Joint inspection of adult support and protection:

overview of progress in partnerships where inspections were undertaken in 2017-18

August 2024

care inspectorate

Healthcare Improvement Scotland

HMICS

6 partnerships inspected and reports published

201 staff views obtained

292 adults at risk of harm records read

Contents

The joint inspection of adult support and protection - overview of progress in partnerships where inspections were undertaken in 2017-18

Introduction

This work builds on the joint inspections of adult support and protection that were undertaken in 2017-18. Reviewing progress of practice is essential for robust public assurance of practice standards, identifying national themes and priorities, and enriching and complementing the learning and improvement activity that takes place locally. This workstream of our phase two programme of joint inspections of adult support and protection commenced in August 2023 and concluded in May 2024. Progress review inspections took place in Dundee, North Ayrshire, East Dunbartonshire, Aberdeenshire, Highland, and Midlothian partnerships.

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead the second phase of joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. In 2017-18 Healthcare Improvement Scotland did not participate as full partners in the joint inspection team.

Updated code of practice

The updated code of practice for the Adult Support and Protection (Scotland) Act 2007 was published in July 2022. At the time of carrying out each review inspection, the six partnership areas made varying progress on embedding the revised code of practice.

Joint inspection methodology

The methodology for the review inspections aligned with the joint inspection methodology for phase one. It consisted of four proportionate scrutiny activities. Core components included:

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

Staff survey – We received 1,558 completed staff surveys across the six partnership areas we reviewed. The survey was issued to a range of health, police, social work and third sector provider staff. It gathered staff views on key adult support and protection processes including outcomes for adults at risk of harm, staff support and training. The survey also focussed on strategic leadership for adult support and protection.

Scrutiny of health, police, and social work records of adults at risk of harm - We read the records of 292 adults at risk of harm across the six areas whose adult support and protection journey progressed to inquiry with investigative powers, under

section 7-10 of the Act, and beyond. We also scrutinised the records of 236 initial inquiries where the partnership took no further action beyond the initial adult support and protection inquiry stage.

Staff focus groups – We met with 201 members of staff from across the six partnership areas to discuss the delivery of key processes, outcomes for adults at risk of harm and strategic leadership for adult support and protection. Staff included multi-agency frontline staff, operational managers and strategic managers.

Quality indicators

The quality indicators for these joint inspections are on our website.

Progress statements

To provide Scottish Ministers with timely high-level information, the review inspection reports include statements about partnerships' 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?

The possible answers to each question were:

- Very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm.
- 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.
- Important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

In 2024 the six partnerships inspected received the progress statements set out in the table below.

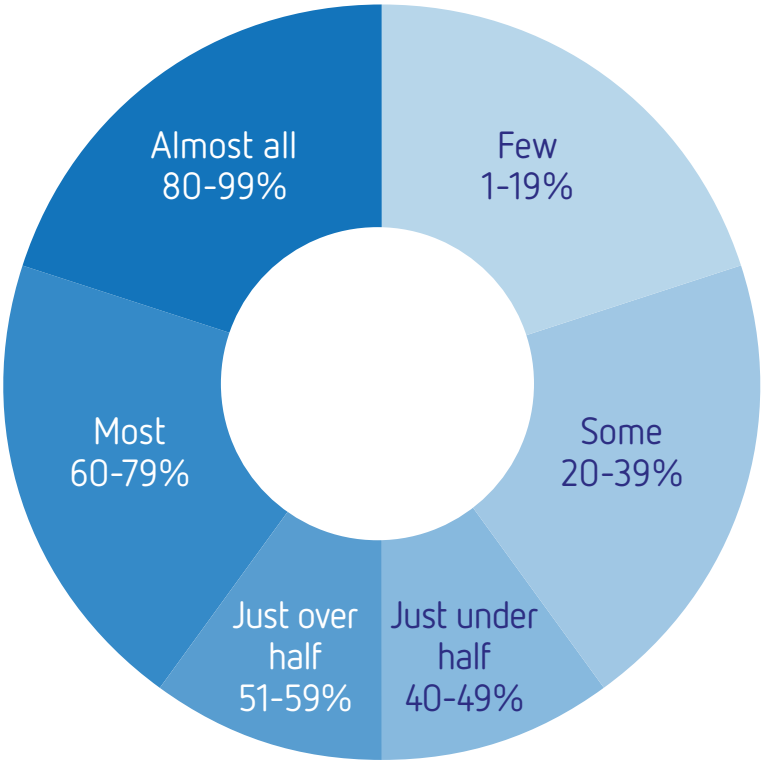
Partnership	Key processes for adult support and protection	Strategic leadership for adult support and protection
Dundee	Effective with areas for improvement	Effective with areas for improvement
North Ayrshire	Effective with areas for improvement	Very effective and demonstrated major strengths
East Dunbartonshire	Effective with areas for improvement	Effective with areas for improvement
Aberdeenshire	Effective with areas for improvement	Effective with areas for improvement
Highland	Effective with areas for improvement	Effective with areas for improvement
Midlothian	Effective with areas for improvement	Effective with areas for improvement

The above table reflects a positive story in the six areas we reviewed. We found all partnerships clearly prioritised adult support and protection priority areas for improvement work since 2017. To indicate progress in relation to the key recommendations set out in the 2017-18 inspections we have used RAG-rated arrow indicators. In our determinations, we have included the principles of a RADAR model (Results, Approach, Deployment, Assessment and Refinement) that helped us to identify how effectively and efficiently partnerships approached their improvement work.

