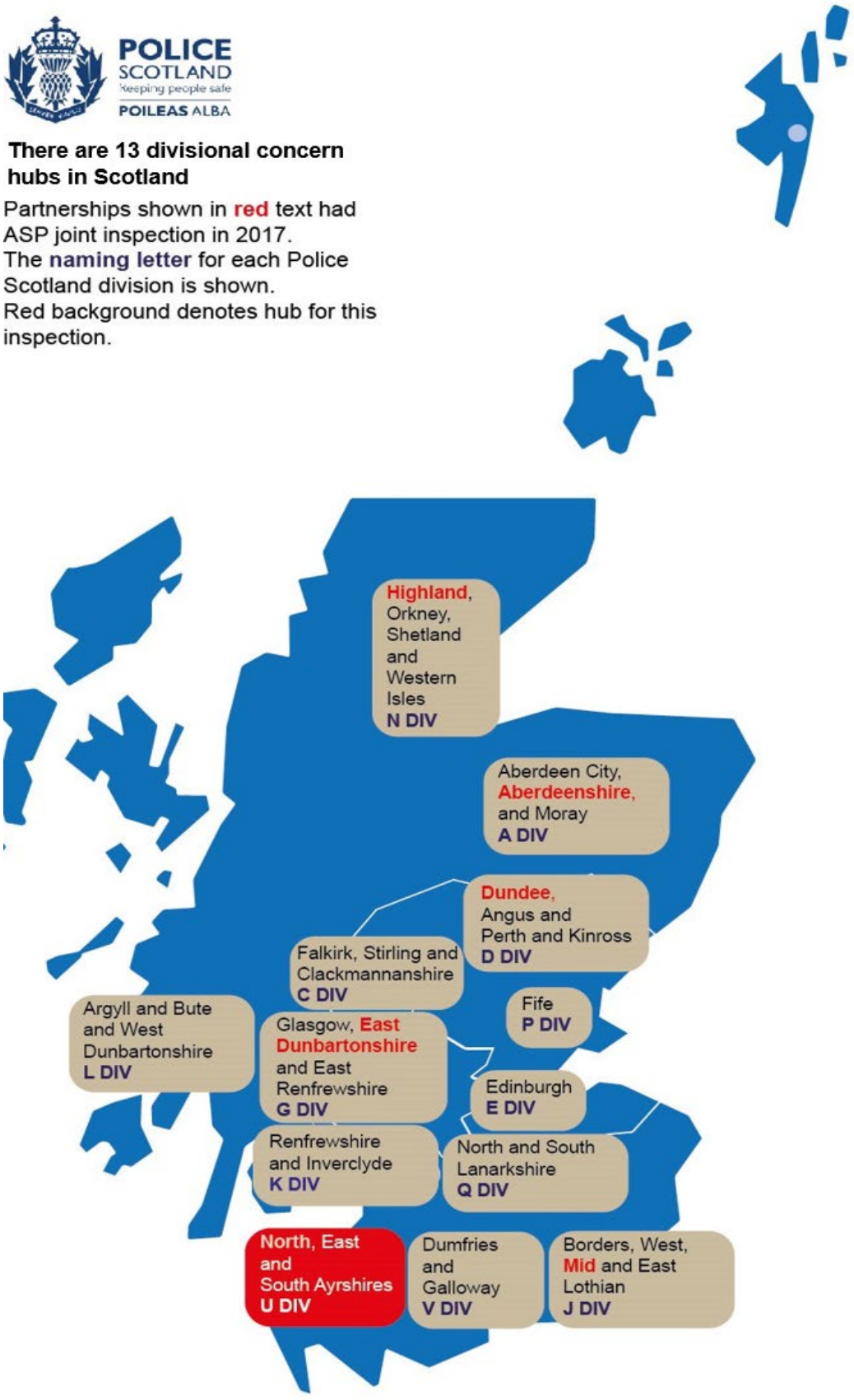
JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

South Ayrshire Partnership November 2021

Contents

Map showing divisional concern hubs



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

The joint inspection of the South Ayrshire partnership took place between August 2021 and November 2021. The South Ayrshire partnership and all others across Scotland faced the unprecedented challenge of recovery and remobilisation after 20 months of the Covid-19 pandemic. We appreciate the South Ayrshire 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.

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.

