



JOINT INSPECTION  
OF **ADULT SUPPORT**  
AND **PROTECTION**

Stirling Partnership February 2022

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## Map showing divisional concern hubs



### 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 Stirling 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<sup>1</sup> 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 Stirling area were safe, protected and supported.

The joint inspection of the Stirling partnership took place between September 2021 and January 2022.

The Stirling partnership and all others across Scotland faced the unprecedented and ongoing challenges of the Covid-19 pandemic. We appreciate the Stirling partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

### Quality indicators

Our quality indicators<sup>2</sup> for these joint inspections are on the Care Inspectorate's website.

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1

[https://www.careinspectorate.com/images/Adult\\_Support\\_and\\_Protection/1.\\_Definition\\_of\\_adult\\_protection\\_partnership.pdf](https://www.careinspectorate.com/images/Adult_Support_and_Protection/1._Definition_of_adult_protection_partnership.pdf)

2

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

## Progress statements

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

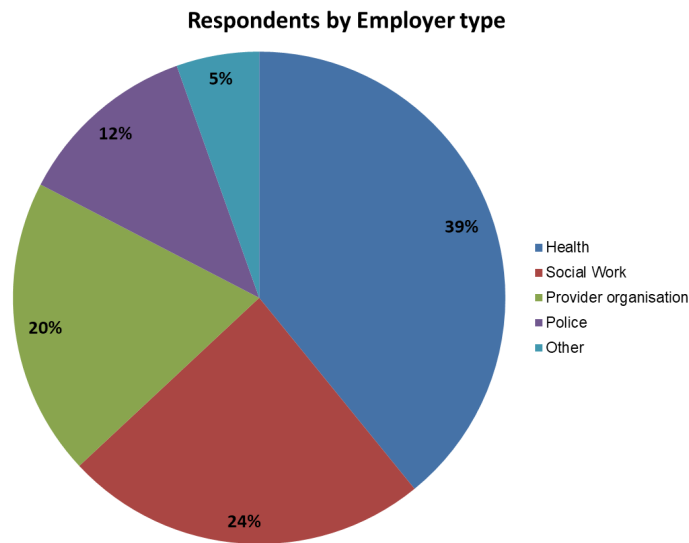
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

## Joint inspection methodology

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

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

**Staff survey.** Ninety-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.

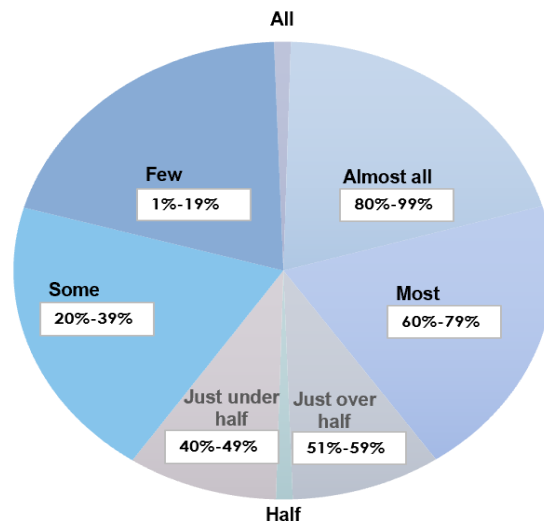


**The scrutiny of the health, police, and social work records of adults of risk of harm.** This involved the records of fifty adults at risk of harm where their adult protection journey progressed to at least the investigation stage. It also involved the scrutiny of recordings of forty adult protection 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 30 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

**Data descriptors for percentage scale**



## **Additional information**

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

## Summary – strengths and priority areas for improvement

### Strengths

- Adults at risk of harm and unpaid carers' views were sought throughout adult support and protection processes.
- Partners worked collaboratively with staff and the community to raise awareness of financial harm. This had a positive impact on reducing risks associated with financial harm.
- Police Scotland Divisional Concern Hub was effective in supporting initial inquiries, particularly Initial Referral Discussions.
- Community health services and acute hospital services helped to improve outcomes for adults at risk of harm through effective information sharing and recording.
- The partnership continued to operate effectively during the pandemic, maintaining ongoing support for adults at risk of harm.
- The partnership worked collaboratively with care home providers to raise awareness of adult support and protection and referral processes.