What we mean by these is set out in the key below:

	Minimal progress	**Improvement is minimal**. The partnership's overall approach to improvement is not comprehensive or put into practice. Its deployment and implementation are limited. It has not embedded improvements or they are still at the planning stage. It does not communicate improvements effectively and they are not well understood by staff. It does not assess and review the effectiveness of its improvement progress.
	Some progress	**Evidence of some improvement**. The partnership's approach to improvement is moderate. Its implementation and deployment of improvements are structured. It is beginning to embed improvements in practice. It communicates improvements partially and staff understand them reasonably well. It has limited measures to evaluate and review the impact and outcomes for adults at risk of harm. It periodically assesses and reviews its improvement progress.
	Significant progress	**Significant improvement**. The partnership's approach to improvement is comprehensive and embedded. Its deployment of improvements is well structured, implemented and effective. It communicates improvements purposefully, and staff understand them fully. It has effective measures to evaluate and review impact and outcomes for adults at risk of harm. It continually assesses and refines its improvement progress.

Standard terms for percentage ranges



Overview of progress in partnerships where inspections were undertaken in 2017-18 – key messages

Overall, priority areas for improvement in the six partnerships we inspected in 2017 were positively addressed. Almost all of the priority areas for improvement we identified in our 2017 findings showed some or significant progress. Commendably, all six partnerships prioritised this work and balanced this with their response to the Covid-19 pandemic. While improvement activity was evident, approaches, deployment and implementation of improvement across partnerships varied, limiting the impact of the changes.

During our review inspections we found other areas of practice in these partnerships that needed improvement. Many of these reflected common themes identified in our phase 1 joint inspections. For example, **chronologies, risk assessment, and risk management plans remained key areas for improvement.** Although the overall presence of chronologies for adults at risk of harm improved since 2017, the quality remained variable. Clear links between trauma-informed practice and use of chronologies would support improvement in practice. While the quality of risk assessment was good or better in most partnerships, we saw an overall decline since 2017/18. More positively the presence of risk assessments had improved. The use of risk assessment frameworks was a promising development. The presence and quality of protection plans lessened in most partnerships and was another area for improvement.

Our review inspections found **there was a decrease in investigation activity from 2017**. This related to the use of investigative powers at an earlier stage in the inquiry. While this was mostly appropriate, a small, but significant number of adults should have progressed to further multi-agency investigatory activity, case conference and protection planning. When carried out, almost all investigation activity was to a high standard. The overall quality of investigations improved since 2017. It is important that partnerships have sufficient supervisory oversight of decisions not to proceed with adult support and protection activity after investigative powers have been used in the early stages of an inquiry.

All six partnerships were in the process of progressing or had fully progressed updates to procedures and practice to comply with the revised code of practice.

The revised code of practice is clear that it is good practice for a council officer to be involved in overseeing or supervising all inquiry and investigation activity relating to the Act. **All partnerships had considered council officer capacity and the effective deployment of council officers in adult support and protection activity.** Some partnerships had reviewed and amended their electronic templates to support council officers to demonstrate compliant practice as they moved through the inquiry process. Where partnerships made these changes, council officer decision making and risk assessment were mostly clear and transparent.

The revised code of practice places emphasis on inquiries with and without the use of investigative powers. In every partnership almost all initial inquiries and subsequent investigative powers were undertaken by council officers. Although the revised code of practice allows for information gathering and desktop inquiries to be carried out by staff who are not council officers, all partnerships mostly utilised council officers to screen, triage and carry out desktop activity. Involvement of council officers at the point of referral led to positive benefits for adults at risk of harm. This included correct application of the three-point criteria and adults at risk of harm progressing to the appropriate stage of the adult support and protection process.

Almost all partnerships did not consistently inform adults at risk of harm that initial inquiries were being made about them. Particularly when inquiries without the use of investigative powers were being undertaken. Adults or their proxies were therefore not always aware of their rights when subject to adult protection processes. This was not consistent with the principles of the Act. This is an ongoing challenge for partnerships nationally. Where, in exceptional circumstances, professional judgement determines it is not in the best interests of the adult to inform them that initial inquiries are being undertaken, the rationale should be clearly recorded in their records.

Almost all partnerships we reviewed progress in included interagency referral discussions within their operational procedures. There was **significant variation in how interagency referral discussions were utilised** in practice. They were most effective and beneficial for adults at risk of harm when used consistently and early in the adult support and protection process. Also, when attended by police, health and social work, were well recorded with a clear focus on collaborative risk assessment and clearly planned further investigation activity.

The revised code of practice indicates that interagency referral discussions in adult support and protection are optional. This differs from child protection where interagency referral discussions are mandatory and understood to be a key multi-agency decision making forum. Joint inspections have consistently highlighted that when interagency referral discussions are carried out effectively there are clear benefits for adults at risk of harm.

As in 2017 **almost all partnerships struggled with attendance of adults at risk of harm at their own case conferences.** In 2024 we saw challenges in almost all partnerships with half of adults invited to their case conferences not attending. It was not consistently recorded if adults at risk of harm were invited, when they had, or why they chose not to attend. These issues are consistent with the findings in our phase one inspection of twenty-six partnerships. This is a national challenge. A few partnerships conducted case conferences virtually, however, there was no evidence this improved the attendance of adults at risk of harm.

The offer and uptake of independent advocacy support was variable across the six partnership areas. Most adults with an advocacy worker were supported to articulate their views and participate in their case conference. There was limited evidence of advocacy support out with case conferences. Advocacy involvement earlier in an adult at risk of harm's adult support

and protection journey may support relationship building and may improve attendance of adults at risk of harm at their case conferences.

Almost all partnerships did not routinely involve adults at risk of harm or unpaid carers in the strategic business of the adult protection committee or associated subgroups. We highlighted this in our 2023 overview report. Most partnerships that we reviewed had actively tried to improve this. Independent advocacy partners were mostly represented on adult protection committees. An action to improve engagement of adults at risk of harm in strategic development and planning was commonly included in adult protection committee delivery plans. A range of initiatives were undertaken by adult protection committees to engage adults at risk of harm. This included the use of social media, in-person engagement events, discussions with community and voluntary sector groups and interactive website offers. Unfortunately, these initiatives had limited success in increasing the involvement of adults at risk of harm in strategy and development.

