Agenda Item 5

Adult Support and Protection Joint Inspection Report

Agenda Item: 5

Falkirk IJB Clinical and Care Governance Committee

25 February 2022

Adult Support and Protection Joint Inspection Report

For Consideration and Comment

1. Executive Summary

1.1 The report provides an overview of the findings of the Falkirk Adult Support and Protection (ASP) Inspection of partners - Falkirk Council, NHS Forth Valley, Police Scotland and the Adult Protection Committee (APC) - and our next steps. The APC has a range of duties linked to what is happening locally to safeguard adults. These include:

- reviewing adult protection practices
- improving co-operation
- improving skills and knowledge
- providing information and advice
- promoting good communication.

1.2 The inspection, one of many taking place across Scotland, was jointly carried out by the Care Inspectorate (CI), Healthcare Improvement Scotland (HIS), and Her Majesty's Inspectorate of Constabulary in Scotland (HMICS). Inspection scrutinised the quality of two important ASP quality indicators - the quality of our ASP Key Processes and the quality of ASP Leadership.

1.3 The partners and all others across Scotland faced the unprecedented and ongoing challenges of the Covid-19 pandemic. The report has found an engaged workforce which prioritises adults at risk of harm, and their carers. Adult Support and Protection processes in Falkirk adapted well to the challenges of the pandemic, with a collaborative structure in place across all key partners. The report has identified 6 areas of improvement, which cover recording of key processes and further opportunities for joint-working.

1.4 The inspection report was published on 8 February 2022 and is publicly available on the CI website. The report has commended the practices and processes in place to ensure adults at risk of harm are safe, protected and supported in Falkirk.

1.6 The inspection concluded that both the partnership's strategic leadership and 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.

1.7 The improvement plan developed by the partners will be produced by the APC and returned to Falkirk's link inspector within the Care Inspectorate on 23 March 2022. Our ASP operational workforce will be invited and encouraged to participate in improvement planning and activity. Improvement implementation and progress will be monitored by the Adult Protection Committee and Falkirk's Integration Joint Board.

2. Recommendations

The Clinical and Care Governance Committee is asked to:

2.1 consider and comment on the inspection report

2.2 note the improvement plan will be produced and returned to Falkirk's link inspector within the Care Inspectorate on 23 March 2022.

3. Background

3.1 The joint inspection is part of a programme of assurance activity taking place across Scotland at the request of Scottish Ministers. Building on previous 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. This is the first inspection of ASP across Scotland since the Act was introduced in 2007.

3.2 Following completion of the inspection programme a report will be submitted to the Scottish Government which will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken.

3.3 The inspections ensure adults at risk of harm are supported and protected by existing national and local arrangements.

3.4 The joint inspection provides Scottish ministers with evaluations based on the partnership's:

- key processes for adult support and protection
- strategic leadership for adult support and protection

3.5 The joint inspection, involved four methods of research:

- Staff survey: promoted by the ASP partners across social work, health and police, the survey sought views on ASP and outcomes for adults at risk of harm, key processes, staff support and training. 65% of respondents were employed within social work.

- Record analysis: The records of 50 adults at risk of harm were reviewed; a further 39 adults where initial inquiries took place were also scrutinised.

- Staff focus groups: Three focus groups gathered views on the impact of the pandemic on ASP measures and adults at risk of harm. This provided insight into the partnership's leadership and response to the pandemic, implementation of measures and associated guidance.

- Consideration of a position statement: The ASP partners provided a Position Statement outlining the ethos, approach and structure which supports effective adult support and protection processes and leadership.

4. Adult Support and Protection Joint Inspection Report

4.1 Overall, the inspection has commended the partnership approach to adult support and protection. The inspection report is attached at appendix 1 for information. Key aspects include:

- Proactive approach: The partnership actively sought engagement and the views of the adult at each stage of their adult support and protection journey.

- Strong governance framework: Strategic governance was diligent and energetic. The adult protection committee had developed a clear vision for adult support and protection. This was underpinned by seven key principles and took a whole systems approach.

- Resilient and responsive: The response to implementing adult support and protection during the pandemic was robust and responsive. This ensured adult support and protection remained a priority and supported the development of community resources.

- Collaborative: The approach to identifying and managing adult support and protection risk within care homes was co-ordinated, structured, and innovative. This was a collaborative approach by all key partners. The partnership also had a comprehensive and robust multiagency training programme.

4.2 The report sets out examples of positive outcomes:

- Information sharing: 100% of cases evidenced information sharing between partners, with 98% of local authority staff sharing information appropriately and effectively.

- Improved outcomes: 82% of staff working in this area felt that adults engaging with ASP experienced a safe quality of life from the support they received.

- Timely response: Timescales were met for almost all case conferences. While opportunities remain for the provision of advocacy, those who accepted advocacy support received it timeously.

- Knowledge sharing: The partnership has a comprehensive training programme available to all partners. Almost all staff reported that training had a positive impact on their skills.

- Leadership: The partnership has a clear vision with underlying principles for adult support and protection practice. This is communicated effectively to all partners.

4.3 There are six areas for improvement identified:

1. Recording at each stage of the adult support and protection process needs to be clearer. This includes the delineation of adult support and protection stages and the application of the three-point test.

2. Involvement of health colleagues, operationally and strategically, needs to be strengthened. For example – inconsistency was highlighted in the recording of adult protection concerns within health records. Case reviews could be strengthened with the attendance of health professionals.

3. Risk assessment and risk management was less evident in investigations and inquires that did not include an initial referral discussion. Risk management plans should be in place for all adults at risk of harm.