### Priority areas for improvement

- The partnership should fully embed quality assurance and self-evaluation processes for adult support and protection.
- The partnership should fully implement the recently developed Adult Support and Protection Improvement Plan and include how the priority areas for improvement set out in this report will be met.
- Decision-making processes of large-scale investigation planning meetings should be clearly recorded in adult at risk of harms' multi-agency records.
- The quality of chronologies, risk assessments and protection plans should be improved to promote better management of risk. Consistent use of templates could contribute to this.
- An adult protection case conference should always be convened when necessary. Police and health should attend when required.
- The partnership must adhere to its statutory obligations where it believes an adult is at risk of harm and an intervention may be required. Investigations must always be completed by trained Council Officers.



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

### Key messages

- The triage of adult support and protection concerns was effective. Subsequent inquiries were timely, undertaken to a high standard and reached the right stage nearly every time.
- Almost all adults at risk experienced positive outcomes in relation to safety and protection. This was mostly due to effective multi-agency working and a strong focus on the involvement of the adult and unpaid carers.
- Timely adult support and protection investigations were jointly carried out on almost all occasions that they should have been. The work was of a good standard. Joint work with Police Scotland was required to strengthen the management of cases involving criminality.
- Large-scale investigations were collaborative and effectively determined and considered multiple cases of complex risk. The outcome of planning meetings needed to be better recorded in the individual adult at risk of harm's multi-agency records.
- The partnership did not always convene case conferences or complete protection plans when it should have. This left adults at risk of harm exposed to unnecessary risk.
- Chronologies and risk assessments were undertaken, but the quality was weak. Multi-agency templates were not being used, leading to a lack of analysis and formulation.
- Adult protection inquiries and investigations were recorded in case notes. This made it difficult to determine where these separate processes started and ended. It is important that these are defined so staff and, importantly, adults at risk of harm, are certain about what is being undertaken.
- Exercise of governance in social work records needed improvement.

**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 partnership had an established duty system in place. It had been reviewed following the initial Covid-19 restricted period and strengthened to safely support the increased volume of referrals. Duty referrals were centrally screened and triaged before onward referral to the various adult locality teams. The daily duty rota included a council officer and a dedicated team manager who had oversight of this process for a week at a time. This supported consistency of approach. Almost all referrals were progressed within appropriate timescales with clear application of the three-point test and evident oversight. Confidence in the duty system was shared by staff.

The partnership had developed a local multi-agency Risk Assessment and Management Procedure (RAMP) approach to assessing risk at the point of referral. This applied to adults with complex needs where they did not meet the threshold as defined by the Adult Support and Protection Act. The RAMP work was helping to streamline appropriate adult protection referrals into the social work duty system. This process helped to ensure adult support and protection referrals reached the correct stage nearly every time and in keeping with the principles of the Adult Support and Protection Act.

### **Initial inquiries into concerns about adults at risk of harm**

The duty to inquire was carried out on almost all occasions and was completed timeously. Management oversight of inquiry work was strong as was the quality of the interventions at this stage. Duty processes were effectively aligned to both the Forth Valley Police concern hub and social work out of hours emergency duty team.

From the records it was often difficult to determine when inquiry work stopped and where investigation work commenced. Staff and partnership leaders acknowledged that the client information system was limited and did not fully support the required distinction. In addition, multi-agency guidance lacked a specific duty to inquire template. Progress and outcomes were therefore recorded in case notes by council officers making it difficult to distinguish inquiry activity which compounded the challenges for front line managers and staff.

Forth Valley Policing Division had dedicated personnel to oversee any Initial Referral Discussion (IRDs). IRDs were recognised as integral to local adult support and protection work and were carried out in almost all instances where requests were made. The value of these referral discussions was evident in the early consideration of risk, and associated protection planning. The design of an established template supported consistent, meaningful discussion, and the detailed recording of protection matters under consideration. Although, the template was not used consistently.

While IRDs effectively contributed to the partnership's management of risk, the approach and timings of these meetings were not consistent. While meetings typically involved all relevant agencies, this was not always the case. Records of these meetings were not routinely included in health or social work records making it difficult to determine the outcomes.

## Investigation and risk management

### Chronologies

Chronologies for adults at risk of harm are an important element of risk assessment and risk management. Most of the adults at risk of harm who should have had a chronology did have one, but a significant minority did not. The quality of chronologies needed improved with just over half rated as weak or unsatisfactory.

