JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Moray Partnership June 2022

Contents

Map showing divisional concern hubs

Joint inspection of adult support and protection in the Moray partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead these joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual local partnership[1] areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017-2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the Moray partnership area were safe, protected and supported.

The joint inspection of the Moray partnership took place between March and May 2022. The Moray partnership and all others across Scotland faced the unprecedented and ongoing challenges of recovery and remobilisation as a result of the Covid-19 pandemic. We appreciate the Moray partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

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

Progress statements

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

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

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

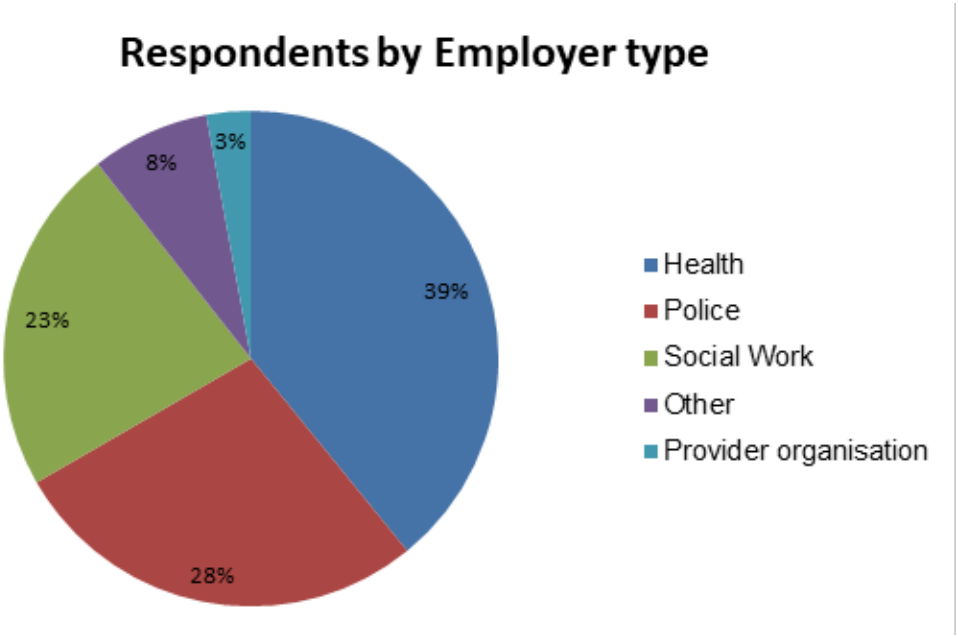
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

Joint inspection methodology

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

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

Staff survey. Two hundred and seven staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

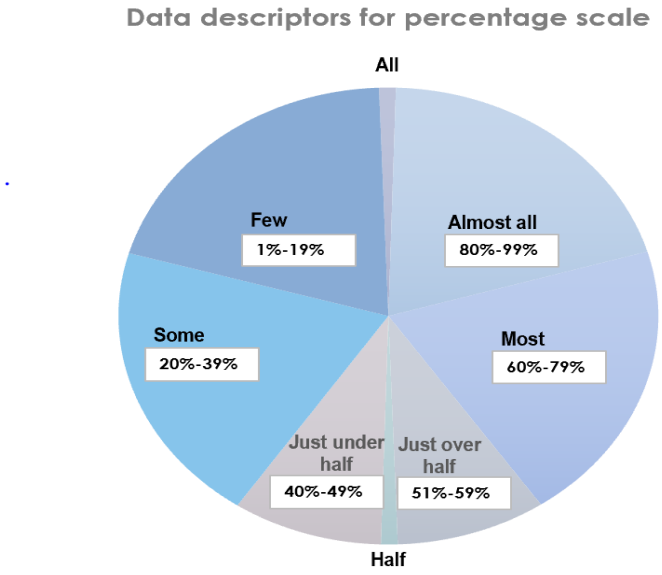


The scrutiny of social work records of adults at risk of harm. This involved the records of 40 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 50 adults at risk of harm where their adult protection journey progressed to at least the investigation stage.

