JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION: REVIEW OF PROGRESS

in the South Ayrshire partnership area

Published October 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[1] 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 36 members of staff from South Ayrshire 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%

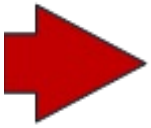
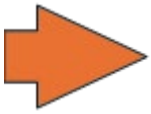
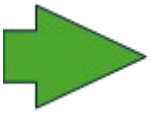
Some – 20% - 39%

Few – 1% - 19%

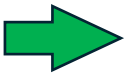
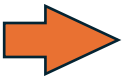
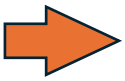
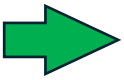
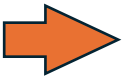
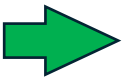
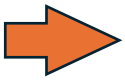
Progress

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 South Ayrshire

Priority areas for improvement from Phase 1 in June 2022		Progress	Progress review findings in September 2024
1	Management of risk for adults at risk of harm including chronologies, risk assessments, and protection plans required improvement.		Significant progress made
2	Social work should involve police and health in adult protection investigations when required. Investigation reports should set out clearly how staff conducted investigations, including interviews with the adult at risk of harm and other parties.		Some progress made
3	Social work should always convene an adult protection case conference when necessary. Social work should invite police and health when required. They should attend when invited.		Some progress made
4	Social work leaders should ensure standards of adult support and protection practices are consistently good, and operational management is sound and effective.		Significant progress made
5	Quality assurance, audit and improvement were minimal for adult support and protection. The partnership should urgently make sure these important activities expand appropriately.		Some progress made
6	The partnership's chief officers' group and its adult protection committee should put robust measures in place to closely monitor adult support and protection practice. They should act decisively to rectify problems when they arise.		Significant progress made
7	Adults at risk of harms' lived experience did not inform the adult protection committee. The partnership should improve in this area.		Some progress made

Significant progress	Some progress	Minimal progress

Progress on priority areas for improvement

Priority area for improvement 1

Management of risk for adults at risk of harm including chronologies, risk assessments, and protection plans required improvement.

Chronologies

The partnership recognised chronologies was a key area for improvement. Positively, almost every record contained a chronology which indicated good progress, but overall, the quality remained weak. Chronologies frequently contained adult support and protection referral information and some general emails from staff. They should be more focussed on protection concerns and accurately reflect the adult's relevant life events and/or past trauma.

Managers and frontline staff acknowledged the limitations of the IT recording system in place. Over reliance on this system to pull through relevant dates and not having a standard chronology template hampered progress. This caused uncertainty amongst staff completing them and undermined assessing of risk. Recent audits undertaken by the partnership echoed our findings and showed the quality of chronologies needed to be improved. They were at the early stages of commissioning a new system. The partnership took positive steps by providing chronology training to staff, but more needed done to address the challenges.

In response to the audit findings, chronologies were discussed in social work staff supervision to drive further improvement. Other positive improvement measures included the re-established council officers' forum where staff shared their suggestions for further improvements and had an active voice in the change process. Chronologies remained a standing item on the adult protection committee improvement plan. This provided effective monitoring of overall progress across these areas of work.

Risk assessment

Almost all adults at risk of harm records included a risk assessment. This was comparable to our first inspection. Importantly, those completed were timely and in keeping with the needs of the adult at risk of harm. They were consistently informed by the views of multi-agency partners. The quality of this critical area of adult support and protection activity had improved significantly.

To drive this improvement, the partnership commissioned and delivered training to staff on managing risk. This impacted on the improvements we found. Feedback from staff indicated improved confidence in managing risks for adults at risk of harm.

A refreshed template implemented since the last inspection sat in the investigation process and supported the accuracy and quality of risk assessments. Newly implemented frontline managerial oversight arrangements further improved decision making and risk management. While most staff liked this more formal approach and strongly agreed the recording template was helpful, a few felt further structure was required. These measures taken by the adult protection committee made a positive difference to the quality of work in this critical area of practice.

Protection Plans

Almost all adults at risk of harm had up to date protection plans. Most of those completed clearly identified the contributions of multi-agency partners and were of good quality. They were mostly SMART (specific, measurable, achievable, relevant and time-bound). These were all measures of good progress made by the partnership. The digital protection plan template implemented by the partnership was clear, comprehensive, and supported accurate work.

The template was well set out in the updated 2022 adult support and protection procedures and the partnership provided additional training for staff. The impact of these measures improved the consistency and accuracy of recording. The partnership strengthened its use of adult support and protection core groups to oversee and manage case conference protection plans. They effectively ensured that protection plans were routinely reviewed and updated. Staff strongly agreed that adults were kept safe and well engaged in protection planning activity.