4. The use and quality of chronologies required improvement. Chronologies provide a useful tool for assessing risk and should include details of significant life events. The report recommends a comprehensive and consistent approach to recording chronologies to inform decision making in adult support and protection. This should be done in consultation with the adult at risk of harm and, where applicable, their carer.

5. Key partners were not always collaborative, or involved when required, in adult protection processes. All members of the partnership need to explore opportunities to make their single/joint contributions to adult support and protection arrangements more effective.

6. Audits should be multiagency with findings from previous audits fully implemented. Priority should be given to improving previously identified key processes. Specifically, the completion of chronologies and risk assessment at inquiry and investigation stage.

4.4 The improvement plan will be produced and returned to Falkirk's link inspector within the Care Inspectorate on 23 March 2022. This will include further detail about actions already underway, such as the implementation of

a new case management IT system, which will progress several areas for improvement.

4.5 Our ASP operational workforce will be invited and encouraged to participate in improvement planning and activity. Improvement implementation and progress will be monitored by the Adult Protection Committee and Falkirk's Integration Joint Board.

5. Conclusions

5.1 The inspection programme has been a valuable means of providing external recognition of our achievements and has assisted us to further focus our areas for improvement. ASP partners have worked hard to meet the demands of inspection in a challenging context. Partners will jointly prepare an improvement plan to address the six priority areas for improvement.

Resource Implications

Inspection highlighted that all partners need to explore opportunities to make their single and joint contributions to adult support and protection arrangements more effective. This will include resourcing ASP specialist roles in public bodies where this is not currently in place. It means having a structure which is able to respond to the demands of our ASP key processes including initial referral discussions, joint investigations, attendance and reporting into case conference and post case conference support and protection activity. It means representative and contingency representation at our joint leadership strategic forums including APC and its subgroups.

Impact on IJB Outcomes and Priorities

Collectively building on our strengths and resourcing our improvement activity will ensure that adults in Falkirk continue to be safe, supported and protected. Our effective and proportionate interventions will encourage self-protection and a positive service user and carer experience.

Directions

A new Direction or amendment to an existing Direction is not required as a result of the recommendations of this report.

Legal & Risk Implications

The partners have specific and important legal duties outlined the ASP act. Our ongoing single and joint contributions to ASP practice and its continued improvement will ensure we are discharging these duties effectively.

Consultation

Improvement activity will include all levels of the workforce, service users and carers and the groups which represent them.

Equalities Assessment

Equalities implications are considered by the APC in all improvement activity.

6. Report Author

6.1 Gemma Ritchie, Adult Support and Protection Lead Officer

7. List of Background Papers

7.1 None

8. Appendices

Appendix 1:	Joint Inspection of Adult Support and Protection: Falkirk Partnership Report

care inspectorate

Healthcare Improvement Scotland

HMICS

JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Falkirk 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 Falkirk 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 Falkirk area were safe, protected and supported.

The joint inspection of the Falkirk partnership took place between October 2021 and February 2022.

The Falkirk partnership and all others across Scotland faced the unprecedented and ongoing challenges of the Covid-19 pandemic. We appreciate the Falkirk 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.

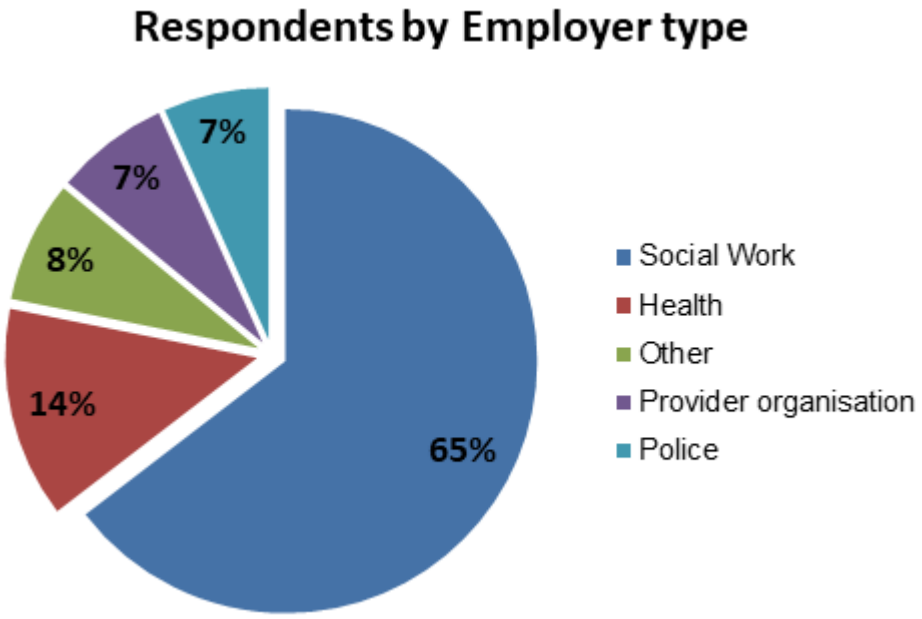
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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.

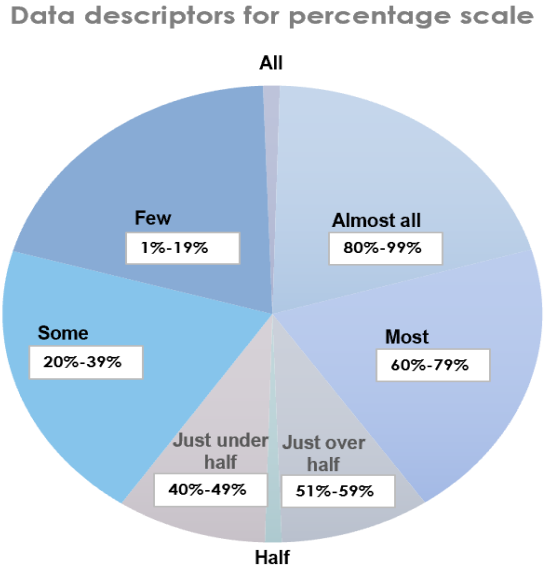
Staff survey. One hundred and ninety-two staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for 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 39 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 three focus groups and met with 29 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



Summary – strengths and priority areas for improvement

Strengths

- Adult support and protection practice prioritised the adult at risk of harm. The partnership actively sought engagement and the views of the adult at each stage of their adult support and protection journey.

