care inspectorate

Healthcare Improvement Scotland

HMICS

PHASE 1

JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

PHASE 1

Question and number	**GUIDANCE FOR FILE READERS AND LOCAL FILE READERS** 
General points & advice for local file readers	**1.** Thanks for participating. Having local file readers is very helpful as you bring your local knowledge and experience to the process. We hope you enjoy the experience. All previous feedback has been that local file readers' involvement has been a useful learning experience for both the local file readers themselves and for their agencies. **2.** Run through agenda for the day in terms of IT input, use of Passwords etc. **3.** File reading is surprisingly tiring and demands considerable powers of concentration. Take your time to read the files. It is not a race. If not sure about something, do not hesitate to ask one of the inspection team (who themselves will no doubt have lots of questions to ask you about local procedures, acronyms etc) **4.** Time keeping. We generally work office hours, but if people have a need to leave a bit early etc, that is OK. People should take tea breaks and stop for lunch when it suits them. **We aim to finish the file reading on Thursday.** Check the availability of the local file readers for the on-site week. Normal experience is that very few files are read on the first day (no need to panic about this), but the pace then picks up. **5.** File reading is not an exact science and requires the exercise of professional judgement. The written guidance and this training are designed to assist the local file readers so that they are able to evaluate in a similar fashion to the fulltime inspectors. Judgements must be based on the evidence available in the files rather than on assumptions about what should be there. We recognise that it is not easy for local file readers to evaluate the records of their own agency/agencies. They need to retain a professional stance. Local file readers should not read any files for adult at risk of harm with which they have a professional or private connection. Remember that for the most part we are seeking to evaluate the combined

impact of the agencies involved, i.e. social work, health and the police. However, there are some questions which may be more single agency specific. The team is asked to apply library conditions to allow team members to concentrate. There will be opportunities throughout when the lead inspector will clarify and issues arising or to have a discussion with the team about local practise issues (e.g. local risk assessment frameworks)

6. **Moderation**. Moderation is about ensuring the inspection team is all broadly evaluating at a similar level. It is also for making sure that the electronic file reading response template is completed accurately and consistently. Given that file reading is about the use of professional judgement there can be a reasonable discussion about whether a risk assessment is of a good or very good standard. However, there is more of an issue if a local inspector evaluates a risk assessment as excellent and a fulltime inspector evaluates the same risk assessment as unsatisfactory. We will pair up a local file reader and an inspector, including for moderation purposes. The inspector will moderate (at least) the first file read by the local file reader. Suggest they complete their first file reading template on paper and using a pencil (refer to resource box). We emphasise that the moderation is not about evaluating the performance of individual local file readers but is about ensuring a consistency of approach across the file reading team.

7. In comments fields left blank (including key strengths and areas for development) when there is no comment to be made could you please tell people to use one standardversion of text, **"nil"** (all in lower case).

8. There are occasionally cases where a file reader has significant concerns (based on the records available) that an adult at risk of harm is/may be at some significant immediate risk, or the file reader has identified a significant issue, which requires urgent clarification from the partnership. Local file readers should discuss these with their paired inspector/lead inspector. The lead inspector will decide whether the case needs to be brought to the attention of the partnership for them to have a closer look at (and in most instances to provide feedback on). In doing so the lead inspector will not identify who in the inspection team has read the file concerned.

9. Signing out and in files. Explain the signing out and in sheet. Also explain file security arrangements requested by the partnership, the arrangements for storing files, returning completed files, and storing partially completed files overnight.

10. Run through the criteria for the file reading sample (e.g. when opened/ closed and the balance of having files with sufficient activity, but also getting an insight into preventative approaches). File readers should check with paired inspector/lead inspector if they think a file should be replaced by a reserve file.

The ASP joint inspection context and focus

It is now 12 years since the adult support and protection legislation was introduced. This is the second time there has been a joint inspection of adult support and protection arrangements in partnerships. We published the joint inspection of adult support and protection (in six partnerships) in July 2018. https://hub.careinspectorate.com/media/3402/review-of-adult-support-and-protection-report.pdf

As far as we can, we have tried to make the file reading database and question set sequential, i.e. from the point of enquiry/referral through case conferences and post case conference activity.

We are mindful that the legislation covers **adult support** as well as adult protection. We want to look at broader support for adults at risk of harm, although our focus is on protection. The short question set in section 12 addresses additional supports for the adult at risk of harm

File Reading Database

The lead inspector along with the strategic support officer should then run through the operation of the electronic file reading tool and then go through the file reading guidance. **This is a new file reading tool with a significant number of changes and new questions to reflect the ASP specific focus of the inspection. Although we have been busy testing it, we fully expect that using it live for the first time will throw up some technical issues and some questions about the logic flow of some of the questions. However, we are also confident that we can work round these. The key message is that if a problem arises is DON'T panic and speak to a member of the inspection team.**

PREAMBLE

These explanatory notes aim to help you assess practice through reviewing case records. The purpose of reading case records is to help us reach conclusions about the extent to which adults at

risk of harm are made safe, protected, supported, involved, and consulted. Therefore, while you may be reading records which are maintained or mainly maintained by staff from one agency only, you will be required to make judgements about the quality of practice across several different adult protection partner agencies. Thus, you should consider material in the records contributed by all the staff involved in the case to answer the questions below.

