JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION: REVIEW OF PROGRESS

In the Western Isles Partnership Area

Published February 2025

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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. We also scrutinised records of 20 initial inquiries, with and without the use of investigatory powers, where the partnership had taken no further action in respect of adult protection activity beyond initial inquiries.

Staff focus groups – We met with 25 members of staff from Western Isles 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%

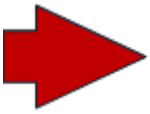
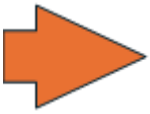
Some – 20% - 39%

Few – 1% - 19%

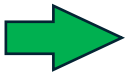
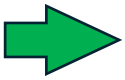
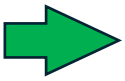
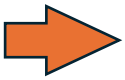
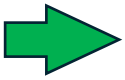
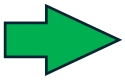
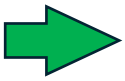
Progress

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. Its deployment and implementation are limited. It has not embedded improvements or they are still at the planning stage. It does not communicate improvements effectively and they are not well understood by staff. It does not assess and review the effectiveness of its improvement progress.
	Some progress	**Evidence of some improvement**. The partnership's approach to improvement is moderate. Its implementation and deployment of improvements are structured. It is beginning to embed improvements in practice. It communicates improvements partially and staff understand them reasonably well. It has limited measures to evaluate and review 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 Western Isles partnership.

Priority areas for improvement from Phase 1 in October 2022		Progress	Progress review findings in October 2024
1	The multi-agency procedures for adult support and protection did not cover all aspects of adult support and protection or fully detail the statutory duties and responsibilities of each agency.		Significant progress made
2	The delivery of key processes was ineffective. Investigation, risk assessment and risk management require significant improvement to effectively support and protect adults at risk of harm.		Significant progress made
3	Delivery and oversight of key processes relied too heavily on a small number of staff. Oversight and business continuity lacked resilience. This needed addressed by the health and social care partnership.		Significant progress made
4	Adults at risk of harm were ineffectively involved and engaged in operational and strategic adult support and protection.		Some progress made
5	There was a lack of multi-agency reporting and governance by the adult protection committee and chief officers' group. Improvement in this area of practice would support more effective delivery of adult support and protection.		Significant progress made
6	All agencies/partners needed to improve their recording of adult support and protection work. This was particularly relevant for social work as the lead agency.		Significant progress made
7	A multi-agency audit was planned to support improvement work. This should put feedback from adults with lived experience, unpaid carers, and frontline practitioners at the centre. Findings from the social work audit should be implemented as a priority.		Significant progress made
Significant progress		**Some progress**	**Minimal progress**

Progress on priority areas for improvement

Priority area for improvement 1

The multi-agency procedures for adult support and protection did not cover all aspects of adult support and protection or fully detail the statutory duties and responsibilities of each agency.

Following the joint inspection of adult support and protection in 2023, the partnership undertook a review of their multi-agency adult support and protection procedures and guidance. This collaborative approach strengthened the collective responsibility of all partners involved in adult support and protection work. The revised procedures and guidance were clearly written, clarifying the duties of health, police, and social work, with clear timescales for the key processes. These were closely aligned to the revised code of practice (2022). The procedures included electronic links prompting important considerations, such as trauma informed practice and national guidance for all key partners.

In addition, the partnership implemented a new social work digital recording system. This was accompanied with a suite of newly designed recording templates that accurately reflected the updated procedures. This enhanced and supported staff in their daily practice.

Staff reported that these changes supported their practice and were positively received. The partnership monitored the positive impact of the procedures through inclusion as a routine item on the adult protection committee (APC) agenda. Their improvement plan was continually reviewed and the partnership implemented changes to the procedures to ensure that they were fit for practice.

We found **significant progress** in this priority area for improvement. The partnership updated and implemented refreshed adult support and protection procedures. A new digital recording system and suite of templates reinforced the approach, which staff complimented. The partnership's own self-evaluation of the impact was positive and concluded that all key partners (health, police, and social work) effectively adhered to the multi-agency procedures. A finding we recognised in our review of progress.

