The Highland Council

Agenda Item	**9**
Report No	**HCW-17-24**

Committee: **Health Social Care and Wellbeing**

Date: **29 August 2024**

Report Title: **Adult Support and Protection Inspection**

Report By: **Executive Chief Officer Health and Social Care**

1. Purpose/Executive Summary

1.1 This report seeks to update members of an inspection carried out by the Care Inspectorate in April 2024. The Care Inspectorate, alongside its partners in Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland, published its Inspection Report of Adult Support and Protection within the Highland Partnership in April this year. The report can be viewed as **Appendix 1** to this report and at the following link:- Joint inspection of adult support protection in the Highland partnership (careinspectorate.com) .

1.2 Joint Inspections aim to provide national assurance about individual local partnership areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. This report provides detail in relation to the findings of that inspection and also sets out details of the Partnership's improvement plan which has been agreed following consideration of the terms of that inspection.

2. Recommendations

2.1 Members are asked to:

i. Note and provide comment upon the terms of the Inspection Report and the accompanying improvement plan.

3. Implications

3.1 Resource - There are no resource implications arising directly from the contents of this report.

3.2 Legal - The delivery of services to protect those adults in need of support and protection are underpinned by significant statutory legislative and regulatory frameworks ensuring that partners involved to carry out various protective functions provided for by the umbrella legislation being the Adult Support & Protection (Scotland) Act 2007.

3.3 Risk – Management of risk is an integral part of the process of protection planning. That management process was part of the inspection process and formed a key part of the inspection which is the subject of this report.

3.4 Health and Safety (risks arising from changes to plant, equipment, process, or people) - There are no such implications arising directly from the contents of this report.

3.5 Gaelic - There are no such implications arising directly from the contents of this report.

4. Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 This is an update report and therefore an impact assessment is not required.

5. The Inspection Process

5.1 Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. That inspection took place in Highland between December 2023 and March 2024. The subsequent report was published in May 2024 and is attached as **Appendix 1** to this report.

5.2 The focus of this inspection was on whether adults at risk of harm in the Highland partnership area were safe, protected and supported. Highland Health and Social Care Partnership is responsible for planning and delivering all adult community health and social care services across Highland, including community mental health and primary care services. Key partners in terms of the inspection process are the Highland Council, NHS Highland and Police Scotland. Third Sector partners are also involved.

5.3 To provide high-level information, the 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?

5.4 In order to provide findings in relation to these key questions, the inspection involved the scrutiny of records held by social work, health and police in relation to adults who are considered to be at risk of harm. The records for between 40 and 50 adults were

considered. Focus groups were also carried out with staff involved in the delivery of service to protect adults in need of support and protection.

6. Assessment by the Care Inspectorate

6.1 In summary the Inspectorate identified the Partnership's Strengths as follows:

- Initial inquiries were carried out in line with legislative principles and supported by good communication and information sharing.
- All investigations were conducted by a council officer. They were of a good quality and supported by comprehensive risk assessments and protection plans. The partnership was transitioning toward the new codes of practice.
- Case conferences were multi-agency and attended by relevant practitioners. They were well chaired, demonstrated a person-centred approach and produced accessibly written minutes, including protection plans.
- The development of both the teleconference model and nominated officer role were impactful. These initiatives supported good information sharing and collaboration between and across organisations.
- The partnership's commitment to joint improvement recognised the need for a senior health manager to hold an adult support and protection remit.
- Effective leadership and governance of adult support and protection as strengthened through good working relationships between the chief officers' group and the adult protection committee. Strategic oversight of initiatives supported strategic and operational improvement.

6.2 Priority areas for improvement were:

- The partnership should continue the work it was undertaking to improve the quality and consistency of chronologies.
- Most service users were informed they were the subject of an inquiry. Where they were not, the reasons why needed to be more clearly recorded.
- An effective communication plan was needed to share and promote the strategic mission and good work of the adult protection committee with staff.
- The partnership's multi-agency self-evaluation framework was not in place due to a significant delay in developing an information sharing agreement. This was in the final stage of being addressed and should be implemented at the earliest opportunity.

6.3 Inspection Conclusion:

The Inspectorate 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.

7. Improvement Plan

7.1 As a consequence of the inspection report the Adult Protection Committee has prepared an Improvement Plan which is appended to this report as **Appendix 2.**

7.2 That improvement plan is managed via the Adult Protection Committee through the sub groups and officers identified in that plan who will report regularly in terms of any actions required to improve service delivery.

Designation: Executive Chief Officer Health and Social Care

Date: 20 July 2024

Author: Fiona Malcolm, Head of Integration Adult Social Care

Background Papers: None

Appendices:
Appendix 1 – Inspection Report
Appendix 2 - Improvement Plan

Appendix 1

JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION

Highland – April 2024

Joint inspection of adult support and protection in the Highland partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

Phase two

This programme follows our phase one inspections. We published an overview report which summarised the findings and key themes identified. Phase two is closely linked to the Scottish Government's improvement plan for adult support and protection, and the national implementation groups which support it.

The joint inspection focus

Phase two joint inspections aim to provide national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. We also offer a summary of the partnerships' progress since their inspection in 2017.

Updated codes of practice were published in July 2022. In recognition that adult protection partnerships were at different stages of embedding these, we issued a single question survey to all partnerships in Scotland. This asked respondents to describe their approach to inquiry and investigation work and outline the role of council officers. Twenty-two partnerships responded, and findings showed that practice and adoption across Scotland is variable, with most areas having work to do in this respect. The Highland partnership indicated it had not yet fully adopted the codes of practice.

The focus of this inspection was on whether adults at risk of harm in the Highland partnership area were safe, protected and supported. The Highland adult support and protection partnership operates within the context of a lead agency model. Highland Health and Social Care is responsible for planning and delivering all adult community health and social care services across Highland, including community mental health and primary care services.

1 https://www.careinspectorate.com/images/Adult_Support_and_Protection/1._Definition_of_adult_protection_partnership.pdf

The joint inspection of the Highland partnership took place between December 2023 and March 2024**.** We scrutinised the records of adults at risk of harm for the preceding two-year period, from December 2021 to December 2023**.**

Quality indicators

Our quality indicators[2] for these joint inspections are on the Care Inspectorate's website.