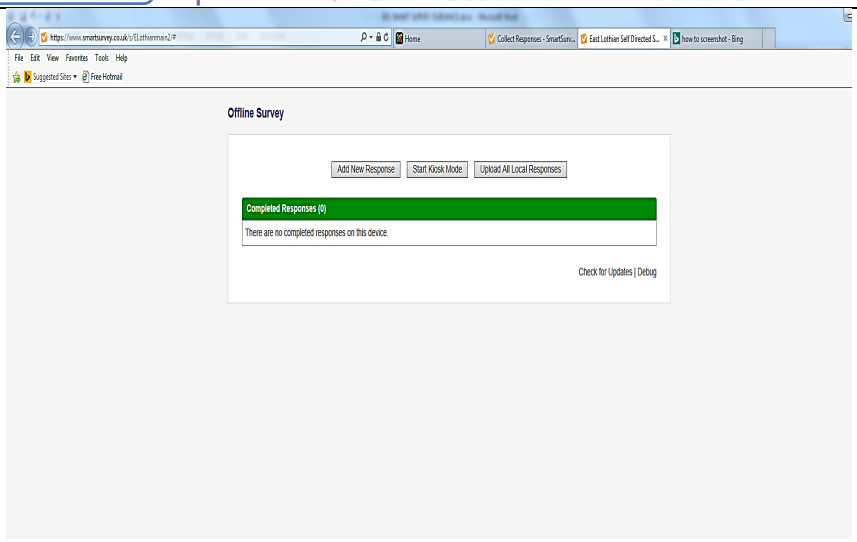
Please read the guidance carefully along with the instructions on the template itself. However, these notes are designed to complement, not replace, your professional judgement.

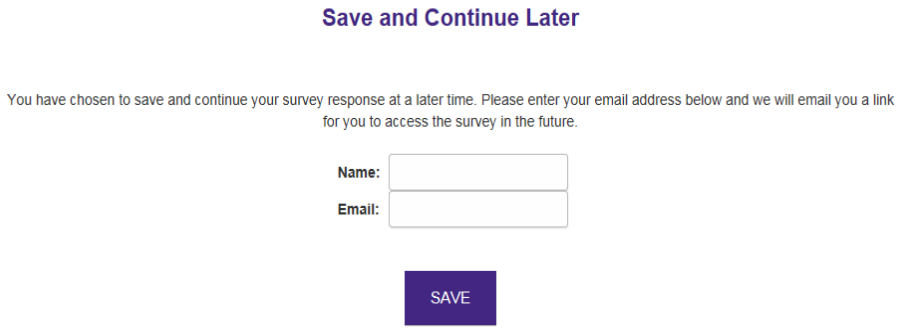
Please focus on practice in the last two years only, to ensure our findings are relevant and helpful.

GUIDANCE FOR USING SMARTSURVEY

SMART SURVEY GUIDANCE
Online Version:

- You will receive an email containing the online link to access the survey
- Copy the link address from the email, open Internet explorer and paste the copied link address into the web address bar at the top of the page and press enter and you are ready to begin entering the file details within the survey.
- Refresh the link in the browser for each new file you read to generate a new survey page.
- Begin the survey and answer all appropriate questions
- If mandatory questions are left unanswered, the user will be prompted to complete these by an on-screen error message.
- **Skip Logic will be available** within the online version of the survey. Readers will automatically be redirected throughout the survey depending on previous answers.
- If you need to go back or forward a page in the survey use the previous page or next page options at the bottom of the page in the survey and not the forward and back arrows on your browser.
- **If you want to clear your chosen response to a question, double click it. Double clicking your response at the bottom of a page will clear the entire page.**





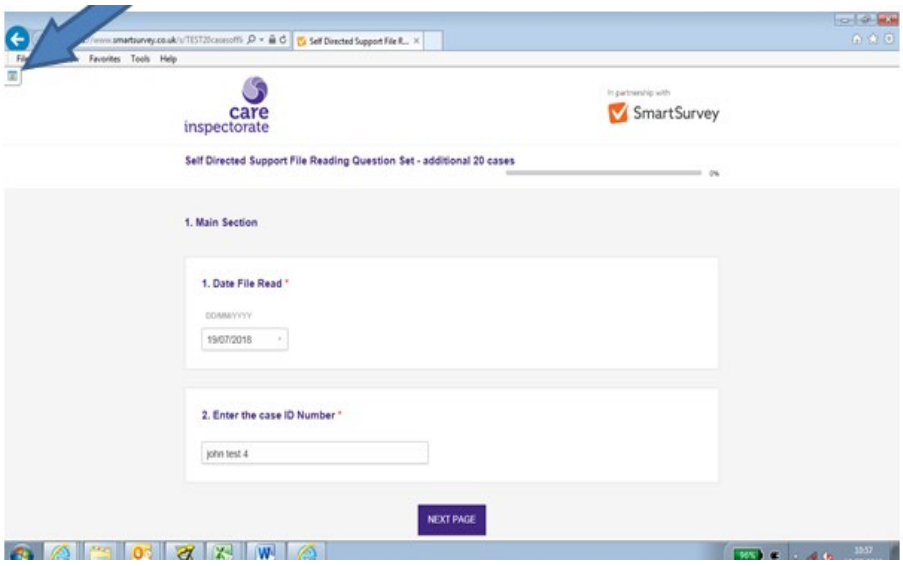
- You can take a break from the survey at any time and still be able to return to where you finished off by using the Save and Continue Later button at the bottom of the page. You will be prompted to enter your name and e-mail address. A link to the partially completed survey will be sent to you by email for you to continue with the survey where you let off. It is vital that you enter an email address that you have access to at the time.

Once you have completed the survey your response will be automatically uploaded.

- **Offline Procedure:**

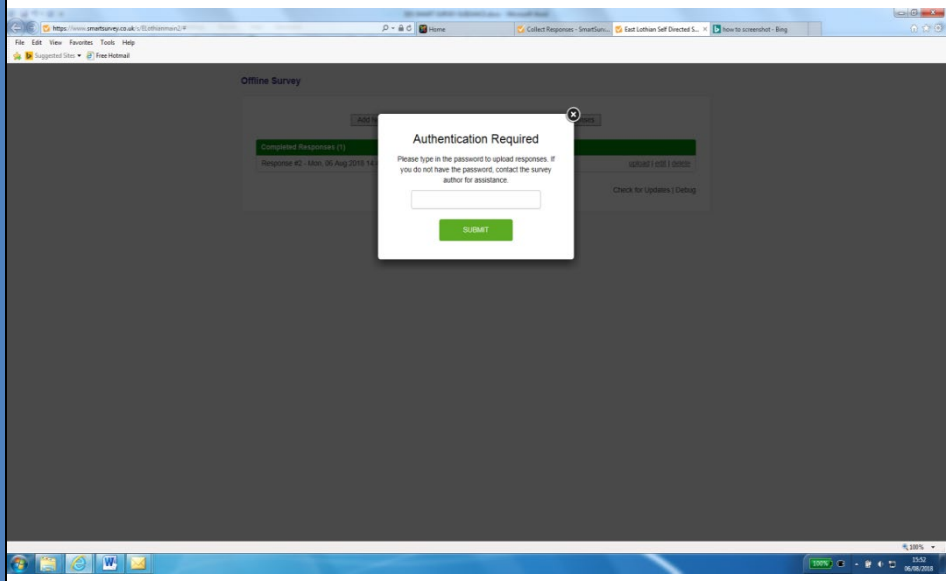
  - You will receive an email containing the offline link to access the survey and an upload password.
  - Please take a note of this password as it must be entered when you are next online and ready to upload the survey information.
  - Copy the link address from the email, open Internet Explorer and paste the copied link address into the web address bar at the top of the page and press enter.
  - The ‘add new response’ page will then appear, and you are ready to begin entering the file details.