The revised code of practice emphasises the importance of taking a trauma-informed approach to adult support and protection. Practice underpinned by trauma-informed principles can lead to better engagement with adults at risk of harm and better outcomes. **Most partnerships were in the early stages of supporting their workforce to embed trauma-informed approaches into adult support and protection practice.** Some partnerships held well attended training events about trauma-informed practice. Promisingly, in a few partnerships, there was evidence of identification of historical trauma in the early stages of inquiry which provided context for understanding current adult support and protection issues.

It was evident across all partnerships we reviewed that **considerable progress had been made in the role of health strategically and operationally** in adult support and protection work. The implementation of the NHS Public Protection Accountability and Assurance Framework supported this. There were positive examples of health leaders taking active roles within adult protection committee structures and driving forward the protection agenda. Health staff across all partnerships reviewed reported a good understanding of their adult support and protection responsibilities.

Key adult support and protection operational roles had been established in some partnerships and these impacted positively on information sharing and risk assessment. We saw some examples of innovative developments within health to support these key processes.

Positively, since 2017, health attendance improved at case conferences in almost all partnerships, however further progress was still needed. In some partnerships health record keeping and documentation was a key area for improvement to ensure good governance, to support practitioners to deliver safe and effective care in relation to adult support and protection, and to better evidence collaborative working.

Police Scotland remained a vital partner in protecting adults at risk of harm. The assessment of risk of harm, vulnerability and wellbeing by attending officers was accurate and informative for almost all adults at risk of harm. The wishes and feelings of the adult were almost always appropriately considered and properly recorded.

In almost all partnerships the creation and quality of iVPDs (interim vulnerable persons database) was a consistent strength. Some areas for improvement were identified. Resilience matrix research and assessments were comprehensive, leading to enhanced informative analysis of police data being shared with partners.

Accurate recording of STORM disposal codes was needed to improve in most partnerships. In almost all partnerships, the initiation of an escalation protocol review (instances of repeat police involvement) was inconsistent. While emerging patterns of wellbeing concerns were identified, single agency measures to mitigate harm and reduce demand were rarely evident.

In partnerships where interagency referral discussions were most effective police made valuable contributions. Case conference attendance by police officers had slightly declined in half of the partnerships, but overall there was police attendance and effective participation at most case conferences.

Dundee adult support and protection partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
Key processes follow a clearly defined path understood by council officers.		Some progress but key processes converged, and role of council officer was not as transparent as it should have been.
Full implementation of ICT system to support council officers in adult support and protection work.		Significant improvements made to ICT system with the development of well-designed electronic forms to support key processes.
Preparation of valid chronologies; risk assessments and risk management plans.		Minimal improvement with further progress required on presence and quality.

Key processes follow a clearly defined path understood by council officers

- The partnership had updated electronic forms and guidance to support council officers to follow a clear pathway for adult support and protection processes.
- Initial inquiry practice complied with the revised code of practice. Almost all initial inquiries including those using investigative powers were undertaken or overseen by council officers.
- A high proportion of cases advanced to adult support and protection case conference. This positively impacted on risk analysis and protection planning for adults at risk of harm.
- Multi-agency procedures were in the process of being updated. These had potential to strengthen practice and support the full implementation of the revised code of practice.
- The council officer role required to be more robustly evident when further investigation was required. This included the recording of investigative interviews.
- The interface and/or distinction between key processes including initial inquiries, investigations, interagency referral discussions and case conferences was not always clear.

Full implementation of ICT system to support council officers in adult support and protection work

- The partnership implemented a transformation programme to oversee protection practices including ICT changes.
- The partnership commendably prioritised ICT improvement work and created considerable financial and human resource capacity to achieve this.

- This led to the implementation of a suite of well-designed electronic templates to support key areas of practice.
- While this work had the potential to make a positive impact, progress was hindered by inconsistent deployment.

Preparation of valid chronologies, risk assessments and risk management plans

- Oversight by frontline and middle managers to drive up standards needed to improve.
- The presence of chronologies declined since 2017. In 2024 they were present in just under half of the records read. Although the quality had improved, further improvement was required.
- Comprehensive guidance on chronologies had been issued to staff to support improved practice.
- In the early stages of an inquiry there was evidence of timely completion of a risk assessment on a multi-agency basis. A well-designed template supported this.
- Risk assessments were in more records than they were in 2017, but the quality had deteriorated.
- The presence of protection plans was maintained but the quality of these had also declined.

Key processes progress

The quality of initial inquiries had improved significantly since 2017 with almost all very good or better. When investigatory powers were used, they were almost always undertaken by a council officer in compliance with the code of practice. Case conferences were high quality and well attended by multi-agency partners. They effectively analysed risk and put measures in place to support and protect adults at risk of harm. The dedicated NHS adult support and protection team was a strong strategic partner and had strengthened the contribution of frontline health professionals in adult support and protection work. Overall, progress in relation to priority areas for improvement identified in 2017 was mixed. The 2024 inspection found important strengths but the partnership needed to make improvements in other key areas of practice including risk assessment, investigations and protection planning.

Strategic leadership progress

The 2017 inspection noted that the partnership's strategic leaders needed to make the necessary timely transformation required to progress and sustain service improvement across key areas of adult support and protection practice. In 2024 this remained an issue for the partnership. There was a strong commitment to resources, innovation and deployment of numerous improvements but the pace and sustainable impact of change needed to increase.