Progress statements

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

- 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?

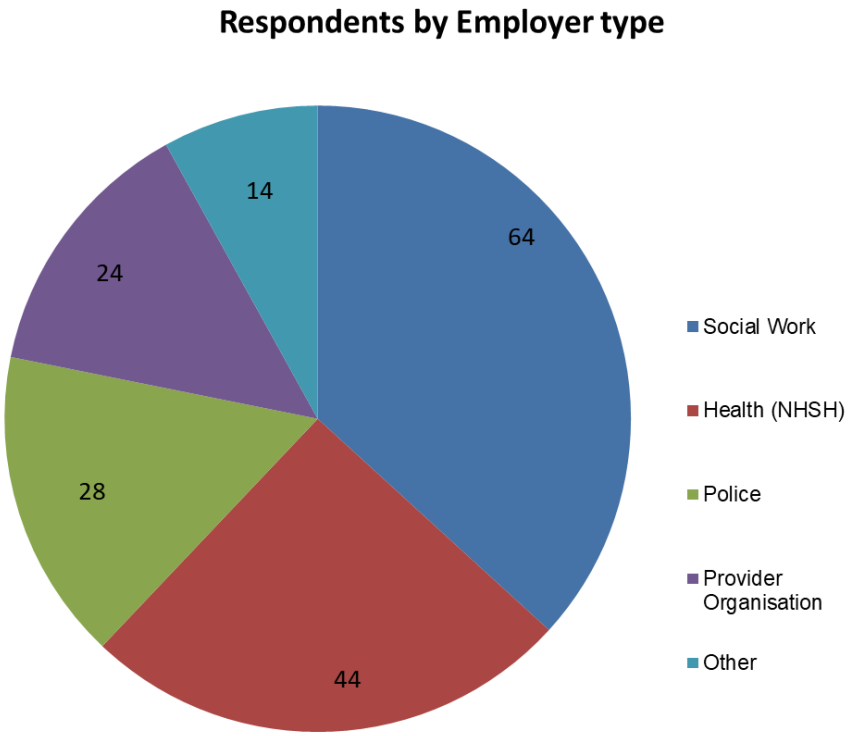
Joint inspection methodology

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

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

Staff survey. One hundred and seventy-four 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.

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

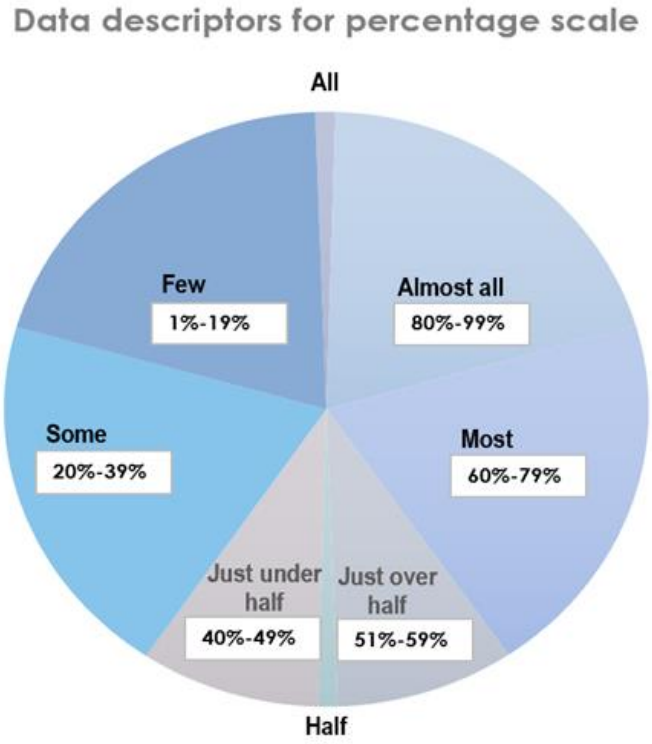


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not require any further adult support and protection intervention beyond the initial inquiry stage.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 50 adults at risk of harm for whom inquiries have used investigative powers under sections 7-10 of the 2007 Act. This included cases where adult support and protection activity proceeded beyond the inquiry with investigative powers stage.

Staff focus groups. We carried out three focus groups and met with 35 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm.

Standard terms for percentage ranges



Summary – strengths and priority areas for improvement

Strengths

- Initial inquiries were carried out in line with legislative principles and supported by good communication and information sharing.
- All investigations were conducted by a council officer. They were of a good quality and supported by comprehensive risk assessments and protection plans. The partnership was transitioning toward the new codes of practice.
- Case conferences were multi-agency and attended by relevant practitioners. They were well chaired, demonstrated a person-centred approach and produced accessibly written minutes, including protection plans.
- The development of both the teleconference model and nominated officer role were impactful. These initiatives supported good information sharing and collaboration between and across organisations.
- The partnership's commitment to joint improvement recognised the need for a senior health manager to hold an adult support and protection remit.
- Effective leadership and governance of adult support and protection was strengthened through good working relationships between the chief officers' group and the adult protection committee. Strategic oversight of initiatives supported strategic and operational improvement.

Priority areas for improvement

- The partnership should continue the work it was undertaking to improve the quality and consistency of chronologies.
- Most service users were informed they were the subject of an inquiry. Where they were not, the reasons why needed to be more clearly recorded.
- An effective communication plan was needed to share and promote the strategic mission and good work of the adult protection committee with staff.
- The partnership's multi-agency self-evaluation framework was not in place due to a significant delay in developing an information sharing agreement. This was in the final stage of being addressed and should be implemented at the earliest opportunity.

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

Key messages

- The teleconference model and nominated officer remit within social work, health, and police, supported effective information sharing and communication between and across agencies.
- Digital templates effectively guided practitioners through the adult support and protection inquiry and investigation process. This was supported by clear operational procedures for staff.
- The adult care review team oversaw effective, well chaired, and accessible case conferences. Minutes included clear protection plans for adults at risk of harm.
- Overall, adult support and protection investigations were of a good quality supported by good risk assessment and protection planning.
- While the quality of chronologies, risk assessments and protection plans was good, more needed done to achieve greater consistency.
- The scope and focus of adult support and protection multi agency training was not as impactful as it needed to be across the partnership.
- The involvement of health staff in adult support and protection work needed to be better recorded within health records. This would more clearly demonstrate the positive supporting role they played in keeping adults safe from harm.

