Item: 11

Policy and Resources Committee: 20 June 2023.

Joint Inspection of Adult Support and Protection.

Joint Report by Chief Executive and Chief Officer, Orkney Health and Social Care Partnership.

1. Purpose of Report

To present the findings from the Care Inspectorate's inspection of Adult Support and Protection.

2. Recommendations

The Committee is invited to note:

2.1.

That, between October 2022 and April 2023, the Orkney Partnership was inspected to ensure that adults at risk of harm in Orkney were safe, protected and supported.

2.2.

That, on 4 April 2023, a joint seminar for Elected Members, Integration Joint Board Members and NHS Orkney Board Members was held to provide feedback following receipt of the draft inspection report.

2.3.

That, on 11 April 2023, the Care Inspectorate published its report of the joint inspection of adult support and protection, attached as Appendix 1 to this report.

2.4.

The key findings arising from the inspection report, summarised in section 4 of this report.

2.5.

That work is progressing to develop the improvement action plan which will be presented to the next meeting of the Policy and Resources Committee, together with a progress update.

3. Background

3.1.

Scottish Ministers requested that the Care Inspectorate lead joint inspections of adult support and protection, in collaboration with Healthcare Improvement Scotland (HIS) and His Majesty's Inspectorate of Constabulary in Scotland (HMICS), across Scotland.

3.2.

The joint inspection took place between 31 October 2022 and 11 April 2023 and reviewed processes and systems to ensure that adults at risk of harm in Orkney were safe, protected and supported. These included:

- Staff survey.
- Meetings with frontline staff and with strategic leadership.
- Scrutinising case files of adults at risk of harm for a two-year period.
- Scrutinising supporting evidence and the position statement.

3.3.

The Care Inspectorate published the Joint Inspection of Adult Support and Protection on 11 April 2023.

4. Key Highlights

4.1.

The Joint Inspection of Adult Support and Protection, attached as Appendix 1 to this report, details a number of strengths including:

- Partnership staff worked collaboratively to support and protect adults at risk of harm.
- The partnership commissioned an independent evaluation of multi-agency adult support and protection processes in 2021. The findings had provided a baseline for some essential improvements.
- The partnership collaborated with a higher education provider to create opportunities for staff to achieve professional social work qualifications. This was an innovative way to address challenging recruitment issues.

4.2.

There are six areas identified as priority areas for improvement, as detailed within Appendix 1:

- Strategic leaders should ensure the delivery of competent and effective adult support and protection key processes for all adults at risk of harm in line with their statutory responsibilities.

- Risk assessment, chronologies, investigations, and protection planning all require immediate improvement.
- Change and improvement following the independent review in 2021 needs to be accelerated. Adult support and protection should be a critical improvement priority for strategic leaders across the partnership.
- The partnership's strategic oversight of progress should be strengthened. Effective governance and quality assurance arrangements are needed to support improvements in practice.
- The involvement of adults at risk of harm at all stages of the adult support and protection process should be improved.
- Strategic planning and decision-making should be informed by the lived experience of adults at risk of harm and their unpaid carers.

4.3.

Work to finalise the improvement plan is progressing. Once completed this will be submitted to the Care Inspectorate and will be presented to Committee regularly to provide assurance that progress is being made.

4.4.

At the joint seminar for Elected Members, Integration Joint Board Members and NHS Orkney Board Members on 4 April 2023 it was advised that work continues to be progressed with embedding the refreshed process and procedures into practice.

5. Corporate Governance

This report relates to the Council complying with governance and scrutiny and therefore does not directly support and contribute to improved outcomes for communities as outlined in the Council Plan and the Local Outcomes Improvement Plan.

6. Financial Implications

There are no immediate financial implications arising from the recommendations contained within this report. Any actions arising from the Improvement Plan must be met from within existing budgets.

7. Legal Aspects

There are no immediate legal implications arising from the recommendations contained within this report.

8. Contact Officers

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9. Appendix

Appendix 1: Joint Inspection of Adult Support and Protection.

care inspectorate

Healthcare Improvement Scotland

HMICS

JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Orkney Partnership April 2023

Contents

Map showing divisional concern hubs

Joint inspection of adult support and protection in the Orkney 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 His 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 Orkney partnership area were safe, protected and supported.

The joint inspection of the Orkney partnership took place between 31 October 2022 and 11 April 2023. We scrutinised the records of adults at risk of harm for a two-year period, November 2020 to November 2022. The Orkney 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 Orkney 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.