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

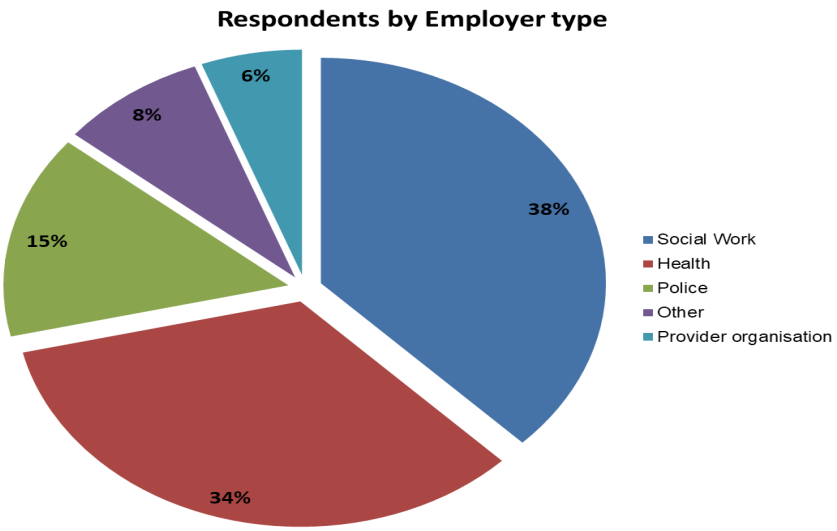
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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.

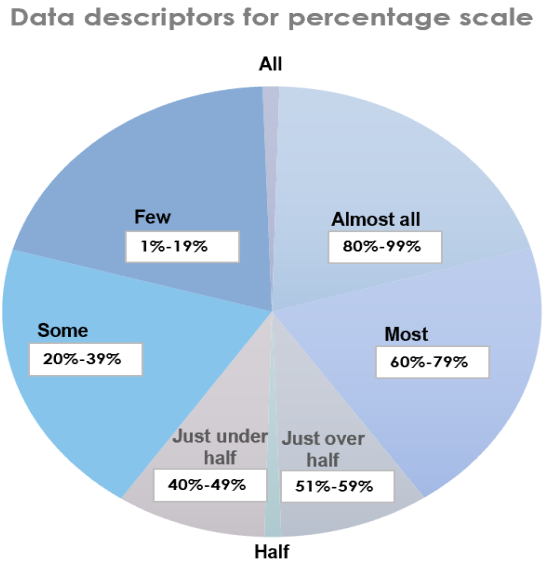
Staff survey. One hundred and ninety-seven staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for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



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

Staff focus groups. We carried out two focus groups and met with 16 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

- Partnership staff contributed to the safety, health, and wellbeing of adults at risk of harm.
- Third sector and independent sector providers supported adults at risk of harm toward improved wellbeing, independence, and inclusion.
- The partnership effectively maintained business continuity for adult support and protection during the Covid-19 pandemic.

Priority areas for improvement

- Management of risk for adults at risk of harm – chronologies, risk assessments, and protection plans – required improvement.
- Social work should involve police and health in adult protection investigations when required. Investigation reports should set out clearly how staff conducted investigations, including interviews with the adult at risk of harm and other parties.
- Social work should always convene an adult protection case conference when necessary. Social work should invite police and health when required. They should attend when invited.
- Social work leaders should ensure standards of adult support and protection practice are consistently good, and operational management is sound and effective.
- Quality assurance, improvement and audit were minimal for adult support and protection. The partnership should urgently make sure these important activities expand appropriately.
- The partnership's chief officers' group and its adult protection committee should put robust measures in place to closely monitor adult support and protection practice. They should act decisively to rectify problems when they arise.
- Adults at risk of harms' lived experience did not inform the adult protection committee. The partnership should improve in this area.

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

Key messages

- Partnership staff contributed to the safety, health, and wellbeing of adults at risk of harm.
- For adults who were financially harmed, partners effectively stopped it.
- Third sector and independent sector providers supported adults at risk of harm toward improved wellbeing, independence, and inclusion.
- Some adults at risk of harm had no chronology, and most had one not fit for purpose.
- Almost all adults at risk of harm had a risk assessment, but the quality of them required improvement.
- Protection plans were absent for just under half of the adults at risk of harm who required them.
- Adult protection investigation reports recurrently did not document the investigation properly. Staff did not clearly record interviews with adults at risk of harm. Police and health were not involved in investigations when they should have been.
- The partnership did not always convene adult protection case conferences when necessary.
- Police and health representatives were often not present at adult protection case conferences. The partnership missed crucial opportunities for collaboration about the safety of adults at risk of harm.