- **IMPORTANT – You must do this step while you have online access so that it is live in your browser when you go offline.**
- Do not switch off your laptop at any point during the file reading session or close down the browser after you have accessed the 'add new response' page' online, as you will no longer have access when offline. If you accidentally close the browser then you will need to find online access and repeat the steps above to begin the survey again.
- When you are ready to input the survey information, click 'add new response', complete the survey and then click 'Finish Survey'.
- Each time you complete the survey you will be taken back to the 'add response page'. Repeat this process until all file information has been entered for each individual.
- To **save and continue** a section after a break, please make sure you complete all questions within a survey page before leaving the survey. If you leave the survey halfway through a page, then only the information up to the end of the previous page will be saved. You will lose anything entered on the current page.
- In the offline survey there is a very small icon in the top left corner of the screen, it looks like a little tiny version of a survey page (screenshot below) At any point when completing the survey offline you can click this and it takes you back to the add new response page where you can either go back in to your partially completed survey or start a new survey.



- The **Skip Logic will not be available** in offline mode so when inputting responses please ensure you follow the guidance and where appropriate skip to the next relevant question.
- **IMPORTANT – When you have completed the survey for all files do not switch off the laptop or close the browser.**

- You will need to leave the 'add response page' active until you find online access.
- When you are ready to upload the survey, responses click on 'Upload all local responses'. At this point you will be asked to enter the upload password which was provided in the original email with the survey link.



- the password, click 'Submit' then 'Start uploading'.
- If the laptop is switched off or the browser closed before you upload your responses all completed forms will be lost.

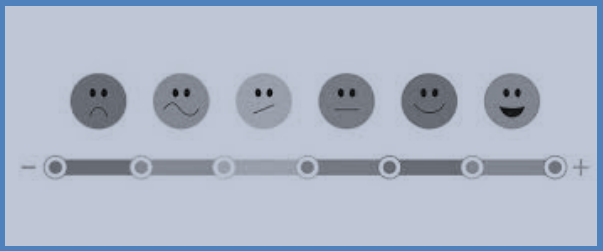
GENERAL GUIDANCE

PHASE 1

General

National Health and Wellbeing Outcomes	**National health and wellbeing outcomes related to services for adults**
	People are able to look after and improve their own health and wellbeing and live in good health for longer.
	People who use health and social care services have positive experiences of those services, and have their dignity respected.
	Health and social care services contribute to reducing health inequalities.
	People who use health and social care services are safe from harm.
	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
	Resources are used effectively and efficiently in the provision of health and social care services.
	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

GENERIC EVALUATION SCALE



PHASE 1

Generic six-point scale evaluation guidance

File readers should refer to this where there is no / limited guidance on how to apply the six-point scale evaluation

Excellent

- In the professional judgement of the file reader, an exemplar of excellent practice. All relevant facets of the scenario have been carried out to the highest of practice standards. No discernible relevant deficits of any kind.

Very good

- In the professional judgement of the file reader, a model of very good practice that just falls short of an excellent evaluation. All relevant facets of the scenario have been carried out to a very good standard of practice. Virtually no discernible deficits.

Good

- In the professional judgement of the file reader, an example of good practice. All relevant facets of the scenario have been carried out to a good standard of practice. There are few discernible relevant deficits.

Adequate

- In the professional judgement of the file reader, an example of adequate practice. Most relevant facets of the scenario have been carried out to an adequate standard, with some gaps. There are some discernible relevant deficits.

Weak

- In the professional judgement of the file reader, an example of weak practice. The majority of relevant facets of the scenario have been carried out in a manner that reflects weak practice. with many gaps. There significant discernible relevant deficits.

Unsatisfactory

- In the professional judgement of the file reader, an example of unsatisfactory practice. All relevant facets of the scenario have been carried out in a manner that reflects unsatisfactory practice, with abounding gaps. There are many critical discernible relevant deficits.

	THREE POINT TEST / CRITERIA 
Three-point test / criteria	**In terms of Section 53 of the Act, "adult" means a person aged 16 or over.** Adult at risk - Section 3(1) defines "adults at risk" as adults who: • are unable to safeguard their own well-being, property, rights, or other interests. • are at risk of harm. and • because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected. The presence of a particular condition does not automatically mean an adult is an "adult at risk". Someone could have a disability but be able to safeguard their well-being etc. It is important to stress that all three elements of this definition must be met. It is the whole of an adult's circumstances which can combine to make them more vulnerable to harm than others. **Risk of harm** - Section 3(2) makes clear that an "adult" is at risk of "harm" if: • another person's conduct is causing (or is likely to cause) the adult to be harmed, or • the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm. The assessment of "harm" and the "risk of harm" are important elements under the Act. The definition of "adults at risk" requires an assessment to be made about the "risk of harm" to the individual at the outset. Because any protection order under the Act represents a serious intervention in an adult's life, a sheriff must be satisfied that an adult is at risk of serious harm, rather than harm, before granting any such order. **Harm** - Section 53 states harm includes all harmful conduct and, includes:

	• conduct which causes physical harm, • conduct which causes psychological harm (for example by causing fear, alarm, or distress), • unlawful conduct which appropriates or adversely affects property, rights, or interests (for example theft, fraud, embezzlement, or extortion), • conduct which causes self-harm. The definition of "harm" in the Act sets out the main broad categories of harm that are included. The list in the definition is not exhaustive and no category of harm is excluded simply because it is not explicitly listed. In general terms, behaviours that constitute 'harm' to others can be physical (including neglect), emotional, financial, sexual or a combination of these. Also, what constitutes serious harm will be different for different persons.
Reading across social work, health, and police records	File readers should read across the social work, police, and health records for the adult at risk of harm. They should use their professional judgement as to how best to answer each question our question set in a manner that reflects adult support and protection practice across the partnership. If file readers need advice and guidance about this, they should consult with their file reading buddy or the lead inspector.
	 ***ADULT PROTECTION***  ***NOT ADULT PROTECTION***
1.7 Has the three-point test been applied correctly in this case?	The purpose of this question to allow the file reader to make an **overall judgement** about the appropriateness of the partnership proceeding along an adult support and protection route. **We would expect an a YES response almost every case.** If a file reader considers making a no response to this question – the partnership should **NOT** have followed an adult support and protection route for the individual – they should consult with their file reading buddy first and then the lead inspector.
	CHRONOLOGY

	
Chronologies	A timeline of social worker or police events/interventions is not acceptable as a chronology. It should contain significant life events (e.g. change of / house / employment, change in family relationship, death of a partner etc.), changes to legal status, and any concerns which have been reported about the adult at risk of harm themselves or others. Chronologies that meet the definition should: • be up to date. • clearly record any actions taken. • clearly have been subject to review and analysis. • contain sufficient detail for the reader to know exactly to what the writer is referring. but not a substitute for case recording **Q 3.1 Is there a chronology of key events contained in the record?** The primary place file readers should look for a chronology and evaluate it is the social work / council officer record. We would expect to see a chronology in the social work records for almost all adults at risk of harm. If there happens to be a chronology in the adult at risk of harm's health records or police records, then the file reader should ensure they give credit for this.
3.2 Evaluation of quality of chronology .	*File readers should use their professional judgement to evaluate the chronology present.* **Excellent** – the chronology present is an exemplar if is comprehensive yet concise. All the elements of an effective chronology are present and the analysis if of a very high standard. It is an excellent tool for the reader to quickly grasp the circumstances of the adult at risk of harm, risk factors, previous interventions. It is fully up to date. It is an excellent contribution for the risk assessment and risk management of the adult at risk of harm **Very good –** the chronology covers well all the key constituent elements but does not meet the exacting standard for assigning and excellent evaluation. It is fully up to date. Its entries are concise, accurate and informative. It is a very good contribution for the risk assessment and risk management of the adult at risk of harm.

	Good – the chronology more of less covers all the bases and is up to date. On balance, a cogent competent tool that provides the reader with what they need to know about the adult at risk of harm. It is reasonably up to date and events are described in sufficient detail. It is a good contribution for the risk assessment and risk management of the adult at risk of harm. **Adequate –** a basic chronology which is of some use to the reader. Key elements of the chronology might be sparsely populated. There might be some gaps and it might not be fully up to date in line with changes of circumstances for the adult at risk of harm. It is an adequate contribution for the risk assessment and risk management of the adult at risk of harm. **Weak –** the chronology is of limited use to the reader as a guide to circumstances of the adult at risk of harm, risk factors, previous interventions and the like. It contains significant gaps. Due to the brevity of some of the entries in the chronology is hard for the reader to make sense of what is going on for the adult at risk of harm. Significant recent events affecting the adult at risk of harm have not been included in the chronology. It is a weak, inadequate contribution for the risk assessment and risk management of the adult at risk of harm. It demonstrates deficient professional competence. **Unsatisfactory –** the content of the chronology is such that it barely meets the criteria for what constitutes a chronology. There are glaring gaps in the list of events. The chronology is of little or no use to the reader as a guide to circumstances of the adult at risk of harm, risk factors, previous interventions and the like. It is not remotely up to date. It is not fit for purpose and makes virtually no contribution to the risk assessment and risk management of the adult at risk of harm. It demonstrates a clear lack of professional competence.
	RISK ASSESSMENT AND RISK MANAGEMENT 
Risk protection	Please answer all questions in this section in relation to protection risks. For example, “risk assessment” means a risk assessment, which covers protection risks.

4.1 Are there any risk issues related to protection type risk (e.g. protecting adults at risk of harm, protection of the public)?	It is highly likely that all the individuals in our sample will have adult protection type risks extant at some point. **File readers should answer yes to the first question, as by default all of the adults at risk of harm in our sample should have a risk assessment**. In the unlikely event that file readers consider a no response is appropriate for this question they should consult with their "buddy" or the lead inspector.
4.2 Is there a risk assessment on file for this adult at risk of harm?	Given the focus of this inspection on adult protection, a detailed risk assessment and associated risk management plan should be available on file. Mark 'yes' to this question if it is evident from the case file that risk has been assessed, even if this has not been recorded on a formal risk assessment template, for example, if it is clearly identified and recorded in detail as a discrete section or sections within the overall assessment or within the care plan.
4.3 Timing of risk assessment	Identify the date the concerns came to light and whether you think the worker acted promptly and appropriately and followed local procedures. Does the most recent risk assessment take account of significant changes in the adult at risk of harm 's circumstances? This question should be answered for the adult at risk of harm whose file is being read where the adult at risk of harm is at risk from others. In instances where the adult at risk of harm poses risks to another individual(s), this question should also be answered. If it relates to another individual, you may not be able to record whether all procedures were followed appropriately but can comment on whether the worker took appropriate action.
4.5 Quality of risk assessment	There are several factors which should be considered when considering the quality of the risk assessment. Assessments should include appropriate analysis. The risk assessment should: • Clearly state the aims and purpose of the risk assessment: • Include risks to self and others. taking account the adult at risk of harm 's right to take risks (risk enablement) • Highlight clearly and specifically what the risks are e.g. physical abuse by a perpetrator, physical harm to self, sexual abuse by a perpetrator, sexual harm to others, financial abuse, alcohol, and drug misuse etc. • Clearly state the **likelihood** of the occurrence of each of the identified risks. • Include an evaluation of the impact of these risks and the consequences if not managed/addressed. • Include reference, where relevant, to the adult at risk of harm's capacity to consent. • Address the communication needs of the service user (for example language spoken, signs, symbols, speech and language therapy, Braille, or audio).