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

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.

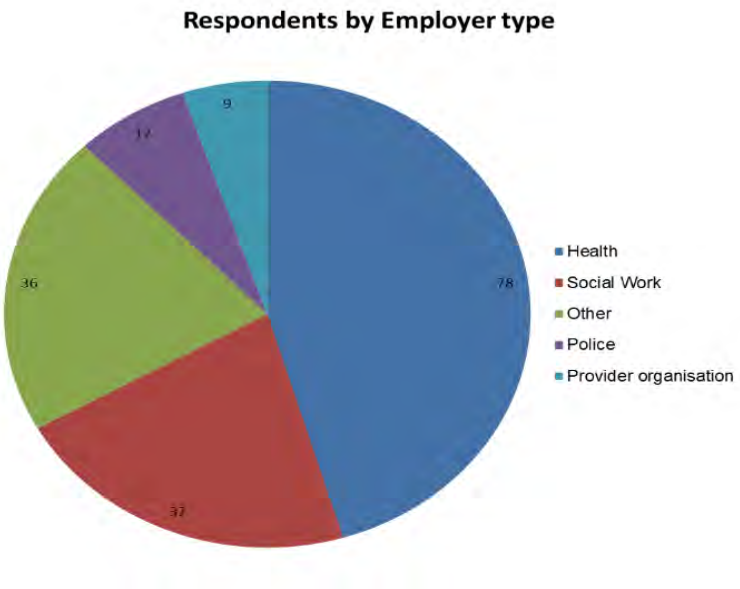
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

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. One hundred and seventy-two 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.

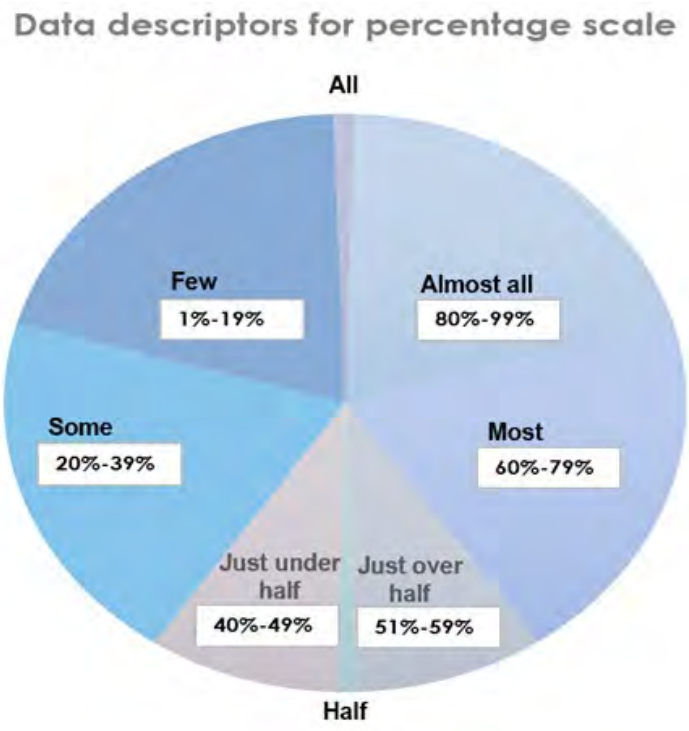


The scrutiny of social work records of adults at risk of harm. This involved the records of 26 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 30 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 a one-to-one discussion. We met with 18 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 worked collaboratively to support and protect adults at risk of harm.
- The partnership commissioned an independent evaluation of multi-agency adult support and protection processes in 2021. The findings had provided a baseline for some essential improvements.
- The partnership collaborated with a higher education provider to create opportunities for staff to achieve professional social work qualifications. This was an innovative way to address challenging recruitment issues.

Priority areas for improvement

- Strategic leaders should ensure the delivery of competent and effective adult support and protection key processes for all adults at risk of harm in line with their statutory responsibilities.
- Risk assessment, chronologies, investigations, and protection planning all require immediate improvement.
- Change and improvement following the independent review in 2021 needs to be accelerated. Adult support and protection should be a critical improvement priority for strategic leaders across the partnership.
- The partnership's strategic oversight of progress should be strengthened. Effective governance and quality assurance arrangements are needed to support improvements in practice.
- The involvement of adults at risk of harm at all stages of the adult support and protection process should be improved.
- Strategic planning and decision-making should be informed by the lived experience of adults at risk of harm and their unpaid carers.