Staff focus groups. We carried out two focus groups and met with 21 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm. This also provided us with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Standard terms for percentage ranges



Summary – strengths and priority areas for improvement

Strengths

- Partnership staff were committed to improving the safety, health, and wellbeing of adults at risk of harm.
- The involvement of health and police in operational practice supported good outcomes for adults at risk of harm. Staff from these agencies were sharing information appropriately in every instance where they had involvement.
- The partnership supported the adult at risk's involvement in adult support and protection processes. The collaborative work with advocacy was strong.
- Following a self-evaluation exercise, the partnership restructured its Access team. This resulted in a more effective approach to triage and screening of initial inquiries.
- The partnership's approach to assessments of capacity was timely and effective.
- Strategic leaders collaborated well to ensure that adult support and protection was a priority during the pandemic. This enabled leaders to begin implementing the partnership's improvement plan at a challenging time.

Priority areas for improvement

- 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 partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them.
- 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.
- 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 should prioritise the full implementation of the improvement plan. Strategic leaders should ensure that the appropriate resources are made available.

- 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.

- 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.

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

Key messages

- Prior to December 2021 Moray HSCP did not have operational adult support and protection guidance. This was a significant gap. It is not clear how strategic and operational management could be confident that practice was being delivered in line with statutory duties.

- The partnership's approach to screening and triage of adult support and protection concerns was effective. The partnership progressed initial inquiries within appropriate timescales, communicated effectively with key partners, and almost always evidenced managerial oversight of the screening and decision-making process.

- The partnership's approach to assessments of capacity was effective. Where required, a formal request for a capacity assessment was made on almost every occasion. In almost all instances, a timely assessment that met the needs of the adult at risk of harm was carried out by a health professional.

- Police demonstrated a high level of performance in their response and triaging of adult support and protection concerns.

- Recording of adult protection key processes in social work and health records was inconsistent and should be improved. This would support consistent decision making and demonstrate the contribution staff were making to outcomes for adults at risk of harm.

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

- The partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them. This would ensure adults at risk of harm and their individual circumstances are fully considered to inform decision-making and planning.

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

We concluded the partnership's key processes for adult support and protection had important areas of weakness that could adversely affect experiences and outcomes for adults at risk of harm. There were substantial areas for improvement.

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

The Access social work team was the single point of contact for all initial concerns and referrals. Following a self-evaluation exercise in 2019, the partnership streamlined the screening process. All adult social work practitioners were responsible for screening and triaging referrals. They were doing so effectively and there was shared responsibility for decision making. Most staff reported that these new arrangements had improved practice.

Initial inquiries into concerns about adults at risk of harm

The quality of initial inquiries was good or better for just over half of adults at risk of harm. Those that were evaluated less positively lacked structure, and the decision-making processes were unclear.

The introduction of operational guidance in December 2021 required all initial inquiries to be formally recorded using a new screening document which included the use of Initial Referral Discussions (IRDs) to support decision making. This was a recent development and it was too early to assess the full impact of this change. However, most staff reported high confidence in the handling of inquiries. The partnership should continue to monitor the quality of the recording of adult support and protection practice at the initial inquiry stage. This will drive greater consistency, improve recording and support better decision making.

In almost all cases, initial inquiries were dealt with in line with the principles of the Adult Support and Protection (Scotland) Act 2007, and the three-point test was applied correctly, although this was not always recorded. The partnership progressed initial inquiries within appropriate timescales, communicated effectively with key partners, and almost always evidenced managerial oversight of the screening and decision-making process.

A few cases that should have progressed beyond initial inquiry to the investigation stage did not. This possibly meant that the adult protection partnership did not offer the right level of protection or ensure the right outcome for this small population of adults at risk of harm.

Investigation and risk management

Chronologies

Chronologies are a key element of risk assessment and risk management. The partnership had identified chronologies as an area for improvement and this was consistent with our findings.

Most adults at risk who required a chronology did not have one. Where there was a chronology, 39% were good or better and, significantly, 38% were weak. Chronologies were used inconsistently. They provided an overview of service led interventions rather than an account of significant life events, with little or no analysis.

The partnership developed a multi-agency approach and tool for producing chronologies as part of their new local guidance. This supported better information sharing amongst adult support and protection professionals and informed risk assessment and management processes. It was too early to evaluate the impact of this measure on outcomes for adults at risk of harm.

