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

Review of progress in the Edinburgh City Partnership Area

Published November 2024

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Background to progress reviews

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 51 members of staff from Edinburgh 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%

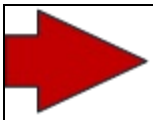
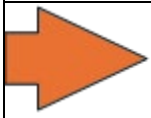
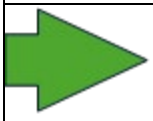
Some – 20% - 39%

Few – 1% - 19%

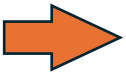
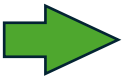
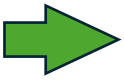
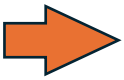
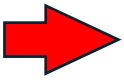
[2] https://www.careinspectorate.com/images/Adult_Support_and_Protection/4._Adult_support_and_protection_-_quality_indicator_framework.pdf

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.

	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 Edinburgh City

Priority areas for improvement from Phase 1 in November 2022		Progress	Progress review findings in October 2024
1	The partnership should improve the quality of chronologies and risk assessments for adults at risk of harm. All adults at risk of harm who require a chronology and a risk assessment should have one.		Some progress made
2	The partnership should carry out prompt adult protection investigations for all adults at risk who require them.		Significant progress made
3	The partnership should take steps to improve the quality of adult protection case conferences. It had undertaken improvements by creating additional posts for minute takers. It was too early to tell the impact of this.		Significant progress made
4	Social work services faced the challenge of 30 social worker vacancies in adult services. This impacted adversely on adult support and protection operations, self-evaluation, and quality assurance activity. Social work leaders should work to increase the service's capacity to carry out adult support and protection work promptly, effectively and efficiently.		Significant progress made
5	The partnership's strategic leaders should ensure there is consistent, competent, effective adult support and protection practice that keeps adults at risk of harm safe and delivers improvements to their health and wellbeing.		Significant progress made
6	The partnership should prioritise recommencement of multi-agency audits of adult support and protection records, quality assurance and self-evaluation activities for adult support and protection.		Some progress made
7	The adult protection committee should ensure it has direct representation from adults at risk of harm and their unpaid carers. Thus, it would benefit from their lived experience of adult support and protection.		Minimal progress made

Significant progress	Some progress	Minimal progress

Progress on priority areas for improvement

Key processes priority area for improvement 1

The partnership should improve the quality of chronologies and risk assessments for adults at risk of harm. All adults at risk of harm who require a chronology, and a risk assessment should have one.

Chronologies

Since the last inspection the partnership developed and implemented templates for duty to inquire with and without investigative powers. These templates included useful fields for chronologies and analysis of them. While these were encouraging steps, our progress review found this approach had not yet improved either the presence or quality of chronologies. Quality remained a challenge for the partnership with only some cases being good or better. Commonly there was a lack of multi-agency content, minimal analysis of key events and lack of detail overall.

Staff lacked confidence in completion of chronologies in the new templates despite supportive partnership briefings aimed at addressing this. Guidance relating to this was only recently implemented. Frontline managers were confident staff saw the benefits of new chronologies but that the quality and consistency needed more time to embed. Importantly, frontline managers were unsure if completion of chronologies was included in council officer training. The partnership recognised this, and their expanding public protection learning and development team made this a priority area for continued improvement.

Risk assessments

After our last inspection, the partnership moved rapidly to reinvigorate use of the TILS (type, imminence, likelihood, severity) framework for risk assessment. In our review of progress, we saw this impacted positively on the presence and quality of risk assessments. Commendably, all adults at risk of harm in our sample had a risk assessment. In 2022 only some risk assessments were evaluated good or better; this rose considerably to most in 2024. While this was a positive indicator of improvement, the partnership needed to remain focussed on consistency because the remaining risk assessments lacked detail and analysis. Senior social workers provided oversight of council officer risk assessments and intervened appropriately to support council officer practice most of the time.