Priority area for improvement 2

The delivery of key processes was ineffective. Investigation, risk assessment and risk management require significant improvement to effectively support and protect adults at risk of harm.

Initial inquiries

Following the last inspection, there had been an increased volume of adult support and protection referrals. Despite this increased pressure, all inquiries clearly applied and recorded the three-point criteria. Almost all evidenced effective communication with partners and management oversight. Almost all of the initial inquires reached the appropriate stage in the adult support and protection process. The quality of most of the initial inquiries were evaluated as good or better, consistent with the evaluation in 2023. Most initial inquiries were completed promptly. Only a few adults were informed they were subject to adult support and protection. Some improvement was needed in this area of practice.

Staff reported they were well supported and understood the inquiry process well. Governance and management oversight was strengthened by the multi-agency initial referral group (IRG). Partners met weekly to review decisions, ensuring all inquiries were robustly assessed and reached the right conclusion. Meetings were accurately recorded, and decisions were consistently documented in the adult's record.

The partnership's revised multi-agency procedures were well designed to ensure that an inquiry was automatically initiated using investigative powers where required. New digital recording templates with mandatory prompts further improved consistency in practice.

Chronologies

Commendably, all records contained a chronology. This was a significant improvement from our 2023 inspection where no records had one. Since then, the partnership had developed a helpful standalone template within the new digital recording system. Positively, this template was used from the initial referral stage and beyond creating an effective foundation for subsequent adult support and protection practice.

That said, there was also a separate chronology used for the ongoing assessment of risk. This template required further work. Clarifying the purpose of each chronology was essential to ensure each served a distinct purpose, prevent duplication and enhance decision making. The newly developed templates were work in progress, and the partnership planned to address this. The overall quality remained weak and was an area requiring further improvement.

There were common factors that affected the quality of chronologies. For example, while the standalone chronology template mostly recorded adult support and protection referral information, chronologies should be more focused on the protection concerns and reflect the adult life events within each referral.

Investigations

All records of adults at risk of harm had a completed investigation. Almost all investigations effectively determined that the adult was at risk of harm, with second workers always deployed including health staff where appropriate. Records consistently evidenced effective partnership working and almost all demonstrated management oversight. Positively, the overall quality of almost all investigations was good or better and all proceeded to a case conference where required. Commendably this was a significant improvement from the last inspection in 2023 where the quality of only some investigations was good or better. There were new mandatory features embedded in the recording system's procedures that strengthened quality, management oversight and multi-agency decision making.

Most investigations were conducted promptly. In a few instances timescales were impacted on for two primary reasons including availability of staff and geographical challenges of delivering protection services in remote and rural areas.

Risk assessment

All records of adults at risk of harm included a risk assessment. Positively, almost all were completed timeously and aligned with the needs of the adult at risk of harm. Almost all were informed and incorporated the views of multi-agency partners and were evaluated as good or better. This critical area of adult support and protection activity had significantly improved. In 2023, just under half of adults at risk of harm had a risk assessment present and only a few risk assessments were evaluated as good or better.

Since the last inspection in 2023, the partnership implemented a new risk assessment template that included a chronology. To support the changes the partnership implemented training for staff, an adult support and protection workshop and risk assessment training. Operational managers collaborated effectively with staff to identify and manage risk during the assessments process. Both approaches had a positive impact on the improvements we observed. Staff confidence in managing and recording risks for adults at risk of harm had grown. Further work on the risk assessment chronology template will accelerate this progress.

Protection plans

Almost all adults at risk of harm had an up-to-date protection plan. Most protection plans clearly identified the contributions of the multi-agency partners with the quality in almost all evaluated as good or better. In 2023, only a few adults' records included a protection

plan, and all were evaluated as weak. The partnership implemented a new template for protection plans which included contingency planning in emergencies. The template was clear, comprehensive, provided good prompts for staff, and supported accurate recording. This template was well set out and complemented the new procedures and guidance. These changes, along with the multi-agency guidance had improved the consistency and quality of protection plans.

