

A large, abstract graphic composed of numerous overlapping, diagonal lines and shapes in various shades of blue and purple, creating a sense of movement and depth. The lines vary in thickness and color, with some being solid and others having white outlines. The overall effect is a dynamic, layered composition that fills the right and bottom portions of the page.

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

Western Isles Partnership March 2023

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Map showing divisional concern hubs

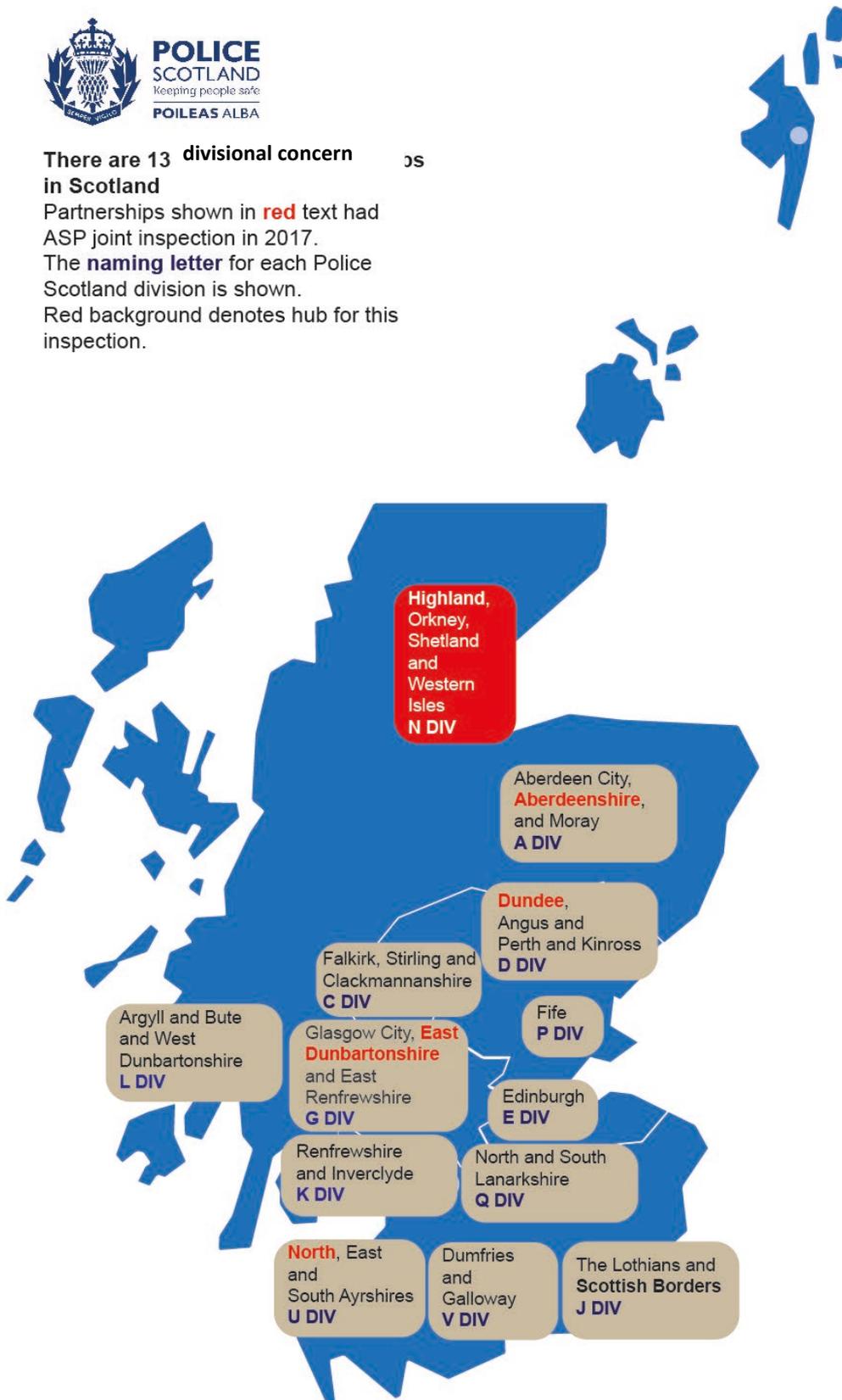


There are 13 divisional concern hubs in Scotland

Partnerships shown in red text had ASP joint inspection in 2017.

The naming letter for each Police Scotland division is shown.

Red background denotes hub for this inspection.



Joint inspection of adult support and protection in the Western Isles 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 partnership¹ areas' effective operation 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 Western Isles partnership area were safe, protected and supported.

The joint inspection of the Western Isles partnership took place between 17 October 2022 and 24 March 2023. We scrutinised the records of adults at risk of harm for a two-year period, 17 October 2020 to 17 October 2022. The Western Isles 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 Western Isles partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

Our quality indicators² 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?