Governance and oversight of progress remained an area for improvement in 2024. The use of self-evaluation and audit frameworks continued to provide the leadership team with an effective mechanism to review strengths and weaknesses across key areas of practice. That said, more impetus was needed around analysis, assessment and refinement of change.

Our review of progress showed health leadership effectively enhanced the adult protection partnership. Health had strengthened its operational and strategic roles. There was scope for the partnership to take advantage of this and seek to address the lack of general practitioner input to adult support and protection work. This was an area of work the partnership was focussed on in 2017.

Overall, the partnership's success in addressing the identified areas for improvement in the 2017 inspection was mixed. It had a sound approach in place but deployment was not as effective as it should have been.

North Ayrshire partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
Minutes of adult protection case conferences should be sent to the police concern hub, where they should be retained and the relevant information extracted and appropriately recorded.		Divisional Concern Hub staff actions and records were good or better in just over half of records. Improving the consistent application of policy and practice within Police Scotland was a priority area for improvement.
The partnership should offer independent advocacy to all adults at risk of harm.		Some progress had been made with advocacy services now being offered more consistently by staff.

Minutes of adult protection case conferences should be sent to the police concern hub, where they should be retained, and the relevant information extracted and appropriately recorded

- The number of police records that contained case conference minutes increased considerably since 2017. Further improvement was still required to ensure police personnel were invited to case conferences where appropriate.
- Police Scotland practice required improvement across several areas of practice. Most cases included an inaccurate STORM disposal code (record of incident type). Operational supervisory oversight and qualitative checks were not meaningful or relevant. Interim vulnerable persons database (iVPD) recording was crime focused rather than about the vulnerability, risk and threat of harm to the adult at risk. The impact of this weakened accurate information sharing with partners.

The partnership should offer independent advocacy to all adults at risk of harm

- There was evidence of some progress in the 2024 review inspection. Independent advocacy was being offered more consistently by staff, but acceptance of this valuable service varied.
- Although advocacy was being regularly offered, accessing it remained challenging.
- The 2024 review of progress found that where independent advocacy was accepted and received the quality was mixed.

Key processes progress

Overall performance in 2024 remained consistent with 2017. It was strong and collaborative in almost every area of core adult support and protection key processes. This included inquiries, investigations risk assessments and protection planning. Case conferences effectively determined what was needed to support and protect adults from harm. The quality of chronologies was mixed with room for improvement. Practice was aligned with the revised code of practice. While the number of Police Scotland records with case conference minutes had improved, their general performance had declined since 2017. Improvement was required in qualitative iVPD submissions, resilience matrix submissions, use of escalation protocol and supervisory oversight.

Strategic leadership progress

In 2017 strategic leaders drove good partnership working and embedded a positive adult support and protection culture. Our review of progress recognised the partnership's leadership as very effective with major strengths. However, critical aspects of operational police work required improvement.

Well planned and regular self-evaluation and audit work continued which effectively informed the work of the adult protection committee. There was evidence of self-evaluation activity delivering improvements with sound governance in place. There were sound examples in the three statutory agencies of well-thought-out practice developments that enhanced and improved the safety, health, and wellbeing of adults at risk of harm.

The leadership team was closely connected to practice and understood the issues needing addressed. This was underpinned by a proactive strategic leadership team who were visible and accessible to the workforce who appreciated this. That said, while some progress was recognised relating to 2017 areas for improvement, critical weaknesses in Police Scotland's key processes remain. Progress in relation to independent advocacy also persists. The partnership's leadership team is transformational and should use this clear strength to address these issues.

East Dunbartonshire partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.		Significant progress had been made on presence and quality of chronologies. A well-designed template supported council officer practice.

The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them

- The 2017 joint inspection of adult support and protection in East Dunbartonshire highlighted chronologies as an area for improvement.
- Subsequent improvements were made with the development of a portable trauma-informed shared chronology template for young people transitioning from children's services into adult services.
- There were some challenges with completion of chronologies in 2017 when just over half of adults at risk, who should have had a chronology, had one. This remained at a similar level in 2024 and was an area for improvement.
- There was significant improvement in the quality of chronologies; almost all were good or better.

Key processes progress

In 2024 we found initial inquiry practice had significantly improved since 2017. Commendably, the quality of all initial inquiries was good or better. Practice at the initial inquiry stage clearly aligned with the revised code of practice with early use of investigative powers by council officers. Presence of risk assessments and protection plans required improvement, but where they were present in the adults' record, they were of a high quality. In 2017 there was some inconsistency in the application of the risk assessment and management procedure. This remained the case in 2024. This meant that some adults at risk of harm did not benefit from the full application of adult support and protection procedures and practice. Commendably health and police attended all case conferences they were invited to.

Strategic leadership progress

The level of staff confidence in strategic leaders had improved since 2017 and was a positive feature of the 2024 review of progress.

In 2017 there was effective oversight of multi-agency practice and the partnership used long-established self-evaluation and audit activities to identify areas for improvement to good effect. While this largely remained the case in 2024, the audit and self-evaluation approaches needed to be reviewed to ensure that key areas for improvement were identified and embedded in adult support and protection improvement plans.

The strategic leadership continued to promote collaborative working. The sector leading chronology work was a good example of this. Close working relationships were evident at all levels, particularly between social work and health staff in adult support and protection work. They were strong operational and strategic partners.