This implementation of the digital recording system and the recording templates had positively impacted on the accuracy and quality of the risk assessments. The partnership acknowledged the views were not always made explicit in these templates. They were committed to improving the templates with the explicit inclusion of the adult's views in future updates.

Case conferences

Following the last inspection, the number of case conferences convened had significantly increased. Commendably, all adults at risk of harm were invited to their case conference and the reasons for any non-attendance were clearly recorded in the minutes. The attendance of representatives appointed on behalf of the adult was also well documented. The quality of almost all case conferences was good or better. Most case conferences were convened in keeping with the needs of the adult at risk of harm. The progress review identified that almost all adults experienced an improvement in their circumstances because of adult support and protection. This was another area that has shown improvement since the inspection in 2023.

A procedural change mandated that every completed inquiry using investigation powers automatically proceeded to a case conference. Case conferences were robust and designed to ensure all decisions and practices were reviewed in a multi-agency decision making forum. Health and police partners were always invited and as a result both health and police attendance at case conferences had improved. This process improved the collective response to decision making, ensuring the adult at risk was safe from harm. Additionally, the case conference focused on the adult's involvement in the process. They consistently ensured their views were captured, recorded, and considered during decision making process.

The partnership was reviewing the mandatory feature that initiated case conferences. They were gathering evidence to determine if earlier intervention prevented the need for prolonged engagement in adult support and protection work. The partnership aimed to ensure changes promoted good practice and balanced effective risk management with the least restrictive option for adults at risk of harm.

Almost all adult support and protection review case conferences took place when required, marking a significant increase from the inspection in 2023. All review case conferences that were convened took place. Almost all convened review case conferences effectively determined actions to keep the adult safe.

We found **significant progress** in this priority area for improvement. The partnership addressed the 2023 inspection's priority effectively. New procedures and a digital recording system improved multi-agency management oversight. Staff adherence to these procedures created a more efficient, transparent, and responsive system for supporting and protecting adults at risk of harm. It was evident both the quality and consistency in practice had improved. Ongoing improvement in the quality of chronologies is an area the partnership had identified and was actively working on.

Priority area for improvement 3

Delivery and oversight of key processes relied too heavily on a small number of staff. Oversight and business continuity lacked resilience. This needed addressed by the health and social care partnership.

In the records of adults at risk of harm we saw evidence of effective management oversight in almost all social work records for the adults at risk of harm. This indicated significant progress from the last inspection in 2023. The partnership's effective changes to recording templates increased operational resilience and ensured a more consistent approach. The refreshed multi-agency procedures and guidance was fully implemented and promoted stronger collaboration amongst key partners.

The key partners responsible for adult support and protection united to achieve improvement. They strengthened their approach by communicating and collaborating more effectively in reviewing and implementing the new procedures. All partners actively participated in joint decision making at all stages ensuring all actions were carried out. We saw evidence of this in investigation, case conferences and protection planning activity.

The partnership reset the adult support and protection lead officer's role, filled a key long standing vacant adult protection supporting post and increased business support. These increased resources strengthened and grew capacity of oversight arrangements. The new recording templates embedded in the digital recording system added essential checks and balances that prompted effective management oversight. This improved recording and documentation as a result. Supervision was used purposefully to reflect on practice and hosting monthly adult support and protection meetings to discuss emerging issues promoted continuous improvement.

After the last inspection, the partnership strengthened weekly multi-agency meetings involving police, health and social work. This improved collaboration and oversight at the early stages of decision-making. One meeting, led by the police, reviewed adult referrals for that week emerging from the interim vulnerable person database (iVPD) concerns. The weekly social work initial referral group (IRG) handled the initial inquires that required no further action. This collaborative approach ensured all key partners

ensured appropriate decisions and final sign off from the group. The decisions were documented and evidenced in the records.

NHS Western Isles remodelled to have a public protection service. This provided a single point of access for health staff to access and provided support and guidance regarding adult support and protection. The new multi-agency processes and procedures positively impacted on how the service managed adult support and protection work. These changes improved how adult support and protection work was managed.