- Strategic governance was diligent and energetic. The adult protection committee had developed a clear vision for adult support and protection. This was underpinned by seven key principles and took a whole systems approach to safeguarding adults at risk of harm.

- The partnership response to implementing adult support and protection during the pandemic was robust and responsive. This ensured adult support and protection remained a priority and supported the development of community resources.

- The partnership had a comprehensive and robust multiagency training programme.

- Adults at risk of harm supported at case conference and beyond benefitted from more robust support and protection arrangements. This meant adults were safer because of the partnership's use of core groups, council officer's reports and updating the risk assessment.

- The approach to identifying and managing adult support and protection risk within care homes was co-ordinated, structured, and innovative. This was a collaborative approach by all key partners.

Priority areas for improvement

- Recording at each stage of the adult support and protection process needs to be clearer. This includes the delineation of adult support and protection stages and the application of the three-point test.

- Involvement of health, operationally and strategically, needs to be strengthened.

- Risk assessment and risk management was less evident in investigations and inquires that did not include an initial referral discussion. Risk management plans should be in place for all adults at risk of harm.

- The use and quality of chronologies required improvement. A comprehensive chronology should inform decision making in adult support and protection. This should be done in consultation with the adult at risk of harm.

- Key partners were not always collaborative, or involved when required, in adult protection processes. All members of the partnership need to explore opportunities to make their single/joint contributions to adult support and protection arrangements more effective.

- Audits should be multiagency with findings from previous audits fully implemented. Priority should be given to improving previously identified key processes. Specifically, the completion of chronologies and risk assessment at inquiry and investigation stage.

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

Key messages

- When an initial referral discussion involving all key partners took place as part of the inquiry, this supported effective decision making. However, the involvement of all relevant key partners, and governance over decisions being implemented, was inconsistent.

- The partnership's approach to engagement and involvement with adults at risk of harm was innovative and dynamic. This included the co-production of protocols and the way feedback from adults at risk of harm was gathered.

- Case conference and post case conference activity was structured and well delivered. This included the facilitation of regular core groups, review of risk assessment and continuing engagement with the adult at risk of harm. This practice supported effective safeguarding for adults at risk of harm.

- The social work recording system adversely impacted on practice as there were no templates for inquiry and investigation. Recording of inquiries and investigations was inconsistent. Combined, these impacted on a clear delineation of the different stages in the adult protection processes. This included the application of the three-point test

- Opportunities existed for health to become more collaboratively involved in the partnership delivery of adult support and protection. In particular, involvement in multiagency processes including initial referral discussions, attendance at case conference and the completion of capacity assessments.

- Police Scotland made a positive contribution to initial inquiries and initial referral discussions, when involved. There was some evidence of silo working by partners at investigation stage, such as the police only investigation. A more holistic and co-ordinated multiagency approach was expected.

- Critical elements of key processes continued to require strengthening, this included chronologies, risk assessment and protection planning.

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.

The Falkirk "Adult Support and Protection Guidance and Procedures for Assessment and Care Management Staff" (2017) covered all aspects of adult support and protection processes. Referrals were screened and triaged by the relevant team in the Falkirk Health and Social Care Partnership (HSCP). If the adult was allocated to a worker, the referral was screened by that worker in line with local procedures. If the adult was not allocated to a worker, then the duty worker screened the referral. In response to increased demand, duty staffing levels had been increased. The referral screening process was mostly effective and timely.

There was a good level of staff confidence in the referral and screening process. In March 2021 the partnership took the positive step of establishing a "Multiagency Escalating Concerns Protocol". The protocol was developed in partnership with adults with lived experience. The protocol considered supports available and provided quality assurance of repeat referrals where the adult had not met the three-point test.

Initial inquiries into concerns about adults at risk of harm

Almost all initial inquiries were completed in line with the principles of the legislation, were timely, and competently executed. The recording of the application of the three-point test was evident in most inquiries. A significant minority (33%) did not clearly record the three-point test. Recording on the social work information system (SWIS) was inconsistent and impacted on documenting the rationale for decision making. There was no template for recording an inquiry which contributed to a lack of consistency by staff in recording.

There was evidence of multiagency communication which contributed to the effectiveness of most inquiries. Management oversight was evident in almost all inquiries. The quality of most inquiries completed was good or better.

Initial Referral Discussions (IRD) were part of the process in Falkirk. The multiagency IRD training delivered in 2021 highlighted that an IRD was a focussed part of the initial inquiry stage. This should be a multiagency discussion with relevant agencies. The purpose is to share information and have shared decision making but should not be a replacement for a case conference. There was a template for each agency involved to record the information gathered and decisions taken. There was evidence of good discussion and shared decision making which supported risk based and proportionate decision making.

The threshold for holding an IRD, recording of professional attendance, and governance of decision making was variable. At times professional challenge around decisions made would have been appropriate and would have made the decision making process more robust. There was also evidence of IRD's being convened at different stages of the adult protection processes, not just at inquiry stage. Templates for recording IRD's were clear, however, these were not consistently held in partners records, particularly in health records. A recent audit of IRD's was completed in October 2021, covering the period April 2021 to October 2021. The requirement for each agency to hold a record of their involvement in the IRD process had been identified as an area for improvement. Poor recording of decisions impacted adversely on overseeing the progress of those decisions. Positively, the outcome of the IRD was recorded in the social work recording system, although the recording of the progress on these decisions was variable.