While a chronology template was available in the Forth Valley multi-agency risk assessment template, it was seldom used and is an area of critical practice the partnership should reflect on and address.

### Risk assessments

Risk assessments are crucial to adult support and protection work. Most adults at risk of harm had a risk assessment in place but a significant minority did not. The majority of risk assessments were undertaken timeously; however, their quality was variable with just under half of risk assessments evaluated as adequate or worse. Primary reasons for unsatisfactory risk assessments included a lack of multi-agency involvement and limited analysis.

Risk assessments were not always easy to identify in the records. The Forth Valley multi-agency guidance was not being followed. Some risk assessments were embedded in standalone documents and others were set in the body of the council officer case notes. Overall, there was a lack of the risk formulation and analysis. This is important not only because it supports the determination whether to proceed to case conference or not but was a missed opportunity to improve safety for adults at risk of harm.

### Full investigations

Timely adult support and protection investigations were jointly carried out nearly every time they should have been, and the overall quality of the work carried out was to a good standard. A second worker was deployed to investigations every time they were required. This included the use of health professionals who were involved on almost every occasion where their support was appropriate. Almost all investigations effectively determined if the adult was at risk of harm.

In a small number of cases where the police were investigating criminality, council officers did not consistently conclude adult support and protection investigations when they should have. They left the outcome of investigations to Police Scotland but there should have been a stronger joint approach shaping the outcome. In a few other cases, the local authority asked care providers to carry out their own internal investigation following an adult protection concern being raised. Upon completion of these complaint investigations adult protection processes would stop. This meant there were missed opportunities for adult protection investigation work and independent scrutiny.

### **Adult protection case conferences**

Adult protection case conferences are important meetings that help to formulate the protection measures needed to keep adults safe from harm. When case conferences were carried out, they almost always effectively promoted multi-agency information sharing and provided an opportunity for the joint assessment of risk and collaborative protection planning arrangements. Case conferences effectively determined the needs of the adult at risk.

While this was positive, the partnership did not convene case conferences when they should have in just under half of instances. The reasons for not holding a case conference were not always clear from the records. This is an important aspect of adult protection activity that the partnership should improve. Case conferences offer a forum for necessary oversight of risk, and a jointly agreed protection plan, with shared responsibility for implementation and monitoring.

It is positive that when partner agencies could not attend case conference they submitted reports, however attendance should be promoted to enhance effective discussions.

More positively, the partnership invited most adults at risk of harm to their case conference. Understandably, some did not attend but importantly the reasons for this were recorded in the council officer records. Good work also went in to involving unpaid carers who attended every time they were invited providing them with an opportunity to contribute to proceedings.

### **Adult protection plans / risk management plans**

Protection plans were in place in just under half of the cases that should have had one. Importantly, this meant that over half did not have a protection plan. This was particularly significant for adults at risk of harm who neither had a protection plan nor progressed to case conference when they should have. This is an area the partnership should seek to address.

Where protection plans were evident the quality and contributions from other agencies was strong.

Overall, adult support and protection case conferences formulated protection plans better. These were multi-agency in nature and laid out protection measures effectively.

### **Adult protection review case conferences**

In almost all cases where a review case conference was required, there was one. Timescales for conducting review case conferences were in keeping with the needs of the adult at risk of harm in those that were convened. Outcomes effectively determined what needed to be done to promote that the adult at risk of harm was safe, protected and supported.

### **Implementation / effectiveness of adult protection plans**

Adult protection plans developed at the investigation stage were largely set out in the council officers' case notes. Similar to inquiry and investigation records, protection plan templates were not consistently used. Those that were recorded were timely, reflected collaboration and were of a good standard. All of them demonstrated that the adult at risk of harm's views were effectively considered.

The Forth Valley multi-agency guidance provided a helpful risk assessment template for staff to use as part of their investigation work. This template encouraged workers to analyse and formulate risks but was not consistently used.

### **Large-scale investigations**

There have been two large-scale investigations in the past two years. We reviewed the partnership's investigation of one of the large-scale investigations. Findings concluded that staff working in care homes would benefit from additional adult support and protection training. Providers were being supported by both the Care Home Assessment and Response Team and additional adult support and protection training opportunities.