- Include the views of the service user, their family carer or advocate as appropriate.
- Include the views of other relevant agencies where appropriate.
- Structure information in a meaningful way.
- Provide an analysis using up-to-date knowledge/theory/research etc.
- Include a summary of previous agency involvement and the service user's response to this (where appropriate).
- Offer a clear recommendation on the way forward.
- Record dissenting views to the majority decision recorded.
- Ensure that the risk assessment is signed off by the adult at risk of harm, advocate, or family carer (where appropriate). and
- Be fully in line with local procedures.
- File readers should rate the risk assessment on one of the 6 scale points outlined in the box below.

Excellent – You will be able to answer 'yes' to all the above questions where they are appropriate. All the areas are strong, and the assessment provides a high level of and/or original insight into the case. An excellent assessment will be of an outstanding level of professional competence.

Very good – You should be able to answer 'yes' to all the above questions where they are appropriate. There are no weak areas and there are areas of real strength. A very good assessment should be of a high standard and should demonstrate professional competence which exceeds an acceptable level.

Good – You should be able to answer 'yes' to almost all the above questions where they are appropriate although there may be some weaker areas. A good assessment should demonstrate an entirely acceptable level of professional competence.

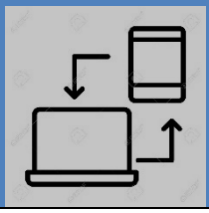
Adequate – You should be able to answer 'yes' to most of the above questions where they are appropriate but there may be some areas of weakness. An adequate assessment should demonstrate a basic level of professional competence, but practice may be variable.

Weak – You cannot answer 'yes' to more than half of the above questions where they are appropriate. Some key areas are weak. A weak assessment demonstrates a lack of professional competence in key areas.

Unsatisfactory – You can answer 'yes' to only a minority of the above questions where they are appropriate. There are major

	weaknesses. An unsatisfactory assessment demonstrates a lack of professional competence.
4.7 Risk management plan / adult protection plan	A separate risk management/protection plan should be available on file in almost all cases. If the risk assessment identifies risk, then there should be a risk management plan to manage/mitigate the identified risk. If an adult at risk of harm is subject to both protection and non-protection type risks, then a number of appropriate solutions are possible. For example: • There are two separate risk management plans – one for the protection type risks and one for the non-protection type risks. • There is one separate risk management plan – it addresses both the protection type risks and the non-protection type risks.
4.8 Is the risk management plan / protection plan up to date?	Account should be taken both of the timescale of the risk assessment and the extent it addresses all assessed and changing risks
4.10 Quality of risk management plan / adult protection plan	NB Some partnerships use the terminology risk management plan, some use adult protection plan, and some may use other terminology for this type of document. Essentially, we are looking for a clear plan that sets out succinctly how the adult protection related risks identified for the adult at risk of harm in the risk assessment are to be eliminated, mitigated, and managed. There are several factors which should be considered when considering the quality of the risk management plan. These include: • Clarity about which agency and lead officer has the primary duty of care in overseeing the risk management plan. • A SMART (specific, measurable, achievable, realistic and time bound) list of actions. • A clear analysis of how the actions taken will eliminate or mitigate the risks to the adult at risk of harm or risk from the adult at risk of harm. • Clarity about who is responsible for each action, and by when. • Clarity about how progress in taking the risk will be monitored and recorded, including near misses. • A statement on how partners will review and monitor the plan and how they will communicate/collaborate with each other. • Clearly stated outcomes. • Sign-off by the service user, advocate, or family carer (where appropriate) and agency lead.

	• Evidence of consideration of appropriate use of legislation if required. and • Evidence that the risk assessment is part of the application for statutory orders. File readers should rate the risk management plan on one of the 6 scale points outlined in the box below. **Excellent** – You will be able to answer 'yes' to all the above questions where they are appropriate. All the areas are strong, and the assessment provides a high level of and/or original insight into the case. An excellent assessment will be of an outstanding level of professional competence. **Very good** – You should be able to answer 'yes' to all the above questions where they are appropriate. There are no weak areas and there are areas of real strength. A very good assessment should be of a high standard and should demonstrate professional competence which exceeds an acceptable level. **Good** – You should be able to answer 'yes' to almost all the above questions where they are appropriate although there may be some weaker areas. A good assessment should demonstrate an entirely acceptable level of professional competence. **Adequate** – You should be able to answer 'yes' to most of the above questions where they are appropriate but there may be some areas of weakness. An adequate assessment should demonstrate a basic level of professional competence, but practice may be variable. **Weak** – You cannot answer 'yes' to more than half of the above questions where they are appropriate. Some key areas are weak. A weak assessment demonstrates a lack of professional competence in key areas. **Unsatisfactory** – You can answer 'yes' to only a minority of the above questions where they are appropriate. There are major weaknesses. An unsatisfactory assessment demonstrates a lack of professional competence.
4.12 Have all concerns regarding protection type risk been dealt with adequately	The focus of this question is on current adult protection or public protection concerns which have arisen in the previous two years rather than historic events. If there is no current risk assessment or risk management plan in a case where you would expect there to be, then the response to this question will be 'No' and this should be noted in the comment box.