A Forth Valley-wide electronic IRD (eIRD) system was being progressed to strengthen practice and recording. The plan was to implement this system in 2022.

Investigation and risk management

Chronologies

Chronologies are an important tool for assessing and managing risk. When an IRD was held chronological information was considered, although this was not a chronology of significant life events. A more comprehensive chronology was required within the risk assessment. The (2017) procedures stated that this should be completed for adults who were supported at case conference. While almost all staff agreed that chronologies were an important part of an investigation report, we found chronologies were not consistently used to inform decision making.

Just over half of the adults at risk of harm had a chronology completed when it was required. Most were rated adequate or lower. Chronologies were completed on different templates resulting in an inconsistent approach. Practice around chronologies was identified as an area for improvement by the partnership. Further consideration was required to ensure that chronologies contain sufficient detail, with analysis, to inform decision making.

Risk assessments

Good risk assessments are critical for effective risk management for adults at risk of harm. The partnership recognised the importance of this in its improvement plans. The staff survey revealed a good understanding of risk assessment.

Risk assessments were completed for most adults at risk of harm. Half were rated good or better. Within the social work recording system there were significant variations in how an assessment of risk was recorded. These were more pronounced for adults at risk of harm who did not proceed to case conference. For adults at risk of harm who progressed to case conference templated reports were completed. Specifically, a risk assessment form and a council officer's report, which had a risk section.

The assessment of risk should be considered at each stage of the adult at risk's journey and be a dynamic process. The partnership's approach, and recording of risk assessment, was inconsistent. Practice around risk assessment was weaker at the investigation stage.

Full investigations

Council officers completed all investigations led by the HSCP. When required, almost all deployed a second worker. A health professional was the second worker in only one of the seven investigations where it was considered appropriate. This finding was supported by the staff survey with only 36% of respondents agreeing that second workers were from other relevant agencies. Encouragingly, all investigations gathered information from appropriate parties, including the adult at risk of harm. Almost all were effective in determining if the adult was at risk of harm.

One of the possible outcomes of an adult support and protection inquiry in the Falkirk partnership was to proceed to a police only investigation. In 2020-21 a police only investigation accounted for 54% of the total investigations carried out. A council officer must lead an adult protection investigation. It was not clear what a police investigation involved or if this met the requirement for the council discharging statutory duties. This led to some incidents where the partnership approach focussed on criminality. A more integrated approach to the well-being of adults at risk may have improved their outcomes.

Timescales were met for most adults at risk of harm investigations. Some investigations experienced delays that were over two weeks, for a few this was between one to three months. The Falkirk procedure stated that the timescale for an investigation was five working days. The quality of investigations was mostly rated as good or better. Significantly a few (13%) were considered weak.

Often the investigation stage was not clearly defined. This was compounded by a variation in recording and lack of templates on the social work recording system. As a consequence, the partnership could not be assured that the adult at risk of harm always knew what stage of the process they were being supported under. This included recording that the adult at risk of harm had been advised of their rights. The partnership expected that the introduction of the new social work recording system would support improved practice in this area.

Adult protection case conferences

Case conferences were convened for almost all adults at risk of harm where it was considered necessary. There was a noteworthy few (14%) where a case conference should have been convened but was not. The reasons for this varied and impacted on protection planning. As part of the preparation for case conference the council officer was required to complete a council officer's report. This was a comprehensive, templated report that supported discussion at the case conference.

Timescales were met for almost all case conferences. The delay in convening a few case conferences was between one to three months. Almost all relevant professionals were invited and just over half of those invited attended. The HSCP had set up a process whereby all agencies were required to submit reports for the case conference. There was limited evidence of these reports being completed. For just under half of case conferences convened there was evidence of limited health and police engagement in the process.

The adult at risk of harm and unpaid carers were invited to case conference in most cases. When they were not invited the reasons were recorded in most cases and were appropriate. Most adults at risk of harm and unpaid carers attended case conferences, with the reasons for non-attendance noted. The practice was person centred and there was evidence of good practice to engage and involve adults at risk of harm. Overall, most case conferences were rated good or better.

Adult protection plans / risk management plans

Almost all protection plans were up to date and were appropriately reflective of the contributions of multiagency partners. Significantly, some (22%) adults at risk of harm who required a protection plan did not have one. This made it difficult to determine that the risk was managed effectively for those adults at risk of harm.

The partnership had a template for protection plans. The protection plan was developed based on the discussion and decisions of the case conference. Most protection plans were rated good or better. A significant few (12%) were rated weak or lower. Indicating that for those adults, risk was not effectively managed.

Adult protection review case conferences

Adult protection review case conferences were convened for almost all adults at risk of harm who required one. Almost all were convened timeously and effectively determined what action was required to keep the adult safe and protected.

Implementation / effectiveness of adult protection plans

Local procedures determined that following a case conference the protection plan was implemented and overseen by a council officer. There was good evidence of core groups taking place to review and update protection plans appropriately.

Prior to a review case conference, the council officer report and risk assessment required to be updated. When completed, these contributed positively to the review of risk and action planning.

The partnership completed an audit of outcomes from case conferences that took place from July 2020 to August 2021 for adults at risk of harm. Several positive outcomes were identified, although the audit did not consider if poor outcomes were present. Protection type risks were addressed for most adults at risk of harm.