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.

Screening and triaging of adult protection concerns

Nominated Officers consulted with the nominated officers of the partner agencies to jointly consider whether an adult who was the subject of a concern met the three-point criteria. They further considered their agency's roles and responsibilities in any proposed investigation and actions their agency should take to support and protect the person.

The partnership operated a valuable joint teleconference arrangement for health, social work, and police to meet weekly and consider arising protection concerns. This provided an effective opportunity to consider whether there was a need to progress a referral. Teleconferences were also used to share information and support well balanced decision-making about the progression of inquiries and investigations. Police officers attending these meetings were trained as nominated officers by NHS Highland's adult social care services and had undertaken Police Scotland's case conference coordinator training. There was also scope for teleconferences to be called as required out with the standing arrangements. This flexible approach strengthened collaborative decision making in adult support and protection.

These screening processes ensured senior officers meaningfully considered all available information and provided informed and effective direction to staff on how to progress. Screening and triage processes effectively established if the three-point criteria were satisfied and where further initial inquiries were needed to ascertain this.

All adult support and protection referrals were received via adult social care social work teams. Their contact details were accessible and provided on the websites of NHS Highland and The Highland Council. Where the receiving social work team member determined an adult support and protection inquiry was required, they always discussed this with a senior social worker or social work team manager (Nominated Officer Social Work (NOSW)). This provided robust, effective oversight and advice for practitioners regarding progression.

Initial inquiries into concerns about adults at risk of harm

The nominated officer social work role was critical to this part of the process. They ensured initial inquiries were initiated and accurately recorded on the electronic system. They would then record their decision regarding the three-point criteria and outcome of the inquiry. Following this, they would appoint and suitably brief a council officer to carry out any subsequent inquiry with investigation activity.

Almost all inquiries were appropriately progressed within a suitable timescale and managed in line with the principles of the Adult Support and Protection (Scotland) Act 2007. Commendably, application of the three-point criteria was clearly recorded on nearly every occasion. The criteria was correctly and consistently applied in the records. Most were managed appropriately, either by onward referral to care management or effectively signposted to other support services. There was evidence of good or better communication between statutory, third and independent sector partners. The correct stage was reached in almost all cases. Most adults were informed that they were the subject of adult support and protection activity.

There was clear evidence of consistent and good quality management oversight regarding process and decision making.

Although the partnership had not fully adopted the new codes of practice, they were transitioning toward this. The partnership was applying investigative powers within inquiry processes in most cases. Most frequently this included the use of visits and to a lesser extent face to face or telephone interview. In terms of compliance with the new codes of practice, a council officer either undertook or oversaw the activity in almost all cases.

Interagency referral discussions

An integrated adult support and protection multi-agency interagency referral discussion (IRD) process was in the early stages of development and implementation. The records we read that included them showed they were purposeful, well attended by police and social work and added value to the decision-making process. These were distinct from the teleconference model. Therefore, as IRD practice develops, monitoring and guidance may be required to ensure staff understand the distinction.

Inquiries including the use of investigatory powers

Chronologies

Chronologies for adults at risk of harm are an important element of risk assessment and risk management. Positively chronologies were present for almost all adults at risk of harm. That said, the quality of those completed was mixed. The inclusion of a chronology template within the online system aided timely completion. However, the system only guided staff to complete a chronology for the current adult support and protection episode. This was a drawback which discouraged the consideration and inclusion of past events. While this provided a useful starting point, weaker chronologies often lacked reference to key past life events and their relevance to overall risk.

The need to improve chronologies was being addressed through comprehensive guidance within the new protection procedure. Developmental work with staff was also underway to support effective chronology use across social work. This included a new, improved template. At the point of inspection, it was too early to assess the impact of these measures. The partnership also recognised their current electronic system did not wholly support the use of chronologies and believed that a move to a new or updated system would assist improvement. Social workers acknowledged the positive value of chronologies but noted the challenge of finding time to compile a well-balanced, high-quality chronology.

Risk assessments

Almost all adults at risk of harm had a current risk assessment which was suitably informed by multi-agency partners' views and reflected the adults needs. The quality of most risk assessments was good. These were clear and provided a comprehensive overview of risks to the adult. Those rated less positively lacked detail and analysis. The electronic system was designed to prompt the completion of a risk assessment using a well-designed template. The operational procedure clearly supported the use of this tool and emphasised the need to analyse risk and consider protective factors alongside the adult's views. Following completion, the social work nominated officer signed off the outcome of the assessment. This was clearly evidenced within case records and demonstrated purposeful oversight of risk and wider assessment processes.

Investigations

Almost all adult protection investigations were conducted where one was required. The quality of completed investigations was good or better in most cases and consistently involved all relevant parties. All investigations were conducted by a council officer and where investigations required a second worker they were deployed nearly every time. In some cases the

second worker should have been a health professional but this was not always achieved. Almost all investigations determined whether the adult was at risk of harm. They were mostly carried out within an appropriate timescale although some cases were delayed, in a few cases between one and three months. A more timely response to all adults at risk would ensure better outcomes for adults at risk of harm.

The need for a physical medical examination was required in some cases. Positively, these were almost always carried out. In the few cases where they were not, this was due to the person declining or not engaging with the adult support and protection process.

Adult protection initial case conferences

Case conferences were arranged and chaired by the adult care review team. Records demonstrated they were well chaired with good attendance. The minutes were well structured, clear, accessible, and included the protection plan. Records indicated the expertise of the chairs in asking searching questions and effectively directing the meetings and maintaining a person-centred approach. Case conferences maintained a focus on the person's needs and used person centred language. The overall quality of case conferences was good or better in almost all instances.

Case conferences were convened in almost all cases where appropriate and were held in good time, with all relevant professionals invited. Multi-agency participation strengthened protection planning but there were a few occasions when police or health did not attend. In the few cases where a case conference did not proceed, an appropriate rationale for this was detailed in the record. This tended to relate to a significant change in the person's circumstances and level of risk.