Risk assessments

Risk assessments were completed for just over half of adults at risk of harm. All adults at risk of harm subject to adult support and protection procedures should have a risk assessment to support and safeguard them effectively. This is an area of critical practice that the partnership should prioritise for improvement work.

More positively, when risk assessments were completed, the quality of these was good or better in most cases and took account of other agencies' views. Almost all were completed in a timescale in keeping with the adults' needs.

The partnership developed a multi-disciplinary complex risk assessment tool. When applied, risk was assessed effectively. Risk assessments had recently been updated to include a risk matrix which facilitated the consideration of likelihood, severity and impact. This strengthened their effectiveness. However, this tool was only completed at the case conference stage, with no consistent approach to assessing risk at earlier stages in the adults' support and protection journey.

Full investigations

Effective adult support and protection investigations ensure that adults at risk of harm and their individual circumstances are fully considered to inform decision-making and planning. An investigation was not carried out for just under half of all adults at risk of harm who required one. Without effective investigation, it was not clear how social work had ensured that the adult at risk was aware of their rights.

When carried out, the quality of investigations was good or better for half of the adults at risk of harm, indicating further room for improvement. Almost all investigations were done in a timescale in keeping with the adults' needs and involved appropriate parties. A second worker was deployed in all investigations where it was deemed appropriate. Health professionals undertook this role on most occasions where appropriate.

Almost all investigations, that were done, effectively determined if the adult was at risk of harm. But a significant few did not. To ensure that adult support and protection practice is in line with legislation, the partnership should ensure it carries out full investigations for all adults at risk of harm who require them. This would ensure that the adult's risk of harm and their individual circumstances are fully considered and inform the protection decision-making process.

Adult protection case conferences

A case conference was convened for just over half of all adults at risk of harm who required one but, significantly, some were not convened when required. Adult protection professionals' meetings were sometimes convened in place of case conferences. Professional meetings were sporadic and took place at different parts of the adult protection process. Sometimes, a series of professionals' meetings took place, when the adult at risk would have clearly benefitted from a proper case conference and review case conference. Professionals' meetings considered risk and safety planning but did not routinely involve the adult at risk of harm. Case conferences and review case conferences should be more clearly defined and be convened for all adults at risk of harm who require them. The practice of convening adult support and protection professionals' meetings is not supported within the new operational guidance.

The quality and effectiveness of case conferences was good or better in almost all cases. When convened, case conferences were almost always timely, and effectively determined what needed to be done to ensure the adult at risk of harm was safe and supported. For all case conferences that took place, the relevant professionals were always invited, but the adults at risk were only invited to just under half of case conferences. When invited, adults at risk attended case conferences on most occasions and, in all cases, there was good support for them to be involved in the process. Positively, when the adults chose not to attend, their views were represented by advocacy. However, for just over half of adults at risk, the reason for not inviting them to case conference was not recorded in the case conference minutes.

Adult protection plans / risk management plans

Most adults at risk of harm who needed a risk management/protection plan had one. Significantly, some did not. For adults at risk of harm with no

protection plan, the outcomes and extent to which risk was effectively managed could not be fully determined.

When completed, almost all protection plans were up to date and clearly identified the contributions of multi-agency partners. In most cases, risk was considered and managed appropriately for adults at risk of harm, and protection plans were rated as good or better. Significantly, concerns were not adequately dealt with for 26% of adults at risk of harm.

Adult protection review case conferences

The partnership convened review case conferences for just under half of the adults at risk of harm who required one. This was an area for improvement. The partnership should strengthen its adult support and protection processes to ensure that, where adults at risk of harm require a review case conference, this is facilitated. The introduction of the 2021 operational guidance should support this.

When the partnership convened review case conferences, almost all effectively determined what was needed to be done to ensure the adult at risk of harm was safe and protected.

Implementation / effectiveness of adult protection plans

Protection planning following case conference was effective, and the multi-disciplinary approach to managing risk contributed to positive outcomes. However, for adults at risk whose support and protection journey did not reach the case conference stage, implementation of risk management plans was inconsistent. Overall, there was room for improvement in the consistency of recording and how SMART all protection plans were.

Large-scale investigations

Large-scale investigations were carried out in line with the Grampian-wide protocol which was refreshed in 2021. They were collaborative and included all appropriate agencies, including the Care Inspectorate. There was regular communication with residents and families, and care homes had an active role in developing the improvement action plan.