There was evidence of risk being dynamically assessed across the adult at risk of harm's journey, although multi-agency input into risk assessments was variable. A potentially effective multi-agency escalation process was in place but under used. Its use was being reviewed at the time of the progress review to strengthen integrated working. When partners attended case conferences, the adult at risk benefitted from multi-agency risk assessment thus demonstrating the value of close collaboration.

The partnership carried out briefings for staff to reinforce the requirement for risk assessments, but staff questioned the effectiveness of them. There was no multi-agency risk assessment training available. Staff were learning on the job and building up knowledge over time through experience.

Risk management plans

The refreshed inquiry templates developed by the partnership supported council officers to effectively record risk management plans. Positively, all adults in our progress review sample had a risk management plan. The quality had substantially improved from just under half being good or better in 2022 to almost all in 2024. At their best, plans were comprehensive and SMART (specific, measurable, achievable, realistic and timebound). They were multi-agency and where necessary, linked well with other public protection processes such as MAPPA (multi agency public protection arrangements) and the Care Programme Approach.

The partnership made **some progress** in managing the area of risk. There was more work to be done to improve the quality of chronologies. The partnership made sound improvement to the quality of risk assessments, with plans for this to continue. Refreshed inquiry templates were useful and had supported improvement in council officer practice, particularly risk management plans. We were assured that the partnership identified the need for multi-agency training on risk assessment and chronologies. This was planned and will support inexperienced staff.

Key processes priority area for improvement 2

The partnership should carry out prompt adult protection investigations for all adults at risk who require them.

Investigations

Introduction of the new duty to inquire with investigative powers template impacted positively on council officer investigatory practice. There was significant improvement in recording and application of the three-point criteria. In 2022 this was recorded in only a few cases but in our 2024 progress review it was evident in almost all of the sample. Clear analysis accompanied decision-making most of the time.

A council officer was involved in all investigations. All investigations were carried out in a timescale in keeping with the needs of the adult at risk of harm. This was a positive improvement from 2022 when most were carried out timeously, and significant delays were noted in some. Quality of investigations had significantly improved with almost all of the sample at good or better in quality in 2024. Overall, council officers were positive about the duty to inquire with investigative powers template. They considered this to be supportive to good investigatory practice and consistency in approach.

More detailed recording of interviews with adults at risk of harm and relevant others would strengthen the rationale for decision-making. It would also make sure the adult at risk of harm's voice was central to the investigatory process. Most adults at risk of harm, in our sample, who needed a capacity assessment from health were referred by social work. Improvement was needed in health professionals completing assessments timeously. Positively, the partnership developed a learning resource covering "formal capacity assessments: the essentials". It was yet to be implemented.

The recently introduced interagency procedure included guidance on joint visits. This was not yet fully embedded in practice. Despite this, a second worker was deployed to the investigation almost every time. This was commonly a health professional who would bring expertise to the risk assessment. Where police were involved in joint visits, it was typically because there was a perceived risk to council officers.

Multi-agency investigation planning would have been more effective if use of the long-established interagency referral discussion (IRD) process was better applied. It allowed for IRDs at any stage of proceedings but relied on partners separately inputting agency information onto an electronic system rather than consistently hosting actual tripartite discussions. While health staff supported this arrangement with an IRD rota, it was disjointed. Health staff on the rota did not always have easy access to the right information at the right time. They felt they were 'junior partners' in the IRD process. The NHS Lothian public protection team advisors, who had knowledge and skills suitable to participate in interagency referral discussions, were unable to take part. They were spread thinly across the Lothians and with a heavy training workload.

Crucially, council officers leading investigations did not have access to the system and were unable to see important IRD information, causing frustration. Council officers would sometimes only get this information upon receipt of interim vulnerable person's database reports shared by police.

There was a separate process whereby senior practitioners in the social care direct response team discussed cases that may suit an IRD with a designated police constable. While this supported early decision-making between social work and police, health staff were mostly absent and this approach undermined the established process.