We found **significant progress** was made in the key area of managing risk. Chronologies, risk assessments and protection plans were consistently applied. The quality of these core key processes was much improved since the last inspection. The quality of chronologies remained an area for improvement.

Priority area for improvement 2

Social work should involve police and health in adult protection investigations when required. Investigation reports should set out clearly how staff conducted investigations, including interviews with the adult at risk of harm and other parties.

Almost all the adults at risk of harm records we read included completed investigations, effectively determined if the adult was at risk of harm and were conducted in a timely manner in keeping with the needs of the adults at risk of harm. The quality of investigations had significantly improved, and most were rated good or better. To strengthen this area of practice the partnership embedded a new template for investigations that improved practice. Investigatory steps including visits to the adult and gathering the views of the family were explicitly laid out. A short-term working group was established after the last inspection. It effectively oversaw all revisions to key processes relating to inquiry and investigation progress.

As well as overseeing the implementation of new templates, a training programme was implemented for staff related to all adult support and protection key processes. Procedural guidance was also amended to include a dual operational frontline manager sign off process. This ensured staff experienced effective managerial support in decision making throughout the adult support and protection process. This resulted in improved decision making and governance. The recently introduced principal social work officer role strengthened work across these areas of practice and brought about greater consistency of practice.

Whilst the quality and consistency of the adult support and protection investigations had improved, police colleagues needed to be more routinely involved in the investigative process. In some of the adult investigations, social work did not involve the appropriate parties, particularly the police where criminality was a feature. Some records showed that where financial harm was committed, staff were unsure of the procedure relating to police involvement. Amongst some social work staff contact arrangements with the police were unclear with some accessing advice and support through the wellbeing hub, rather than the concern hub. Importantly, even when police were alerted about harm they did not consistently intervene or respond. Police procedures relating to criminality remained a key priority area for improvement from our phase 1 inspection.

We found **some progress** in this priority area for improvement. The partnership robustly undertook adult support and protection investigations and significantly improved their quality. A refreshed template drove positive change and clearly set out how staff conducted investigations. These positive steps were undermined by the inconsistent involvement of the police. This remained an area for improvement. The involvement of all partner agencies is critical to the effective mitigation of risk and harm.

Priority area for improvement 3

Social work should always convene an adult protection case conference when necessary. Social work should invite police and health when required. They should attend when invited.

The quality of case conferences was much improved since our last inspection with the quality of most being good or better. All case conferences effectively determined the necessary actions to support and protect adults at risk of harm. To achieve this, the partnership recently established principal social worker posts in each locality with responsibility for chairing adult support and protection case conferences. They received specific training aligned to refreshed procedural guidance for staff that defined their role. The principal social worker also provided additional oversight by reviewing investigations not proceeding to case conference, strengthening confidence in decision making.

A quarterly peer review audit tool was completed by the principal social worker that enabled the partnership to assess the quality of case conferences and encourage a culture of self-reflection and continuous improvement. Furthermore, adult support and protection procedures were revised so chairs consistently requested chronologies prior to convening a case conference. Staff agreed this supported a more robust approach to decision making, risk management and oversight.

Positively, all adults at risk of harm were invited to their case conference and the reasons for not attending was clearly recorded in the minute. The attendance of representatives appointed on behalf of the adult were also well recorded. Almost all case conferences were convened when needed and mostly in keeping with the needs of the adult at risk of harm. Training provided by the partnership to those with responsibility for accurately recording case conferences was impactful and the minutes were circulated promptly. These approaches were welcomed positively by staff involved.

The attendance of relevant partners invited remained mixed. Health partners were consistently invited and attended, indicating sound improvement from our last inspection. Police representation remained an area for improvement. Police were not consistently invited to case conferences when they should have been. When they were invited, the frequency of their attendance was mixed. This affected the strength of collaboration and communication regarding risk. Records of case conferences were lacking in police records making it unclear how they followed up their case conference protection plan responsibilities.

All review adult support and protection case conferences took place when required. Most review case conferences convened took place without delay, and almost always determined actions to keep the adult safe.

We found **some progress** was made in terms of convening case conferences when necessary. Both presence and the quality of case conference had improved. Determinations made at case conferences were always accurate. Both invites made to the police, and their subsequent attendance when invited, remained areas for improvement. Police attendance at case conference is critical to protection planning in matters relating to criminality. Protection is significantly undermined when they are not present.