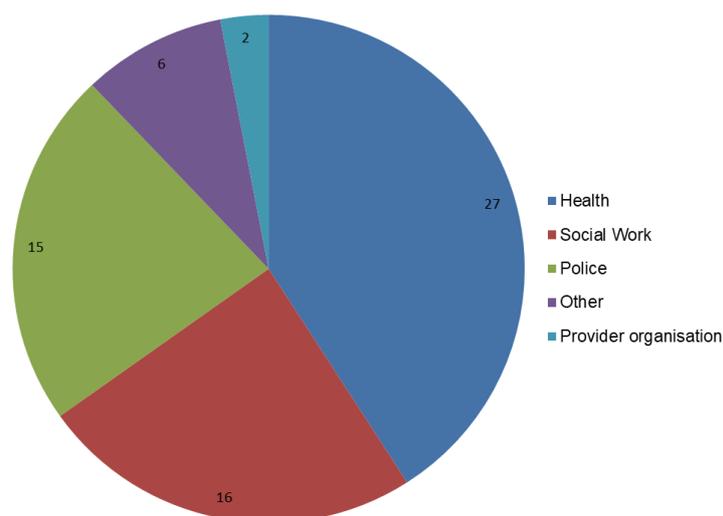
Joint inspection methodology

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. Sixty-six 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.

Respondents by Employer type



The scrutiny of social work records of adults at risk of harm. This involved the records of 39 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

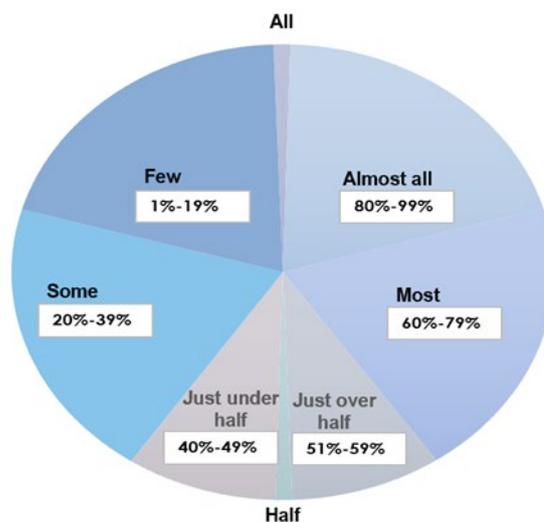
The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 18 adults at risk of harm where their adult protection journey progressed to at least the investigation stage.

Staff focus groups. We carried out two focus groups and met with 20 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

Percentage ranges only refer to staff survey and duty to inquiry case file template findings.

Data descriptors for percentage scale



Summary – strengths and priority areas for improvement

Strengths

- The partnership responded well to the demands of the pandemic for adult support and protection.
- In January 2022 NHS Western Isles reconfigured their public protection service. This made a positive strategic contribution to adult support and protection.
- Following the appointment of a new independent convener in November 2021 the adult protection committee established subgroups to support improvement and development.

Priority areas for improvement

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

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

Key messages

- Adults at risk of harm experienced some positive outcomes as a result of multi-agency working.
- Police Scotland contributed positively to early adult support and protection arrangements, through the delivery of national practice in a local context. There were missed opportunities for greater police involvement in key processes that would have strengthened the delivery of investigations and case conferences.
- Protection matters were often inappropriately conflated with assessment and care management processes. This impacted adversely on effective risk assessment and risk management.
- The inquiry and investigation process had significant weaknesses around communication, information gathering and management of risk.
- The partnership adult protection procedures were out of date and ineffective. They did not include timescales or clearly outline key adult protection activities such as the inquiry process or chronologies. The partnership was in the process of updating their procedures.
- Management oversight and recording of social work practice was lacking and required strengthening.
- Support and governance for decision making around key processes was ineffective and relied too heavily on a small number of staff. As a result, business continuity lacked resilience.
- Support to engage and involve individuals in their adult support and protection journey was often ineffective or not available.
- While there was evidence that partners were communicating and sharing information this did not translate into effective collaboration for adult support and protection practice.
- During the pandemic training had largely stalled. The partnership had developed a comprehensive draft training plan that needed to be implemented and delivered.

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

All referrals received by the partnership were triaged and screened by the duty worker from the assessment and care management team. There were limited oversight arrangements in place that needed strengthening. Staff making a referral were confident that they were supported to do so, and that the pathway was clear.

This process was supported by a weekly multi-agency meeting including police representation from the divisional concern hub based in Inverness. Communication between the divisional concern hub and local operational policing was enhanced by a member of hub staff being located on the Western Isles. While this was a positive meeting arrangement more work was needed to strengthen practice in this important area of work. The purpose of this meeting was to review all concern reports from the police, however, data presented to the adult protection committee indicated that referrals from other agencies were also discussed. This blurred the focus of the meeting. There was oversight built into this process to ensure immediate concerns were responded to but there was no guidance for these meetings, and the outcomes were not always clearly recorded. The partnership had indicated that it planned to review the operation of this group.