We were assured by the partnership that cases which did not need to progress to a large-scale investigation were dealt with through a large-scale planning meeting. However, this was not always clearly recorded in the individual's record. We read the records of a few adults at risk of harm where people were involved in large-scale investigations. The partnership hosted LSI planning meetings which were well attended by partner agencies. While next steps for minimising risks were effectively determined at these meetings, they were not consistently followed through. Investigations were not always completed and the reasons for this were not always provided.

We concluded that the outcome of decisions made during the large-scale investigation planning meetings should be clearly recorded in multi-agency records. This is an area for improvement. The partnership will continue to monitor the quality of care and improvements in care homes.

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

### **Overall effectiveness of collaborative working**

Key stages of the adult protection pathway demonstrated that adult protection partners were appropriately sharing information almost all of the time. There were some good examples of how agencies shared information and worked in partnership to ensure the adult at risk of harm's needs were met. Almost all staff said they were supported to work collaboratively, to achieve positive outcomes for adults at risk of harm.

Inquiries, IRDs, investigations and case conferences were all examples that highlighted good collaboration where they were convened. Some opportunities for engagement were missed, for example, protection planning and case conferences that should have been convened but were not.

### **Health involvement in adult support and protection**

Health leaders were committed to improving adult support and protection knowledge and practice in healthcare settings. An example of this was the provision of mandatory adult support and protection training on the NHS Learn-pro database for Forth Valley NHS staff. Almost all health staff indicated that they fully understood their role in relation to adult support and protection and knew what to do if they had concerns about an adult at risk of harm.

Commendably, almost all health staff were aware of the three-point test and how it applied to adults at risk of harm. In all cases, health staff had conducted a capacity assessment where one was requested, and these were done timeously on almost every occasion. Medical examinations were also carried out appropriately in almost all cases.

The intervention provided by health care services was rated as good or better on every occasion. The quality of health service record keeping, and documentation was an area for improvement with just over half evaluated as good or better.

## **Police involvement in adult support and protection**

Where calls were made to the police about adults at risk they were almost always effectively assessed by officers and staff for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). Incidents almost always had an accurate STORM Disposal Code (record of incident type). STORM markers were used effectively to flag potential adult concerns.

Officers used the interim vulnerable persons database (iVPD) to efficiently and promptly process all adult support and protection referrals received.

In this partnership, the IRD was referenced as the first point of police involvement, in most cases. Officer response, including contribution to referral discussions was almost always good or better. Assessment of risk of harm, vulnerability and wellbeing was accurate, well considered, and informative in almost all records. In a few cases officers dealt with the criminal activity of a third party but did not always recognise the associated impact on the adult at risk. Where the matter was progressed through IRDs there was evidence of the contributing officer consistently recording relevant detail on the iVPD as part of the police process. This was recognised as good practice, and an effective way of ensuring that police records were accurate and aligned to the case information held by partners. Supervisory oversight was noted and viewed as being good or better in almost all records.

The Divisional Concern Hub recorded the triage process to prioritise risk in all cases. Records almost always contained an appropriately detailed resilience matrix, with evidence of diligent research, assessment, and input by staff. Almost all referrals were shared with partners in a timely matter. The Divisional Concern Hub actions and records were good or better in almost all cases, and excellent in a few.

## **Third sector and independent sector provider involvement**

The third and independent sector worked collaboratively with partner agencies to ensure additional health and social care needs were met. Most provider organisations agreed that they were invited to participate in regular learning and development opportunities provided by the partnership.

Providers delivered most of the ongoing support to adults at risk of harm. This is positive but the partnership could better engage provider organisations in evaluating the wider impact of adult support and protection improvement work.



Following learning arising from an LSI, the partnership engaged with provider organisations to develop awareness of adult support and protection duties and to improve collaborative working. The Care Home Assessment and Response Team promoted the use of escalating concern procedures and contributed to an increase in adult support and protection referrals from care homes.

The third and independent sectors were well embedded in early intervention and prevention work aimed at addressing hidden harm. There was an enthusiastic approach to volunteering in the community to support people at risk of harm.