We concluded the partnership's key processes for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

The partnership screened adult protection concerns effectively. There were clear procedures for this area. In 2021, the partnership carried out a data audit of how it handled adult protection referrals. This showed most (78%) of adult protection referrals passed to social work area teams proceeded to the initial inquiry stage. There were differences in the time it took area teams to do inquiries – overall almost all inquiries were done within the allotted timescale of five days. This was consistent with our scrutiny of initial inquiries. Almost all staff surveyed thought the partnership screened adult protection referrals accurately.

Initial inquiries into concerns about adults at risk of harm

The partnership did initial inquiries competently and promptly. It respected the principles of the legislation in all initial inquiries. It did almost all of them on time, correctly applied and recorded the three-point test, and managers signed off the inquiries' conclusions. Partners communicated effectively in almost all initial inquiries. The divisional concern hub passed almost all adult protection concerns to social work without delay. Staff respected the human rights of all adults at risk of harm. Trained council officers carried out all initial inquiries. The partnership's handling of initial inquiries was good or better for most of them. Most staff surveyed thought the partnership handled initial inquiries effectively.

Staff used sign language interpreters well, to engage with adults at risk of harm who were deaf. Staff fully included them in the initial inquiry process.

For a few (15%) initial inquiries, we considered the partnership's decision to take no further adult protection action, was incorrect. The partnership should have further investigated the circumstances of these adults at risk of harm to find out if they were safe.

Investigation and risk management

Chronologies

Chronologies for adults at risk of harm were an important part of risk assessment and risk management. There was no standard template in use for chronologies, so practice was inconsistent.

While most adults at risk of harm had some form of chronology, over a third did not. Quality of chronologies needed to greatly improve. Almost all were adequate or worse, with just under half unsatisfactory. They were sparsely populated, not up-to-date, and lacked important details and lucid analysis. For adults at risk of harm who had no chronology or an inadequate one, it was difficult to discern patterns of risk.

Risk assessments

Positively, almost all adults at risk of harm had a risk assessment, which was timely, and the views of multi-agency partners informed most of them. Risk assessment fields were part of almost all adult protection investigation templates. But the later version of the investigation template did not have fields for risk. The quality of risk assessments warranted improvement. Most were adequate or worse, and just over one-third were weak or unsatisfactory. Risk assessments were not explicit enough about the risks faced by adults at risk of harm. They did not consider likelihood of risks occurring and the impact on the adult at risk of harm.

Full investigations

Investigations into concerns about adults at risk of harm were a critical key process for adult support and protection. On the positive side, council officers undertook almost all investigations promptly. And almost all effectively determined if the adult was at risk of harm. But a significant few (nearly one-fifth) did not do this.

Almost all investigation reports electronic templates did not have any fields for the council officer to set out how they conducted the investigation, including their interview with the adult at risk of harm. This was a critical omission. It was often not possible to tell if staff spoke to the adult at risk of harm during the investigation. Other important details such as interviews with alleged perpetrators were often missing from investigation reports. For these reasons, most investigations were adequate or worse, with some weak or unsatisfactory.

Around ten percent of investigation reports used a revised template. This had fields to record how staff conducted the investigation, but none for assessment of risk. The partnership should ensure it does competent risk assessments for adults at risk of harm, when it uses the revised investigation template.

Concerningly, over a third of investigations failed to involve key partners – mainly police and health. Furthermore, in almost all instances where the second worker should have been a health professional, there was no health professional deployed. Overall, investigations required improvement to effectively support the safety of adults at risk of harm.

Adult protection case conferences

Adult protection case conferences were the partnership's opportunity to hear the views of all parties, synthesise all relevant information, analyse risks and determine required actions. Most adults at risk of harm who required an adult protection case conference got one, but significantly nearly a third (30%) did not. These individuals did not have the opportunity to have their circumstances and risks fully discussed, and to make their views known to the professionals charged with protecting them. The partnership held planning meetings in several instances when it should have convened a case conference. Planning meetings should not substitute for a case conference.

The partnership convened almost all case conferences promptly. Almost all effectively determined actions to keep the adult at risk of harm safe.