Large-scale investigations

The partnership completed three large-scale investigations during the time period being considered. The investigations were completed in line with "Forth Valley Large Scale Investigation Protocol" (2014). The learning from these investigations had been considered and there were plans to review and update the guidance.

The partnership developed an 'Adult Support and Protection in Care Homes Practitioners Guide' for staff working in care homes. This included a matrix to support the referral of concerns. To promote a preventative approach and support good practice in care homes, an early indicators of harm multiagency group met regularly. The partnership had also developed a multidisciplinary Care Home Focus Group and a Care Home Assurance Review Team, both supported good practice within care homes.

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

Overall effectiveness of collaborative working

The partnership had contributed to the development of the "Forth Valley ASP Multi-Agency Guidance" (2018) which complemented the 2017 local procedures. It was planned that both these would be updated following the publication of the updated national Adult Support and Protection code of practice.

There was a good level of collaboration with the police throughout the process, although it was not consistent. For example, good involvement in the IRD process, less evidence of collaboration at the investigation stage. Collaboration with health professionals was less evident. Although examples such as the Care Home Assurance Review Team and work around LSI's demonstrated a robust multiagency response that included health professionals.

The partnership was progressing the implementation of a tripartite eIRD. This was part of a wider Forth Valley approach. The development and training on eIRD were intended to support collaboration at the inquiry stage and ensure the rationale for action was recorded by all agencies. In 2021 the partnership provided training for staff from a range of agencies that worked directly in adult support and protection.

Collaboration at case conference stage required further development. This was intended to support an improved response to managing ongoing risks.

In response to the pandemic, the partnership developed an ASP Covid action plan and was involved in the Forth Valley-wide ASP multiagency oversight group. This supported the management of risk for adults at risk of harm on a strategic and operational level. This group reported on a regular basis to the adult protection committee and the Chief Officers Group (COG) for Public Protection. The partnership had identified a need to strengthen the involvement of health by developing a strategic NHS lead post.

Health involvement in adult support and protection

Procedures identified health professionals as key to the tripartite IRD process. Evidence of health involvement in this process was limited. Health participated in the multiagency training programme. The staff survey highlighted positive feedback from most health professionals that had been involved in training, with increased levels of understanding and confidence. Health were key partners in the multiagency Care Home Focus Group and Early Indicators of Concern meeting which provided robust support for care homes.

There were critical weaknesses in the involvement of health in operational adult support and protection processes. Where there was evidence of adult protection concerns recorded in health records, the quality of the record keeping was adequate or worse for most adults at risk of harm. From the evidence provided the involvement of health professionals required development. The collaboration and contribution made to improving outcomes for adults at risk of harm was rated adequate or worse for most adults. Health professionals were not the second worker for most of the investigations where it was identified as appropriate. Just over half of case conferences were attended by the relevant parties. Health attendance at case conference was an area for improvement.

For some adults at risk of harm the assessment of capacity was delayed following referral. Just under half did not have an assessment of capacity completed following referral. Positively, almost all adults that required a medical examination had one carried out.

Health involvement in adult support and protection had been recognised by the partnership as an area that needed strengthened.

Police involvement in adult support and protection

Almost all contacts made to the police about adults at risk were effectively assessed by officers and staff for threat of harm, risk, investigative opportunities, and vulnerability (THRIVE). Some incidents had an inaccurate STORM Disposal Code (record of incident type). On occasion this led to adults with multiple concern types not being identified, this was particularly evident in no-crime domestic abuse episodes.

Often an IRD was referenced as the first point of police involvement. There was good representation by the Police at IRD, where officer contribution to this early engagement was good or better in most cases.

Good practice was evident, whereby in response to all IRD's convened an interim Vulnerable Persons Database (iVPD) record was created. This supported the recording of IRD's. The submission of an iVPD allowed for an auditable record of a third-party referral.

For adults at risk of harm discussed at IRD where criminality was suspected, a 'Police only Investigation' outcome was frequently recorded. This led to a silo approach by partners, whereby the focus was primarily on the criminality and not the wellbeing of the adult at risk of harm. Importantly, in a minority of instances, the Police did not discharge actions approved at IRD or report outcomes to partners. This led to a lack of partner understanding of risk and need for a holistic approach.

All records were submitted in a timely way. Supervisory oversight was noted and viewed as being good or better, in just over half.

Divisional Concern Hub (DCH) records demonstrated diligent research, assessment, and input by staff, resulting in informative resilience matrix entries. DCH actions and records were good or better in almost all cases.

Officers attended most case conferences, when invited. The Police attended just under half of case conferences convened, where there was Police involvement. Non-attendance was an equal combination of no invitation being received and a Police representative not attending. The Police discharged most single agency actions allocated at case conference.

Third sector and independent sector provider involvement

Almost all adults at risk of harm who required additional support got it. For most adults at risk of harm the support provided was comprehensive and effective. There were several examples of person centred and integrated support being delivered that improved outcomes for adults at risk of harm.

The third and independent sector were viewed as a key partner. Additional support had been given to providers and they were involved in multiagency groups and case conferences. Funding had been provided by the partnership to increase involvement and support for provider organisations. Adult protection training had been developed and delivered to people working in the third and independent sector. Provider organisations reported a good level of awareness of adult support and protection and training delivered had supported their knowledge in this area.

Key adult support and protection practices

Information sharing

Information sharing was evident between agencies at every stage of the adult protection process. The quality and recording of information shared varied between agencies and stages. If an IRD did not take place, the recording of information gathered was weaker. When an IRD took place, there was a template for completion. The information gathered and shared by police and social work was clear. Information shared by health at an IRD was less clear.