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

Overall effectiveness of collaborative working

Staff from all partner agencies, including those who worked in the third and independent sectors, were identified as being source contributors to concern referrals for adults at risk of harm. In almost all instances, staff were working collaboratively and most had a sufficient understanding of the role of other agencies in delivering adult support and protection.

There was a good level of interaction and collaboration amongst partners in delivering the local response to adult support and protection. However, whilst the partnership understood the importance of achieving positive outcomes for adults at risk of harm, greater evidence of a shared embedded approach and consistency in delivery of key processes may have been expected.

Health involvement in adult support and protection

NHS Grampian appointed an ASP nurse practitioner to support operational delivery of adult support and protection and a public protection lead who had a strategic function. These posts were well positioned to lead on the improvements required.

Almost all health staff indicated that they fully understood their role in relation to adult support and protection. They were confident about raising or escalating adult protection concerns appropriately. Most health staff were aware of the three-point test and how it applied to adults at risk of harm.

In almost all cases, health professionals were sharing information appropriately and had attended almost every case conference that they were invited to. When a referral was initiated by health, feedback was provided by social work regarding the outcome of the referral most of the time. The recently introduced single point of contact for health should strengthen the contribution of health professionals at the initial inquiry stage of adult support and protection.

In all cases where there was evidence of repeat adult protection related presentations to emergency departments, the response by health professionals was rated good or better. Interventions were mixed for adults at risk of harm who were re-admitted to hospital and for those subject to repeat referrals for community health services.

When present, the quality of adult protection recordings in health records was good or better in just over half of cases. This needed to be addressed and the health board should explore ways to improve how adult protection interventions are recorded. This should aid the partnership to better govern

the contribution health professionals were making to outcomes for adults at risk of harm.

Capacity and assessment of capacity

Commendably, on almost every occasion that a formal request for a capacity assessment was made, this was promptly carried out by a health professional.

The recently introduced Grampian-wide Decision-Specific Capacity Assessment Tool was innovative and strengthened the partnership's approach to assessment of capacity.

Police involvement in adult support and protection

All contacts made to the police about adults at risk of harm were effectively assessed by officers and staff for threat of harm, risk, investigative opportunity, and vulnerability (THRIVE). Almost all cases had an accurate STORM Disposal Code (record of incident type).

Initial attending officers' actions were good or better on almost all occasions, with evidence of appropriate interventions and meaningful contribution to the multi-agency response. In all cases, the assessment of risk of harm, vulnerability and wellbeing was accurate and informative, and the wishes and feelings of the adult were carefully considered and recorded.

Where adult concerns were referred to the hub, officers did so swiftly in every instance, using the Interim Vulnerable Person's Database (iVPD).

Almost all records showed evidence of frontline supervisory footprint, and this contribution was good or better in just over half of cases reviewed. There were occasions where greater detail of the supervisory input on the assessment and management of risk may have been expected. This included cases that were more complex.

Divisional Concern Hub staff actions and records were good or better in most instances, with a resilience matrix containing a well-developed narrative in support of police concerns recorded in every case. There was evidence of research, considered assessment, and input by hub staff, and on every occasion the iVPD referral was shared swiftly with partners.

Where the escalation protocol was initiated due to repeat police involvement, there was evidence of it being used effectively, including some records where supervisory action was viewed as being very good or better. In these cases, the level of detail recorded, actions taken with partners, and transparency of decision making was of a high standard.

The use of adult support and protection trigger plans (pre-agreed interventions) was evident. These were developed in collaboration with partners in response to escalating circumstances and supported a consistent response and meaningful intervention. This approach was recognised as being good practice.

Initial Referral Discussions (IRDs) have recently been introduced within the partnership. The introduction of IRDs should help enhance local information sharing and decision making across the professionals group. Where IRDs were held, the policing contribution was good or better on all occasions.

Police attended all case conferences, when invited. The contribution of officers was viewed as being good or better in most instances.

Third sector and independent sector provider involvement

The third sector was represented on the Moray adult support and protection committee and had a key role in keeping adults at risk of harm safe and protected. Staff from the third sector were making appropriate adult support and protection referrals and attended all adult protection case conferences when invited. Where adults at risk of harm required additional health and social care support, the third sector played a pivotal role in providing this.

