JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION: REVIEW OF PROGRESS

in the Moray partnership area

Published October 2024

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Background

Joint inspection partners

In June 2023 Scottish Ministers requested that the Care Inspectorate lead the progress reviews of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. These relate to six partnerships across Scotland where important areas of weakness outweighed strengths in our phase 1 inspection programme between 2020 and 2023.

Joint inspection focus

The purpose of these six joint inspection team progress reviews is to provide assurance about the extent to which improvement has progressed in each of these partnership[1] areas.

Updated code of practice

The updated code of practice for the Adult Support and Protection (Scotland) Act 2007 was published in July 2022. Partnerships should have implemented the new code of practice guidance for the cases scrutinised in this progress review.

Joint review methodology

The methodology for these six progress reviews includes:

The **analysis of supporting documentary evidence** and a focussed position statement submitted by each partnership. This evidence relates specifically to areas for improvement identified in the phase 1 inspection reports.

Reading a sample of health, police, and social work records of adults at risk of harm. We read the records of 20 adults at risk of harm whose adult support and protection journey progressed to an inquiry with investigative powers and beyond.

Staff focus groups – We met with 39 members of staff from the Moray partnership to discuss improvements they have made to the delivery of key process, and strategic leadership for adult support and protection. Staff included multi-agency frontline staff, middle managers and strategic managers.

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

Quality indicators

Our quality indicators for these joint reviews are on the Care Inspectorate's website.[2] We have used the same quality indicators that were used in the phase 1 inspection.

Standard terms applied to the sample of records we read.

All – 100%

Almost all – 80% - 99%

Most – 60% - 79%

Just over half – 51% - 59%

Half – 50%

Just under half – 40% - 49%

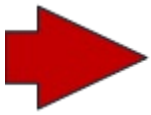
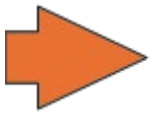
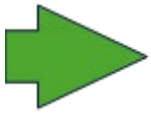
Some – 20% - 39%

Few – 1% - 19%

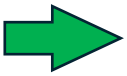
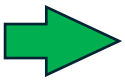
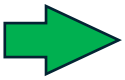
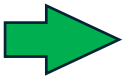
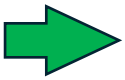
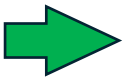
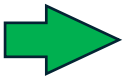
Progress

Priority areas for improvement were identified in the phase 1 inspection. To indicate progress, 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.

[2] https://www.careinspectorate.com/images/Adult_Support_and_Protection/4._Adult_support_and_protection_-_quality_indicator_framework.pdf

	Minimal progress	**Improvement is minimal**. The partnership's overall approach to improvement is not comprehensive or put into practice. It's 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 impact and outcomes for adults at risk of harm. It periodically assesses and reviews its improvement methodology.
	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 methodology.

Overview of progress made in Moray partnership

Priority areas for improvement from Phase 1 in June 2022		Progress	Progress review findings in September 2024
1	The partnership should ensure the application and delivery of key processes for all adults at risk of harm is consistent and in line with the Moray Health and Social Care Partnership (HSCP) and Grampian interagency procedures.		Significant progress made.
2	The partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them.		Significant progress made.
3	The partnership should seek to improve the quality of chronologies, risk assessments, and protection plans. This will impact positively on the management of risk for adults at risk of harm.		Significant progress made.
4	Case conferences and review case conferences should be clearly defined, involve the adult at risk of harm and unpaid carer where appropriate and should be convened for all adults at risk of harm who require them.		Significant progress made.
5	The partnership should prioritise the full implementation of the improvement plan. Strategic leaders should ensure that the appropriate resources are made available.		Significant progress made.
6	Strategic leaders should strengthen governance of adult support and protection practice. There should be robust measures in place to identify concerns early and promptly implement remedial action.		Significant progress made.
7	Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement work.		Significant progress made.

Significant progress	Some progress	Minimal progress

Progress on priority areas for improvement

Key processes priority area for improvement 1

The partnership should ensure the application and delivery of key processes for all adults at risk of harm is consistent and in line with the Moray Health and Social Care Partnership (HSCP) and Grampian interagency procedures.