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

Key messages

- Most initial inquiries into the circumstances for adults at risk of harm were competent and effective.
- Multi-agency working and information sharing was evident at all stages of adult support and protection. This included the effective deployment of second workers where appropriate.
- Critical adult support and protection key processes including the assessment and management of risk were not always carried out. This meant some adults at risk of harm did not get the protection they should have had.
- Some adults at risk of harm had poor outcomes because of either lack of social work input or multi-agency working.
- The quality of chronologies, risk assessments, investigations and protection plans were insufficient and should be improved to effectively support adults at risk of harm.
- Adults at risk of harm were not always involved when they should have been. Steps should be taken to improve involvement and how this is recorded in the records.
- Management oversight did not ensure the application of guidance and use of templates. Consistent, effective, and competent practice would improve outcomes for adults at risk of harm.
- Health contributions to outcomes for adults at risk of harm varied. The quality of adult support and protection recordings in health records required improvement.

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

Social work services were designed to receive adult support and protection referrals 24-hours a day. On the day of receipt, a team leader or service manager screened and triaged referrals using the three-point criteria. Multi-agency support for screening was also available 24-hours via Police Scotland and an on-call community psychiatric nurse. The outcome of the screening was recorded on the same form that held the initial referral information. Sometimes this made it difficult to separate information pertaining to the referral from the screening outcome. Team leader vacancies meant decision-making and oversight for adult support and protection were carried out by the same person. This was a vulnerability in the process.

More general adult concern reports were appropriately raised by Police Scotland. These were discussed at a weekly police-led, multi-agency teleconference call. Its purpose was to determine if the adult met the three-point criteria and if the referral should progress under adult support and protection. This arrangement had the potential to support early adult support and protection interventions, but it required some improvement. There were no terms of reference for the meeting which meant the range of outcomes for adults discussed were not defined. The connection with interagency referral discussions was not clear. Agency responsibilities would benefit from being more clearly laid out and understood.

Initial inquiries into concerns about adults at risk of harm

Refreshed multi-agency adult support and protection procedures were launched in September 2021. They included guidance and a template for initial inquiries. It was not consistently used impacting on the quality of work undertaken at this stage. A further revision of procedures was planned for spring 2023 to incorporate the updates from the Adult Support and Protection (Scotland) Act 2007: Code of Practice (2022).

Initial inquiries for adults at risk of harm were almost always dealt with promptly and managed in line with the principles of the Adult Support and Protection (Scotland) 2007 Act. Positively, all inquiries involved sharing information between multi-agency partners. The quality of this communication was good or better in most cases. The three-point criteria was correctly applied in almost all cases but the recording of it needed to improve. The quality of the handling of referrals was good or better in most cases.

For a few adults at risk of harm adult support and protection activity should have progressed beyond the inquiry stage but did not. This was because the level of risk was not sufficiently assessed or addressed. Management oversight was present in almost all cases, but the quality of this required improvement.

An interagency referral discussion or equivalent formed part of a few initial inquiries for adults at risk of harm. The partnership's guidance clearly outlined the threshold for an interagency referral discussion where repeat concerns were raised. However, it was not clear about the circumstances relating to individual cases. This would have supported more consistent practice.

Investigation and risk management

Chronologies

Chronologies for adults at risk of harm are an essential element of risk assessment and risk management. Basic guidance and appropriate templates to support this important area of practice were available. The use of chronologies to support adult support and protection activity was only recently introduced. Almost all adults at risk of harm had a chronology. The quality was variable, with most being weak or unsatisfactory. Mainly because they were not recorded on appropriate templates or did not include critical analysis of risks or events. Those that used an appropriate template were completed to a better standard. This was encouraging and should be built upon.

The partnership acknowledged that more progress was needed. Further guidance and training were required to ensure high-quality chronologies were consistently undertaken. A new template was being tested, this was comprehensive and incorporated a priority rating scale (RAG rating). Full implementation of this template would be a positive addition to practice. If supported by appropriate guidance and training these templates had the potential to become exemplars of effective chronologies.