Key adult support and protection practices

Information sharing

Whilst there was evidence of adult support and protection partners sharing information in almost all instances, the recording of information shared during adult support and protection key processes was inconsistent. Significantly, the level of recording in some cases was not in keeping with the needs of the adult at risk of harm. In these instances, interventions were recorded in emails between staff, and it was not clear from these emails how adults at risk of harm had progressed through the key stages of adult support and protection.

The new operational guidance for adult support and protection provided a robust framework to support stakeholders to share information effectively at all key stages. This was yet to be fully embedded into practice, and the partnership should continue exploring ways to ensure staff are supported to consistently apply the new guidance. The Advanced Practitioner for ASP introduced in September 2021 was well placed to support the improvements required. This included sharing information at the right stage of the adult support and protection process, to inform better decision making.

Management oversight and governance

There was evidence of management oversight in almost all police records and most social work records. Evidence of governance was less apparent in health records. This was not necessarily a deficit, due to the types of health records scrutinised.

In most cases, decisions and discussions from supervision were recorded in social work records and there was evidence that the line manager had periodically read the records in just over half of cases.

Involvement and support for adults at risk of harm

When adults at risk of harm were involved, they were appropriately consulted on almost every occasion and their views were considered at every stage of their adult support and protection journey. The support provided to adults at risk of harm was mostly effective, and where potential barriers to engagement had been identified, these were almost always addressed appropriately.

Unpaid carers had been involved and consulted on most occasions when it was appropriate to do so. When unpaid carers were not consulted, the reasons for not involving them should have been recorded more clearly.

Independent advocacy

Independent advocacy was offered appropriately on most occasions. In most instances, the offer was accepted and advocacy was provided. The provision of advocacy was almost always timely, and in almost all instances it was evident that advocacy had supported the adult at risk to articulate their views.

Some adults at risk of harm who would have benefitted from independent advocacy support did not receive it. This included cases where input would have helped to ensure rights were protected, communication supported, and the process better understood.

Financial harm and alleged perpetrators of all types of harm

There was evidence of financial harm in a few cases. In each of these, the partnership had intervened appropriately to stop the harm. In almost all, the partnership response was collaborative and had included appropriate multi-agency partners.

In most instances, the partnership response to financial harm was effective. However, there were some cases where the risk of financial harm could have been explored further at the investigation stage.

The partnership effectively undertook work with the perpetrator in most cases when required. This included implementation of a banning order to keep the adult at risk of harm safe.

Safety outcomes for adults at risk of harm

The partnership had supported improvements to safety and protection of adults at risk in almost all instances. This was mainly due to effective multi-agency collaboration. When required, additional support for adults at risk was always provided. In most cases this support was effective.

Significantly, a few adults had experienced poor outcomes. For half of these adults, this was due to lack of social work involvement at the appropriate stage of the adult's support and protection journey.

Adult support and protection training

Staff training and development was identified as one of the key priorities in the partnership's improvement plan. The Grampian 'Protecting Adults: learning and development strategic framework' was the overarching guidance for training and development. This was supplemented by the training for adult support and protection health and social guidance.

Initial learning and development plans were affected by the pandemic over

the last few years. The new framework provided a solid platform for the partnership to address the training needs identified in a recent multi-agency training needs analysis. A range of bespoke training was planned for staff, including council officer training, enhanced training for health staff attending case conferences, and access to online training for staff from the third sectors.

Commendably, the partnership had implemented adult support and protection training for staff recruited as Covid-19 vaccinators and contact tracers. This was excellent practice. These newly recruited staff were often the only in-person contact for members of the public. It was vital that they were able to confidently identify potential adults at risk of harm and respond accordingly.

Most staff were confident about the level of mandatory training provided by the partnership. In all cases, they felt this training had improved their knowledge, skills, and confidence to undertake their adult protection roles in relation to adult support and protection. Staff were less positive about their experiences of multi-agency training and development opportunities.

The partnership hosted an end of year 'adult support and protection live' event to update staff and reflect on recent developments and future planning. This was a positive example of staff engagement. There was good attendance from multi-agency staff, including those who work for third sector organisations. Positively, the partnership adopted an innovative and modern approach, using interactive technology to engage staff and gather feedback to inform improvement. The event was received well by staff and strengthened visibility of the leadership team. There were plans to build on this.