4.13 If no, give date concerns came to light & explain why you think they were not dealt with adequately.	**If file readers consider that any previous adult protection concerns were not dealt with properly then they should discuss the issues with the lead inspector. For example, the file reader might consider there were missed opportunities to make sure the adult at risk of harm was safe and protected.**
	INFORMATION SHARING 
Information sharing	Evidence could be in the form of the recording of telephone conversations, the sending and receipt of e-mails or letters, the sharing of reports and attendance at meetings.
5.1 Is it evident from the records that the adult protection partners are sharing information?	This question asks file readers to consider if there is evidence to indicate that partners have used and analysed the shared information to appropriately protect and support the adult at risk of harm.
5.2 Are local authority staff (council officers etc) /health/police sharing information appropriately and effectively?	This is a similar question to the previous one but with a different emphasis. It is looking at whether the relevant information is shared with the appropriate other agencies etc given the specific circumstances of the adult at risk of harm.
	POLICE RECORD SCREENS AND POLICE RECORDS 

5.9 If partnership has submitted no police records?	Brief explanation to reflect the effectiveness or otherwise of the approach taken.
5.10 If police records submitted that are not on list?	State any other submission that may be relevant but not shown on list of police records.
5.11 From STORM Command & Control record has Incident been accurately coded?	Please see attached STORM Command and Control codes. Where there is more than one incident and multiple command and control records any indication of risk of harm or vulnerability should result in the relevant code being shown at closure on each occasion. The list of codes is provided for file reader.
5.12 From STORM Command & Control record has THRIVE Assessment being accurately recorded?	Was THRIVE completed by service advisor and reviewed by area control room. THRIVE is an assessment of (Threat, Harm, Risk, Investigation, Vulnerability and Engagement) and is used for every 101 and 999 call or report made to Police Scotland to understand the most appropriate response. The use of THRIVE is being rolled out across all policing areas but may not presently be active in the partnership under consideration – you will be advised accordingly.
5.13 From iVPD has assessment of risk, vulnerability and wellbeing been conducted and recorded by initial enquiry officer?	Evidence that due consideration has been given to personal circumstances and any potential risk of harm. This may vary from case to case however the default should always recognise the need for swift action and ordinarily before end of shift or within 24 Hours.
5.14 From iVPD has initial enquiry officer had regard for wishes and feelings of the adult?	Evidence that person being supported has been able to appropriately contribute to the process.

5.15 Has iVPD been submitted timeously by initial enquiry officer?	If iVPD not submitted on day of event is there a supporting narrative to providing the reason for any delay.
5.16 Rate the quality of the initial enquiry officer response?	An objective assessment based on professional judgement. (HMICS will be available to support as required) seegenericscaleguide
5.17 Has supervisory officer quality check been conducted and recorded?	Notes to reflect this may be minimal, however comment must be relevant to case under consideration. Not known" has been provided as an option here where the contribution of a supervisor simply cannot be understood based on available information. HMICS will be available to assist with consideration of this question.
5.19 Rate the quality of the information recorded by initial enquiry officer's supervisor?	An expectation that having considered the iVPD, subsequent direction and guidance provided. An objective assessment based on professional judgement. (HMICS will be available to support as required). Where "Not known" becomes the previous choice this option will not be visible. seegenericscaleguide
5.20 Has three-point test recorded on iVPD been reviewed by Risk & Concern Hub?	Evidence that the Hub has considered the detail of the initial operational assessment made around risk of harm and well-being, including persons wishes and feelings. (With due consideration to the principles of the Three Point Test)
5.21 Have Risk & Concern Hub recorded Resilience Matrix on iVPD?	Refer to attached guidance on Risk and Resilience Matrix.

5.22 Have Risk & Concern Hub referred iVPD to Partnership timeously?	Police Scotland are silent on time intervals for submission to partners. However significant or likely risk of harm should ordinarily generate an immediate referral.
5.23 Rate the quality of the Risk & Concern Hub officer's actions and record?	An objective assessment based on professional judgement. (HMICS will be available to support as required) seegenericscaleguide
5.24 Has Risk & Concern Hub escalation protocol been undertaken and recorded? 3 episodes – Constable 6 episodes – Sergeant 9 episodes – Inspector	This will broadly be assessed on the shown criteria (the recorded episodes within a three-month period). Some situations will demand an immediate action plan where the escalation process is not appropriate, and this must be considered as part of our assessment. If no escalation required, please move to Third Party Reporting.
5.27 Rate the quality of the Risk & Concern Hub supervisor's actions and record (only applies if Escalation Protocol implemented)?	An objective assessment based on professional judgement. (HMICS will be available to support as required) This will only apply where Escalation Protocol implemented. seegenericscaleguide
5.28 Has a Crime Management Report been recorded?	A Crime Management Report relates solely to criminal activity under Scots Law and provides an electronic record (with unique reference number) of the crime under consideration.
5.29 Rate the quality of the Crime Management Report?	An objective assessment based on professional judgement. (HMICS will be available to support as required) seegenericscaleguide

5.30 Has an Inter-agency Referral Discussion (IRD) been held?	There is a variance in approach nationally to IRDs. Due consideration should be given to the existence of local processes that discharge this function – be alert to nomenclature. (Different title but purpose similar to IRD).
5.31 Was IRD conducted by an appropriate supervisor?	An officer of Detective Sergeant or higher rank would ordinarily facilitate this part of the process. "Don't know" is provided as an option in this question however it is anticipated that the contribution of Police to this part of the process will be evident.
5.32 Rate quality of Police Scotland's contribution to Inter-agency Referral Discussion? ***- correct decisions made*** ***- risk considered & documented*** ***- relevant actions discharged*** ***- discussions proportionate*** ***- all parties contributed***	Our assessment seeks to identify the presence of key elements around decision making, risk management and communication (HMICS will be available to support as required). File readers should rate (**one** rating) Police Scotland's contribution in line with the following criteria: • risk considered & documented • relevant actions discharged • discussions proportionate • all parties contributed. seegenericscaleguide
5.34 Was Police Scotland invited to attend Case Conference?	Police Scotland staff are not required to attend and input to all case conferences.
5.35 Did Police Scotland attend Case Conference?	Consider instances where Police Scotland may have been expected to attend but did not.
5.37 Was Police Scotland attendee appropriately experienced and suitably trained to attend Case Conference?	This may not be obviously apparent. Did the officer contribute meaningfully to discussions? (HMICS will support further consideration of attendee skills base and relevance). Don't know" has been provided as an option where the appropriateness/skills of the attendee are simply not known.