Staff confidence in the partnership's approach to adult support and protection work had improved since the last inspection. Staff reported managers as approachable, supportive, and accessible in a blended approach of in person and digital ensuring enough support to all staff in remote and rural areas.

We found **significant progress** in this priority area for improvement. Strategic leaders effectively re-focused and the increased management capacity distributed responsibilities more evenly across management. Improved management oversight promoted a shared approach to decision making. Robust multi-agency forums were strengthened to support staff and ensured consistent service delivery. Training programmes supported the change, and a versatile team was in place to cover multiple roles and responsibilities on an 'as needed' basis.

Priority area for improvement 4

Adults at risk of harm were ineffectively involved and engaged in operational and strategic adult support and protection.

New procedures and templates were designed and implemented to ensure adults at risk of harm were consulted throughout their journey. This created good opportunities for adults to participate in decision-making processes and ensured their voices were heard and valued. Positively, the investigation template made the offer of advocacy mandatory for every adult.

In 2023, just over half of the records of adults at risk of harm showed evidence of people receiving support throughout their adult protection journey, with only some of this support being evaluated as good or better. In 2024, almost all records evidenced good or better support. Additionally, there was an evident improvement in the safety and protection of adults at risk of harm in almost all records read in the progress review

Staff and advocacy services were both very positive about the extent of engagement with adults and the support provided. Staff noted a significant cultural shift in the partnerships operational approach to seeking adults lived experience of adult support and protection since the last inspection.

The partnership had recently introduced a questionnaire for adults at risk of harm with lived experience. This was used to review and improve their operational procedures and guidance. They planned to use this further and report biannually to the adult protection committee. This initiative was new and not yet fully embedded.
Following the last inspection, a new independent convenor was appointed to the adult protection committee (APC). Both the former and the new independent convenors of the adult protection committee acknowledged the challenges linking the views of adults to wider adult protection strategic change and improvement activity. Privacy challenges and rurality issues combined to make the active participation of adults with lived experience in APC work difficult to achieve.

The APC included a representative from the community care forum on the adult protection committee to ensure community voices were heard. They needed to be more explicit and specifically incorporate the voice of lived experiences of carers in adult support and protection. The partnership was very positive about the renewed connection with independent advocacy service, which they integrated to support and develop feedback processes for adults.

Overall, the partnership was committed to raising the profile of adult support and protection within the community. They recognised the need for alternative strategies to ensure initiatives impacted on strategic decisions. This highlighted the importance of continuing to refine their approach and seek additional methods of effectively incorporating these crucial perspectives.

We found **some progress** in this priority area for improvement. Operationally, the partnership had made progress in canvassing the views of adults with lived experience and incorporating feedback by introducing a well-designed questionnaire. This effectively gathered the views of adults at risk of harm, and ensured their voices were heard and considered through the process. Strategic involvement and feedback was at an early stage and needed to develop further. Despite the challenges the partnership was committed to creating opportunities for adult participation in strategic decision-making.

Priority area for improvement 5

There was a lack of multi-agency reporting and governance by the adult protection committee and chief officers' group. Improvement in this area of practice would support more effective delivery of adult support and protection.

After the 2023 inspection, the partnership took steps to enhance multi-agency collaboration and its governance framework. Despite a critical cyber-attack incident, they responded positively and refreshed procedures essential for delivering adult support and protection services. They prioritised adult support and protection resources as well as improvement activities. During recruitment delays, strategic managers took

on additional roles to bridge the gaps and prioritise progress in the adult support and protection improvement plan.

The chief officers' group (COG) and the adult protection committee (APC) strengthened their approach by revisiting their terms of reference and membership to ensure appropriate multi-agency representation. Attendance registers were implemented to monitor participation. These steps enhanced collaboration, decision-making and overall governance measures. Overlapping representation between the COG and APC helpfully linked cross cutting agendas and improved communication between key adult support and protection agencies.

The chief officers' group recently approved a newly structured formal reporting template that strengthened how they evidenced scrutiny. The recently appointed independent convenor to the adult protection committee, also served as the independent chair of the child protection committee (CPC). The chief social work officer and heads of service met monthly and reported feedback to the COG.