The recently reviewed Grampian interagency adult support and protection procedures were comprehensive, and well-designed. It referenced the Scottish Government's revised code of practice (2022) well. There was a helpful multi-agency Moray adult support and protection procedure specifically for Moray staff. It reflected the adult support and protection context in Moray. There was training for council officers and other staff to support implementation of the revised code of practice.

The positive results of our reading the records of adults at risk of harm showed staff followed the partnership's adult support and protection procedures meticulously.

Frontline staff at our focus group were confident and highly professional about adult support and protection. They found the partnership's adult support and procedures helpful. The adult protection committee exercised due governance over the revising and updating of the adult protection procedures.

The partnership made significant progress. The partnership overall followed its comprehensive multi-agency adult support and protection procedures rigorously.

Key processes priority area for improvement 2

The partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them.

Inquiries with investigative powers were much improved. The partnership rectified the issue of sometimes not carrying out investigations when necessary. It successfully put in place the quality assurance measure of double reading inquiry reports. Advanced social work practitioners reviewed all inquiry reports. They gave insightful feedback to the council officer. This system worked well. The partnership redesigned its template for inquiry reports, which improved their quality.

In 2024, the partnership carried out an inquiry with investigative powers when required for all adults at risk of harm in our sample. This compared favourably to just over half of the time in 2022 – a significant improvement. Quality of inquiries was similarly improved, from just over half being good or better in 2022, to almost all good or better in 2024 – another impressive improvement. All inquiries with investigative powers were timely, effectively determined if the adult was at risk of harm, involved a council officer, and deployed a second worker when necessary.

Council officers were very positive about the quality assurance and improvement measures in place. They said the standard template for inquiries was helpful, as was the double reading process. Partnership staff collaborated effectively for inquiries. Speech and language therapists purposefully supported council officers and other staff when the adult at risk of harm had difficulties with communication.

The partnership made significant progress. The partnership conducted inquiries with investigative powers when required.

Key processes priority area for improvement 3

The partnership should seek to improve the quality of chronologies, risk assessments, and protection plans. This will impact positively on the management of risk for adults at risk of harm.

Chronologies

The partnership developed a simple and effective template for the preparation of chronologies for adults at risk of harm. It was a multi-agency tool. Case conference delegates always discussed the adult at risk of harm's chronology. As did core groups (multi-agency meetings to discuss progress with the adult at risk of harm's protection plan) when they reviewed progress with protection planning for the adult at risk of harm. Chronologies was a topic at the partnership's multi-agency learning events. The partnership planned a programme of multi-agency training on chronologies.

The partnership's view was that "they were on a journey with chronologies", with further improvements required. Our record reading results suggested there was more improvement than they thought.

Chronologies were much improved. In 2024, all adults at risk of harm in our sample who required a chronology had one, and almost all chronologies were good or better for quality. This compared very favourably to only some adults at risk of harm had a chronology in 2022, and some good or better for quality. Staff shared the chronology with the adult at risk of harm when appropriate. This was an inclusive approach.

Risk assessment

The partnership undertook a range of multi-agency quality assurance and improvements for risk assessment. They included development of a well-designed multi-agency complex risk assessment template, staff training, and dynamic updates to risk assessments via core groups. There was a Grampian multi-agency risk assessment training workshop.

In 2024, most adults at risk of harm in our sample had a risk assessment – a modest improvement from just over half in 2022. But in 2024 some had no risk assessment. The reason for this, acknowledged by the partnership, was staff did not prepare risk assessments when the episode did not proceed to an adult protection case conference. There were exceptions. The otherwise comprehensive and well-designed inquiry template did not have appropriate fields for the explicit assessment of risk. The partnership considered the risks for the adult but did not explicitly assess and record them. Given the sound improvements the partnership achieved for all our priority areas for improvement, we are confident it can quickly rectify the risk assessment issue. Positively, almost all completed risk assessments were good or better for quality. Staff inclusively shared risk assessments with the adult at risk of harm when appropriate.

Protection plans

The partnership developed a well-crafted electronic protection plan template. This was clearly effective.

Commendably, in 2024 almost all adults at risk of harm in our sample who required a protection plan had one, and quality was good or better for almost all of them. This compared favourably to most adults at risk of harm had a protection plan in 2022, most of which were good or better for quality. Again, a notable improvement. Staff shared protection plans with the adult at risk of harm. This showed an ethos of involving the adult at risk of harm throughout their adult support and protection journey.