Risk assessments

Risk assessment is a critical component of adult support and protection. Where present in the records risk assessments were multi-agency informed and timely. Significantly, just under half of adults at risk of harm who required a risk assessment did not have one. Too often the guidance template was not applied, incomplete or lacked detail. This meant that not all risks were fully assessed and considered. Overall, most adults at risk of harm did not have a risk assessment that was fit for purpose. This required improvement.

Full investigations

Adult protection investigations were mostly timely and involved other parties as appropriate. Council officers were always involved and where a second worker was required to support investigations, one was allocated in almost all cases. Adult protection investigations were carried out for most adults at risk of harm who required one. Importantly, this meant that some adults that needed an investigation did not get one. Reasons included a lack of formal documentation, no interview with adult at risk of harm and proceeding straight to a case conference from the initial inquiry stage.

For some adults at risk of harm their adult protection investigation did not effectively determine if they were at risk of harm. Identified risks were not fully considered or the recording was insufficient. The quality of investigations was weak and unsatisfactory in just under half of cases and required improvement. Specifically, council officers needed to ensure all risks were adequately considered, relevant parties involved, and interviews and involvement of the adult were clearly documented. Critically, there were examples where it was not clear the adult at risk of harm was aware they were subject to adult support and protection investigations. The partnership needed to address deficits in investigations to ensure they meet their statutory responsibilities.

Adult protection case conferences

Adult protection case conferences are a valuable multi-agency discussion and decision-making forum. These were almost always convened promptly. Multi-agency partners were mostly invited and attended but there was room for improvement to ensure agencies always work jointly to consider and mitigate risks. Case conferences effectively determined the action required to ensure adults at risk of harm were safe, protected and supported in almost all cases. The quality and effectiveness of case conferences was good or better in most cases. Minutes of the case conferences were circulated to attendees in all cases.

While clear guidance was in place describing when a case conference was required this was not always followed. Some adults who required a case conference did not receive one. Adults at risk of harm were not consistently invited to their case conference. This occurred in just over half of cases. The reasons for this were not always clearly recorded. When invited, adults attended their case conferences most of the time and were appropriately supported in all cases. This was positive. As was the engagement of unpaid carers in case conferences. They were invited in all cases when they should have been and always attended when invited.

Adult protection plans / risk management plans

Most protection plans in place had good multi-agency contributions and almost all were up to date. However, just under half of adults at risk of harm had no documented protection plan. Where present half were weak in quality. Issues included not using the available template, a lack of sufficient detail and not being protection focused. Most adults who required a protection plan to manage or minimise their risks did not have one that was fit for purpose.

Adult protection review case conferences

A small number of adult support and protection review case conferences were required. These were arranged in almost all cases and in a timely manner. They were always effective at identifying the action needed to keep adults at risk of harm safe, protected and supported.

Implementation / effectiveness of adult protection plans

Protection plans did not always include clearly defined outcomes for adults at risk of harm. This made effective implementation of plans difficult. Improving the quality of protection plans will make evaluating outcomes for adults at risk of harm more effective. The partnership was appropriately considering protection orders in its range of measures to address complex adult support and protection work.

Large-scale investigations

One large-scale investigation was carried out within the past two years. This was completed in an appropriate timescale. It involved relevant local partners.

A few adults at risk of harm whose records we read were part of the large-scale investigation. The adult support and protection processes were effectively conducted alongside the large-scale investigation process. Relevant minutes and recordings were available in the adults' records.

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

Overall effectiveness of collaborative working

The refreshed guidance and procedures had strengthened collaborative working over the past two years. They clearly described the roles, responsibilities, and involvement of multi-agency partners at each stage of the adult support and protection process. This resulted in almost all staff understanding their role in relation to adult support and protection. Furthermore, most staff had sufficient understanding of the role of other agencies and agreed they were supported to work collaboratively to achieve positive outcomes for adults at risk of harm. There were clear examples of collaborative working to support adults at risk of harm.

Health involvement in adult support and protection

Almost all health staff knew what to do if they were concerned an adult was at risk of harm. This was clear from the many referrals they made to social work. In almost all cases health received appropriate feedback about the outcome of their referral.

Health staff effectively shared information about adults at risk of harm. Positively, almost all health records provided contained evidence of adult protection concerns. However, the quality of these recordings was mixed and required improvement.

Some investigations required a health member of staff as a second worker, and they were utilised most of the time. Second worker training was required to enable workers to fill this role more confidently. Most health staff agreed training had equipped them with the knowledge, skills, and confidence to undertake their role in relation to adult support and protection. Almost all staff agreed training enabled them to understand risks in the context of adult support and protection. Health was invited to almost all case conferences where appropriate and almost always attended.