## **Key adult support and protection practices**

### **Information sharing**

The partnership recognised that the current Forth Valley Adult Support and Protection Multi-Agency Guidance was due to be reviewed. Abbreviated adult support and protection guidance was available to staff across the partnership. Most staff said adult support and protection guidance was easy to obtain.

The partnership recognised that partner agencies used different recording systems to access and record information. This had presented some challenges, particularly during the early stages of the pandemic when remote working was introduced. Staff reported this had improved over time. Our file reading evaluations supported this view with evidence throughout that all partner agencies were appropriately sharing information, almost all of the time.

### **Management oversight and governance**

There was evidence of good oversight in the council's duty to inquire activity. However, evidence of decisions and discussions being recorded in records or line managers periodically reading adult support and protection records was significantly less. Exercise of governance in social work records was evident in just over half the cases we read. Progress in this area would help to address the quality of work in key areas such as chronologies, investigation, protection planning and decisions to proceed to case conference or not.

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.

### **Involvement and support for adults at risk of harm**

Almost all adults at risk of harm were included in decisions that affected their lives. Positively, this continued throughout the pandemic. Adults at risk of harm and unpaid carers' views were sought at various stages of the adult support and protection processes.

### **Independent advocacy**

Independent advocacy was offered on almost all occasions where it should have been. While this was a positive aspect of practice, it was only accepted in just over half of cases, and the reasons for this were not clearly recorded. Where advocacy support was accepted by the adult, provision was always timely, and almost always helped the adult at risk articulate their views.

## **Capacity and assessment of capacity**

There were concerns about adults' level of capacity in some instances. In most of those, a formal request for a capacity assessment was made. Of the requests made, all assessments were undertaken by a health professional, in a timeframe that was almost always relevant to the needs of the adult at risk of harm. In some instances, a request for assessment was not made where it may have been expected. This included cases where a formal record of assessment would have provided a clearer understanding of additional care and protection planning requirements.

## **Financial harm and perpetrators of all types of harm**

The partnership worked closely with communities to promote greater awareness of financial harm. Staff working in NHS Forth Valley had access to online learning about financial harm. Care provider forums also promoted an opportunity for information sharing and interventions, which helped to reduce the risks associated with financial harm. The partnership set up a coordinated, multi-agency financial harm group to help tackle local financial harm. The group was well represented by partnership staff, charities, and the independent sector. The partnership supported national initiatives such as Neighbourhood Watch Scotland alert initiative and promoted awareness of Powers of Attorney in collaboration with Solicitors for Older People Scotland.

Some cases involved financial harm activity. On almost every occasion, the partnership took effective action to stop financial abuse and where the partnership did act, the financial abuse stopped.

## **Safety outcomes for adults at risk of harm**

Nearly every case evidenced improvements in the adult at risk of harm's circumstances in relation to safety and protection. This was mostly due to effective multi-agency working. The contribution of partnership agencies was key to improved wellbeing in almost all cases where a positive outcome occurred.

## **Adult support and protection training**

Most staff said they had participated in adult support and protection training and those opportunities to participate had continued during the Covid-19 restricted period. Staff who had participated in adult support and protection training developed confidence to undertake the role required of them and had a greater understanding of adult support and protection legislation and the role they played including general contact staff.

There was a robust ASP training calendar available to a range of multi-disciplinary staff and they have adopted short, focused briefings to communicate key developments to staff. The Public Protection Committee had established a learning and practice development sub-group which had continued to develop the knowledge, practice and skills of staff by devising and developing a comprehensive learning and practice development training programme. This was delivered through virtual face-to-face training, e-learning and practitioner forums and there were various examples where it had been applied including council officer training. Importantly, both Police Scotland and NHS Forth Valley had continued to deliver mandatory training to core staff groups. The partnership was committed to delivering adult support and protection training for all partnership staff and made this a key strategic priority in their draft integrated improvement plan.

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

### Key messages

- The partnership had refreshed its adult protection priorities and vision. These were laid out in their recently developed improvement plan which needed to be cascaded to all staff to ensure a stronger shared understanding.
- The partnership's collaborative approach to improving care home quality, safety and assurance was commendable.
- There was good evidence that leaders were promoting strategic collaboration across the partnership in response to adults at risk of harm and the pressures of Covid-19.
- The health and social care partnership was at the early stage of implementing a new performance and quality framework. This was needed to improve the quality of audit, self-evaluation, and a more consistent approach to reporting.
- The partnership needed to do more to ensure staff felt involved in adult support and protection self-evaluation and improvement activity.
- The partnership should seek to appoint an NHS lead for adult support and protection. Health is embedded in collaborative initiatives, but this will strengthen health leadership presence.
- Multiple recording systems and the consequent data available for reporting purposes needed alignment. The partnership was procuring a new business support system which should enable staff to record protection work more consistently.