The adult at risk of harm was invited in most cases. The main reason for not inviting them was based around their ability to understand the process due to known capacity issues. The adult at risk of harm attended their conference in just over half of instances, when invited. Reasons for non-attendance mainly related to the person not wishing to attend or being unable to attend due to health issues. Where they did attend, all adults were effectively supported to participate. Unpaid carers were invited and attendance was high.

Almost all case conferences effectively determined what needed to be done to support and protect the adult at risk of harm, and a minute was appropriately circulated to attendees.

Adult protection plans / risk management plans

The risk management plan formed part of the risk assessment template supporting early protection planning. This was valuable, allowing risks to be considered or addressed prior to case conference if required. These

were completed and up to date in almost all cases and included contributions from multi-agency partners. Although quality could have been improved, most were good or better, clearly outlining risks and mitigating actions. Case conference minutes also purposefully included protection planning based upon submissions and discussions from all relevant parties.

Adult protection review case conferences

The partnership called a review case conference on almost all occasions when required and they were held within suitable timescales. Again, in almost all cases the review case conference effectively determined the actions required to support and protect the adult at risk of harm.

Implementation / effectiveness of adult protection plans

Protection planning effectively addressed identified risks. Risks were also reviewed post case conference using a core group model where required. Almost all records demonstrated barriers affecting the adult at risk's engagement were successfully addressed as were their support and protection concerns. This view was echoed amongst most staff, who agreed that adults at risk of harm experienced a safer quality of life as a result of the support they received.

Large-scale investigations

NHS Highland adult social care services had a comprehensive and clear procedure for large scale investigations (LSI) which supported a cohesive and consistent multi-agency approach.

In addition to the LSI process itself, the adult protection committee (APC) received a useful report, advising of current LSIs and overall themes, risks and protective factors. The APC in turn reported to the chief officers' group (COG) regarding any specific learning which informed effective governance.

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

Overall effectiveness of collaborative working

There was clear evidence of extensive collaboration on an inter and intra agency basis in the records we read and in the focus groups. This included information sharing, joint working across agencies and sectors, and innovative person-centred practices.

The nominated officer role established in police, health, and social work services created a notably high level of collaboration, especially within the initial stages of the adult support and protection process. This was supported by weekly multi-agency teleconferences which created a valuable forum for agencies to collaborate, share information and consider concerns about adults at risk of harm. These supported decision-making about the progression of concerns, inquiries and investigations. These systems and approaches were supported by accessible multi-agency online operational procedures. These were comprehensive and well compiled to support practitioners across the partnership.

Almost all staff agreed they understood their role and responsibilities in terms of adult support and protection, could effectively apply the three-point criteria and were confident in escalating issues to their supervisor. These views correlated with our findings. The same proportion of staff knew where to obtain adult support and protection advice and were supported to work collaboratively.

A senior member of the NHS Highland health management team was recently allocated the adult support and protection remit. The aim was to enhance and develop the contribution of NHS Highland health staff in adult support and protection practice.

Health involvement in adult support and protection

Health staff made a referral to adult support and protection in a few of the cases reviewed and importantly always received appropriate feedback for referrals made. With regard to feedback, the staff group identified issues with it being timely. Staff were appropriately sharing information in almost all cases, and in most cases the quality of information sharing was good or better. However, adult support and protection activity was not consistently recorded and the quality of record keeping required improvement. Just over half of health staff surveyed did not consider they had access to systems to support accurate recording of concerns about adults at risk of harm. There was no clear place in the health record for recording adult support and protection activity. Information was not therefore readily and consistently available for all health staff.

Commendably, health professionals' contributions to improved outcomes was good or better in most cases. Importantly, for health conditions that may have been related to the risks around the adult, most community health service interventions were rated as good. However, less favourably, most interventions provided following emergency re-admissions and most emergency department interventions were adequate or worse. This was an area for improvement.

Health staff were invited to all case conferences and were appropriately represented in almost all cases. Although interagency referral discussions were at the development stage, health workers contributions were limited as they did not participate in half of them.

A clear strength lay in the fact that almost all health staff indicated that they understood their role and what to do if they had a concern. Importantly, almost all felt they were encouraged to make appropriate referrals. Positively, most health staff believed the training they received provided them with the knowledge and confidence to undertake their role. Most were aware of the three-point criteria and understood it. Significantly, almost all health staff were confident that adult support and protection concerns they raised were handled efficiently. Less positively, confidence in the leadership of adult support and protection and provision of capacity to meet the needs of adults at risk of harm was low. These concerns required consideration to understand their basis and to address them as necessary. The NHS board's arrangements for a senior manager to hold the adult support and protection remit should assist this work.

Capacity and assessment of capacity

Where a capacity assessment was required, a request was made in most cases. In a few cases requests were not made when they should have been. Following the request, a subsequent assessment was carried out by a relevant health professional in just over half of cases. The main reason for assessments not being carried out related to adults declining assessment. Positively, the timing of completed assessments met the adult's needs in almost all cases. This evaluation was based upon relatively small numbers and does not highlight a major concern. However, it indicates an issue around appropriate referral for assessment and the need to track requests and responses more effectively to improve engagement with capacity assessments.

Police involvement in adult support and protection

Importantly, contacts made to the police about adults at risk were almost always effectively assessed for threat of harm, risk, investigative opportunity, vulnerability and engagement required (THRIVE). Some cases had an accurate STORM disposal code (record of incident type) but there was significant scope to improve these.

In most cases the initial attending officers' actions were evaluated as good or better, with some evidence of effective practice and meaningful contribution to the multi-agency response. The assessment of risk of harm, vulnerability and wellbeing was accurate and informative in almost all cases. Positively, the wishes and feelings of the adult were almost always appropriately considered and properly recorded.

Where adult concerns were recorded, officers did so efficiently on almost all occasions, promptly using the interim vulnerable persons database. In most instances suitable frontline supervisory input was evident, this contribution was good or better in just under half of the cases reviewed. Records of supervisory oversight and governance were generic, lacking relevance and meaning regarding the specific episode. However divisional concern hub (DCH) staff actions and records were effective, being good or better in almost all cases. There was a resilience matrix and relevant narrative of police concerns appropriately recorded in almost all instances. Resilience matrix research and assessments were comprehensive, this undoubtedly led to enhanced informative analysis of police data being shared with partners, aiding timely collaborative approaches to interventions and support to adults at risk of harm. Almost all referrals were shared efficiently by the DCH with partners.