Some adults at risk of harm required a medical examination to support risk assessment. When requested health carried out medical examinations every time. In some cases, medical examinations were not requested when they should have been.

A few adults had repeat hospital re-admissions, repeat referrals to community health services and repeat presentations to emergency departments. Actions taken by health staff to support and protect adults were mixed, ranging from very good to weak responses. Health contributions to improved outcomes for adults at risk of harm were mostly good or better.

Capacity and assessment of capacity

Social work requested an assessment of capacity from health in most cases when required. More needed to be done to improve consistency and ensure everyone got access to this crucial opportunity. When requested an appropriate health professional carried out a capacity assessment in a timely manner. Consultant psychiatrist resources were limited making planning an assessment challenging, but processes were effective once arrangements were in place. GPs also provided relevant input.

Police involvement in adult support and protection

Contacts made to the police about adults at risk of harm were always effectively assessed by control room staff for threat, harm, risk, investigative opportunity, vulnerability, and engagement required (THRIVE). Almost all had an accurate STORM Disposal Code (record of incident type).

Officers' actions were good or better in almost all cases. Actions included meaningful interventions to support adults at risk of harm. There was evidence of effective practice and a positive contribution to community response. Officer assessment of risk of harm, vulnerability and wellbeing was accurate and informative in all cases. The wishes and feelings of the adult at risk of harm were almost always appropriately considered and properly recorded.

When required, officers made an onward referral for adults at risk of harm using the interim vulnerable persons database (iVPD). This was done promptly in almost all cases. Frontline supervisory input was included most of the time and their overall contribution was good or better almost all the time.

Divisional concern hub staff actions/records were good or better in most cases. With evidence of meaningful contributions from staff to adult support and protection arrangements, including diligent assessment and research. All cases showed a resilience matrix, with an appropriate narrative reflecting police concerns present in almost all cases. The referral was always shared promptly with partners.

An interagency referral discussion involving the police was held for some adults at risk of harm. Officer contributions were good or better in most of these cases. Opportunities remained for the partnership to better record, share and use the outcome from these meetings. Hub officers also participated in a weekly multi-agency teleconference call to consider and manage police generated adult concern referrals. Improved information pathways would add further value to this arrangement to help ensure that all appropriate adult support and protection related information was effectively disseminated.

Where repeat police involvement triggered the escalation protocol, there was an inconsistent approach. An escalation review was not always carried out when it should have been. Opportunities remained for the local area command team to better evidence strategic input to this element of local adult support and protection arrangements.

Police were invited to almost all case conferences and attended almost all of the time. Involvement was consistently to a good standard with evidence of relevant participation, including management engagement in this part of the process.

Overall, police officers and staff contributed positively to adult support and protection arrangements. Meaningful community outcomes were supported by the delivery of established national policing practice in a local context.

Third sector and independent sector provider involvement

When adults at risk of harm required additional support the third and independent sectors responded effectively. The additional support was comprehensive and effective in most cases. Third and independent sectors were appropriately involved in adult support and protection key processes including interagency referral discussions. This was positive and strengthened collaboration across the partnership.

The partnership recognised they needed to improve the involvement of the third sector at a strategic level and this was reflected in their strategic plans.

Key adult support and protection practices

Information sharing

Adult protection partners shared information appropriately in almost all cases. Interagency referral discussions were a feature for some adult support protection cases. This was a valuable multi-agency forum to share information. Professional meetings were also held in some cases, but the role and function of these meetings was not clearly documented. This made it difficult to understand the purpose of these meetings in relation to the adult support and protection process.

Independent advocacy

Just under half of adults at risk of harm who should have been offered advocacy were provided the opportunity. Where advocacy was offered adults at risk of harm accepted and received this service in just over half of cases. On all occasions where advocacy was accepted the service provision was timely for the adult at risk and made a positive difference. The partnership needed to improve their offer of advocacy services for adults at risk of harm.

The contract with independent advocacy services was recently terminated. An interim arrangement for the provision of advocacy was in place and a retendering process was in progress.