There was no template for social work inquiry or investigation, which adversely impacted on recording. Although information shared with social work was recorded in case notes, and informed the response, there was a lack of consistency. Relevant professionals attended just over half of case conferences. When they did attend information was effectively shared. Feedback to the referrer was an area for improvement, this had already been identified by the partnership and was within the improvement plan.

Management oversight and governance

Management oversight and governance was of a good standard in social work and police records. The level of recording was in keeping with the needs of almost all adults at risk of harm. Decisions from social work supervision were recorded in most adult at risk of harm files.

The exercise of governance in records was evident in most of the relevant police and social work files. Although the governance of decisions taken at an IRD required strengthening. Evidence of exercise of governance was less apparent in health records. This is not necessarily a deficit, due to the types of health records scrutinised. It was recognised by health professionals that consideration was required as to how adult support and protection concerns were recorded and linked to any IRD involvement.

Involvement and support for adults at risk of harm

The partnership involved almost all adults at risk of harm at every stage of the adult support and protection process. When appropriate, the partnership involved almost all unpaid carers. On most occasions this effectively supported the adult to be involved and engage in their adult protection journey.

The partnership had developed tools to support involvement. This included easy read leaflets and an information gathering form to be completed with the adult to support them to express their views at case conference. A questionnaire to gather views from adults that had received an adult support and protection intervention had also been developed. These tools encouraged positive engagement and provided feedback on the adult's experience.

Independent advocacy

The advocacy service had a service plan updated in 2021 that had identified service outcomes for the adult at risk of harm. The outcomes were based on the "National Health Wellbeing Outcomes" published by Scottish Government in 2015. The delivery of advocacy was monitored by the Officer Monitoring and Evaluation Group which meets twice a year.

Most of the adults that required it were offered advocacy. Just under half of adults at risk of harm accepted this support. When advocacy was accepted it provided effective support to the adult at risk of harm to articulate their views. This support was provided timeously for most adults. Opportunities remained to develop the provision of advocacy.

Capacity and assessment of capacity

The HSCP had a structured process with guidance and a referral form to request an assessment of capacity.

Most adults at risk of harm who required an assessment of capacity had this requested by health professionals. A capacity assessment was completed for just over half of these adults. Some of those completed experienced significant delays of over three months. Delay in completing a capacity assessment impacted adversely on protection planning.

The recognition by social work that a capacity assessment was required needed to be strengthened. The process for completion by the relevant health professional required to be significantly improved to ensure adults were safe and protected without unnecessary delay.

Financial harm and alleged perpetrators of all types of harm

Financial harm was prevalent for some of the adults at risk of harm. In most situations the partnership took effective multiagency action to stop the harm.

The partnership carried out work with the alleged perpetrator in just over half of the situations where it was identified appropriate. Where work was undertaken with the alleged perpetrator, this was almost always of a good quality. The partnership's actions against alleged perpetrators were effective in just under half of cases. For 24% of adults at risk of harm, the actions against alleged perpetrators were weak, and on one occasion unsatisfactory, indicating more work needs done in this area.

Safety outcomes for adults at risk of harm

Almost all adults experienced improved outcomes from the adult support and protection intervention. This was mostly attributed to multiagency working. Poor outcomes were identified for a few adults at risk of harm. While the reasons for these outcomes varied, they included the lack of social work involvement and lack of multiagency working.

Commendably, we saw several examples where workers had ensured a person-centred and flexible approach under difficult circumstances. This contributed positively to the co-production of safety outcomes for adults at risk of harm.

Adult support and protection training

The partnership had a comprehensive training programme that was overseen by the learning and development group which was a subcommittee of the adult protection committee. The training programme was multiagency and was targeted for staff based on their role and task. For council officers there was a detailed check list to support learning and development specific to this role. Training continued to be delivered during the restricted period, although the approach had changed to a hybrid model.

Almost all staff reported that training had a positive impact on their knowledge and skills in adult support and protection. The partnership had completed an evaluation of training that highlighted mostly positive feedback. The partnership was committed to continue to develop and deliver training to support practice. Examples included the development and delivery of the Professional Curiosity training and training being developed for the new social work recording system.

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

Key messages

- The partnership had a clear vision with underlying principles for adult support and protection practice and leadership. This was communicated effectively.

- The partnership's response to the Covid-19 pandemic was robust. Community capacity was developed to support and safeguard adults at risk of harm.

- Governance was clear with good links across the public protection sphere. The Chief Officers Group had developed a risk register which was used to assess and address risk.

- Involvement of health at a strategic level needs further development.

- The partnership has continued to self-evaluate and complete audits on specific areas of practice including IRD's. This has supported service development. However, findings from case file audits completed in 2018 and 2019 are outstanding and should be fully addressed.

- While there is evidence of positive and productive collaboration there remains opportunities for increased collaboration and engagement between all partners. This includes the development of multiagency audit, increased involvement of frontline workers and streamlining improvement plans.

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 Falkirk partnership has developed a compelling and clear vision for adult support and protection. This was reviewed in July 2021 when the partnership adopted a whole systems approach to supporting adults at risk of harm. The vision outlined seven multiagency principles to underpin local adult support and protection practice. Most staff reported a good understanding of the adult support and protection vision.

The partnership had a multiagency improvement plan that was overseen by the adult protection committee and delivered via its subcommittees.

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

The Chief Officers Group (COG) was responsible for overseeing all aspects of public protection including adult support and protection. From March 2020 to March 2021 the Falkirk COG amalgamated with the COG for Clackmannanshire and Stirling to form a Forth Valley COG. To enable a more detailed focus on their respective geographical areas, the COG separated in March 2021. Following this the Falkirk COG developed a Falkirk public protection risk register to highlight areas that required further consideration and action. An example of this was the identification of risk relating to recruitment of staff. The Falkirk COG considered this issue with a plan to address this challenge and mitigate the risk. The risk register was updated and developed for each meeting of the adult protection committee and COG.

