement work following self-evaluation activity.

Next steps

We ask the Inverclyde partnership to prepare an improvement plan to address the identified areas for improvement. 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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 79% of episodes passed to the concern hub were raised in good time
- 33% (1 case) delay in the concern hub passing on concerns by less than one week, 67% (2 cases) were deleyd by one to two weeks.
- 13% of episodes where the application of the three-point test was clearly recorded
- 89% of episodes where the three-point test was applied correctly
- 97% of episodes were progressed timeously
- 100% (1 Case) delayed in the HSCP passing on concern which totalled less than one week, 0% totalling one to two weeks.
- 82% of episodes evidenced management oversight of decision making
- 79% of episodes were rated good or better.

Staff survey results on initial inquiries

- 77% concur that the partnership accurately screens initial adult at risk of harm concerns, 9% did not concur, 14% didn't know
- 74% concur they are aware of the three-point test and how it applies to adults at risk of harm, 13% did not concur, 13% didn't know
- 83% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 4% did not concur, 13% didn't know
- 82% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 7% did not concur, 11% didn't know

Information sharing among partners for initial inquiries

- 95% of episodes evidenced communication among partners

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

Chronologies

- 66% of adults at risk of harm had a chronology
- 48% of chronologies were rated good or better, 52% adequate or worse
- 100% concur chronologies form an important feature of ASP investigation reports,

Risk assessment and adult protection plans

- 71% of adults at risk of harm had a risk assessment
- 63% of risk assessments were rated good or better
- 59% of adults at risk of harm had a risk management/ protection plan
- 59% of protection plans were rated good or better, 41% were rated adequate or worse
- 100% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors.

Full investigations

- 98% of investigations effectively determined if an adult was at risk of harm
- 96% of investigations were carried out timeously
- 80% of investigations were rated good or better

Adult protection case conferences

- 94% were convened when required
- 93% were convened timeously
- 63% were attended by the adult at risk of harm
- Police attended 57%, health 71% (when invited)
- 94% of case conferences were rated good or better for quality
- 93% effectively determined actions to keep the adult safe
- 60% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences, 40 % didn't know

Adult protection review case conferences

- 82% of review case conferences were convened when required
- 89% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 84% of adult protection concerns were sent to the HSCP in a timely manner
- 73% of inquiry officers' actions were rated good or better - 5% of which rated excellent
- 63% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 95% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 84% good or better rating for the quality of ASP recording in health records
- 89% 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

- 84% of cases evidenced partners sharing information
- 95% of those cases local authority staff shared information appropriately and effectively
- 90% of those cases police shared information appropriately and effectively
- 95% of those cases health staff shared information effectively

Management oversight and governance

- 70% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 74%, police 14%, health 20%

Involvement and support for adults at risk of harm

- 86% of adults at risk of harm had support throughout their adult protection journey
- 95% were rated good or better for overall quality of support to adult at risk of harm
- 86% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 4% did not concur, 9% didn't know

Independent advocacy

- 40% of adults at risk of harm were offered independent advocacy
- 45% of adults at risk of harm accepted this offer
- 100% of adults at risk of harm who received advocacy got it timeously.
- 92% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy, 8% didn't know

Capacity and assessments of capacity

- 58% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 72% of these adults had their capacity assessed by health
- 92% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 20% of adults at risk of harm were subject to financial harm
- 50% of partners' actions to stop financial harm were rated good or better
- 38% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 73% of adults at risk of harm were safe and protected, 90% had some improvement for safety and protection
- 91% of adults at risk of harm who needed additional support received it
- 81% concur adults subject to ASP, experience safer quality of life from the support they receive, 5% did not concur, 15% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 71% concur local leaders provide staff with clear vision for their adult support and protection work. 10% did not concur, 19% didn't know

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

- 72% concur local leadership of ASP across partnership is effective, 10% did not concur, 18% didn't know
- 68% concur I feel confident there is effective leadership from adult protection committee, 8% did not concur, 24% didn't know
- 63% concur local leaders work effectively to raise public awareness of ASP, 12% did not concur, 26% didn't know

Quality assurance, self-evaluation, and improvement activity

- 57% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 10% did not concur, 33% didn't know
- 60% concur ASP changes and developments are integrated and well managed across partnership, 11% did not concur, 29% didn't know