Financial harm and alleged perpetrators of all types of harm

A few adults were at risk of financial harm. The partnership's action to stop the harm was inconsistent. Where the partnership intervened the quality of actions taken to stop the harm was weak or unsatisfactory in most cases. Multi-agency involvement was underused, and the quality of risk assessment and risk management required improvement. The partnership had appropriately identified financial harm as a focus for learning and development in 2023.

There was an alleged perpetrator of harm in just under half of cases. Nearly all the perpetrators were known to the partnership. Action was taken against the alleged perpetrator in just half of the cases. Where this happened the effectiveness of this work was mostly good or better. The partnership undertook work with the alleged perpetrator in just over half of cases when required. Where work was undertaken with perpetrators the quality of the work was good or better in most cases. The partnership needed to ensure opportunities for interventions with alleged perpetrators were considered in all cases.

Safety outcomes for adults at risk of harm

Improvements in the adult at risk of harm's circumstances were identified in most cases. Improvements were mostly due to multi-agency working. Significantly, some adults at risk of harm experienced poor protection outcomes as a result of either poor collaboration between agencies or lack of social work involvement. Outcomes for adults at risk of harm were not always clearly recorded. Available documentation used to record outcomes was not applied in practice. This needed addressed.

Adult support and protection training

The 2021 independent evaluation of adult support and protection highlighted that access to appropriate training was lacking. As a result, the partnership reinvigorated the availability and uptake of adult support and protection training to enable staff to fulfil statutory responsibilities. Positively, this included multi-agency training. Most staff agreed they had access to the right level of mandatory adult support and protection training. Where staff undertook specific adult support and protection training almost all felt it was effective.

Training and development were key strategic priorities for the public protection committee. While this was positive the Orkney Adult Support and Protection Training and Development Plan 2023 lacked detail. Further development to support implementation and staff in understanding their individual learning needs was required. NHS Orkney had developed a draft Public Protection Learning and Development Strategy 2022-2025. While this was not implemented it will help to take this agenda forward.

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

Key messages

- Strategic leaders had ensured there was improved emphasis on adult support and protection since the independent evaluation two years ago. A clear vision was required to focus the partnership and support improved engagement with staff and the public.
- The independent evaluation findings informed the partnership's improvement plan. This outlined a range of necessary work. Overall, some elements had been implemented but progress was slow.
- Strategic leaders needed to ensure initial and significant case reviews were undertaken in line with national guidance. All learning and improvement actions should be clear, measurable, and outlined in the adult support and protection improvement plan.
- Strategic leaders did not effectively oversee the delivery of competent and effective adult support and protection key processes. Critical deficits were known, but action to address matters was limited.
- Strategic planning and service developments were not informed by the lived experience of adults at risk of harm and unpaid carers. Strategic leaders needed to deploy an approach that effectively gathered their views.
- Strategic leaders did not prioritise updates to adult social work business recording systems in line with procedures. The lack of progress affected performance monitoring.

We concluded the partnership's strategic leadership 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.

Vision and strategy

The partnership did not have a vision for adult support and protection. They did have an improvement plan for 2022-2023 which included the key deliverables for the partnership. This plan provided the strategic foundation for adult support and protection work. Prior to this adult support and protection had not been afforded sufficient priority. While this plan had supported some areas of positive change the partnership recognised significant improvement was still required.

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

Orkney public protection committee met quarterly and was appropriately overseen by the chief officers' group. Adult support and protection was a regular agenda item at chief officers' group meetings. In 2021 the Orkney health and social care partnership commissioned an independent evaluation of multi-agency adult support and protection activity and processes. It found deficits in many core aspects of adult support and protection work including procedures, delivery of key processes, training, strategic leadership, knowledge, and recording. Importantly it highlighted staff recognised significant improvement in adult support and protection work was needed.

In response, two development days for members of the chief officers' group, public protection committee and sub-groups took place, and more were planned. This incorporated a review of roles, responsibilities, and culture. This independent evaluation and development work re-emphasised adult support and protection and created the foundation for change. While some strategic priorities had been delivered a number remained outstanding and the pace of change needed accelerated. Staff reflected this with just under half confident in leadership, including the public protection committee. Just under half of staff felt valued for the adult support and protection work they did.

Health staff contributed effectively to operational adult support and protection work. Senior health leaders acknowledged gaps in relation to their specific insight on health performance relating to public protection responsibilities. NHS Orkney planned to carry out self-evaluation using the newly available NHS public protection accountability and assurance framework (2022) as a positive means of addressing this. If carried out this would provide a vital baseline for better understanding their current position and strengthening collaborative leadership. Health leaders needed to ensure they were aware of the scope of the adult support and protection legislation. Particularly in terms of staff legislative responsibilities to raise adult support and protection concerns.