The adult protection committee and COG had appropriate representation from the key partners and met regularly. The lead officer came into post in 2019 and the chair was appointed in 2021, both had contributed positively to the development of adult support and protection in Falkirk. Committee membership also included agencies such as the Scottish Ambulance Service and Scottish Fire and Rescue. The partnership recognised the need to strengthen the input from health. Options to progress were being considered. While there was no carer or adult with lived experience on the committee there was representation from the advocacy service.

There was evidence of consideration of the relevant elements of the adult protection code of practice for adult protection committees at every committee meeting. Regular data reports were provided for discussion and consideration at the committee. This enabled the consideration of changes in referral rates and patterns. A council officer and team manager from an operational team were invited to attend and present an example of adult protection work. This raised awareness of the work of the committee and supported committee members to understand operational practice. Staff surveyed were less positive about strategic leadership. Just under half of respondents felt confident that leaders understood the impact and quality of

their work. This suggested that the adult protection committee required to continue to develop its links and communication with frontline staff.

The work of the committee was delivered by a subcommittee structure, with some groups being Forth Valley-wide. All groups were multiagency and had their own improvement plans which link to the wider Falkirk adult protection improvement plan. The adult protection committee linked with other relevant governance groups, such as the Health and Social Care Partnership clinical and care governance group.

Many of the plans had recently been updated and were comprehensive. As many of the actions were on-going at the time of inspection the implementation and impact of these plans could not be fully assessed.

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

Leaders demonstrated collaborative adult support and protection practice. Strategically, the adult protection committee and subcommittees worked collaboratively to safeguard adults at risk of harm. The work around the implementation of eIRD's was being progressed by health, police, and social work. This included the development of procedures and participation in multiagency training.

In response to the pandemic, the partnership took part in the Forth Valley Covid-19 oversight group, and a Care Home Assurance and Review Team was developed. To support operational practice there was an ASP multiagency group that met weekly to review and monitor key processes. In June 2021, the partnership surveyed practitioners about adult support and protection. The feedback about recent strategic developments was positive.

It had been recognised by strategic leadership, that a specific health professional with lead responsibility for adult protection would strengthen the involvement of health. Along with multiagency subcommittees there was a single agency NHS Forth Valley subgroup. Many of the actions for this group overlapped with the overarching actions of the other Falkirk adult protection subcommittees and there was some duplication of actions. Over the past three years audit information had been limited however the adult protection committee had collected data and considered it appropriately. This could be developed further by considering data from agencies other than the HSCP.

Effective collaboration at an operational level was less positive, particularly around health involvement. The quality of information sharing and collaboration from health staff in key processes was adequate or worse for most adults at risk of harm that they were involved with.

Quality assurance, self-evaluation and improvement activity

The remit of the continuous improvement subcommittee was to oversee self-evaluation and audit work. At the commencement of the pandemic a decision was taken that planned audit activity would be paused.

The last comprehensive audit was completed 2018, with limited audit work completed in 2019. The findings from both informed the improvement plan. It was notable that the findings from both audits highlighted improvement was required around chronologies, risk assessment and defining an investigation. These findings were also identified from the files that we read, suggesting some delay in realising improvements in these important areas.

The partnership had an audit and self-evaluation plan and while elements had been paused, the partnership had continued to undertake thematic self-evaluation, reviews, and surveys. This included a regular review of IRD's and a self-evaluation of the adult at risk's participation in adult support and protection during Covid-19.

Staff were less positive about opportunities to become involved in audit and transformation work. Only some respondents stated they had been involved in evaluating the impact of the adult support and protection work. While there had been improvements in practice based on audit findings more needed to be done to ensure there was improvement in the critical elements of adult support and protection practice in Falkirk. Most improvement plans adopted a PDSA approach but would benefit from being developed and streamlined further. A more integrated approach from all key partners in improvement activity would reduce duplication and promote a more holistic approach. The partnership has the capacity to address these issues via the work of the subcommittees

Initial case reviews and significant case reviews

During the timeframe being considered two initial case reviews were completed in line with the Scottish Government guidance. The first was an initial case review that resulted in a multiagency improvement plan that led to innovative action to support adults who experience self-neglect and hoarding. The processes for both initial case reviews were impacted by the pandemic which caused some delay.

The findings from the initial case reviews were disseminated to staff and a 7-minute briefing was developed. The partnership had developed a multiagency case review group that was a subcommittee of the adult protection committee, this group considered referrals for a review and actions around case reviews.

Impact of Covid-19

The partnership took the approach that adult support and protection should continue to be a priority during the pandemic and all key processes should continue to be implemented. This was in line with the Scottish Government guidance. In response to the pandemic the adult protection committee developed a specific action plan for adult support and protection. An ASP operational oversight group was established to consider practice and identify areas for action. This group reported to the adult protection committee and COG.

Staff expressed confidence that measures during the restricted period ensured adults at risk of harm were safe and protected although they had less confidence in leadership and communication. For all the adults in the case file sample, who were subject to adult protection processes during the restricted period, key processes were effectively implemented. The intervention was rated good or better in almost all cases. During this period, the partnership raised awareness around adult support and protection issues via media campaigns and leaflet drops.

In April 2020, the partnership completed an assurance exercise which was reported to the adult protection committee. This was to provide information and assurance about the impact of the pandemic on operational practice and the experience of adults at risk of harm. This illustrated approaches workers undertook to ensure they carried out key processes safely and effectively.

The work the partnership undertook with the Covid-19 community response forums and the third sector were commendable. This supported adults at risk of harm and other people who may be vulnerable. The HSCP commissioned a report to review this on a wider basis to reflect, build on and develop future resources in the community.