**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 adult support and protection vision, priorities and strategy were clearly set out in the partnership's recently developed adult support and protection improvement plan. The improvement plan was comprehensive but was in the early stages of implementation, therefore its impact could not yet be determined.

The partnership's adult support and protection improvement plan appropriately recognised that work was required to refresh the Forth Valley Adult Support and Protection Multi-Agency Guidance (2018). This guidance was due to be reviewed in April 2021, but the partnership confirmed it would delay this pending the Scottish Government's review of the Adult Support and Protection Code of Practice.

Responding on the basis of the 2018 vision for adult support and protection, just under half of the staff felt that the vision could be clearer. This was despite various approaches applied by leaders to engage staff including regular newsletters and staff engagement events.

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

The Chief Officers Group (COG) and Public Protection Committee (PPC) provided effective adult support and protection oversight and leadership. Both the COG and the committee were effectively linked with other key strategic planning and delivery groups including community planning partnerships, clinical and care governance groups and the Integration Joint Board. The health and social care partnership had recently made significant investments to boost their operational leadership capacity, and this was strengthening oversight of adult support and protection arrangements.

The PPC received quarterly and annual data reports detailing the source of referrals. These included the nature of harm being investigated and the profile of adults at risk of harm for whom an investigation has taken place. This was a limited data set, and we welcome the partnership's decision to further develop their business systems and performance and quality framework approach to improve in this area.

The Clackmannanshire and Stirling Joint PPC was established in March 2020. Following a process of recruitment, a new independent chair was appointed in March 2021. The PPC met every six weeks to provide oversight and assurance to the Chief Officer Group and there was an active sub-group infrastructure in place. This included a financial harm group (collaboratively with Falkirk Adult Protection Committee), performance and quality indicators group, learning and development group and a practitioner's forum.

In June 2020 the partnership introduced a Forth Valley Multi-Agency Care Home Strategic Oversight Group, which met weekly. The group provided oversight and scrutiny of care home data and information, and supported the good work undertaken by the multi-agency Care Home Assessment and Response Team.

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

The partnership had taken positive measures to respond to an increase in adult support and protection referrals regarding residents in care homes. The newly developed adult support and protection improvement plan included details of how the partnership aimed to improve knowledge and skills within care home settings. The Care Home Assessment and Response Team was set up to provide support and assurance to care home staff and their residents. A dedicated care home team undertook monthly visits, to provide support and guidance for staff and care home managers. The STORM Care Home Notification process created by Police Scotland was implemented, and this improved governance in relation to the early identification of risk of harm.

A Care Home Practitioners Group was established to promote the “Quality in Care” model. The group was made up of multi-agency professionals who worked across a number of teams including psychiatric nurses and council commissioning colleagues responsible for quality of care.

In response to Covid-19, a Local Resilience Partnership was established which was chaired by the Head of Planning within the health and social care partnership. This group focused on the practicalities of the impact of the pandemic and provided a forum for third sector providers to share community intelligence as well as quickly refer individuals perceived as vulnerable for suitable support.

The partnership fostered a culture of collaborative engagement with the Scottish Fire and Rescue Services, housing services and independent providers. These services actively participated in risk assessments and protection planning which helped to improve outcomes for adults at risk of harm.

The partnership recognised that current social work recording systems could be improved, particularly around IRDs, chronologies, risk management, and decision-making processes. The new electronic IRD system aimed to improve recording and was to be implemented by Spring 2022. In addition, the partnership planned to develop a multi-agency and integrated chronology tool to promote a cohesive approach to the management of risk. The PPC and sub-committees were well placed to drive forward the improvement plan progress which was the primary catalyst for collaborative change.