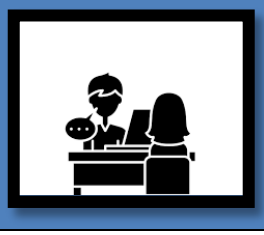
5.38 Did Police Scotland discharge any actions arising from Case Conference? - Evidence of governance post Case Conference?	Evidence of governance supporting the furtherance of actions owned by Police Scotland following the meeting. "Don't know" has been provided as an option where the information sought here is not available on record.
5.39 Rate the quality of Police Scotland's contribution to Case Conference?	An objective assessment based on professional judgement. (HMICS will be available to support as required). It is anticipated that this will be understood from case conference minutes or other supporting documentation. seegenericscaleguide
	ADULT PROTECTION INVESTIGATIONS 
Delegation of investigation to a care provider?	A care provider could be the provider of care home, care at home or housing with support services. Where these services are in the independent/voluntary sector it is not entirely uncommon (in certain circumstances) for the local authority to agree with providers that they will carry out an initial investigation. This is more likely to be the case for larger scale providers and/or where the alleged perpetrator is a member of staff. Where the adult at risk of harm is in a care service directly provided by the local authority and the referral indicates possible inappropriate conduct by a staff member, the expectation would be that any initial investigation would be carried out by staff/managers of sufficient seniority and also possibly not working directly in that service.
5.41 Is there evidence that a care provider or party other than the local authority have been asked to carry out an initial investigation ?	File readers should take account of local procedural requirements on timescales, but greater weight must be given to the file reader's professional judgement.

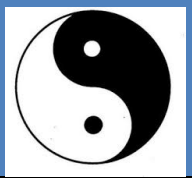
5.58 - 5.60 Second worker for investigations	These questions ask the file reader to make a judgement if the investigation required the presence of a second worker to support the council officer. The code of practice for the Adult Support and Protection (S) Act 2007 states: The council officer may be accompanied by another person. A joint visit with another person could assist the investigation in a number of ways, for example by: • allowing the council officer to jointly investigate concerns with, for example, a key worker, a police officer, health professional or representative from the Care Inspectorate or Office of the Public Guardian. • assisting an assessment of the risk to the adult, such as with a general practitioner, community nurse, key worker or other person already known to the adult and any other members of the household • assisting communication with the adult (or any other member of the household) by being accompanied by an interpreter in British Sign Language, lip speakers, Makaton communicator, deaf-blind communications interpreter or a language interpreter where English is not the visited person's first language. File readers should first consider if deployment of a second worker was warranted and then answer if a second worker was actually deployed. The next questions invite the file reader to consider whether the second worker **should** have been a suitably qualified health professional, and then state whether a suitably qualified health professional was actually deployed as the second worker. It would be desirable to have a health professional as the second worker if the suspected harm to the adult at risk of harm was specifically health related. For example, wilful neglect which has caused the adult at risk of harm to have pressure sores, harm related to misuse of medication, or harm related the adult at risk of harm's inadequate diet. Or where health professional/s know individual well.
5.64 Timescale for completion of investigations	File readers should take account of local procedural requirements on timescales, but greater weight should be given to the file reader's professional judgement.
5.91 Protection powers	The orders which can be considered are Assessment Orders, Removal Orders & Banning and Temporary Banning Orders. More detailed guidance on these is available from the inspection team. As file readers will be aware, relatively limited use have been made of protections orders across Scotland.

5.96 Timescale for review ASP case conference	File readers should take account of local procedural requirements on timescales, but greater weight should be given to the file reader's professional judgement.
H Health screen (specific questions about the bundle of health records submitted)	**HEALTH RECORDS** 
h.4 From health records is there evidence of emergency hospital re-admissions for health condition which was/may have been related to adults' risk of harm?	Definitions: Emergency hospital re-admission – readmission following discharge within 28 days or less. Frequent attenders at Emergency Departments (ED) are defined as patients age 16 and over who attend any ED 10 or more times within a year or attend 5 or more times within a 3-month period. Both frequent presentations to ED (question 9) and emergency re-admission to hospital are a significant indicator of harm as identified specifically in the Ellen Ash SCR
h.6 From the health records is there evidence of repeat referrals for community health services for a health condition which was/may have been related to the adults' risk of harm?	Repeat episodes of community care to be agreed – may be locally determined. Community health services include: • Addiction services • Mental health services • Learning disability services • Intermediate care services • Palliative care services • District nursing services • AHP community services.

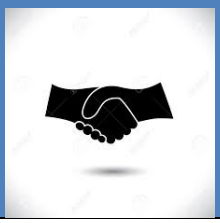
h.8 From the health records is there evidence of frequent presentations to emergency departments (A&E) with a health condition which was/may have been related to the adults' risk of harm?	Frequent attenders at Emergency Departments (ED) are defined as patients age 16 and over who attend any ED 10 or more times within a year or attend 5 or more times within a 3-month period. Data from this question would be valuable to for ASP partnerships to consider systems and processes which capture this information.
h.9 If YES, please rate the intervention from Emergency Department teams to keep the adult safe and protected	**If there is evidence of recent care provision and the response has been scored weak or unsatisfactory in questions 5-10 a discussion with the local NHS lead will determine if escalation is required.**
h.13 Quality of record keeping	*Considerations for file readers:* Is record keeping/documentation accurate, contemporaneous and up to date? Where risks or problems have arisen, that the steps taken to deal with them are recorded clearly, so that colleagues have all the information needed? Is ASP information used to inform other assessment and plan care e.g. discharge planning, risk assessment? If appropriate has the health professional referred to the criteria, principles or other aspects of ASP in their records? seegenericscaleguide
h.14 Rate health professional contribution to ASP outcomes	Where the health professional has not been involved it may be that not applicable is the most appropriate answer. Consider wrap around responsive care and health responses seegenericscaleguide

h.15 Rate the ASP information sharing & collaboration which has taken place between agencies	Evidence would include records of joint visits, joint assessment, sharing relevant information e.g. risk management plan. seegenericscaleguide
	FINANCIAL HARM 
Financial harm	Financial harm (abuse) Section 4 of the ASP Act places a duty on councils to make inquiries about an adult at risk's well-being, property, or financial affairs where the council knows or believes intervention may be necessary to protect the adult.
6.2 Monetary value of the financial harm	We recognise this will be a guesstimate on the part of the file reader.
	PERPETRATORS OF HARM 
6.11 Perpetrators of harm	You should answer yes to this question irrespective of whether it has been proven by a criminal (beyond a reasonable doubt) or civil (balance of probabilities) standard of proof that the alleged perpetrator was responsible for the harm to the adult at risk of harm.
6.16 Did the partnership carry out work with the alleged perpetrator (harmer)?	**We were specifically asked by the adult protection leads group to include this question.** File readers should use their professional judgement to consider (if such work was warranted) if the partnership carried out ameliorative work with the alleged perpetrator. For the next question, file readers should use their professional judgement to evaluate the quality of the work undertaken, using our standard six-point scale.