The partnership made **significant progress** in carrying out inquiries with investigative powers. Commendably, all investigations were completed timeously. The duty to inquire with investigative powers template had supported significant improvements in the quality and consistency of council officer practice. Notably, recording application of the three-point criteria had increased significantly. Clearer and more consistent recording of engagement with adults at risk of harm was required. As was stronger evidence of multi-agency planning for and participation in investigations. The interagency referral discussion was not used to best effect and should be addressed.

Key processes priority area for improvement 3

The partnership should take steps to improve the quality of adult protection case conferences. It had undertaken improvements by creating additional posts for minute takers. It was too early to tell the impact of this.

Case conferences

Since the last inspection the partnership prioritised improving the quality of case conferences. All case conferences for the adults at risk of harm in our sample effectively determined what needed to be done to ensure the adult was safe, protected and supported. The overall quality of case conferences had risen significantly since 2022. In 2024, the quality of almost all case conferences in our sample, was good or better

Senior social work staff led a review of the pressure on frontline staff delivering adult support and protection activities. This included the high volume of case conferences that peaked in August 2023 at over 150. This impacted on capacity including minute-takers, chairs, stakeholder attendance and council officer preparation for and attendance at case conferences. Commendably, the new arrangements promoted conversations between senior social worker staff, council officers and senior social workers to consider appropriate thresholds for progression to case conference. Our progress review found this work was beginning to impact with the volume of case conferences stabilising around 60 per month. This was a significant turnaround that created capacity in the system.

The partnership purposefully increased the staffing resource to support case conferences. Five adult support and protection senior practitioner posts were established with three filled and two vacant. Their purpose was to chair all initial and first review case conferences. These impacted positively bringing more consistency and increased independence. Both of which were valued by staff. There was considerable pressure on the senior practitioner role, and at times it was not manageable. This drew in senior social workers and put pressure on them. When all five senior practitioners are appointed, the benefits of this approach will be fully realised.

Despite resource challenges, the partnership convened case conferences for almost all adults at risk of harm, in our sample, who needed one. Case conferences were mostly convened within appropriate timescales. Police and health professionals were not always invited when they should have been. More positively, when invited, police and health staff almost always attended. This indicated good progress since our last inspection. The police information submitted for case conferences was variable in quality, often being cut and pasted from the interagency referral discussion limiting its usefulness. Case conference minutes were seldom evident in health records limiting clarity of the helpful role they often played.

Adults at risk of harm were invited to case conferences most of the time. When not, the reasons were not always recorded, which was a similar picture to our last inspection. Unpaid carers were invited all the time and almost always attended. The adults in our sample who attended were all effectively supported to participate. Positively, the offer of independent advocacy had increased and those who accepted received a timely service.

The partnership routinely conducted a “restricted” part of the meeting prior to the adult at risk of harm being invited to join, meaning they could have an anxious wait. There was a need to consider a more trauma informed approach.

Following our last inspection three case conference minute takers were appointed. A survey completed by chairs at the conclusion of case conferences showed steady progress in reducing the amount of case conferences having to be recorded by council officers or their seniors. Staff also noted improvement in quality of minutes and welcomed the more truncated template that had been introduced. Less positively, delays in circulation of minutes was a challenge. A recent 48 hour performance target was put in place for circulation of protection plans, but it was too early to tell if this was impacting positively.

The partnership had made **significant progress** in the quality of case conferences. Since August 2023, the partnership had prioritised improvement in the quality of case conferences. The oversight and priority afforded to this work was clear and commendable. The quality and consistency of approach had improved, and determinations were accurate. Attendance was positive. Chairing and minuting commitments were positive, but the full benefits had yet to be realised. Achieving a trauma informed approach to case conferences would further improve the adult at risk of harm's experience.

Strategic leadership priority area for improvement 4

Social work services faced the challenge of 30 social worker vacancies in adult services. This impacted adversely on adult support and protection operations, self-evaluation, and quality assurance activity. Social work leaders should work to increase the service's capacity to carry out adult support and protection work promptly, effectively and efficiently.