## **Quality assurance, self-evaluation and improvement activity**

The leadership team had taken the decision to suspend planned multi-agency self-evaluation activity during the pandemic. They had decided to focus their efforts on single agency quality assurance work. They had developed quarterly performance and quality indicators to monitor adult protection performance, monitoring and benchmarking. These were routinely presented to the PPC and COG for scrutiny. This included information requested by Scottish Government each week. While audits provided a suite of useful adult support and protection data, the partnership recognised they were limited. Business systems across Stirling and Clackmannanshire were not aligned and this made collecting and presenting like for like data difficult. Both partnerships were working on plans to procure a joint system which would help to address these challenges.

The health and social care partnership was at the early stage of implementing a new performance and quality framework. The framework had a clear governance structure, from the performance and quality indicator sub-group through to the PPC and COG. This new model was to include integrated manager involvement to ensure a more multi-agency approach. During the pandemic routine team manager audits of the quality of social work practice slipped. Only some staff felt that the impact of their work was fully evaluated or that they were being involved in the evaluation process. Leaders should aim to use the new approach bring a fresh focus in this important area of practice.

The health and social care partnership had recently recruited a new adult support and protection lead officer. They will play a critical role in driving self-evaluation and improvement work forward. The partnership was also seeking to appoint an NHS adult support and protection lead to further support the effective collaborations already in place as well as the future work developing within the PPC. The partnership had improvement plans in place. There was a noticeable cultural shift towards self-evaluation within the partnership with plans to include this inspection's findings in the adult support and protection improvement plan.

## **Initial case reviews and significant case reviews**

The Clackmannanshire and Stirling Health and Social Care Partnership was responsible for the strategic leadership and governance of initial case reviews and significant case reviews in the Stirling area. Forth Valley Multi-Agency Guidance (2018) reflected the Adult Support and Protection (Scotland) Act Code of Practice (2014). The partnership had not carried out any initial case reviews or significant case reviews in the Stirling area.



## Impact of Covid-19

The leadership team was relatively new when the pandemic emerged and, positively, adult support and protection responsibilities continued to be prioritised. The partnership implemented an emergency response to the pandemic, which meant responses to all non-essential activity was paused. The partnership operated a command-and-control system, whereby bronze, silver and gold indicators appropriately determined responses to incidents. They also kept their risk register under close review.

The partnership's responses to ensuring adults at risk of harm were safe and protected during the restricted period were rated as good or better in most cases.

The partnership continued to contact adults who required support and protection during the pandemic, ensuring their views continued to be sought through face-to-face or other methods of communication.

Multi-agency operational meetings, chaired by a representative of health and social care partnership, were held frequently, providing opportunities for partners to discuss performance and practice. The Public Protection Committee worked closely with Solicitors for Older People Scotland to raise awareness about the benefits of Power of Attorney. They were also working with Falkirk Adult Protection Committee to develop an Early Indicators of Concern framework, to help improve adult support and protection governance and risk management.

Most staff said that the pandemic had not adversely affected their ability to carry out their roles. Only some staff felt that changes and developments during Covid-19 were integrated and well managed. Staff also said communication of the changes could have been improved.

## Summary

When key stages of the adult support and protection pathway occurred, the quality of information was typically strong. However, risk assessments, chronologies, protection plans, and initial case conferences were not always carried out when they should have been. This meant most adults at risk of harm did not have their level of risk considered as extensively as it could have been.

The partnership's approach to initial inquiries promoted an effective response to adult support and protection. IRDs were strong when carried out. A more collaborative and consistent approach was needed to enable a cohesive assessment of risk.

Investigation processes were effective, however multi-agency teams needed to work more collaboratively to ensure every investigation was conducted robustly.

Records provided a clear account of the collaboration, assessment and interventions carried out by partner agencies to help minimise risks for the adult at risk of harm. The quality of information in some risk assessments, chronologies and protection plans lacked detail. This is a critical area of weakness and required significant improvement in practice.

Adults' and unpaid carers' views were considered, and advocacy made a positive contribution to key stages of the adult support and protection pathway. The partnership responded well to concerns raised in care homes which was an essential intervention in keeping adults at risk of harm safe and protected.

Strategic leaders were not robustly planning for self-evaluation and improvement. Positively, leaders recognised several areas for improvement were required and had recently developed an adult support and protection improvement plan. The partnership's vision for adult support and protection required wider engagement with the workforce and partners to ensure they were involved in planning and evaluating the adult support and protection vision and strategy. This had been constrained as some methods of staff engagement were limited to virtual means during the pandemic.