For case conferences to be fully effective, all key partners needed to attend. For this partnership, police attended only five out of twenty case conferences, where their input was desirable. Social work failed to invite police to nearly half of them, and police only attended just under half when invited. Health attendance at case conferences also warranted improvement; a health representative only attended half when invited. These were among the reasons we rated just over half of case conferences as adequate or worse for quality.

The adult protection committee's biennial report (2020) acknowledged the effectiveness of case conferences depended on participation of partners: "In many instances representation and participation was limited and remains an area for improvement".

Social work invited the adult at risk of harm to most case conferences. They attended just under half of them and got good support to understand the process and put forward their views. Social work invited unpaid carers to case conferences when appropriate and most attended.

Adult protection plans / risk management plans

In contrast to chronologies, the partnership had a template for protection plans. Just over half of adults at risk of harm who required a protection plan had one. Just under half did not. This was another aspect of the management of risk for adults at risk of harm with clear room for improvement. Where protection plans were in place, almost all were up-to-date and reflected views of multi-agency partners. Just over half of protection plans were adequate or worse, with some weak and a few unsatisfactory.

Adult protection review case conferences

The partnership convened adult protection review case conferences when necessary. They effectively determined actions to keep the adult at risk of harm safe and support their wellbeing.

Implementation / effectiveness of adult protection plans

Adults at risk of harm who had protection plans experienced improved safety, and wellbeing outcomes. The partnership persevered with adults at risk of harm who did not readily engage with efforts to protect and support them. Adults at risk of harm had support for their meaningful involvement in implementation of their protection plans.

As just under half of adults at risk of harm lacked a protection plan, this called for improvement.

Large-scale investigations

The partnership carried out a successful large-scale investigation into neglect of residents in a care home. It followed the Pan-Ayrshire large-scale investigation procedure. All multi-agency partners purposefully participated, including the Care Inspectorate. The exercise was well led and managed and carried out competently and collaboratively. Health and police played key roles. It delivered improved safety and wellbeing outcomes for the residents. The partnership constructively identified what it learned from the large-scale investigation.

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

Overall effectiveness of collaborative working

Collaborative working to safeguard adults at risk of harm showed variable performance. There were examples of partners working well to support adults at risk of harm and deliver positive safety and wellbeing outcomes for them. The large-scale investigation into neglect of care home residents was characterised by all partners working purposefully together to successfully achieve its objectives. Partners collaborated extensively and effectively to manage the challenges of the Covid-19 pandemic. Almost all staff surveyed said they got support to work collaboratively to deliver positive outcomes for adults at risk of harm.

The partnership had comprehensive, accessible, inter-agency adult protection procedures, and associated guidance for staff on key aspects of adult protection practice. They reflected the national health and social care standards.

Partners needed to collaborate better in critical areas. Adult protection investigations did not routinely involve police or health when their input would have been invaluable. Lack of police and health presence at adult protection case conferences meant vital opportunities for collaborative working were frequently missed.

Health involvement in adult support and protection

Some (20%) of the adult concern referrals in our sample of initial inquiries came from a health professional, as did a few (14%) in our sample of adults at risk of harm who reached at least the investigation stage. The adult protection committee biennial report 2019-20 reported a rising trend of adult protection referrals from a health source. It attributed this to health's successful work to raise its staff's awareness of adult support and protection. Health created a "Symphony" electronic adult protection referral pathway, which made it easier for health professionals to pass on adult protection concerns promptly and accurately.

Health staff made appropriate referrals to social work if they suspected an adult was at risk of harm. They got prompt feedback on the outcome. There were several examples of sound work by health professionals to pass on their concerns about an adult to social work. Council officers investigated the concerns and acted to keep the adult at risk of harm safe.

Health staff recorded adult protection matters competently, with most recordings good or better. They made an important contribution to the partnership's delivery of positive outcomes for adults at risk of harm – in most instances we rated this good or better.

There were examples of adults at risk of harm who had complex physical and mental health needs. Acute and community health services delivered extensive supports to these individuals. Doctors, nurses, and allied health professionals worked hard to improve the safety, health, and wellbeing of these adults at risk of harm.

Police involvement in adult support and protection

Police officers and staff effectively assessed almost all inquiries about adults at risk of harm for threat, potential harm, risk, investigative opportunity and vulnerability (THRIVE).