Social work capacity

Edinburgh health and social care partnership had successfully prioritised the recruitment and retention of social work staff since 2022. Various effective approaches were deployed by strategic leaders to address this challenge.

The chief officer of the integration joint board established a workforce board to provide governance and accountability in relation to recruitment, retention, scrutiny of vacancies and sickness absence across the partnership. This included a specific focus on social worker vacancies. A report, relating to the areas of focus above, was submitted to the workforce board in June 2024 about progress. The report was challenging to deliver but provided managers with comprehensive and wide-reaching analysis across a range of recruitment and retention measures. While this level of detailed analysis was not requiring to be regularly reported, the social work vacancy and recruitment rate continued to be reported monthly. Systems to support comprehensive data collection and analysis are critical for ongoing senior leader oversight of recruitment and retention challenges.

Senior social work leaders adopted a whole system approach to understanding council officer capacity and the effective delivery of adult support and protection activity. They ensured that statutory foundations were in place across the service to support key elements of practice. Root cause analysis work showed that adults remained in the adult support and protection process too long, impacting council officer caseloads and limiting capacity for allocation. Senior social workers and council officers were being overwhelmed and the quality of adult support and protection was affected. The measures the senior social work leaders took to direct and support staff positively addressed the capacity challenges and impact on practice. For example, the social worker vacancy rate reducing from 26% in February 2023 to 8% in April 2024. This

curbed reliance on agency staff down from 26.5 whole time equivalent posts in February 2023 to less than five at the time of our progress review.

Staff acknowledged vacancies were being filled but the impact was still filtering down to adult support and protection work. The partnership introduced a student hub which supported students during their placements in Edinburgh City. This innovation yielded some positive results with seven of them applying to adult posts in the health and social care partnership. While this was positive, staff recognised that supporting newly qualified social workers brought additional demands on their time. Also, they needed to complete one year post qualifying experience prior to undertaking level three council officer training.

That said, there was a clear improving picture with adult support and protection inquiries being prioritised and allocated timeously. The social care direct team supported this. Adult protection referrals were appropriately screened and duty to inquire without investigative powers completed by them.

The partnership made **significant progress** working to increase the service's capacity to carry out adult support and protection work promptly, effectively and efficiently. It was clear by the numbers provided and innovation applied that recruitment gaps were being effectively filled. While not all the additional capacity went towards adult support and protection activity the overall quality of key processes showed considerable improvement. Understandably, staff continued to feel pressured, and uncertain about future changes. The partnership should be sensitive to this and develop systems capable of producing reliable workforce information to support future change.

Strategic leadership priority area for improvement 5

The partnership's strategic leaders should ensure there is consistent, competent, effective adult support and protection practice that keeps adults at risk of harm safe and delivers improvements to their health and wellbeing.

Ensuring consistent, competent, and effective adult support and protection practice

The partnership focussed on strengthening senior social work oversight of adult support and protection. In 2023, the health and social care partnership established the improvement plan oversight group to oversee required developments. This was jointly chaired by the chief officer of the integrated joint board and the chief social work officer thus emphasising the priority given to improvement work. The approach effectively began to evidence positive results. It evidenced an understanding of the critical need for a senior social work manager to lead improvement in adult support and protection, with rigour, consistency and pace across the city.

In August 2023, social work governance was strengthened by the appointment of a new, impactful post of principal social worker. They oversaw a root cause analysis of adult support and protection key processes that began to affect positive change. This was strengthened by engagement between senior social workers and senior practitioners through forums such as the adult support and protection supportive leadership forum and adult support and protection operational oversight group. Much needed interagency adult support and protection procedures were introduced, and these were ratified by the chief officers' group in July 2024.

In November 2023, other key health and social care partnership posts were filled by social workers. This further strengthened social work leadership in the partnership. There was a clear understanding of the improvement challenges facing the partnership and a drive for improvement. Significantly, the chief social work officer was also the director of performance, quality and improvement, therefore ideally positioned to oversee and hold accountability for improvement in adult support and protection practice. A quality assurance framework supported this role but was only recently developed and was in the early stages of implementation. The health and social care partnership recently appointed to the new post of head of service for assessment and care management. The postholder also functioned as deputy chief social work officer.