Priority area for improvement 4

Social work leaders should ensure standards of adult support and protection practice are consistently good, and operational management is sound and effective.

Commendably, the partnership had succeeded in strengthening oversight of adult support and protection practice. The partnership invested resources and supported this with the necessary structural and procedural changes. For example, the principal social worker role and team leaders' joint decision making throughout the inquiry, investigation and case conferences processes worked effectively. Almost all records in social work services evidenced line management oversight, thus demonstrating the strength of the new working arrangements. The new investigation template was instrumental in driving significant improvement. The design, and dual team manager sign off arrangements strengthened operational oversight. It enabled the partnership to evidence decision making and actions in adult support and protection activity that were not in place during our first inspection. The revision of critical key processes and procedures for adult support and protection was a necessary improvement that augmented good practice.

Various training was also commissioned by the partnership. For example, social work staff received training in risk management and chronologies to address the identified areas for improvement.

The strategic leadership team promoted a culture of self-improvement, continuous learning and professional curiosity across social work services. Most managers underwent training in continuous improvement. The partnership made trauma informed practice a central focus across adult support and protection work.

In addition to social work, health had strengthened its strategic and operational roles considerably. That said, health records needed to better evidence the adult support and protection work they engaged in. Health partners carried out adult support and protection awareness events and training in both the community and acute services. More recently, health staff had completed second worker training. Feedback from training was positive, with staff reporting increased confidence.

We found **significant progress** was made to ensure the standard of social work adult support and protection practices was of consistently good quality. The leadership team effectively implemented and oversaw much change which ensured impactful improvement was generated.

Priority area for improvement 5

Quality assurance, improvement and audit were minimal for adult support and protection. The partnership should urgently make sure these important activities expand appropriately.

The partnership implemented an adult support and protection improvement plan to oversee and address all the identified areas for improvement, including its approach to self-evaluation and quality assurance. In a positive step, the adult protection committee reviewed its subgroups to drive change, re-focus their approach to improvement, and ensure proportionate representation existed. Progress updates from subgroups were noted at every adult protection committee meeting. The subgroup framework supported more effective governance, scrutiny, and monitoring. The subgroup with responsibility for overseeing the annual audit framework agreed by the committee was critical to this and performed its role effectively.

There was an audit and self-evaluation framework in place. An audit schedule included single agency thematic adult support and protection audits every six months including chronologies, investigations, case conferences and risk assessment. There was good evidence of both health and social work single agency audit activity. The framework also included plans for annual multi-agency audits. While these were positive steps, there was no audit activity that included the police. This limited the partnership's ability to identify and address the critical weaknesses we saw reading records. Also, staff were not routinely involved in any audit activity due to the demand on frontline services. This was a missed opportunity to involve staff in the successful change management work we saw. Their involvement would further strengthen the value of such a framework.

Both the adult protection committee and the chief officers' group received quarterly performance reports compiled by principal social workers. They were well-crafted reports that kept strategic leaders informed of current practice. The reports provided an overview and analysis of all adult protection audit activity across all teams. Resultingly, effective decisions that drove improvement were being taken by the leadership team and were making a positive difference to the overall quality of practice across adult support and protection. Strategic leaders were positively addressing the need to become more learning focussed and were successfully applying this to deliver change and improvement.

We found **some progress** was made through single agency audits of key processes. Planned multi-agency self-evaluation approaches were also embedded in the improvement framework. The approach was structured and generated improvement. The adult protection committee and chief officers' group provided effective oversight. Health was a strong supporting partner, but self-evaluation activities lacked police and staff involvement. This weakened the strength of the approach overall and needed addressed.

Priority area for improvement 6

The partnership's chief officers' group and its adult protection committee should put robust measures in place to closely monitor adult support and protection practice. They should act decisively to rectify problems when they arise.

The chief officers' group was appropriately plugged into the health and social care partnership's health and care governance group, social work governance group and NHS Ayrshire and Arran's governance committee. This ensured good cross cutting arrangements were in place.

The recently appointed convenor of the adult protection committee initiated a broad consultation with staff, services users, and other relevant partners to review the adult protection committee role and function. This was a positive step that led to restructuring of subgroups, and new approaches. For example, including provision of an induction pack for all new members of the adult protection committee. The adult protection committee convenor, adult protection lead officer and the chief officers' group worked together in tandem to strengthen adult support and protection and were represented at council officer and other partnership forums.