The partnership made significant progress. It significantly improved the three elements of management of risk for adults at risk of harm – chronology, risk assessment, and protection plans. Presence of risk assessments required further improvement so that all adults at risk of harm have one.

Key processes priority area for improvement 4

Case conferences and review case conferences should be clearly defined, involve the adult at risk of harm and unpaid carer where appropriate and should be convened for all adults at risk of harm who require them.

The partnership undertook substantial multi-agency improvement work for adult protection case conferences. This included a multi-agency audit of 27 case conferences in 2023. It focused on effective participation of the adult at risk of harm, and redesigned case conference processes, as well as the template for recording them. It purposefully identified additional police officers for training, to make sure the police always attended adult protection case conferences when invited. Our 2024 record reading results clearly showed this was successful.

In 2024, the partnership convened an adult protection case conference for all adults at risk of harm in our sample who required one. This was an improvement from 2022, when it convened a case conference for just over half of the adults at risk of harm who required one. This was compelling evidence the partnership rectified the issue we identified with case conferences in 2022. Case conference quality was improved too, with almost all good or better for quality in 2024.

Police officers and health professionals attended all case conferences when invited. And all case conferences effectively determined what needed to be done to keep the adult risk of harm safe, supported and protected.

Only some adults at risk of harm attended and participated in their case conference when invited. This was despite the partnership's strenuous efforts to support adults at risk of harm to participate. The partnership worked with a third sector independent advocacy organisation to support participation and also linked with a university which was carrying out a study of participation of adults at risk of harm in their case conference. The partnership also changed the process to make it easier for the adult at risk of harm to participate; prior to the case conference the adult at risk of harm could speak with the chair if they wished. It provided an accessible information pack to adults at risk of harm and their families to help them understand the process.

Review adult protection conferences were much improved in 2024, with almost all in our sample convened when required. This compared to just under half convened when required in 2022. Effectiveness of review case conference improved too. In 2024, all review case conferences determined required actions to keep the adult at risk of harm safe. In 2022, the equivalent figure was almost all.

The partnership made significant progress. It convened competent, well-executed case conferences when required for adults at risk of harm.

Strategic leadership priority area for improvement 5

The partnership should prioritise the full implementation of the improvement plan. Strategic leaders should ensure that the appropriate resources are made available.

Following our joint inspection of adult support and protection in 2022, the partnership determined the improvement actions needed to implement our seven priority areas for improvement. And how it would measure progress. It established the governance arrangements for oversight of improvement activity. The favourable results of our reading the records of adults at risk of harm in 2024 are convincing evidence the partnership implemented its improvement plan effectively. The partnership had an electronic application to support its improvement work.

The partnership instigated a range of notable improvement focused activities. It successfully assigned the role of adult support and protection champion to some health professionals. It established a post of adult protection specialist nurse and set up professional practice forums for adult support and protection.

Since 2022, the consultant practitioner team was reconfigured to better support adult support and protection activities. It had four consultant practitioners supporting specific business areas, including adult support and protection. All consultants managed the operational delivery of adult support and protection. This enabled the lead officer for adult support and protection to better support strategic developments and the delivery of the improvement plan for adult support and protection.

Policing capacity to effectively carry out adult support and protection work was enhanced with the appointment of a coordinator for interagency referral discussions for the divisional concern hub.

NHS Grampian's appointment of a specialist adult protection nurse, and adult protection champions enhanced its capacity to carry out adult support and protection work.

The partnership made significant progress. It created additional capacity to support improvements for adult support and protection and successfully delivered the improvements our 2022 joint inspection identified.

Strategic leadership priority area for improvement 6

Strategic leaders should strengthen governance of adult support and protection practice. There should be robust measures in place to identify concerns early and promptly implement remedial action

The substantial progress evidenced by our 2024 progress review data showed the overall effectiveness of the audits and quality assurance activities the Moray partnership did. This was evidence of real improvement. It strongly verified the partnership's assertions they have made good progress with improvements.