The comprehensive adult protection committee improvement plan clearly aligned to the priority areas for improvement set out in the inspection report, and steady progress was made on most areas. It was evident that progress was regularly reported and reviewed by the chief officers' group. The partnership had recently appointed an independent convenor for the adult protection committee. That prompted swift engaged with the challenges including approval to revise the adult support and protection committee subgroup structure. This approach was sound in its intention to deliver tangible improvements. To support continuous improvement and development, the critical post of adult support and protection lead officer post had recently been filled. An early focus for the postholder was improving the quality of performance and data reporting to the adult protection committee. This was aligned to the national minimum dataset.

A restructure was progressing in the Edinburgh health and social care partnership that caused anxiety amongst staff. The loss of managers in localities and reduction in the level of social work managers above them created gaps. Strategic leaders explained that the next stage of the restructure would address any management gaps and include consultation with senior social workers. Strategic leaders were aware of these views and held a briefing event that over 100 staff attended.

The partnership made **significant progress** in strategic leaders ensuring effective adult support and protection practice. This was evident from record reading and feedback from staff. The health and social care partnership took positive steps to review the position and then strengthen social work leadership. Experienced social workers were appointed to key senior posts in the partnership. They undertook important joint work that impacted positively on service delivery. The amount of progress they made in collaboration with the adult protection committee over a short time was commendable. This model is critical to the partnership's success in achieving long-term sustainability and improvement.

Strategic leadership priority area for improvement 6

The partnership should prioritise recommencement of multi-agency audits of adult support and protection records, quality assurance and self-evaluation activities for adult support and protection.

Quality assurance and self-evaluation

The adult protection committee had a well-developed plan to carry out regular multi-agency audits. The approach ensured 72 cases would be audited every year. This was a robust approach. The partnership trialled the approach in recent months and was in the early stages of implementation with some frontline managers purposefully contributing. The quality assurance subcommittee of the adult support and protection committee developed an "end to end" multi-agency assurance process. This approach facilitated self-evaluation across key areas of the adult protection process. The quality assurance subcommittee aimed to review key areas twice annually to ensure oversight and progress.

Importantly, while the multi-agency approach was in development, the partnership undertook comprehensive single agency audits as a means of ensuring they were sighted on quality of adult support and protection activity. They focussed on fundamental adult support and protection practice. Single agency social work audits provided progress updates for senior leaders who effectively drove improvements in key practice areas including application of the three-point criteria; risk assessment; investigations; case conferences and middle manager oversight.

Six bi-monthly audits of social work adult support and protection practice took place since 2023. A total of 140 cases were audited by quality assurance officers and team managers. This provided the adult protection committee with important information about the quality of practice. The purpose of this audit activity was shared with staff through a briefing paper. This paper was trauma aware. It acknowledged that case file audit can be anxiety provoking for frontline workers. The briefing paper successfully communicated the balance between assurance, learning and continuous improvement to staff. Staff were aware of the audit activity but had not directly taken part. It would strengthen the partnership's approach to audit to include frontline staff in audit. This would contribute to developing a culture of continuous improvement at all levels of the organisation.

Social work adult services carried out an audit of interagency referral discussions held between February and April 2024. This was valuable work which effectively set out strengths and learning themes. It was notable that the partnership already had an interagency referral discussion review group that met every two weeks. The group comprised multi-agency managers and was ideally placed to carry out multi-agency audit and report findings to the adult protection committee.

We found the partnership had improved quality assurance at frontline manager level since the last inspection. Almost all social work records read evidenced management oversight throughout the case and supervisory decisions and discussions. On some occasions there was evidence of frontline managers intervening to improve quality of decision making and recording by council officers.

The partnership made **some progress** restarting multi-agency audits, self-evaluation and quality assurance activities. Our review of progress found social work audits were well-embedded and delivering improved oversight. They provided valuable performance information for the adult protection committee. The partnership had a dedicated adult support and protection committee quality assurance subgroup, and it had a sound multi-agency plan in place. This was in the early stages of implementation.