These close working relationships provided the impetus for a new approach to improvement work across the partnership. There was investment in new roles within the leadership team for adult support and protection. New operational management roles in both health and social care had been established. Three principal social workers and three clinical nurse managers with a specific focus to drive change and enhance the quality and oversight in adult support and protection work were created. Principal social work officers conducted quarterly peer reviews of adult protection case conferences, and they considered cases not progressing to case conference. Training for all staff in key areas of practice was implemented. Frontline manager oversight was strengthened, and changes to practice were captured in refreshed procedures.

As part of NHS public protection services remodelling, the role of associate nurse director was created to provide strategic leadership for adult support and protection. The NHS Public Protection Accountability and Assurance Framework Toolkit was in use, and self-evaluation work was carried out informing the NHS Ayrshire and Arran improvement plan.

Police Scotland's strategic leadership team in this divisional area was subject to frequent changes, over a lengthy period, negatively impacting on the consistency of operational adult support and protection activity. There was a reduction of management oversight in police records and supervisory comments were not meaningful or relevant. Additionally, feedback from focus group reported police staff struggled to participate in multi-agency training opportunities.

We found **significant progress** was made overall. The chief officers' group and adult protection committee worked well together and had put robust measures in place to strengthen their oversight and response to improvement actions. There was evidence of multiple initiatives that were effective but these were limited because not all partnership areas were equally involved. Police Scotland had work to do to ensure robust measures in place to closely monitor adult support and protection practice.

Priority area for improvement 7

The lived experience of adults at risk of harm did not inform the adult protection committee. The partnership should improve in this area.

The adult protection committee convenor led several engagement sessions involving adults with lived experience, and frontline staff. There was a strong commitment to better involve adults at risk of harm and their unpaid carers in the work of the adult protection committee. Both the adult protection committee and subgroups actively sought representation and reviewed their efforts. Positively, there was a strong emphasis on trauma informed practice throughout the committee's work.

The adult protection committee actively invited adults with lived experience to attend with mixed success. As an interim alternative measure, they used case studies to bring lived experience to life at their meetings to ensure decisions made were through the lens of the adult at risk. The adult protection committee noted this approach positively influenced discussions and decision making at meetings helping to shape and inform their work. The committee actively sought other new opportunities for adults with lived experience and their carers to inform and contribute including digital options. Initiatives being explored were at the pilot stage and required further evaluation. Further engagement sessions with adults and staff were planned to include discussions at partnership locality forums with wider stakeholders.

The partnership had made **some progress** to include the views of adults with lived experience on the committee. The partnership was exploring options thoroughly but had yet to adopt a well-structured approach.

Summary of progress

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

In response to the 2021 inspection, the partnership commendably oversaw significant improvement in almost all key areas for improvement including investigations, risk assessments, protection plans and case conferences. The drivers for change were initiated by decisions made by the strategic leadership team and overseen by staff from across the partnership.

The approach to improvement was sound and well structured. The partnership had a firm understanding of what needed to improve and clearly laid this out in their improvement plan. Capacity and resources were prioritised, new roles developed, tools and templates re-designed, operational guidance revised, and operational oversight strengthened considerably. Training for staff supported these initiatives and there was evidence of progress assessment and refinement.

Thematic audits of work in key areas of adult protection practice showed progress was being made and our findings concur with this.

Police Scotland's operational contribution needs improved. Key partners need to better understand when and where it is appropriate to engage police colleagues in issues relating to criminality. And in response, the police need to better respond to requests for assistance.

Strategic leadership progress including findings out with priority areas for improvement.

The partnership's strategic leadership team had made significant progress to improving the overall quality of adult support and protection working practices. New key leadership roles were initiated and there was much needed change to their adult protection committee structure. As a result, the leadership team was more accurately sighted on the performance of adult protection work.

Leadership was founded on strong collaboration and a culture of continuous improvement and learning. Strategic leads empowered staff to drive improvement initiatives and clearly prioritised the work. Investment in frontline and strategic oversight through robust audit activity and reflection opportunities had proved successful in driving improvement.

Areas of focus for strategic leaders include undertaking their planned multi-agency self-evaluation activity. Police partners should collaborate in this activity and also ensure single agency audit work is carried out and reported to the adult protection committee and chief officers' group where appropriate. The chief officers' group should ensure this. Work is also needed to ensure that the voice of lived experience is reflected more strongly to the adult protection committee to better support operational and strategic change and improvement activity.

Next steps

The Care Inspectorate's link inspector will continue to engage with the partnership to inform future improvement work. HMICS will arrange to discuss continuing priority areas for improvement with the partnership. The partnership should ensure it is represented on the National Implementation Group's chronology subgroup so that it partakes in the learning opportunities this forum presents. This will support improvement in this area of practice.

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