Summary

Falkirk partnership's focus on ensuring adults at risk of harm were engaged, consulted, and involved throughout their adult support and protection journey was commendable. The partnership completed initial inquiries to a good standard. When the partnership held an initial referral discussion this made decision making at inquiry stage more robust.

At times the delineation of inquiry and investigation was not clear, this was compounded by poor recording of the application of the three-point test. The partnership was in the final stages of updating the social work recording system which is anticipated to support improvement in recording.

Practice around chronologies, risk assessment and risk management particularly at investigation stage required improvement. The partnership's management and support for adults at risk of harm was more effective for adults who were supported at case conference and beyond.

The partnership delivered a comprehensive multiagency training programme accessible to all agencies. The partnership's work around supporting care homes was collaborative and supportive.

The partnership had a well-developed vision which was supported by a clear governance structure and subcommittees to progress the improvement plans and oversee practice. While there was evidence of collaboration there remained opportunities to refine and develop this further. Particularly in the delivery of key processes and improvement actions.

Audit and self-evaluation were limited due to the impact of the pandemic but had continued. The findings of these activities contributed to improvements in service delivery. Despite improvement work being undertaken by the partnership there remains the outstanding realisation of improvement actions from previous audits undertaken in 2018 and 2019.

The partnership recognised the need to strengthen the adult support and protection strategic role for health. This should include a partnership plan to develop collaboration between partners at all stages of the adult support and protection journey.

The partnership had a robust response to the pandemic that ensured that adult support and protection continued to be prioritised. This was an energetic and considered partnership that was committed to continuing to improve outcomes for adults at risk of harm.

Next steps

We ask the Falkirk partnership to prepare an improvement plan to address the priority areas for improvement (see prioritysareasforimprovement 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

- 97% 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
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 67% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 92% of episodes where the three-point test was applied correctly by the HSCP
- 92% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 67% (2 Cases) two weeks to one month, 33% (1 Case)
- 87% of episodes evidenced management oversight of decision making
- 77% of episodes were rated good or better.

Staff survey results on initial inquiries

- 85% concur that the partnership accurately screens initial adult at risk of harm concerns, 11% did not concur, 4% didn't know
- 88% concur they are aware of the three-point test and how it applies to adults at risk of harm, 5% did not concur, 7% didn't know
- 82% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 7% did not concur, 10% didn't know
- 87% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 5% did not concur, 8% didn't know

Information sharing among partners for initial inquiries

- 90% of episodes evidenced communication among partners

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

Chronologies

- 58% of adults at risk of harm had a chronology
- 24% of chronologies were rated good or better, 76% adequate or worse
- 89% concur chronologies form an important feature of ASP investigation reports, 7% did not concur, 4% didn't know

Risk assessment and adult protection plans

- 72% of adults at risk of harm had a risk assessment
- 50% of risk assessments were rated good or better
- 78% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 66% of protection plans were rated good or better, three4% were rated adequate or worse
- 86% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors, 4% did not concur, 10% didn't know

Full investigations

- 89% of investigations effectively determined if an adult was at risk of harm
- 70% of investigations were carried out timeously
- 60% of investigations were rated good or better

Adult protection case conferences

- 86% were convened when required
- 88% were convened timeously
- three1% were attended by the adult at risk of harm (when invited)
- Police attended 6three%, health 78% (when invited)
- 67% of case conferences were rated good or better for quality
- 96% effectively determined actions to keep the adult safe
- 84% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences, 9% did not concur, 7% didn't know

Adult protection review case conferences

- 94% of review case conferences were convened when required
- 94% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 100% of adult protection concerns were sent to the HSCP in a timely manner
- 87% of inquiry officers' actions were rated good or better
- 81% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 38% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 32% good or better rating for the quality of ASP recording in health records
- 33% rated good or better for quality information sharing and collaboration recorded in health records

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

Information sharing

- 100% of cases evidenced partners sharing information
- 98% of those cases local authority staff shared information appropriately and effectively
- 88% of those cases police shared information appropriately and effectively
- 86% of those cases health staff shared information effectively

Management oversight and governance

- 62% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 88%, police 86%, health 41%

Involvement and support for adults at risk of harm

- 90% of adults at risk of harm had support throughout their adult protection journey
- 73% were rated good or better for overall quality of support to adult at risk of harm
- 85% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 6% did not concur, 8% didn't know

Independent advocacy

- 76% of adults at risk of harm were offered independent advocacy
- 46% of those offered, accepted and received advocacy
- 75% of adults at risk of harm who received advocacy got it timeously.
- 61% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy, 27% did not concur, 11% didn't know

Capacity and assessments of capacity

- 75% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 58% of these adults had their capacity assessed by health
- 43% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 34% of adults at risk of harm were subject to financial harm
- 71% of partners' actions to stop financial harm were rated good or better
- 88% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 80% 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
- 82% concur adults subject to ASP, experience safer quality of life from the support they receive, 6% did not concur, 12% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 63% concur local leaders provide staff with clear vision for their adult support and protection work. 11% did not concur, 26% didn't know

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

- 64% concur local leadership of ASP across partnership is effective, 7% did not concur, 30% didn't know
- 61% concur I feel confident there is effective leadership from adult protection committee, 8% did not concur, 30% didn't know
- 46% concur local leaders work effectively to raise public awareness of ASP, 19% did not concur, 35% didn't know

Quality assurance, self-evaluation, and improvement activity

- 49% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 15% did not concur, 36% didn't know
- 54% concur ASP changes and developments are integrated and well managed across partnership, 12% did not concur, 34% didn't know