Police attendance at weekly teleconference meetings was meaningful and supported timeous partnership discussions to consider adult concerns, the need for a duty to inquire and the progression of inquiries and investigations.

The initiation of an escalation protocol review (instances of repeat police involvement) was inconsistent with organisational guidance. Practice improvement was required in identifying instances of emerging patterns of wellbeing concerns.

The police attended case conferences, on almost all occasions when invited and their contribution was meaningful, being good or better on almost all occasions.

Third sector and independent sector provider involvement

The third and independent sectors made a few adult support and protection referrals. Positively all adults requiring additional health and social care support received it. Just over half of this support was provided by the third and independent sector in conjunction with additional supports from the statutory sector. This demonstrated a valuable contribution from the third and independent sectors in the support and protection of adults at risk of harm.

Key adult support and protection practices

Information sharing

Effective information sharing relating to adults at risk of harm was evident throughout the key processes and structures in place. Both the nominated officer role, and teleconference approaches provided consistency to information sharing. This provided front line managers with the information required to make well-balanced decisions regarding next steps. Staff agreed there was strong confidence across the partnership about their skill level in identifying adults at risk of harm and escalating any concerns they had regarding adults and families they worked with.

There was extensive work to develop a multi-agency information sharing protocol and supporting memorandum of understanding, to support audit and self-evaluation. Reaching an agreement between all parties took too long. This delayed activity in this critical area of practice but the protocol was moving to the final sign off stage.

Management oversight and governance

There was evidence of discussion regarding adult support and protection cases within social work supervision in just over half of cases. There was only evidence of a line manager periodically reading records in just under half of social work records. Improvement in these areas of practice would better evidence oversight of complex cases, supporting staff in their decision making.

Positively, most social work records had been subject to some form of governance. Just over half of police records demonstrated this and only some health records. This was not necessarily a deficit due to the types of health records scrutinised. The approach in social work services used a nominated officer social work to sign off decisions and recommendations. This had a positive impact in terms of governance.

Involvement and support for adults at risk of harm

Support to adults throughout the adult support and protection process was evident in almost all cases. Significantly, the quality of support was good or better in almost all cases. Practice was person-centred. The adults' views were considered almost all the time at each stage of the process. Well-planned and skilfully chaired case conferences were clearly inclusive and described the adult at risk of harm as the 'focus person'. Minutes demonstrated that every effort was made to include the person throughout the meeting and consider their needs, views, and aspirations. The application of these principles to unpaid carers was also evident in almost all cases.

Independent advocacy

Clear local procedures and processes prompted council officers to consider independent advocacy. There were two advocacy organisations operating, one offering support to service users, the other to unpaid carers. The organisation that provided support to service users was funded by NHS Highland and was represented on the adult protection committee and relevant sub-groups.

Independent advocacy was offered appropriately in almost all cases. Where it was accepted and provided this was done in a timely way and successfully assisted the adult in almost all cases.

Financial harm and alleged perpetrators of all types of harm

Financial harm was a factor, sometimes amongst other types of harm, in some of the records we read. The partnership acted successfully to stop financial harm in almost all cases. This was achieved through good quality and effective multi-agency responses.

Where there was a perpetrator of harm (all types), their identity was known to the partnership in almost all cases but actions or sanctions against them were only taken in just under half of cases. However, where direct work with the perpetrator was undertaken, as opposed to sanctions, this was appropriately undertaken in most cases, with the quality being good or better.

Safety outcomes for adults at risk of harm

Significantly, there were improvements in the circumstances of almost all adults at risk of harm because of the work undertaken by the partnership. These positive outcomes were mostly due to multi-agency working with some being due to social work involvement. We found that people were almost always supported and protected to live a safer quality of life and staff concurred with this.

Adult support and protection training

Most staff were confident that the right level of mandatory training was being provided for their staff group. Almost all staff agreed that the training gave them the knowledge, skills, and confidence to carry out their role in relation to adult support and protection. Furthermore, they believed it allowed them to understand risks within this context. Regarding specific council officer training, almost all agreed that it had underpinned their understanding of the legislation and their duties and roles. These views reflected the effective practice we saw.

Just over half of staff surveyed agreed that participation in regular multi-agency training strengthened their contribution to adult support and

protection joint working. This indicated that more work needed done in addition to core training. There were staff who had not accessed training they believed would be relevant to their role. This was already being addressed by the partnership and a schedule of training was in place, monitored through reports to the adult protection committee. Importantly, training that was provided was of a high quality and clearly valued by staff.

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

Key messages

- The partnership's mission was well laid out in their continuous improvement framework, but awareness needed strengthened amongst staff.
- The partnership demonstrated effective leadership and governance of adult support and protection. Strategic oversight, various initiatives, and well embedded supporting documents all contributed.
- The partnership promoted effective and collaborative relationships between the adult protection committee and chief officers' group. This strengthened the competence of the strategic agenda.
- The partnership was committed to an improvement approach. However, some of the initiatives were in the early stages and there was a need to accelerate the pace of change.
- The planned strategic engagement of service users and community groups to inform the adult protection committee agenda should be expedited.
- The partnership needed to find better ways of showcasing positive adult support and protection activity across staff groups.
- The partnership's multi-agency self-evaluation framework was significantly delayed due to a lack of partnership agreement around information sharing. This was in the final stage of being addressed and should be implemented at the earliest opportunity to aid the joint improvement agenda.

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 partnership's mission statement was clear, concise, outcome focussed and embedded within its continuous improvement framework. Strategic work being carried out or planned related directly to the statement, which made progress more transparent. There was evidence these were positively impacting on front line key processes and practice. However, while the mission was clearly set out just over half of staff agreed it was clear to them. Some indicated they did not know what the mission was. The existing online material and newsletters do not appear to be fully impacting in this regard. The partnership had more work to do to further promote and embed the strategic mission and work of the APC.