Just under half of incident reports had an accurate STORM disposal code (record of incident type). Police Scotland's national guidance was that adult protection incidents should have specific codes.

Almost all initial attending officers' actions were good or better. Their assessment of risk of harm, vulnerability and wellbeing was accurate and informative. Officers sought appropriate support and secured immediate interventions where necessary. Supervisory oversight was present in most records and was good or better in most.

On a few occasions, attending officers recognised and dealt with third party criminality but did not identify the consequential impact on the adult at risk of harm.

Officers efficiently and promptly shared information using the interim vulnerable persons database (iVPD). The concern hub recorded the triage process to prioritise risk in most cases. Most of these reports had an appropriate level of detail in the resilience matrix. This enabled partners to understand police concerns.

On a few occasions, such as domestic abuse incidents, following an assessment that no crime had taken place, hub staff did not share information with partners. This included individuals who remained vulnerable.

The divisional concern hub officers' actions and records were good or better in most cases.

Third sector and independent sector provider involvement

All adults at risk of harm who needed additional support got it. Most adults at risk of harm received comprehensive, effective support to deliver their desired personal outcomes. Third sector and independent sector providers played a key role supporting adults at risk of harm toward improved wellbeing, independence, and inclusion.

Third sector and independent sector staff appropriately raised adult protection concerns and contributed to adult protection case conferences when invited. All provider staff surveyed thought their adult support and protection training was effective.

Key adult support and protection practices

Information sharing

Almost all adults at risk of harm benefitted from routine communication among social work, police, and health partners. The partnership purposefully convened multi-agency meetings at the initial inquiry stage for adults at risk of harm with complex circumstances. But initial case conferences and investigations were critical areas where inter-agency communication was weak.

Management oversight and governance

Recording was appropriate in the records of most adults at risk of harm, but for some it was not. There were crucial gaps in recordings of adult protection investigations, which made it difficult to tell precisely what happened. These recording deficits undermined sound, defensible decision making for adult support and protection. Operational managers needed to ensure staff's adult protection recording was complete and competent.

Line managers have a key role ensuring the quality of adult support and protection practice. A line manager read just over half of adults at risk of harm's records.

Just under half of social work records had no information about supervision discussions between the line manager and the worker. Both line managers reading all adult protection records, and the recording of key supervision discussions in social work records called for improvement.

There was evidence of governance for almost all social work records, most police records, and a few health records. Evidence of exercise of governance was less apparent in health records. This was not necessarily a deficit due to the types of health records scrutinised.

Involvement and support for adults at risk of harm

Most adults at risk of harm received continued support throughout their adult protection journey. Most of this support was good or better. Most staff surveyed thought adults at risk of harm got support to be involved in decision-making.

The partnership did not support some adults at risk of harm appropriately. Examples included proxies appointed under the Adults with Incapacity (Scotland) Act 2000 not invited to key meetings about the adult at risk of harm for whom they had decision-making powers. Council officers did not routinely record in investigation reports steps taken to consult and involve the adult at risk of harm. This required improvement.

Independent advocacy

In 2019-20, the independent advocacy service supported 35 adults at risk of harm. The partnership offered most adults at risk of harm independent advocacy when they needed it. Just under half of them accepted and received advocacy, and almost all got an advocate quickly. But the partnership did not offer independent advocacy to some adults at risk of harm who would have benefitted from it. Independent advocates effectively supported adults at risk of harm to make their views known.

Capacity and assessment of capacity

Social work requested a capacity assessment for most adults at risk of harm where there were concerns about their capacity. Social work did not seek a capacity assessment for a third of the adults at risk of harm who needed one. This called for improvement. Social work requested capacity assessments from health on a well-designed form.

Health clinicians assessed most adult at risk of harm's capacity promptly. This was despite the pressures of the Covid-19 pandemic for health. Other partners faced pressures from the pandemic.

Financial harm and perpetrators of all types of harm

A quarter of adults at risk of harm suffered financial harm. The partnership prevented financial harm and stopped it when it occurred. Collaborative working that included the banks and the Office of the Public Guardian put a stop to the financial harm in almost all instances.

The partnership took appropriate actions against perpetrators. These included banning orders.

Safety outcomes for adults at risk of harm

Almost all adults at risk of harm experienced at least some improvement to their safety and wellbeing. Multi-agency working was by far the largest factor that supported the improvement.