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

Most staff agreed adults at risk of harm were supported to participate meaningfully in adult support and protection decisions that affected their lives. However, there was no approach deployed to seek feedback from adults at risk of harm to inform either operational or strategic developments. Nor was there active engagement of the lived experience of adults at risk of harm or their unpaid carers on the public protection committee. The strategic leader's development session involved lived experience reflections from a young person. This was well received and there was a commitment to include the lived experience of adults at risk of harm. This had not been developed or implemented.

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

The independent evaluation and subsequent improvement plan reinvigorated the strategic leaderships emphasis on adult support and protection. This generated developments in procedures, roll out of training and leadership activity. There was also a notable improvement to professional curiosity, use of common adult support and protection terminology and recording. Although important developments were being made, progress was at an early stage. There has been significant activity across the partnership over the past 12-24 months to address substantial deficits in adult support and protection processes. As such, many of the fundamental processes, which should have been established much earlier, were only recently introduced. This was partial progress. Strategic leaders needed to prioritise adult support and protection work to support the wider delivery of effective practice. This will address the significant areas for improvement in key processes including risk assessment, chronologies, investigations, and protection planning.

Adult social work business systems did not fully support the recent developments in adult support and protection practice. This hindered the implementation of changes and performance monitoring. Adult systems updates were not carried out as improvements to children's services recording systems were prioritised. Further delays in updates to the adult systems were expected. Only some staff agreed changes and developments were integrated and well managed across the partnership. Staff were not always aware of changes or what was expected of them. This was evidenced by the inconsistent use of templates to support practice and the delivery of key processes.

Management oversight of key processes required improvement. Due to social work vacancies critical aspects of key processes were being overseen by a very small number of people, often individuals, working alone. This undermined independent oversight, scrutiny, and decision-making processes. Regular collaborative review and oversight would serve to share knowledge, understanding and inform improvements.

The partnership experienced staff recruitment and retention issues, particularly in relation to qualified social workers. Leaders collaborated with a higher education provider to develop a 'fast-track' opportunity for existing council staff to become qualified social workers. This 'grow your own' initiative was successful with two staff enrolled and more waiting.

Quality assurance, self-evaluation and improvement activity

The 2021 independent evaluation of adult support and protection established a baseline for the required improvements to key processes. A further case file audit of social work records was carried out in July 2022. These both highlighted ongoing areas for improvement in systems, similar to those identified in the independent review and our findings. The audit did not evaluate the quality of adult support and protection work limiting the value of this exercise. The file audit report lacked sufficient detail to be able to fully understand the extent of the issues. More detailed reporting and better governance of progress would support the implementation of improvements. Importantly, the partnership was not taking the necessary improvement action where issues were repeatedly identified through these quality assurance processes.

There were quality assurance and performance sub-groups which supported the public protection committee. Their role in supporting and driving change and improvement should be clearer and stronger. Only some staff felt leaders evaluated the impact of adult protection work to inform improvements. Although there had been some audit activity the approach lacked rigour and findings were not fully addressed or implemented. A multi-agency self-evaluation and quality assurance framework should be developed. Closer governance and more effective oversight from strategic leaders was needed to promote a culture of continuous improvement.

Initial case reviews and significant case reviews

Two initial case reviews were carried out in the past two years. These were co-authored by the chair of the public protection committee. This was a clear conflict of interest. The initial case reviews did not clearly identify the care and support delivered and received. Recommendations were not formalised into an improvement plan for progress to be monitored. The partnership planned to implement the adult protection learning review guidance (2022). This would support the development of a more robust case review process.

Summary

Overall, adult support and protection practice had taken some positive steps over the last two years. But considerable improvement across critical areas of practice was still needed. Key duties were not always carried out for adults at risk of harm who needed them. This meant the partnership did not consistently evidence their statutory responsibilities under the Adult Support and Protection (Scotland) 2007 Act.

Improvements to the quality of risk assessments, chronologies, investigations, and protection plans was required. The implementation of revised procedures had reinvigorated adult support and protection activity, but their application needed reinforced and monitored more effectively by front line managers. Operational oversight roles needed strengthened to ensure consistent high-quality decision making.