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

Key messages

- The partnership's vison for adult support and protection was clear and well understood by staff.
- Strategic leaders delivered an integrated and robust response to the Covid-19 pandemic. This reflected a collaborative ethos in the partnership.
- The partnership started implementing its improvement plan at a challenging time, resulting in new adult protection operational guidance and improvements to access arrangements. There was evidence of early progress, but a lack of resource had adversely impacted on progressing change.
- Prior to December 2021, Moray HSCP did not have operational adult support and protection guidance. This was a significant gap. It is not clear how strategic and operational management could be confident that practice was delivered in line with statutory duties.
- Strategic leaders' governance of adult support and protection was a significant area for improvement. Effective governance would have picked up that critical areas of key processes were not implemented.
- Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement.

We concluded the partnership's strategic leadership for adult support and protection was effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

Vision and strategy

The partnership had a clear vision for adult support and protection. Its focus was on raising awareness of adult protection and promoting early intervention and prevention. The partnership did not have a strategy specific to adult support and protection. The priorities for adult support and protection in Moray were set out in the adult support and protection multi-agency improvement plan.

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

Operational guidance for adult support and protection practice in Moray was implemented in December 2021. It was a significant gap that this was not in place before then and it is not clear how strategic and operational management could be confident that practice was being delivered in line with statutory duties.

The chief officer's group oversaw all public protection groups in Moray, including adult support and protection. Both they and the adult protection committee had appropriate multi-agency representation. The chief officer's group had recently completed a leadership survey based on the Care Inspectorate quality indicator framework. While the findings of the survey were broadly positive, around one third of members identified areas for improvement. The majority considered that there was not sufficient staffing capacity to meet the needs of adults at risk of harm.

When strategic groups convened, the meetings were quorate with evidence of collaborative discussions. Despite effective frameworks in place, the partnership needed to strengthen governance of adult support and protection in Moray. Important weaknesses in the delivery of adult support and protection key processes showed that strategic leaders needed to do more to implement improvement and to ensure that appropriate action was taken to improve practice.

Recently, strategic leaders decided to formalise the sub-groups supporting the function of the adult protection committee. This included establishing a planning and performance sub-group. This work was still in early development but represented a positive step towards strengthening strategic leaders' oversight of adult support and protection practice. The biennial report 2018-20 detailed that a project manager would support the work of the adult protection committee. This resource had not always been available, with support being provided by an adult protection consultant practitioner who also had significant operational responsibilities.

Strategic leaders delivered an integrated response to the challenges of the pandemic over the past few years. This supported the implementation of stage one of the partnership's improvement plan at a challenging time. As the nation continues to recover from the effects of the pandemic, the

partnership is well placed to build on the early progress already made. Strategic leaders should ensure that improvements in practice are sustainable and leading to positive outcomes for adults at risk of harm.

The care home oversight group had recently introduced the support and monitoring group. This group sought to identify any issues within care homes early, allowing appropriate remedial action to be implemented before issues escalated. Whilst it was too early to assess impact, this was a positive proactive approach that involved multi-agency and external partners.

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

In the 2018 – 2020 biennial report, the partnership highlighted the importance of including the lived experience of the adult at risk of harm at strategic level. While adults at risk of harm and their unpaid carers were not represented on the adult protection committee, the partnership had developed the APC "hear me" sub-group, which was led by the independent advocacy service and involved adults with lived experience.

The sub-group was introduced in March 2022, along with the adult support and protection engagement and communication plan. This provided a framework for involving adults at risk of harm and ensuring their feedback was reported to the adult protection committee. The partnership was well placed to capitalise on these developments and enable feedback from these groups to inform meaningful improvement in adult support and protection policy and practice.

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

Both the strategic leadership team and staff demonstrated a collaborative ethos. Yet, there were significant areas for improvement in the delivery of the partnership's adult support and protection key processes.

There were critical weaknesses across initial inquiries, investigations, assessment of risk, protection plans and adult protection case conferences. Inconsistent application of the Grampian inter-agency procedures meant that adult support and protection processes were often convoluted and did not conform to the standards clearly laid out in the guidance. Too often, staff failed to accurately record the work done to keep adults at risk of harm safe.