The Moray adult protection committee and the chief officer group had a regular flow of audit and other data submitted for them to appraise. The adult protection committee had a risk register, which logged risks associated with our priority areas for improvement. These, among other things, enabled these groups to exercise sound muti-agency governance over the delivery of improvements to adult support and protection.

Operational managers with responsibility for adult support and protection systematically worked diligently and effectively to bring about necessary improvements to adult support and protection. This was a key factor for the partnership's successful delivery of improvements to adult support and protection.

The partnership strengthened the role of first-line managers for operational oversight and governance of adult support and protection. There were regular purposeful team meetings to discuss adult support and protection quality assurance issues.

The quality assurance tool "the adult's journey" was a promising development. The consultant practitioner team used it to quality assure adult support and protection practice. They completed two templates per month. They communicated the results to the practitioners involved and updated the tool to reflect learning from practice.

The partnership made significant progress. It exercised sound, effective multi-agency governance for adult support and protection.

Strategic leadership priority area for improvement 7

Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement work.

There was evidence of regular, multi-agency quality assurance and audit activities. For example, audits of adult protection case conferences, interagency referral discussions, and double reading of adult support and protection investigation reports. The partnership created the required capacity to carry out these activities rigorously and effectively. Frontline staff (council officers) were involved in the double reading of investigation reports. They considered this was effective. Advanced practitioners, who are frontline staff, participated in multi-agency audits of adult support and protection activities.

There was a recent multi-agency audit of interagency referral discussions in which frontline staff participated. We did not generate any statistical data on this, but from our record reading and the focus groups their interagency referral discussion system was highly effective.

The partnership made significant progress. Its cohesive programme of multi-agency audits and quality assurance activities was successful. Frontline staff were suitably involved.

Summary of progress

Key processes progress including findings out with priority areas for improvement.

The Moray partnership's interagency referral discussions for adults at risk of harm were highly constructive. Their approach to interagency referral discussions was Grampian wide. Social work, police, and health staff purposefully and consistently attended these virtual forums, as did other partners, such as care providers. The meetings were timely, focused, and well recorded. Staff at all levels attested to the significant benefits derived from them. Interagency referral discussions contributed effectively to keeping adults at risk of harm safe, supported and protected, with enhanced health and wellbeing. Moray's approach to interagency referral discussions was an exemplar for the sector.

Our joint inspection in 2022 identified that recording of adult support and protection matters in the health records of adults at risk of harm warranted improvement. The partnership initiated several improvement actions for this. There was helpful guidance and multi-disciplinary training for health professionals about adult support and protection recording. The partnership issued an advice note on adult support and protection recording to all health professionals. This was accompanied by an online training video.

In 2024, adult support and protection recording in health records remained an area for improvement. In 2024 and 2022 just over half of adult support and protection recording in health records was good or better. There was no repository in the NHS electronic recording system for adult support and protection materials such as inquiry reports and minutes of case conferences. Health staff said it would be helpful if one was created. Health staff also said the electronic recording system could be difficult to use.

The Moray partnership instituted its interagency vulnerable adults process (MIVA). It afforded partnership representatives the opportunity to explore interventions for individuals repeatedly intimated to social work in police concern reports (iVPDs). An advanced practitioner chaired the meetings. And NHS staff, the police harm reduction unit, and community safety participated. There was a reduction in police reports for individuals discussed at MIVA.

Overall, Moray's key processes for adult support and protection were much improved. Risk assessment presence for adults at risk of harm needed further improvement. Key process improvements ensured adults at risk of harm were safer, included and had improved wellbeing.

Strategic leadership progress including findings out with priority areas for improvement

Overall, Moray's strategic leadership for adult support and protection was further improved. There was significant progress for the three priority areas for improvement for strategic leadership. The partnership's operational and strategic governance for adult support and protection was well-established and effective. Moray's adult protection committee and the chief officer group exercised sound, rigorous governance over adult support and protection.

Next steps

The Care Inspectorate's link inspector will continue to engage with the partnership. We have shared the full record reading results with the partnership to inform future improvement work. A multi-agency adult support and protection quality improvement framework is about to be published that the partnership should consider. This has the potential to positively inform their self-evaluation approach. The partnership should also keep track of the National Implementation Group's work relating to inquiries and investigations. National discussions will help them to determine at what stage risk assessments are needed and inform any future review of key processes.

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