Strategic leadership priority area for improvement 7

The adult protection committee should ensure it has direct representation from adults at risk of harm and their unpaid carers. Thus, it would benefit from their lived experience of adult support and protection.

Engaging adults with lived experience

Our review of progress found the adult protection committee had made little progress in this important area. The partnership acknowledged that this was an on-going challenge. They referenced work carried out by advocacy partners to gather feedback from adults at risk of harm, however, there was no evidence of this informing the adult support and protection committee's decision-making.

The newly appointed independent convenor of the adult protection committee led a restructure of the adult support and protection committee subcommittees. A new subcommittee was to be established to address the gap in lived experience of adults at risk of harm. This group aimed to gather the views and experiences of adults at risk of harm and unpaid carers, and report to the adult protection committee. It was unclear exactly how this would work in practice. Staff were not aware of the plan for the subcommittee and their possible involvement. More positively, a chair from the voluntary sector was identified to advance this work.

The partnership made **minimal progress** in ensuring direct representation in the adult protection committee and associated structure. The partnership had considerable work to do to make sure that their discussions and decisions are fully informed by the interests and concerns of adults at risk of harm.

Summary of progress

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

Since 2022 the partnership made steady progress improving key processes. Refreshed duty to inquire templates were implemented quickly post-inspection. These templates were now commonly used in practice and supported improved council officer practice in most areas where weak practice previously existed.

While clear improvement was needed with the consistency and quality of chronologies, steady progress was evident across the other key priority areas for improvement. The partnership had supported this with refreshed tools and templates, staff briefings and a commitment to address capacity issues. New posts and approaches were created to strengthen case conference activity and well-structured operational audits oversaw the quality of frontline social work practice.

The partnership have work to do to improve the morale of staff. The refreshed guidance was only recently introduced and should be accompanied with training to increase confidence and consistency. Interagency referral discussions have the potential to significantly strengthen risk management processes. This process should be reviewed and amended to ensure a more comprehensive and cohesive multi-agency approach.

The quality of health recording of adult support and protection was mostly good or better. That said, there was room for improvement. It could be difficult to find evidence of health involvement and there was inconsistency in recording practice standards. Case conference minutes were frequently absent from health records.

Key strategic leadership progress including findings out with the priority areas for improvement

Since 2022, the health and social care partnership had considerably strengthened the senior social work leadership team and the adult protection committee. Key posts, including that of principal social worker, were added to the structure. These made a significant impact to adult support and protection leadership and governance within a relatively short timeframe.

There was a subsequent review of adult support and protection processes, linked to the adult protection committee improvement plan. Decisive measures were taken to address gaps in practice. Priority areas of practice were identified, and resources made available to address them. Internal audit work effectively tracked progress. Tangible progress was evident because of all these measures.

While this was positive, more emphasis needs to be focussed on strengthening aspects of multi-agency practice. There are gaps in key areas of practice where closer joint working and information sharing will support the management of risk including interagency referral discussions and self-evaluation activity.

Attention is also needed to consolidate the good social work recruitment work being done. This should be aimed at supporting experienced staff and new recruits to ensure they have access to the guidance and training that will make them proficient in their work.

Next steps

The Care Inspectorate 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. The partnership should accelerate plans to implement their multi-agency self-evaluation plans. Our quality improvement framework is a tool for consideration that would support this work. The national implementation, user voice subgroup recently produced national guidance for involving adults at risk of harm in case conferences. The partnership should consider this as they strive to make case conferences more trauma informed. Interagency referral discussion processes have had long standing challenges that the partnership would clearly benefit from addressing. The partnership is effectively recruiting and strengthening social work governance. This is impactful and should be supported to promote a sustainable long-term approach to change and improvement.

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

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.gov.scot
Care Inspectorate Enquiries: 0345 600 9527

@careinspect careinspectorate