Aberdeenshire partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
Timely progression of adult support and protection referrals		Some referrals were delayed and some should have progressed further in the ASP process
Consistent application of key processes across the partnership		Maintained positive practice since 2017 and consistently interpreted procedures across teams with oversight from the adult protection network
Set specific timescales for key stages in the process		Timescales had been set out in procedures and embedded in practice
The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them		Most adults had a good quality chronology, recorded on a well-designed template. Effectively used at case conference.
Council officers and other staff are appropriately trained		Well-embedded training and development programme. Multi-agency training and development officer post

Timely progression of adult support and protection referrals

- Since 2017 the partnership augmented their adult protection network. It was a well-resourced and efficient team that provided a single point of contact for all adult support and protection referrals. It comprised social workers and senior practitioners all of whom were qualified council officers. The team was supported by dedicated administrative staff.
- Despite a sound approach, screening, triage, and initial inquiries were conflated between the network and locality teams. Recording was weak. This led to indistinct recording in relation to decision making when an adult required an initial inquiry, whether the adult met the three-point criteria and governance of actions when an adult at risk required initial inquiries.
- For some adults it was unclear how risks were being managed and some adults should have progressed further in the adult support and protection process.
- The recording of accountable decision making was weak for adults whose circumstances were triaged, screened and had initial inquiries that were not further actioned.

Consistent application of key processes across the partnership

- Since 2017 the partnership introduced interagency referral discussions. The partnership developed a well-designed template which clearly evidenced risk analysis, decision-making and governance. Interagency referral discussions were gradually increasing, and the quality was good or better most of the time.
- The quality of inquiries using investigatory powers, chronologies, risk assessments, case conferences and protection planning was high.
- The partnership not only maintained those areas of practice since the 2017 joint inspection but made improvements to their chronologies and quality of investigations.
- Senior practitioners in the adult protection network were pivotal in overseeing the quality of key processes. They also ensured greater consistency in the interpretation and deployment of different adult support and protection meetings.
- Police attendance had significantly improved at case conferences; a police representative attended on almost all occasions. Health attendance required further improvement.

Set specific timescales for key stages in the process

- Since the 2017 inspection the partnership implemented timescales for all stages of key processes.
- These were well understood by council officers and embedded in practice. Management oversight effectively monitored timescales.
- The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them
- The presence of chronologies in the records had improved since 2017 from just under half to most.
- The quality was good or better in most chronologies.
- Chronologies were effectively used by council officers as a tool to assess risk by identifying patterns and triggers in the adult's life.
- A well-designed template supported council officers to record chronologies.

Council officers and other staff are appropriately trained

- Training opportunities have been strengthened since 2017. Most partnership staff viewed multi-agency training as positively contributing to multi-agency adult support and protection working.
- Council officer training was updated to reflect the revised code of practice, and almost all council officers experienced the training as effective.
- Council officer training was well received and wider development opportunities for council officers were valued.

Key processes progress

In 2024 we found the quality of screening, triage and initial inquiry activity had declined since 2017. Improvement was needed in management oversight and systems to evidence council officer decision making and actions. More positively, council officers were deployed at the early stages of referral in compliance with the revised code of practice. Beyond the initial inquiry stage, adults at risk of harm benefitted from high quality adult support and protection processes. Council officer practice was strengthened by a well-designed set of electronic templates for key process points. Since 2017 the partnership introduced a very effective interagency referral discussion process which was well supported by police, health and social work. Police practice in relation to updating the interim vulnerable person database needed to be aligned with national practice and guidelines.

Strategic leadership progress

The 2017 inspection recommended increased capacity in the adult protection network. Leaders responded positively and effectively addressed this. A specialist nurse for adult support and protection was positively impacting on health staff attending adult support and protection meetings. Our review of progress found that strategic leaders oversaw a commendable improvement in many critical areas of adult support and protection key processes.

In 2017 we highlighted that audit activity was variable across the partnership. Some progress was made by 2024 in relation to regular multi-agency audits, specifically in relation in interagency referral discussions.

Data generation in relation to outcomes remained a challenge for the partnership in 2024. Were this to be positively addressed it would improve their audit activity. An analysis and research officer post was created and a data subgroup reporting to the adult protection committee was now in place. Better engagement with adults at risk of harm and gaining their feedback was recognised in 2017. This remained in 2024 and was a key area identified in the adult protection committee action plan. The new post and subgroup had the potential to improve this area of practice.

Highland partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
The partnership should make sure that all adult protection referrals are processed timeously.		Significant progress with almost all referrals now being progressed in appropriate timescales.
The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.		Some progress in that almost all adults had a chronology, however, quality was mixed and further improvement was required.
The partnership's review of the governance of adult support and protection should streamline the governance landscape and strengthen the links between the chief officers' group and the adult protection committee.		Significant progress including a restructure of the strategic governance model and the development of clear links between the chief officers' group and the adult protection committee.

The partnership should make sure that all adult protection referrals are processed timeously

- Since 2017 the partnership had made significant improvements to ensure that almost all inquiries were now appropriately progressed within suitable timescales.
- The nominated officer social work role was vital to the efficiency of the process. They made sure that referrals were appropriately progressed to inquiries and would appoint a council officer to carry out any necessary investigation activity.
- The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them
- Presence of chronologies had significantly improved since 2017. Quality of chronologies continued to remain an area for improvement.
- The chronology template only supported council officers to focus on the current adult support and protection episode. This was a missed opportunity to develop a fuller history of the adult's life events including trauma experience.

The partnership's review of the governance of adult support and protection should streamline the governance landscape and strengthen the links between the chief officers group and the adult protection committee

- The 2017 inspection recommended that the partnership reviewed its governance of adult support and protection. In 2024 this was 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 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. Additionally, an NHS Highland senior health manager was recently allocated the adult support and protection remit.

Key processes progress

In 2024 almost all inquiries appropriately progressed within a suitable timescale. Commendably, most adults were informed that they were subject to adult support and protection activity early in the inquiry. Practice complied with the revised code of practice and council officers applied investigative powers in almost all cases. An effective set of digital templates guided council officer practice; this was supported by clear operational procedures. Case conferences were good or better on almost all occasions, with clear protection plans evident in minutes. Investigations were mostly of good quality and were supported on most occasions by effective risk assessments. There was still room for improvement in the quality of risk management plans and risk assessments. Better health recording of adult support and protection was needed to evidence the important role health staff played in protecting and supporting adults at risk of harm.