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

There was a clear strategic leadership framework with effective governance through the partnership's public protection chief officers' group (COG). There was an open and honest relationship between the chief officers' group and the adult protection committee (APC). This encouraged healthy professional challenge and discussion. Adult support and protection was a clear and distinct element of the COG agenda. The COG met quarterly, and its membership included relevant senior managers and the convener of the APC. There was a risk register, and papers were presented by the convener. Key decisions were well recorded. The COG undertook development sessions and the chief social work officer worked in partnership with external bodies to drive improvement.

The adult protection committee met quarterly and undertook a wide range of strategic work to inform its decision-making. Senior leaders articulated a shared view about the need to continue improving their position based on data collection and analysis. The APC was well supported by purposeful sub-groups based upon the committee's needs and priorities. Their work was outlined in each sub-group's terms of reference and monitored through an action tracker presented routinely to the APC. All of the sub-group chairs were APC members and provided action trackers from the sub-groups.

The principal officer for adult protection attended all sub-groups and acted as a vice chair if required. Updates from sub-groups were clearly discussed at adult protection committee, along with other items of business with decisions recorded. This included a joint group with the child protection committee, focussed upon improving transitions for young adults at risk of harm and a specific group focussed upon improving the participation of adults at risk of harm. Some of this work was in the early stages of development making it difficult to assess the impact.

There was a collaborative leadership team driving strategic adult support and protection activity. They positively responded to areas for improvement

and the needs of adults at risk of harm. However, staff awareness of the good work undertaken by the adult protection committee and strategic leaders was limited. Leaders had more work to do in promoting their activities with staff and involving them in improvement activity.

There was a recent NHS Highland health-based review of public protection arrangements. This effectively highlighted areas where there was a lack of engagement or support for the public protection agenda. A recommendation was made to the NHS Highland board, to allocate specific resources to drive this work forward. This was effectively addressed by encapsulating the adult support and protection remit within the role of a senior NHS Highland health manager. They recently began scoping work to inform the prioritisation of the improvement activity required.

The effective use of teleconferences and multi-agency nominated officers clearly supported process improvements. Since the last inspection it was clear this had brought about stronger oversight and driven up the quality of improvement in key areas of practice.

Effectiveness of leaders' engagement with adults at risk of harm and their unpaid carers

The adult protection committee (APC) did not have an adult at risk of harm representative, but they did have a participation sub-group aimed at addressing this. The chair of this group was a member of the APC. This sub-group planned to seek the views of adults in local communities to assist with setting the agenda for the APC based upon their concerns and priorities. This work was at an early stage.

The adult care review team arranged and chaired adult support and protection case conferences. This team had developed expertise in creating and maintaining a person-centred approach which took account of the person's views, therefore aiding engagement in this critical area of practice. The invitation letter for case conference was amended recently following feedback from adults with lived experience. This triggered subsequent plans to review other paperwork, such as agendas, to make them more accessible. In addition to this, there was a useful, informative, and inclusive leaflet which supported adults at risk of harm who were attending a case conference.

Information sharing measures were well embedded. The appropriate contact details for sharing adult concerns were promoted through general practice surgeries, community pharmacies, the adult support and protection newsletter and on partnership agency websites.

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

The adult protection committee (APC) membership was relatively broad including third sector and carers' representation. Strategic leaders put in place collaborative models of support and structures that enhanced multi and intra agency working. Clear protection procedures were accessible to staff and linked well to related guidance. These steps assisted the transition toward the revised adult support and protection codes of practice.

The adult protection committee used data compiled through case file audit regarding key processes and practice, to develop and monitor their improvement plan. They were also informed by a learning review summary report, outlining the work underway. The partnership also demonstrated a collaborative approach to large scale investigations with service providers. The committee addressed a wide range of issues robustly and challenges and delays were clearly discussed, and actions agreed. The leadership group expressed confidence that the committee's position regarding improvement activity had notably improved over the last three years. They noted this was in the context of increased demands placed upon staff during that time. This was evidenced by the improvement work and planning undertaken.

It was noteworthy that the leadership team faced issues specifically driven by the partnership's remote and rural location. Positively, within the partnership there was a specific focus on the future workforce required for social work, social care, allied health professionals and enabling a more effective workforce for third and private sector providers.

Quality assurance, self-evaluation and improvement activity

Multi-agency self-evaluation and improvement activity was affected by a significant delay in gaining agreement across partnership agencies for a new information sharing protocol to support multi-agency self-evaluation. Despite the delay, leaders were committed to developing their use of self-evaluation data to inform decision making and improvement activity.

While there was no multi-agency self-evaluation approach in place, there were several quality assurance exercises undertaken by the adult protection committee. These effectively provided them with assurance and usefully highlighted areas for improvement. Commendably some staff had been involved in the evaluation of adult support and protection practice. Unfortunately, staff awareness of evaluation activity to inform improvements was limited. This was despite important improvements being successfully implemented. The pace of improvement activity to address findings from quality assurance work was improving but needed to accelerate further. The quality assurance sub-group was awaiting sign off of the information sharing agreement after which it planned to schedule a timetable of multi-agency audit.

More positively, single agency audit and evaluation activity being carried out by social work services had identified areas for improvement. There was evidence of a recent strategic evaluation of this approach that highlighted strengths, areas for improvement and actions. Although this had not been measured in terms of progress, the actions formed part of the adult protection committees overarching action tracker.

Carers views were represented at the APC and work was underway to incorporate the views of both them and adults at risk of harm in their self-evaluation work. This was at an early stage. The participation sub-group was sighted on this issue and strategic leaders agreed with us that this was an area for improvement.

Learning reviews

The new national learning review guidance was being adopted across the adult and child protection committees. There were separate sub-groups for each of these committees. The adult protection committees sub-group provided the forum for this work. This included the consideration of the need for learning reviews and the management and support of those that progressed.

At the time of inspection two cases were being considered in terms of the need for a learning review and another two learning reviews were underway, both with independent chairs. This was due to appropriate referrals made to the APC and chief officers' group. The progress of learning reviews was effectively tracked by the APC through a summary report.

The partnership had not published any learning reviews within the period upon which the inspection was focussed. However, the decision-making process to inform learning reviews was robust.

Summary

Key processes

The previous inspection recommended the partnership should ensure adult support and protection referrals were processed in good time. This inspection found that almost all inquiries were now appropriately progressed within suitable timescales.