Adult support and protection training

The chief social worker's report for 2019-20 informed the partnership delivered 14 training courses at three different levels, from awareness raising to training for council officers. One hundred and forty-three delegates – including those from the third and the independent sectors – benefitted from this training.

Just over half staff surveyed said that they had participated in multi-agency training. Nearly a third said they had had no multi-agency training. The partnership intimated training largely stopped due to the Covid-19 pandemic.

Almost all council officers surveyed expressed a positive view about the specific council officer training they received.

Senior managers acknowledged the pandemic caused adult protection training to virtually cease. They were confident the recent appointment of a training officer for public protection would deliver the required improvements.

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

Key messages

- Partnership leaders delivered business continuity for adult support and protection during the Covid-19 pandemic. The partnership maintained critical levels of service to adults at risk of harm and other vulnerable individuals.
- The partnership lacked an adult protection strategy and an associated improvement plan.
- Leaders had not delivered consistent competent practice for adult support and protection.
- Leaders had not ensured operational management of adult support and protection was robust and effective.
- Quality assurance, improvement and audit activity was minimal for adult support and protection.
- The partnership's chief officers' group and its adult protection committee needed to improve their governance for adult support and protection, with sound measures to effectively monitor adult protection practice.
- The adult protection committee did not benefit from the lived experience of adults at risk of harm.

We concluded the partnership's leadership for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Vision and strategy

The partnership had a compelling vision for adult support and protection. It communicated this to its staff and others. The partnership did not have a strategy and improvement plan for adult support and protection. Its improvement plan was at the development stage.

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

Partnership representatives regularly attended the adult protection committee and the chief officers' group. These groups endeavoured to exercise sound, motivational leadership for adult support and protection. But serious weaknesses in adult protection key processes showed these strategic groups needed to do more to oversee the delivery of improvements for adult support and protection.

Strategic leadership for adult support and protection should include the lived experience of adults at risk of harm. Adults at risk of harm were not present on the adult protection committee or any of its subgroups. Strategic leaders needed to rectify this important omission. Unpaid carers who cared for adults at risk of harm were unrepresented at strategic level.

The Scottish Fire and Rescue service participated purposefully in adult protection strategic forums and operationally. Adults at risk of harm benefitted from the work of this service.

The partnership recently developed an extremely useful quarterly performance report for adult protection activity. It was a well-constructed informative document. It enabled the adult protection committee and chief officers' group to monitor and track adult protection activity levels.

During the pandemic, the adult protection committee purposefully led the local response to public messaging on adult protection, substance misuse, domestic abuse, and protection of the public from dangerous individuals.

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

Key processes for adult support and protection had important areas of weakness. There were key process weaknesses across management of risk for adults at risk of harm, adult protection investigations, and adult protection case conferences. These were all critical to ensure adults at risk of harm were safe, supported, and protected.

There were examples of good collaborative working, such as stopping financial harm. But sound collaborative working was frequently absent for adult protection investigations and case conferences.

The partnership's strategic leaders were ultimately accountable for the consistent delivery of competent, effective adult protection practice. They needed to closely monitor adult protection practice and take decisive action to rectify problems. The important areas of weakness for key processes showed operational management for adult support and protection required improvement.

The appointment of a health lead for adult support and protection was a positive development. This led to improved knowledge of adult support and protection among health staff. And increased their confidence to raise adult protection concerns with social work and work collaboratively to support adults at risk of harm.

The appointment of a stand-alone chief social work officer and additional staffing support for quality assurance and improvement enhanced the partnership's capacity to do improvement work.

Quality assurance, self-evaluation and improvement activity

The partnership did not have an improvement plan for adult support and protection. There was no evidence of self-evaluation for adult support and protection that led to improvement actions.

Strategic leaders initiated minimal quality assurance, improvement, and audit for adult support and protection. There was an audit of adult protection referrals in 2021. Leaders initiated a survey of the views of adults at risk of harm. But staff were unable to recruit adults at risk of harm to take part in the survey. There were informative surveys of the views of people who used adult services, and unpaid carers. These did not mention adult support and protection, which was a missed opportunity.

There were no practice audits of the records of adults at risk of harm. Thus, strategic leaders had limited means to identify critical weaknesses in key processes for adult support and protection, and operational management problems.