The APC increased the frequency of meetings to monitor their improvement plan and address issues more promptly. Consequently, oversight of learning and development and adult quality assurance sub-groups improved. Both had multi-agency representation, a revised terms of reference and meeting structure, to ensure focused and productive outcomes. Improved data analysis was generated through the recent multi-agency audit. This confirmed new procedures were well deployed and kept adults at risk of harm safe overall. The results, shared with the APC and COG, reinforced the effectiveness of the strategies in place whilst highlighting further areas for improvement.

Health partners were more actively involved in all aspects of adult support and protection work. The annual public protection report was linked with the NHS public protection accountability and assurance framework. It was evident that health and police had representation in all aspects of the adult support and protection work.

Following the last inspection, the partnership had implemented a new recording system, which improved the accuracy of data collection and reporting structures. This enhancement provided improved reporting, decision-making and strategic oversight for adults at risk of harm.

We found **Significant progress** in this priority area for improvement. Despite a critical cyber-attack, the partnership successfully implemented a refreshed adult protection committee and sub-committee structure. This strengthened governance and multi-agency working. The structure was well connected into other areas of public protection work. The accuracy of quality reports had improved, and they were being effectively used to drive speedy change and improvement work.

Priority area for improvement 6

All agencies/partners needed to improve their recording of adult support and protection work. This was particularly relevant for social work as the lead agency.

Commendably, the quality of recording in adults' records had improved significantly. In 2023, the quality of information recorded was not adequately maintained. In our review of progress found the quality of information recorded was evaluated as good or better in almost all records. Again in 2023, the management oversight was present in just under half of adults' records. In 2024 management oversight was evident in almost all records, with supervision notes and quality checks throughout the documentation demonstrating thorough scrutiny. The ability to track decisions accurately using information recorded in the social work system had improved significantly. Management oversight clearly drove the overall quality of social work records.

In 2023, health professionals contributed to improved outcomes in less than half of the records. In 2024, their contributions improved outcomes in almost all records. The quality and consistency of the adults' health records also improved significantly. The quality of the recording of adult support and protection work was evaluated as good or better in most records in 2023, and in almost all records in 2024. Information sharing and collaboration in health records were evaluated as good or better in just under half of the adult records, and in almost all records in 2024.

The quality of information recorded in almost all police records was rated good or better, with all police records clearly documenting the wishes and feelings of the adult. From 2023 to our review of progress the quality of police records was high. Almost all records evidenced management oversight and evaluated as good or better. Almost all adult protection concerns were shared promptly. The quality in recording the actions of concerns hub officers needed improvement. In 2023, almost all records were rated good or better, but by 2024, this quality dropped to just under half of the police records.

Overall, across the partnership agencies adult's records were more detailed and comprehensive than in 2023 inspection. Improved clarity made it easier to understand the rationale behind decisions. The new social work digital recording system ensured better data entry, storage, and retrieval, enabling staff to maintain more accurate records. Regular supervision sessions improved the quality and consistency of recording practices. The partnership dip sampled adult records and reported on strengthening management oversight.

We found **significant progress** in this priority area for improvement. The partnership's initiatives enhanced recording quality and established a unified approach to adult support and protection. They implemented effective training programs for staff; standardised recording templates and procedures; and introduced multi-agency audit activity. These measures significantly enhanced the quality of recording and created a more cohesive documentation process.

Priority area for improvement 7

A multi-agency audit was planned to support improvement work. This should put feedback from adults with lived experience, unpaid carers, and frontline practitioners at the centre. Findings from the social work audit should be implemented as a priority.

The partnership created and regularly updated the adult support and protection improvement plan to address all the identified areas for improvement. The recently appointed independent convenor of the adult protection committee (APC) reviewed the membership of the subgroups and their priorities. The multi-agency quality assurance subgroup arranged and carried out a multi-agency audit of all adult support and protection key processes to support their improvement work.