It also recommended the partnership should ensure well-balanced, valid chronologies were compiled. Positively, we found chronologies were present for almost all adults at risk of harm. Although the quality was mixed, the partnership had put sound measures in place to improve this further.

Overall, adult support and protection processes across Highland were successful in sharing and analysing information which provided a solid basis upon which good quality investigations were made, leading to good quality risk assessments and protection plans in most cases. Case conferences were a clear strength. They were well attended and skilfully chaired and recorded in a person-centred way. The innovative development of the nominated officer role and teleconference model meaningfully supported the overall process. All of this demonstrated a clear improvement from the previous inspection. Further improvement work should continue to drive a more consistent quality of chronologies, risk assessment and protection plans. Most adults were made aware of the adult support and protection process and work was completed timeously. Finally, there was a clear person-centred approach evident throughout the process.

A training schedule was ongoing and should address issues of relevant training being provided. This in turn should enhance the involvement of health staff and particularly the level of recording within health records. Importantly, it was evident that those staff who received training clearly valued it, speaking to the quality of the training on offer.

Strategic leadership

The previous inspection recommended that the partnership reviewed its governance of adult support and protection, including streamlining the landscape and strengthening links between the chief officers' group and the adult protection committee.

This previous recommendation was now clearly addressed. There were clear links between the adult protection committee (APC) and the chief officers' group (COG) with evidence of open and frank discussions between the members of the two groups. The governance landscape was clear with the APC having initiated purposeful sub-groups and clear routes for decision making with issues such as learning reviews. This clearly

addressed the issues raised in the previous inspection, demonstrating implementation of the required improvements. The strategic governance structure was formed within the lead agency model that was committed to identifying, resourcing and addressing priority areas for improvement. This was effective in developing strategic and practice improvement approaches. In addition to this, an NHS Highland senior health manager was recently allocated the adult support and protection remit. The aim was to promote the engagement of health staff with the adult support and protection agenda. This demonstrated a renewed commitment to the improvement agenda.

The leadership team have driven innovative and practical responses to key process practice issues and the needs of adults at risk of harm. This is supported by improved strategic planning and effective supporting documents which were well designed, clear and concise.

The partnership demonstrated commitment to an improvement approach. That said, some initiatives were in the early stages and their impact might be delayed in the context of local and national challenges the partnership highlighted. In respect of this, robust, systematic, and collaborative governance would assist in mitigating against any significant delivery problems. The strategic leadership team should also continue to promote the improvement work already underway to maintain momentum. They should also more effectively promote their strategic mission and the work of the adult protection committee with staff.

Next steps

We asked the Highland partnership to prepare an improvement plan to address the priority areas for improvement we identify. The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in 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

- 98% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 100% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 98% of episodes where the three-point criteria was applied correctly by the HSCP
- 83% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 29% less than one week, 29% one to two weeks, 29% two weeks to one month, 14% one to three months
- 100% of episodes evidenced management oversight of decision making
- 93% of episodes were rated good or better.
- 100% of interagency referral discussions (done at initial inquiry stage) were rated good or better.
- 63% of initial inquiries used investigative powers, 63% of initial inquiries done by a council officer

Staff survey results on initial inquiries

- 85% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 11% did not concur, 4% 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, 6% did not concur, 16% didn't know
- 78% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 12% did not concur, 10% didn't know

Information sharing among partners for initial inquiries

- 90% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm

Chronologies

- 90% of adults at risk of harm had a chronology
- 28% of chronologies were rated good or better, 73% adequate or worse

Risk assessment and adult protection plans

- 93% of adults at risk of harm had a risk assessment
- 61% of risk assessments were rated good or better
- 90% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 61% of protection plans were rated good or better, 39% were rated adequate or worse

Full investigations

- 94% of investigations effectively determined if an adult was at risk of harm
- 77% of investigations were carried out timeously
- 76% of investigations were rated good or better

Adult protection case conferences

- 90% were convened when required
- 93% were convened timeously
- 55% were attended by the adult at risk of harm (when invited)
- Police attended 81%, health 85% (when invited)
- 85% of case conferences were rated good or better for quality
- 85% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 85% of review case conferences were convened when required
- 94% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 97% of adult protection concerns were sent to the HSCP in a timely manner
- 70% of inquiry officers' actions were rated good or better
- 67% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 60% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 40% 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

- 92% of cases evidenced partners sharing information
- 100% of those cases local authority staff shared information appropriately and effectively
- 89% of those cases police shared information appropriately and effectively
- 96% of those cases health staff shared information effectively

Management oversight and governance

- 48% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 64%, police 56%, health 20%

Involvement and support for adults at risk of harm

- 84% of adults at risk of harm had support throughout their adult protection journey
- 91% were rated good or better for overall quality of support to adult at risk of harm
- 81% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 5% did not concur, 14% didn't know

Independent advocacy

- 81% of adults at risk of harm were offered independent advocacy
- 50% of those offered, accepted and received advocacy
- 92% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 69% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 55% of these adults had their capacity assessed by health
- 83% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 24% of adults at risk of harm were subject to financial harm
- 75% of partners' actions to stop financial harm were rated good or better
- 63% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 94% of adults at risk of harm had some improvement for safety and protection
- 100% of adults at risk of harm who needed additional support received it
- 75% concur adults subject to ASP, experience safer quality of life from the support they receive, 6% did not concur, 20% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 59% concur local leaders provide staff with clear vision for their adult support and protection work. 16% did not concur, 25% didn't know

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

- 58% concur local leadership of ASP across partnership is effective, 9% did not concur, 33% didn't know
- 50% concur I feel confident there is effective leadership from adult protection committee, 13% did not concur, 37% didn't know
- 29% concur local leaders work effectively to raise public awareness of ASP, 29% did not concur, 42% didn't know

Quality assurance, self-evaluation, and improvement activity

- 45% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 14% did not concur, 41% didn't know
- 45% concur ASP changes and developments are integrated and well managed across partnership, 14% did not concur, 41% didn't know

care inspectorate

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HMICS

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

Appendix 2

Highland Adult Protection Committee: Improvement Plan

Adult Support and Protection

[June 2024]

The aim of improvement activity in health and social care is to make services better for the people who use them. That might mean making services:

- *safer*
- *more effective*
- *more efficient*
- *more person-centred*
- *more equitable, or*
- *more timely.*

Understanding if aims have been achieved requires identification and definition about what 'better' would look like, and appropriate measures to know if the changes made resulted in the improvements sought.