Strategic leaders said the recently formed improvement subgroup of the adult protection committee was developing an audit plan for adult support and protection. This was to be in place by early 2022. The partnership should progress this work quickly.

Initial case reviews and significant case reviews

The partnership had carried out two significant case reviews, led by an independent reviewer. These were published in 2019 and 2021 respectively. They reviewed the circumstances of tragic occurrences for vulnerable individuals, who were deceased. They made important recommendations for improvement.

In June 2021, the chief officers' group recognised recommendations from the significant case review (April 2019) were not fully implemented. The adult protection committee was concerned in February 2021 that 179 reviews for adults who used social care services were overdue. This was forty-eight percent of overdue review figure stated in the significant case review report. By October 2021, there were 75 overdue reviews. This was good progress.

The partnership had made progress with a secure email system for social workers, police, and health professionals to share confidential information.

The partnership had not incorporated the recommendations and the learning from the significant case reviews into a coherent improvement plan for adult support and protection.

The partnership implemented the recommendations of the 2021 significant case review timeously.

The partnership submitted material on two initial case reviews. It did these in accordance with its initial case review procedure.

The partnership remitted the significant case reviews and the initial case reviews to the chief officers' group and the adult protection committee. The partnership constructively disseminated the learning from its significant case reviews and initial case reviews.

Impact of Covid-19

The partnership successfully maintained business continuity for adult support and protection during the Covid-19 pandemic. Partnership leaders collaborated effectively to continue essential adult support and protection activities.

The partnership's adoption of Microsoft Teams supported staff to communicate effectively electronically when carrying out adult protection work.

Adult protection partners collaborated constructively across Ayrshire. The partnership worked closely with third sector and independent sector providers to maintain critical levels of service during the restricted period. The partnership effectively prioritised the most vulnerable individuals to give them the support they needed.

It was commendable the partnership maintained its care at home service delivery at pre-pandemic levels. This was despite the numbers of care at home staff who were ill or forced to self-isolate. Adults at risk of harm were among those who benefitted from the resilience of care at home services.

Almost all adults at risk of harm who required to see partnership staff in person got a home visit. The partnership took appropriate steps (such as provision of personal protective equipment) to keep staff safe. For most adults at risk of harm the crisis operational management response to keeping them safe was good or better.

Most staff who stated a view about the partnership's handling of the pandemic were positive about the partnership's response to ensuring adults at risk of harm were safe and supported. Most thought the partnership supported them to do adult protection work during the restricted period.

The partnership prepared a learning from Covid-19 report. This timely and well-balanced document comprehensively set out what the partnership learned from the pandemic.

Summary

The partnership did initial inquiries into adult protection concerns promptly and proficiently. It should have proceeded to the investigation stage for a few adults at risk of harm to find out if they were safe.

Partnership staff contributed to the delivery of positive outcomes for adults at risk of harm.

The Covid-19 pandemic created challenges for the partnership's delivery of adult support and protection. The partnership maintained business continuity effectively. It prepared a well-balanced report on what it learned from the pandemic.

Crucially, weaknesses in key processes extended right across management of risk, adult protection investigations, and initial case conferences.

The management of risk for adults at risk of harm required improvement. This was a critical area for the partnership to ensure adults at risk of harm were safe and protected.

Social work did not routinely involve police and health in adult protection investigations when their contribution would have been invaluable. Investigation reports frequently did not document how staff conducted the investigation and their conversation with the adult at risk of harm and other parties. This undermined sound, defensible decision-making for adults at risk of harm. Investigation practice warranted improvement.

The police only attended five out of twenty adult protection initial case conferences. This was because social work did not invite them when they should have. And because police did not attend when invited. Health attendance at case conferences also called for improvement. The partnership acknowledged partners' attendance at case conferences was a problem. The partnership missed vital opportunities for meaningful collaborative working when police and health did not attend initial adult protection case conferences.

Adults at risk of harms' lived experience did not inform the adult protection committee. This needed to improve.

The partnership did not have an agreed strategy and improvement plan for adult support and protection. An improvement plan was at the development stage. It had not incorporated recommendations and learning from significant case reviews into a coherent adult support and protection improvement plan. It carried out sparse quality assurance, improvement and audit work for adult support and protection. The partnership should progress its planned work in this area quickly.

Without robust audit and quality assurance for adult support and protection, the chief officers' group and the adult protection committee lacked the tools to exercise appropriate governance. These strategic groups should make sure operational management of adult support and protection is sound and effective.