Strategic leaders had recently improved their focus on adult support and protection work. Prior to this sufficient priority had not been given to this critical area of work resulting in ineffective delivery of adult support and protection key processes. The independent evaluation exercise undertaken in 2021 provided a helpful baseline to understand the improvements needed. It highlighted broad-ranging issues in the leadership and delivery of adult support and protection.

The improvement plan based on the independent evaluation had consolidated the work required to move forward. Despite some early achievements, leaders needed to drive this forward to ensure continued improvement. The partnership should develop and implement a rolling audit and self-evaluation framework, with clear links to the overarching improvement plan and governance arrangements. This will enable the partnership to capitalise on the early positive steps they have taken.

Next steps

We asked the Orkney partnership to prepare an improvement plan to address the 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

- 96% 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
- 73% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 92% of episodes where the three-point criteria was applied correctly by the HSCP
- 92% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% one to two weeks and 50% two weeks to one month
- 85% of episodes evidenced management oversight of decision making
- 62% of episodes were rated good or better.

Staff survey results on initial inquiries

- 70% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 18% did not concur, 12% didn't know
- 59% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 6% did not concur, 35% didn't know
- 66% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 16% did not concur, 18% didn't know

Information sharing among partners for initial inquiries

- 100% of episodes evidenced communication among partners

File reading results 2: for 30 adults at risk of harm

Chronologies

- 83% of adults at risk of harm had a chronology
- 40% of chronologies were rated good or better, 60% adequate or worse

Risk assessment and adult protection plans

- 57% of adults at risk of harm had a risk assessment
- 29% of risk assessments were rated good or better
- 43% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 30% of protection plans were rated good or better, 70% were rated adequate or worse

Full investigations

- 68% of investigations effectively determined if an adult was at risk of harm
- 74% of investigations were carried out timeously
- 26% of investigations were rated good or better

Adult protection case conferences

- 76% were convened when required
- 85% were convened timeously
- 71% were attended by the adult at risk of harm (when invited)
- Police attended 82%, health 91% (when invited)
- 61% of case conferences were rated good or better for quality
- 92% effectively determined actions to keep the adult safe

Adult protection review case conferences

- 88% of review case conferences were convened when required
- 100% of review case conferences determined the required actions to keep the adult safe

Police involvement in adult support and protection

- 93% of adult protection concerns were sent to the HSCP in a timely manner
- 86% of inquiry officers' actions were rated good or better
- 71% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 61% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 39% good or better rating for the quality of ASP recording in health records
- 56% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 30 adults at risk of harm and staff survey results (purple)

Information sharing

- 90% of cases evidenced partners sharing information
- 96% of those cases local authority staff shared information appropriately and effectively
- 89% of those cases police shared information appropriately and effectively
- 93% of those cases health staff shared information effectively

Management oversight and governance

- 50% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 40%, police 79%, health 50%

Involvement and support for adults at risk of harm

- 63% of adults at risk of harm had support throughout their adult protection journey
- 71% were rated good or better for overall quality of support to adult at risk of harm
- 65% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 8% did not concur, 27% didn't know

Independent advocacy

- 41% of adults at risk of harm were offered independent advocacy
- 56% of those offered, accepted and received advocacy
- 100% of adults at risk of harm who received advocacy got it timeously.

Capacity and assessments of capacity

- 64% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 100% of these adults had their capacity assessed by health
- 71% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 13% of adults at risk of harm were subject to financial harm
- 25% of partners' actions to stop financial harm were rated good or better
- 60% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 77% of adults at risk of harm had some improvement for safety and protection
- 84% of adults at risk of harm who needed additional support received it
- 59% concur adults subject to ASP, experience safer quality of life from the support they receive, 8% did not concur, 33% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 42% concur local leaders provide staff with clear vision for their adult support and protection work. 24% did not concur, 33% didn't know

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

- 42% concur local leadership of ASP across partnership is effective, 19% did not concur, 39% didn't know
- 40% concur I feel confident there is effective leadership from adult protection committee, 16% did not concur, 45% didn't know
- 31% concur local leaders work effectively to raise public awareness of ASP, 28% did not concur, 41% didn't know

Quality assurance, self-evaluation, and improvement activity

- 31% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 18% did not concur, 51% didn't know
- 33% concur ASP changes and developments are integrated and well managed across partnership, 20% did not concur, 47% didn't know