Measurement for improvement asks questions like:

- *What does "better" look like?*
- *How will we recognise better when we see it?*

- *How do we know if a change is an improvement?*

What needs to improve? ***What is the improvement goal?***	***Barriers to improvement***	***Action plan*** ***(who, what, where, when, how)***	***Monitoring progress*** ***(how, when)***
Identify areas for improvement. Agree what will change as a result of making improvements (improvement goal).	*Identify what the barriers are to making improvements and how these might be overcome.*	*Specify who needs to do something differently, what needs to change, and where, when and how changes can be made.*	*Specify how success will be measured, when it will be measured and who will do this.*
The partnership should continue the work it was undertaking to improve the quality and consistency of chronologies.	Practice Issues in respect of: time, knowledge, and skills. System issue in respect of ease of recording	1. ASC NHSH (Head of Service, Social Work) to continue with Development sessions and other work with social workers in relation to promoting the quality of Chronologies. Progress to be reported via the Practice Improvement Sub-group to AP Committee 2. Ensure CareFirst replacement has functionality to record Chronologies efficiently	Quality of Chronologies to be included in multi-agency case file Audit in 2025
Most service users were informed they were the subject of an inquiry. Where they were not, the reasons why needed to be more clearly recorded.	Practice Issues in respect of: time, knowledge, and skills. System issue in respect of ease of recording	1. Local ASP Policy and Procedure to be updated. Update to be supported by Development sessions and included in Council Officer Training. Head of Service (QA) supported by Practice Improvement Sub-group 2. CareFirst Replacement to provide	Update to Policy and Procedure by Head of Service Quality Assurance (1 month) Existence of records to be clearly visible within AP recording. To be audited in 2026

		appropriate recording field	
An effective communication plan was needed to share and promote the strategic mission and good work of the adult protection committee with staff.	Interest of staff in QA processes in mission and continuous improvement framework	Community Awareness Sub-group to produce Communication plan (based on engagement with all relevant staff) to appropriately promote work of Committee (6 months) This will include: Regular face-to-face engagement by Principal Officers (SW and AP) of frontline practitioners. Principal Officer Adult Protection seeking to recruit frontline staff to Sub-committees. Work to raise awareness of Strategic Agenda at Executive level in Health (Medical and Clinical)	HAPC to monitor frequency and types of engagement of frontline practitioners. Community Engagement sub-committee to report to HAPC on progress HAPC to monitor frontline staff membership of Sub-committees
The partnership's multi-agency self-evaluation framework was not in place due to a significant delay in developing an information sharing agreement. This was in the final stage of being addressed and should be implemented at the earliest opportunity.	Complexity Compliance with Corporate expectations across agencies	1. Police Scotland N Division (Assistant Detective Chief Inspector) to lead on completion, agreement and publishing of draft ISA. Progress to be reported via the QA Sub-group to AP Committee. Target Date September 2024 2. Quality Assurance Sub-group to	1. Committee to monitor progress and receive agreed ISA within 3 months 2. Multi Agency Audit to be

		schedule diet of Audits including Multi-Agency Audit	planned and diarised before end of 2024
The planned strategic engagement of service users and community groups to inform the adult protection committee agenda should be expedited.	Time Resource Complexity of engagement task	Principal Officer (Adult Protection) to provide leadership in this area; including to: • Consolidate and communicate the strategy • Identify partners • Conduct Engagement	Communicable Strategy developed within 3 months Engagement activity reported to APC via Participation Sub-committee
The scope and focus of adult support and protection multi agency training was not as impactful as it needed to be across the partnership	Identifying the correct staff to target for higher level training across agencies and sectors	Deliverable Training matrix to be further developed/consolidated– this will include liaison with Health colleagues to address training needs of acute clinical staff (see below)	Training compliance and participation numbers reported regularly to APC
The involvement of health staff in adult support and protection work needed to be better recorded within health records.	Identifying the appropriate mechanism and resource to address this observation	Open discussion with Acute Clinical leads, QI and Records staff to assess the requirement and likely solutions, in context of NHSH and National policies on record keeping. Senior Nurse (Corporate Services) to provide implementation and monitoring plan to HAPC. This will be integral to work to meet the Health Board Accountability	Monitoring to be integrated within developing audit schedule. QA Sub-committee to oversee.

		Framework (6 months)	
Significant scope to improve STORM disposal coding	Compliance to standards across a large workforce dependent on recognition of Adult at Risk	Police Scotland C3 Division Quality Assurance Manager to consider STORM incident closure codes. Guidance previously distributed nationally to improve - and re-emphasised recently.	Discussion ongoing with C3 Division QA team (PI in N Division) to monitor compliance nationally.
Use of the escalation protocol review was inconsistent with organisational guidance		On 6th June 2023, iVPD was upgraded to version 9.3 this included the introduction of a new automated system-based escalation process which includes a specific suggested action to brief Local Area Commander(s) for tasking a local policing response.	This is an automated system. N Division to introduce a QA process through the sub-group. (All VPDs are reportable to the National Risk and Concern Hub). This will be monitored as part of Audit Calendar of QA Subgroup
Records of supervisory oversight lacked relevance and meaning regarding the specific episode		The iVPD Version 9.2 upgrade introduced a meaningful supervisory footprint on all Concern Reports and, also required reporting officers to sign a mandatory declaration on the content / quality of the Concern Report raised.	This is an automated system that should negate the need for QA work.

Community service interventions were good but for emergency re-admissions and ED they were adequate or worse	Health to have identified appropriate leadership and resource capacity to implement Accountability Framework	Acute Clinical Leads and Deputy Chief Officer (Acute) to review the current training provision. This will be supported by the Senior Nurse (Corporate Services) and the HAPC Training Officer. Training Needs Analysis to be conducted and a training plan to be produced and implemented. Training needs analysis to be presented to HAPC in 6 months	Training compliance and attendance at training to be closely monitored. ED workforce surveys to be conducted post training, and a maintenance plan to be initiated. Routine Health documentation audits to include ASP specific focus.