The introduction of new operational guidance and improvements to access arrangements was well received. There were early signs of improvement. As the new guidance further embeds into practice, strategic leaders need to strengthen their oversight of adult support and protection. The quality of practice should be closely monitored to ensure key processes are

effectively delivering improved safety outcomes for adults at risk of harm.

The partnership made some key appointments to support the delivery of adult support and protection. A new Consultant Practitioner for adult support and protection was appointed in July 2021. They had a key role to lead change and support staff in the operational delivery of adult support and protection practice. NHS Grampian appointed an adult protection lead who had oversight of adult support and protection across the health board area. These appointments were positive and beginning to make an impact. Strategic leaders acknowledged that important gaps remained. In particular, a strategic lead to support the functions of the adult protection committee, and to coordinate the improvement plan, would be beneficial.

Quality assurance, self-evaluation and improvement activity

The local multi-agency improvement plan was implemented following a multi-agency self-evaluation exercise in 2019. This had identified six priority areas for improvement. This included adult support and protection processes, policies and procedures. However, some areas identified for improvement mirrored those identified in the partnership's 2016 –2018 biennial report. The pace of change and improvement across adult support and protection needed to be accelerated.

Implementation of the improvement plan coincided with the start of the pandemic, which placed partnership resources under a period of sustained pressure. This caused a delay in implementing the plan. Furthermore, there was no consistent project manager in post to coordinate change and drive forward the improvement project. The post was still vacant at the time of our inspection.

Moray HSCP was developing a quality assurance framework. This had paused but, in the advent of the new guidance, there had been some single-agency evaluations of the newly implemented adult support and protection processes and tools.

The police divisional concern hub carried out quality assurance checks on concern reports and NHS Grampian had some quality assurance checks on initial referrals that originated from health. The partnership recognised the need to improve in this area and multi-agency audits were identified as a priority in the improvement plan. Staff did not feel involved in the self-evaluation of their practice. Strategic leaders should develop the role of staff in self-evaluation activity and ensure that they are fully involved in the design and implementation of the proposed improvements. This will add value to future self-evaluation work and strengthen improvement activity in adult support and protection.

The adult protection committee risk register was revised in February 2021. This aligned to the risks identified in the 2018 – 2020 adult support and protection biennial report. The register was reviewed regularly by the adult

protection committee and reported to the chief officers, and some progress had been made in mitigating identified risks.

Initial case reviews and significant case reviews

'The Grampian Adult Protection Serious Case Review and Case Review Protocol' clearly set out the process to be followed when a case had been notified for review. The partnership had received five notifications to be considered for case review in the last two years.

A pan-Grampian external multi-agency significant case review group was recently established. This was at an early stage but provided a good opportunity for partners to consider learning from national significant case reviews, to inform improvements in local practice.

Summary

Moray partnership had a clear vision for adult support and protection. The partnership's priorities were set out in the adult support and protection multi-agency improvement plan. This was the strategic vehicle for delivering the partnership's vision. Partnership staff were committed to improving the safety, health, and wellbeing of adults at risk of harm.

Prior to December 2021, Moray health and social care partnership did not have operational adult support and protection guidance. This was a critical deficit. Strategic and operational management had not ensured practice was delivered in line with statutory duties. Application of the Grampian inter-agency procedures was inconsistent. Combined, this adversely impacted on adult support and protection practice.

Important weaknesses in the delivery of adult support and protection key processes meant that for a significant minority of adults at risk of harm, adult support and protection had potentially not delivered positive outcomes. This was a critical area for improvement. Strategic leaders needed to do more to identify areas for improvement and to ensure that the appropriate action was taken to improve practice.

The Moray partnership response to the pandemic was robust and supportive to practice. This enabled implementation of stage one of the improvement plan at a challenging time. This had resulted in improvements in adult support and protection access arrangements and the implementation of operational guidance in December 2021. The new operational guidance provided a clear structure for practice. More time was needed to assess how well this was being embedded in practice. Responsibility for this rests with the strategic leaders and their ability to effectively capture data, report progress, and govern improvement activity.

The improvement plan was comprehensive and provided a good structure. These improvements needed to be resourced, progressed, and audited, to ensure change was effectively implemented.