Strategic leadership progress

In 2024 the partnership demonstrated effective leadership and governance of adult support and protection. The partnership's vision was well embedded in its continuous improvement framework, but awareness needed to be increased with staff. The partnership was committed to an improvement approach, although some initiatives remained at an early stage. There were some delays in implementing the partnership's multi-agency self-evaluation framework which partners were working to resolve, and would positively impact the improvement agenda.

Midlothian partnership progress

Progress summary table

2017 recommendation	Progress	2024 finding
The partnership should make sure that all adult protection referrals are processed timeously.		Some progress had been made but delays persisted for some adults at risk of harm.
The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them.		Some progress had been made to quality of chronologies but their presence in the records of adults at risk of harm had reduced.

The partnership should make sure that all adult protection referrals are processed timeously

- Since 2017 the partnership had put clear measures in place for the adult support and protection team leader to screen all referrals. A council officer was then allocated to progress initial inquiries if required.
- Positively, screening guidance was introduced to promote a consistent approach.
- In 2024 our progress review found improvement was made but some adults at risk of harm continued to experience delays in their referrals being progressed.

The partnership should make sure that council officers prepare well-balanced, valid chronologies for all adults at risk of harm who require them

- Where adults at risk of harm had chronologies, the quality was mostly good or better.
- A significant number of adults did not have a completed chronology in 2017. This continued to be a challenge. In fact, in 2024 the presence of chronologies had declined.
- Procedures had recently been revised to guide council officers to complete chronologies for all adults at risk of harm rather than only for those progressing to case conference.
- Training was planned to support staff on the use of chronologies.

Key processes progress

In 2024 the partnership had made changes to reflect the new code of practice. A well-designed template supported council officers to move seamlessly from desktop information gathering and initial use of investigative powers into further investigatory work. The template supported robust management oversight of work undertaken by council officers. Since 2017 the partnership

had developed a framework for managing risk which was clear and well-embedded. Case conferences effectively determined actions to support and protect adults at risk of harm. However, police and health attendance was inconsistent, and minutes were not always evident in their records. The purpose and function of interagency referral discussions were unclear, and the electronic format did not support tripartite discussions.

Strategic leadership progress

The 2017 joint inspection found that leadership within the partnership had major strengths. The 2024 review of progress found strategic leaders still oversaw the delivery of a competent and effective adult support and protection practice.

Strategic leaders' vision for adult support and protection was strong and well understood by staff. The partnership should ensure it capitalises on its strong leadership foundation to ensure effective change in these areas and other areas we identified in our progress review such as interagency referral discussions and case conferences.

Overview of progress in partnerships where inspections were undertaken in 2017-18 - summary of key processes

Our review of progress showed that all partnerships made at least some progress in meeting nearly all the areas for improvement highlighted in the 2017 inspections. There was good evidence that partnerships developed improvement plans following the 2017 inspections and had dedicated time and capacity thereafter to address the priority areas for improvement. Commendably this was maintained through the COVID-19 pandemic to the time of these inspections although their deployment was interrupted. The partnerships involved welcomed our review of progress and collaborated positively with us.

Screening and triaging of adult protection concerns

Almost all partnerships faced challenges with managing the year-on-year increase in referrals. Some partnerships moved council officers upstream to make early determinations about whether an adult met the three-point criteria. This supported sound decision-making with referrals being routed to the most appropriate resource for the adult's needs. A few partnerships had multi-agency approaches to screening and triage which were promising. Highland implemented a valuable joint teleconference arrangement for health, social work and police. This promoted sound consideration of how referrals should proceed.

Initial inquiries

In line with the revised code of practice, investigative powers were enacted by almost all partnerships early in inquiries. Powers used were mainly visits to the adult and investigative interviews. Council officers almost always conducted or oversaw initial inquiry activity. In partnerships where initial inquiries were most effective, partnerships had well-designed templates to support council officer decision-making. There was clear consideration of the three-point criteria and oversight from operational managers.

Effective multi-agency communication and information sharing contributed to the right decisions being made for adults at risk of harm. In a few partnerships, inter-agency referral discussions were an effective mechanism for joint risk assessment and protection planning early in an inquiry.

Positive practice example

Aberdeenshire partnership developed a highly effective interagency referral discussion summary form which evidenced multi-agency decision-making, application of the three-point criteria and effective governance.

Chronologies

Chronologies for adults at risk of harm are an important element of risk assessment and risk management.

While there was some progress in those partnerships we inspected in both presence and quality of chronologies, more improvement was required. Partnerships should ensure chronologies are dynamic tools that inform risk assessment and risk management. A cultural shift away from chronologies being viewed as a separate task to an integral component of risk assessment is required. A well-designed template, informative guidance and meaningful training evidenced some positive impacts. Making clear connections between trauma history and chronologies will support improved practice

Positive practice example

East Dunbartonshire demonstrated strengths including concise level of detail recorded and clear layout of key events council officers were supported to consider a trauma-informed approach to chronologies, taking account of complex past and present life events.

Risk assessments

Robust and timeous risk assessments are central to supporting and protecting adults at risk of harm. Presence of risk assessments was positive with further improvement required on quality. Best practice in risk assessments was evident where multi-agency partners had collaborated and had shared ownership of risk assessments.

Midlothian used the TILS (type, imminence, likelihood, severity) framework. This clearly articulated framework was well understood by staff and embedded in recording templates.