The partnership's key processes and strategic leadership for adult support and protection had important areas of weakness. Weaknesses in key processes increase the likelihood of adverse outcomes for adults at risk of harm.

Next steps

We ask the South Ayrshire partnership to prepare an improvement plan to address priority areas for improvement (see prioityareasforimprovement 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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 92% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- Of those that were delayed, 100% (1case) delay in the concern hub passing on concerns by 2 weeks to 1 month.
- 95% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 88% of episodes where the three-point test was applied correctly by the HSCP
- 98% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 100% (1 case) more than 3 months.
- 95% of episodes evidenced management oversight of decision making
- 73% of episodes were rated good or better.

Staff survey results on initial inquiries

- 86% concur that the partnership accurately screens initial adult at risk of harm concerns, 12% did not concur, 2% didn't know
- 91% concur they are aware of the three-point test and how it applies to adults at risk of harm, 7% did not concur, 3% didn't know
- 79% 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, 15% didn't know
- 73% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 12% did not concur, 15% didn't know

Information sharing among partners for initial inquiries

- 88% of episodes evidenced communication among partners

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

Chronologies

- 64% of adults at risk of harm had a chronology
- 7% of chronologies were rated good or better, 93% adequate or worse
- 85% concur chronologies form an important feature of ASP investigation reports, 8% did not concur, 7% didn't know

Risk assessment and adult protection plans

- 90% of adults at risk of harm had a risk assessment
- 33% of risk assessments were rated good or better
- 57% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 45% of protection plans were rated good or better, 55% were rated adequate or worse
- 86% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors, 3% did not concur, 11% didn't know

Full investigations

- 82% of investigations effectively determined if an adult was at risk of harm
- 82% of investigations were carried out timeously
- 33% of investigations were rated good or better

Adult protection case conferences

- 70% were convened when required
- 95% were convened timeously
- 47% were attended by the adult at risk of harm (when invited)
- Police attended 45%, health 50% (when invited)
- 48% of case conferences were rated good or better for quality
- 86% effectively determined actions to keep the adult safe
- 82% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences, 10% did not concur, 8% didn't know

Adult protection review case conferences

- 92% of review case conferences were convened when required
- 92% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 96% of adult protection concerns were sent to the HSCP in a timely manner
- 89% of inquiry officers' actions were rated good or better
- 63% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 79% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 73% good or better rating for the quality of ASP recording in health records
- 64% 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

- 88% of cases evidenced partners sharing information
- 86% of those cases local authority staff shared information appropriately and effectively
- 89% of those cases police shared information appropriately and effectively
- 98% of those cases health staff shared information effectively

Management oversight and governance

- 55% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 89%, police 61%, health 15%

Involvement and support for adults at risk of harm

- 72% of adults at risk of harm had support throughout their adult protection journey
- 61% were rated good or better for overall quality of support to adult at risk of harm
- 78% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 10% did not concur, 12% didn't know

Independent advocacy

- 69% of adults at risk of harm were offered independent advocacy
- 40% of those offered, accepted and received advocacy
- 88% of adults at risk of harm who received advocacy got it timeously.
- 70% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy, 10% did not concur, 20% didn't know

Capacity and assessments of capacity

- 67% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 79% of these adults had their capacity assessed by health
- 82% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 26% of adults at risk of harm were subject to financial harm
- 54% of partners' actions to stop financial harm were rated good or better
- 25% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 88% of adults at risk of harm had some improvement for safety and protection
- 100% of adults at risk of harm who needed additional support received it
- 71% concur adults subject to ASP, experience safer quality of life from the support they receive, 9% did not concur, 19% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 58% concur local leaders provide staff with clear vision for their adult support and protection work. 16% did not concur, 26% didn't know

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

- 59% concur local leadership of ASP across partnership is effective, 11% did not concur, 30% didn't know
- 55% concur I feel confident there is effective leadership from adult protection committee, 9% did not concur, 36% didn't know
- 41% concur local leaders work effectively to raise public awareness of ASP, 18% did not concur, 41% didn't know

Quality assurance, self-evaluation, and improvement activity

- 44% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 15% did not concur, 41% didn't know
- 47% concur ASP changes and developments are integrated and well managed across partnership, 19% did not concur, 34% didn't know