Governance structures in the partnership were developing from a low base. The use of the risk register supported leadership to make decisions to mitigate risk. Grampian-wide groups supported the development of practice, and a comprehensive learning and development plan and tool, to support the assessment of capacity. Moray-specific groups required more development and a strategic lead to progress actions.

This partnership made a number of positive changes recently to improve leadership and the delivery of key processes in adult support and protection. The partnership needed to accelerate these changes to ensure adults in Moray are effectively safeguarded.

Next steps

We asked the Moray partnership to prepare an improvement plan to address the priority areas for improvement (see priority areas for improvement we identify). The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and HMICS will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key process 1

Initial inquiries into concerns about adults at risk of harm scrutiny recordings of initial inquiries

- 93% of initial inquiries were in line with the principles of the ASP Act
- 100% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 0% delay in the concern hub passing on concerns by less than one week, 0% were delayed by one to two weeks.
- 58% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 88% of episodes where the three-point test was applied correctly by the HSCP
- 98% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 100% one to two weeks
- 85% of episodes evidenced management oversight of decision making
- 58% of episodes were rated good or better.

Staff survey results on initial inquiries

- 87% concur they are aware of the three-point test and how it applies to adults at risk of harm, 6% did not concur, 6% didn't know
- 72% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 5% did not concur, 23% didn't know
- 78% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 10% did not concur, 12% didn't know

Information sharing among partners for initial inquiries

- 93% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm, staff survey results (purple)

Chronologies

- 27% of adults at risk of harm had a chronology
- 39% of chronologies were rated good or better, 61% adequate or worse

Risk assessment and adult protection plans

- 56% of adults at risk of harm had a risk assessment
- 75% of risk assessments were rated good or better
- 68% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 64% of protection plans were rated good or better, 37% were rated adequate or worse

Full investigations

- 85% of investigations effectively determined if an adult was at risk of harm
- 89% of investigations were carried out timeously
- 52% of investigations were rated good or better

Adult protection case conferences

- 57% were convened when required
- 82% were convened timeously
- 63% were attended by the adult at risk of harm (when invited)
- Police attended 100%, health 94% (when invited)
- 83% of case conferences were rated good or better for quality
- 94% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 44% of review case conferences were convened when required
- 86% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 100% of adult protection concerns were sent to the HSCP in a timely manner
- 82% of inquiry officers' actions were rated good or better
- 78% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 72% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 55% good or better rating for the quality of ASP recording in health records
- 62% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 50 adults at risk of harm and staff survey results (purple)

Information sharing

- 96% of cases evidenced partners sharing information
- 94% of those cases local authority staff shared information appropriately and effectively
- 96% of those cases police shared information appropriately and effectively
- 96% of those cases health staff shared information effectively

Management oversight and governance

- 52% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 74%, police 97%, health 50%

Involvement and support for adults at risk of harm

- 85% of adults at risk of harm had support throughout their adult protection journey
- 69% were rated good or better for overall quality of support to adult at risk of harm
- 77% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 4% did not concur, 18% didn't know

Independent advocacy

- 66% of adults at risk of harm were offered independent advocacy
- 74% of those offered, accepted and received advocacy
- 94% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 81% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 88% of these adults had their capacity assessed by health
- 100% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 14% of adults at risk of harm were subject to financial harm
- 71% of partners' actions to stop financial harm were rated good or better
- 67% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 90% of adults at risk of harm had some improvement for safety and protection
- 97% of adults at risk of harm who needed additional support received it
- 68% concur adults subject to ASP, experience safer quality of life from the support they receive, 7% did not concur, 25% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 62% concur local leaders provide staff with clear vision for their adult support and protection work. 9% did not concur, 29% didn't know

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

- 58% concur local leadership of ASP across partnership is effective, 5% did not concur, 37% didn't know
- 55% concur I feel confident there is effective leadership from adult protection committee, 5% did not concur, 40% didn't know
- 47% concur local leaders work effectively to raise public awareness of ASP, 14% did not concur, 39% didn't know

Quality assurance, self-evaluation, and improvement activity

- 48% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 7% did not concur, 45% didn't know
- 48% concur ASP changes and developments are integrated and well managed across partnership, 7% did not concur, 45% didn't know