Aberdeenshire partnership adopted a shared risk assessment framework. Multi-agency risk assessment was embedded in case conference minutes. A risk matrix strengthened multi-agency risk assessment. These approaches strengthened the quality of work in this critical area of adult support and protection practice.

Investigations

The revised code of practice describes an inquiry as a single entity. Therefore, inquiries can be conducted with or without the use of investigative powers. Most partnerships were appropriately using investigative powers at the initial stage of the inquiry. When further inquiry with investigative powers was required beyond the initial stage, this was most effectively planned on a multi-agency basis, sometimes via an inter-agency referral discussion. A few partnerships

had updated their electronic forms to support council officers in moving seamlessly from the initial stage of an inquiry, with or without the use of investigative powers, to further inquiry using investigative powers. In Midlothian, a well-designed electronic template supported council officer practice across the entire inquiry. Council officer decision-making and analysis, as a result of desktop information gathering, and where appropriate use of investigative powers was clear in the early part of the inquiry. This then flowed well into further investigation activity.

In almost all partnerships council officers carried out inquiries with investigative powers timeously and effectively determined if the adult was at risk of harm. A second worker was mostly deployed as required, and where necessary this was a health professional. For some adults this contributed to a more person-centred experience because they already had a relationship with the second worker.

Since 2017 most partnerships had either maintained good practice in investigatory practice or had made improvements.

Initial adult support and protection case conferences

Almost all initial case conferences were carried out timeously and effectively determined actions kept the adult safe. In accordance with the principles of the Act, there should be a presumption of attendance of the adult at risk, and if it is decided not to invite the adult or the adult chooses not to attend, this should be clearly recorded in their records. Almost all partnerships struggled to consistently achieve attendance of adults at risk at their own case conferences.

Well-trained chairs, high-quality minutes, person-centred approaches and the relevant professionals' attendance were all contributing factors to effective case conferences.

Initial case conferences are multi-agency forums that are critical for collaboratively identifying and managing protection risks. Police attendance had fallen slightly in half of the partnerships since 2017, but overall, there continued to be police attendance at almost all case conferences. In almost all partnerships improvements had been made from 2017 in attendance of health professionals at initial case conferences. However, there was still room for improvement. There was evidence in some partnerships of informative reports, particularly from police, being submitted to case conferences.

Risk management/protection plans

Adults at risk of harm should have a salient, multi-agency protection plan that effectively sets out what the partnership plans to do to keep the adult safe, supported and protected. A plan to manage risk may be pertinent at any stage in the adult support and protection journey and is likely to be dynamic and evolve across the process. Most adults had protection plans which were evident in a variety of ways including being embedded in interagency referral discussion meeting minutes, case conference minutes, and stand-alone protection plan electronic forms.

Quality was variable. Production of effective multi-agency protection plans remained an area for improvement. In Aberdeenshire protection plans clearly identified contributions of multi-agency partners. Plans were clear about actions planned or taken to reduce risk, who was responsible and in what timescale. Minutes were shared and present in police and health records. Police and health professionals attended most case conferences.

Implementation of protection plans/outcomes for adults

Almost all partnerships convened review case conferences when needed for adults at risk of harm. They were convened timeously and effectively determined if the protection plan was mitigating risks for adults at risk of harm. Positively some partnerships developed a core group approach to offer further opportunities for multi-agency monitoring of protection plans and necessary adjustments between review case conferences. Most staff agreed that adults at risk of harm were safer as a result of adult support and protection processes and interventions in their partnership area.

Overview of progress in partnerships where inspections were undertaken in 2017-18 - summary of strategic leadership

Vision and strategy

All partnerships had a clear vision for adult support and protection or public protection where appropriate. Most embedded their vision statement into adult protection committee delivery plans and/or other key strategic documents. Most made efforts to promote their vision and strategy. Partnerships undertook a range of activities to raise awareness about adult support protection. This included the use of social media, engagement events with staff, using a website to share the work of the adult protection committee and participation in national adult support and protection awareness days. Results were mixed from these activities. For example, staff in some partnerships were not clear about the vision and strategy for adult support and protection. There is a need for partnerships to consider communication barriers and how they share their vision and strategy with staff because traditional methods do not always deliver the desired results. In East Dunbartonshire, almost all staff agreed that leaders gave them a clear vision for their adult support and protection work. Staff and managers clearly worked in close proximity to front line staff and this promoted a positive culture of co-production.

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

Senior leaders were committed to improving services for, and the experiences of, adults at risk of harm in all the partnerships we reviewed. All partnerships had clear governance systems in place for adult support and protection. Public protection, including adult support and protection, was overseen by chief officer groups. Adult protection committees, or equivalent, reported effectively to chief officers groups. In some partnerships self-evaluation or development sessions supported relationship building and agreeing priorities in chief officers groups. In North Ayrshire, annual joint development sessions attended by members of the adult protection committee and chief officers group strengthened and maintained effective working relationships.

Adult protection committees were typically supported by subgroup structures that were often the engine room of committees. These groups were usually chaired by members of the adult protection committees and were most effective with multi-agency representation. Some subgroups were shared with the child protection committee. This was where cross-cutting themes or duplication of effort indicated a joint approach was more efficient. In East Dunbartonshire, joint subgroup arrangements facilitated the development of a well-designed chronology tool used across children and adult services.

Most adult protection committees made good use of performance data relating to adult support and protection. Trends and exceptions were reported to the chief officers groups. Rigorous collection, analysis and reporting of data was a challenge for most of the partnerships

in the 2017 inspections. Progress had been made but this remained a key area of focus for senior leaders to improve. Overall, there continued to be a lack of qualitative data about the outcomes and experiences of adults at risk of harm. This was also a significant factor in the twenty-six partnerships inspected in phase one. The introduction of the adult support and protection quality improvement framework will support improvement. More needs done to grow understanding about how effectively to deploy improvement activity.