The team included representatives from social work, health, police, and an external representative from a neighbouring partnership. The external involvement of a critical friend added a positive independent lens and additional layer of scrutiny. This robust approach facilitated a culture of shared learning and improvement.

In February 2024, the partnership conducted a staff survey for adult support and protection. It included council officers, social care assessors and business support staff. The results positively showed the new procedures, processes and frameworks provided more clarity and guidance in undertaking adult protection activity. Staff widely acknowledged these changes had informed and progressed their practice, resulting in more concerns being addressed under adult support and protection. This improvement was clearly evident in the record reading results.

The partnership attempted to engage GPs through a questionnaire, but without success. This was followed up at the APC meeting, where they reviewed actions to highlight the role of GPs in adult support and protection, and planned future development work to encourage better engagement.

In March 2024, a service user survey was designed and issued to adults subject to adult support and protection between October 2023 and 2024. This was to capture their lived experience following the implementation of the new procedures. The findings informed the partnership's improvement activity.

In June 2024, the partnership conducted a multi-agency audit to examine the adult support and protection process established with the new procedures introduced in June 2023. The involved 17 records of adults at risk of harm and covered all key processes. The findings were shared with key partners to review and improve their own practices. This collaborative approach ensured each partner actively contributed to enhancing their adult support and protection measures.

We found **significant progress** in this priority area for improvement. The governance and quality assurance are embedded in the multi-agency approach with key partners for self-evaluation. This triangulation approach identified improvements comparable with the findings of the progress review. The commitment to continuous improvement and collaboration among key partners led to more robust and reliable outcomes in adult support and protection.

Summary of progress

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

Following the 2023 inspection, key partners effectively implemented necessary changes in procedures and recording. Despite a critical cyber-attack, increased activity, and limited staffing resources the partnership improved quality and consistency of all key processes as identified in the 2023 inspection. Commendably, the partnership managed the operational challenges well and took forward major improvement activities.

The partnership adopted a multi-agency approach to improvement, prioritising actions, and resources. Amongst these was a new digital recording system that embedded well-designed templates reflecting updated procedures and guidance. Staff demonstrated a strong understanding of these new adult support and protection arrangements, and this was supported by a learning culture. Staff training was prioritised and built confidence.

The unified approach among health, police and social work coordinating their efforts enhanced governance and management oversight to ensure the safety and well-being of adults at risk of harm. This significantly augmented resilience and drove substantial improvements and better outcomes for adults at risk of harm. This collaborative approach led to better outcomes and ensured their needs are met more comprehensively.

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

Following the 2023 inspection, strategic leadership for adult support and protection improved overall. Strategic leaders strengthened their connection and alignment to adult support and protection, sharing common goals and promoting a culture of self-improvement. They made significant progress in enhancing the quality of adult support and protection practices, even during challenging times.

Strategic leaders gained a clearer understanding of adult protection performance through accurate data collection, which enabled better decision-making. New management appointments, including convener, re-focused leadership roles and responsibilities. The adult protection committee was reviewed, and the chief officers' group became more interconnected, achieving better oversight through robust audit and reflection opportunities.

The partnership had improved the feedback from adults with lived experience in matters relating to participation and decision-making. The partnership needed to strengthen how this linked to the work of the APC and strategic change and improvement activity. Despite challenges they are fully committed to enhancing the voices of lived experience.

Using audits and self-evaluation approaches, leaders captured performance data the views of lived experiences and staff, which drove improvements. These efforts were crucial in acknowledging significant progress and need for ongoing work. Strategic leaders planned additional development sessions to maintain the trajectory of continuous improvement in adult support and protection practices.

Next steps

The Care Inspectorate link inspector will continue to engage with the partnership and facilitate the planned development opportunities. The partnership should continue its progress by utilising the quality improvement framework for adult support and protection to guide future self-evaluation and improvement. We have shared the full record reading results with the partnership to inform future improvement work. The partnership should ensure representation on the relevant national implementation group's chronology and the voice of lived experience so that it partakes in the learning opportunities on practice these forums present. This will support improvements in the identified areas of practice.

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This publication is available in alternative formats on request.

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