## Next steps

We ask the Stirling partnership to prepare an improvement plan to address the priority areas for improvement (see we identify). The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and Her Majesty's Inspectorate of the Constabulary Scotland 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
- 50% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 95% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 93% of episodes where the three-point test was applied correctly by the HSCP
- 93% of episodes were progressed timeously by the HSCP
- 90% of episodes evidenced management oversight of decision making
- 73% of episodes were rated good or better.

#### Staff survey results on initial inquiries

- 72% concur that the partnership accurately screens initial adult at risk of harm concerns, 28% did not concur
- 86% concur they are aware of the three-point test and how it applies to adults at risk of harm, 12% did not concur, 2% didn't know
- 78% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 13% did not concur, 9% didn't know
- 77% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 21% did not concur, 2% 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

- 76% of adults at risk of harm had a chronology
- 9% of chronologies were rated good or better, 91% adequate or worse
- 81% concur chronologies form an important feature of ASP investigation reports, 7% did not concur, 12% didn't know

### Risk assessment and adult protection plans

- 65% of adults at risk of harm had a risk assessment
- 23% of risk assessments were rated good or better
- 56% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 64% of protection plans were rated good or better, 37% were rated adequate or worse
- 65% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors, 23% did not concur, 12% didn't know

### Full investigations

- 88% of investigations effectively determined if an adult was at risk of harm
- 90% of investigations were carried out timeously
- 57% of investigations were rated good or better

### Adult protection case conferences

- 59% were convened when required
- 100% were convened timeously
- 29% were attended by the adult at risk of harm (when invited)
- Police attended 63%, health 90% (when invited)
- 90% of case conferences were rated good or better for quality
- 100% effectively determined actions to keep the adult safe
- 65% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences, 14% did not concur, 21% didn't know

### Adult protection review case conferences

- 80% of review case conferences were convened when required
- 100% of review case conferences determined the required actions to keep the adult safe

### **Police involvement in adult support and protection**

- 100% of adult protection concerns were sent to the HSCP in a timely manner
- 97% of inquiry officers' actions were rated good or better
- 92% of concern hub officers' actions were rated good or better

### **Health involvement in adult support and protection**

- 80% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 56% good or better rating for the quality of ASP recording in health records
- 60% 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

- 90% of cases evidenced partners sharing information
- 100% of those cases local authority staff shared information appropriately and effectively
- 87% of those cases police shared information appropriately and effectively
- 87% of those cases health staff shared information effectively

#### Management oversight and governance

- 42% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 54%, police 76%, health 40%

#### Involvement and support for adults at risk of harm

- 87% of adults at risk of harm had support throughout their adult protection journey
- 77% were rated good or better for overall quality of support to adult at risk of harm
- 75% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 16% did not concur, 9% didn't know

#### Independent advocacy

- 85% of adults at risk of harm were offered independent advocacy
- 52% of those offered, accepted and received advocacy
- 100% 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, 9% did not concur, 21% didn't know

#### Capacity and assessments of capacity

- 79% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 100% of these adults had their capacity assessed by health
- 91% of capacity assessments done by health were done timeously

#### Financial harm and all perpetrators of harm

- 22% of adults at risk of harm were subject to financial harm
- 54% 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**

- 90% of adults at risk of harm had some improvement for safety and protection
- 94% of adults at risk of harm who needed additional support received it
- 68% concur adults subject to ASP, experience safer quality of life from the support they receive, 12% did not concur, 20% didn't know

## **Staff survey results about strategic leadership**

### **Vision and strategy**

- 53% concur local leaders provide staff with clear vision for their adult support and protection work. 24% did not concur, 23% didn't know

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

- 50% concur local leadership of ASP across partnership is effective, 17% did not concur, 33% didn't know
- 48% concur I feel confident there is effective leadership from adult protection committee, 14% did not concur, 38% didn't know
- 34% concur local leaders work effectively to raise public awareness of ASP, 25% did not concur, 41% didn't know

### **Quality assurance, self-evaluation, and improvement activity**

- 36% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 21% did not concur, 43% didn't know
- 36% concur ASP changes and developments are integrated and well managed across partnership, 27% did not concur, 37% didn't know