Effective use of data is a key activity to drive improvement in the delivery of adult support and protection. This remained a challenge for most partnerships reviewed.

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

In 2017 almost all adult protection committees struggled to include adults with experience of adult support and protection or their unpaid carers in their adult protection committee or associated structures. Despite clear efforts made by most partnerships, this continued to be a challenge in 2024. In Dundee, an adult with lived experience of adult support and protection meaningfully attended the adult protection committee.

Quality assurance, self-evaluation and improvement activity

Almost all partnerships had an adult protection subgroup with a focus on continuous improvement. Some partnerships had a calendar of audit activity that transparently set out their plans for single, multi-agency and thematic audit activity across a year. Almost all partnerships undertook some level of multi-agency audit at least once per year and this was enhanced with smaller more frequent single agency audits and thematic deep dives. A few partnerships had been slow to return to systematic audit activity post-Covid-19 pandemic.

In almost all partnerships frontline staff and managers were not directly involved in casefile audits. Overall, staff across all partnerships who responded to our survey indicated seldom being involved in audit activity. Involving staff in audit activity fosters an improvement culture and encourages ownership of change. Senior leaders indicated it was challenging to release staff for audit work given frontline pressures.

Some of the partnerships had put in place learning review subgroups. This was a development from the previous inspections in 2017. These subgroups focused on learning from internal and external learning reviews and endeavoured to make improvements as a result of recommendations from published reviews. In Aberdeenshire, there was a strong emphasis on driving up practice standards because of learning reviews. A learning review tracker supported the adult protection committee to oversee the progress of improvement actions. Attitudes to learning reviews had shifted from negativity to staff and middle managers viewing findings as being opportunities to learn and improve.

Next steps

The quality and consistency of chronologies, risk assessment, protection plans remain variable. As was the extent to which adults at risk of harm were effectively engaged operationally and strategically. These are persistent issues consistent with our phase one inspection findings.

Next step - We are pleased the national implementation group is sighted on these important areas of practice and that they are developing additional support and guidance. Partnerships should continue to work closely with the national implementation group to ensure they effectively implement the work being done. If so, this will strengthen adult support and protection practices locally and nationally.

Most partnerships had the option of convening interagency referral discussions within their procedures. Consistent with phase one inspections, the use of and quality of interagency referral discussions was variable. Joint inspections have consistently highlighted that when interagency referral discussions are carried out effectively, at the initial stage of an inquiry, there are clear benefits for adults at risk of harm.

Next step – Partnerships should consider fully embedding interagency referral discussions into practice to support early multiagency risk assessment and investigation planning for adults at risk of harm. Interagency referral discussions provide an early opportunity for partners to consider the circumstances of adults with escalating risks where it is unclear if the three-point criteria is met, and support early consideration of trauma history.

Quality assurance and audit work were variable. This impacted the pace of change and improvement activity. While partnerships made effective progress in those priority areas for improvement we identified in 2017, it was evident that other areas of key practice required improvement. It is clear partnerships find it challenging implementing self-evaluation approaches that maintain a consistent and sustainable standard across all areas of practice.

Next step - The Scottish Government should consider what role the joint inspection team play in promoting the impact of the improvement work undertaken by the national implementation group and subgroups. This could include further inspections, thematic scrutiny and improvement work using the QIF, focussed on persistent areas for improvement.

Appendix 1

North Ayrshire joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	94%	100%
Chronology quality - good or better	Not measured	42%
Risk assessment presence	96%	98%
Risk assessment quality - good or better	84%	63%
Protection plan presence	86%	86%
Protection plan quality - good or better	90%	69%
Investigation quality - good or better	83%	86%
Case conference quality - good or better	94%	88%
DTI quality - good or better	43%	80%

Aberdeenshire joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	46%	79%
Chronology quality - good or better	Not measured	61%
Risk assessment presence	77%	83%
Risk assessment quality - good or better	90%	87%
Protection plan presence	97%	87%
Protection plan quality - good or better	74%	78%
Investigation quality - good or better	86%	100%
Case conference quality - good or better	96%	95%
DTI quality - good or better	68%	42%

Dundee joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	66%	48%
Chronology quality - good or better	Not measured	26%
Risk assessment presence	57%	88%
Risk assessment quality - good or better	67%	27%
Protection plan presence	65%	62%
Protection plan quality - good or better	61%	60%
Investigation quality - good or better	83%	48%
Case conference quality - good or better	88%	81%
DTI quality - good or better	54%	82%

East Dunbartonshire joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	59%	61%
Chronology quality - good or better	Not measured	95%
Risk assessment presence	90%	74%
Risk assessment quality - good or better	75%	63%
Protection plan presence	95%	58%
Protection plan quality - good or better	94%	73%
Investigation quality - good or better	95%	72%
Case conference quality - good or better	87%	93%
DTI quality - good or better	54%	100%

Highland joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	60%	90%
Chronology quality - good or better	Not measured	28%
Risk assessment presence	98%	93%
Risk assessment quality - good or better	53%	61%
Protection plan presence	96%	90%
Protection plan quality - good or better	56%	61%
Investigation quality - good or better	67%	76%
Case conference quality - good or better	72%	85%
DTI quality - good or better	53%	93%

Midlothian joint inspection of adult support and protection comparison data

	2017	2023/24
Chronology presence	71%	58%
Chronology quality - good or better	Not measured	69%
Risk assessment presence	94%	78%
Risk assessment quality - good or better	71%	77%
Protection plan presence	100%	97%
Protection plan quality - good or better	78%	75%
Investigation quality - good or better	84%	79%
Case conference quality - good or better	77%	79%
DTI quality - good or better	76%	78%

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com

This publication is available in alternative formats on request.

@careinspect careinspectorate