	BARRIERS TO COMMUNICATION  
7.2 Evidence that all dealings with adult at risk of harm adequately addressed all potential barriers?	It is not possible to provide an exhaustive list of "barriers" to engaging with the adult at risk of harm. File readers should use their professional judgement. Barriers might include: • Communication difficulties. • English not first language. • Challenges due to learning disabilities, mental health problems, dementia, sensory impairment, or other. Examples of efforts to overcome barriers: • Deploying an interpreter if the adult at risk of harm's first language is not English. • Use of appropriate communication aids. • Securing the assistance of someone who knows the adult at risk of harm well and can readily communicate with them.
	CAPACITY 
8.6 Granting of power of attorney	Adults at risk of harm must have capacity for them to grant Power of Attorney.
8.7 Does the adult at risk of harm have capacity?	The Adults with Incapacity (Scotland) Act 2000 defines incapacity as: Incapable of - • acting on decisions. or • making decisions. or • communicating decisions. or • understanding decisions. or • retaining the memory of decisions due to mental disorder or inability to communicate because of physical disability.

	Capacity is assumed in persons over the age of 16 and this can only be overturned on evidence of formal assessment. Capacity is decision specific, can fluctuate and can be regained.
8.8 Is there evidence of concerns about the individual's capacity?	Capacity may be assessed in relation to a person's functional abilities as reflected in the definition above. Capacity can also be assessed in accordance with the person's diagnosis however it is important to note that a person does not have impaired capacity simply by virtue of e.g. • having a psychotic illness • having dementia, particularly in the early stages • having an addiction • having learning difficulties or disabilities • being vulnerable or at risk from him or herself or others • having a brain injury • having a physical disability • having an acquired or progressing neurological condition. A capacity assessment may be required to establish Power of Attorney or other decisions about the persons finance, welfare or unmet needs.
8.10 Did a health professional carry out a capacity assessment?	Doctors have principal responsibility for the formal assessment of capacity - However the importance of multi-disciplinary assessment is essential. It may be necessary to involve a specialist clinician for a person over 65 this could be a psychiatrist in old age or for a younger person a neurologist. or a clinical psychologist in this specialist area
8.13 Was the timing of the capacity assessment in keeping with the adult at risk of harm's needs?	Capacity is decision specific, can fluctuate and can be regained. This means whilst simple decisions can be made using residual capacity, complex decisions may not depend on circumstances. Fluctuations of capacity over a period of time may be symptomatic of some conditions e.g. mental illness or dementia including from morning – night. Every effort must be made to support the person in communicating his/her views and feelings. Where appropriate others such as family or care worker included.
	ADULT PROTECTION OUTCOMES 

9.1-9.7 Pick lists of positive and negative outcomes for the adult at risk harm	File readers should complete these lists carefully and holistically based on all they have read in the social work, police, and health records for the adult at risk of harm. We are asking file readers to holistically assess the adult protection outcomes that the partnership has delivered for the adult at risk harm. File readers should use their professional judgement to consider all the circumstances the adult at risk of harm as set out in their records. If file readers want to record negative adult protection outcomes it is important to distinguish between negative outcomes that are entirely outwith the control of the partnership, and negative outcomes for which, in the judgement of the file reader, the partnership has some responsibility. **Important to tick the safe and protected box if file reader considers on balance the adult at risk of harm is safe and protected.**
	RECORDING, SUPERVISION, AND OVERSIGHT BY MANAGERS  
10.1-10.5 Recording, supervision, and oversight	There are also some questions related to supervision and oversight in the police records screen. Refer firstly to the social work (council officer) record to answer this set of questions. We wish to determine if there is evidence of oversight by more senior officers and appropriate governance in relevant police records. If file readers note evidence of appropriate staff supervision and oversight by managers in the health records, they should note this good practice in the general observations screen and the end of the question set.
10.4 Is there evidence of exercise of governance in the records 	Evidence of **governance** might be: • Record has been audited. • Evidence record included in other self-evaluation or quality assurance activity. • Specific aspects of the adult protection practice – such as adherence to agreed timescales – for completion of adult protection activities have been checked • Manager /s other than line manager (generally more senior officers) have read the record. • Other evidence from the record that in the file readers' professional judgement constitutes governance activity. • **NB we would not expect to see evidence of governance in all adult support and protection records in our sample, rather evidence of governance would be present in a <u>reasonable</u> proportion of records.**

	ADDITIONAL SUPPORT FOR THE ADULT AT RISK OF HARM 
11.1-11.9 Additional support for the adult at risk of harm	Answer this set of questions if you think the adult at risk of harm has additional health and social care support needs – not all adults at risk of harm will have these. The question set is self-explanatory. We want to find out if adults at risk of harm have health and support needs which are additional to their adult protection related needs. And if these needs are met by the partnership.
	GENERAL OBSERVATIONS 
12.1 General observations	This final screen provides the file reader the opportunity to note anything that they think is important but is outwith all of their responses to all of the preceding questions. If, following discussion with the lead inspector, a case requires escalation this should be noted here. File readers should try to keep their observations succinct.
	APPROPRIATE ADULT 
Appropriate adult	This is a general question about the appropriate adult role, not only about their role in respect of a case conference.