Initial inquiries into concerns about adults at risk of harm

Adult support and protection practice in the Western Isles was underpinned by Multi-agency Procedures and Guidelines (2016). The partnership identified that they needed improved and were in the process of updating them. Critically, the procedure did not include any timescales and did not support the effective delivery of key processes, including inquiry work.

Almost all inquiries were completed in line with the principles of the adult support and protection legislation. Most inquiries recorded the application of the three-point criteria with almost all evidencing communication between relevant adult support and protection partners.

The partnership procedures referenced inquiries and social work had a useful template for recording them, but the procedure did not outline the process of undertaking an inquiry. Just over half of inquiries evidenced communication that was good or better. Only some inquiries were rated as good or better for quality. Timescales for completing an inquiry were mostly in keeping with the adult's needs. For a few adults at risk of harm the inquiry was delayed by over a month. Significantly, some inquiries should have progressed further along the adult support and protection process.

Management oversight was evident in almost all inquiries. However, for some adults at risk of harm, their circumstances were not fully considered or robustly risk assessed. Resultantly, the decision for no further action was incorrect.

The partnership procedure detailed an option for a planning meeting and/or inter-agency referral discussion. The function was unclear and use in practice was inconsistent. Overall, the standard of inquiry work was insufficient and needed strengthened.

Investigation and risk management

Chronologies

Chronologies inform effective decision making on risk and protection for adults at risk of harm. Yet, they were not referenced in the partnership's procedure. Learning materials to support workforce training on chronologies were available but these were child focused.

Only three out of 14 cases included a chronology. From those completed, two were adequate and one was weak. While the partnership indicated it planned to incorporate chronologies into the updated procedures, more needed to be done to embed this important tool in adult support and protection within the Western Isles.

Risk assessments

Risk assessment is a critical component in adult support and protection. While the partnership's procedures referenced risk assessment, this was limited. They interchangeably used assessment and risk assessment. This conflated care management and adult support and protection processes. This finding was identified in the partnership's own social work audit reported in July 2022.

The partnership had a specific adult support and protection risk assessment template, but social workers did not use this consistently. Seven out of 17 cases had a risk assessment completed when required. The quality of the risk assessment was good or better for only one of the seven completed. It was evident from those completed that multi-agency partners' views did not always inform the assessment, and there were significant delays in completing the risk assessment. Nearly every adult at risk of harm did not have a risk assessment that was fit for purpose indicating significant improvement was needed in this critical area of practice.

Full investigations

Investigations took place when required for 15 of 18 adults at risk of harm. From the 15 that took place all involved a council officer and nine involved staff from a partner agency. Of those that did not involve appropriate partners, police were identified as the most common partner not involved when they should have been. A second worker was required in eight cases that went to investigation but only deployed on four occasions.

Positively, 13 out of 15 investigations determined if the adult was at risk of harm. Despite having a template for investigations that could better support practice, the quality and timescale for investigations were insufficient. There was no timescale for completing an investigation set out in the partnership's procedures, further compounding this issue. For five out of 15 adults at risk of harm the duration of investigation delays was between one week to over one month. The quality of the investigation was variable and was good or better in four from 15 cases.

The partnership's procedures referenced planning meetings that could be held before or after investigations. There was no evidence these forums were convened. Like inquiries, there was a lack of support and oversight for decision making and an over reliance on care management procedures to manage protection type risk.

Adult protection case conferences

There were very low numbers of case conferences in the Western Isles. From the 18 cases that proceeded to investigation, only three proceeded to case conference. We identified 10 that should have progressed to case conference. Taking these complex cases to case conference would have supported competent, effective multi-agency working, collaboration, and better management of risk for adults at risk of harm.

From the three case conferences that took place, one was significantly delayed by between one to three months. None involved all the relevant professionals, the adult at risk of harm or the unpaid carer. None of the case conferences were rated good or better. Only one of the three case conferences effectively determined a plan for the adult at risk of harm. There was a lack of support and oversight for decision making in case conferences.

While there was only a small number of case conferences, it was expected given the statutory duties and updated code of practice that these meetings would be better organised and prioritised by all agencies.

Adult protection plans / risk management plans

One out of 11 adults at risk of harm that required a risk management or protection plan had one. While the one plan that was completed identified contributions from other agencies, the quality was unsatisfactory. No adults at risk of harm benefitted from a competent risk management or protection plan when required. Critically, for those adults, risk was not well managed, and they were not fully protected.

The partnership's multi-agency procedures and guidelines were not clear around the management of risk. The partnership had a standard template for a protection plan. This was not used in practice. The partnership's own social work audit identified that risk assessment and risk management were areas for improvement.

Adult protection review case conferences

Of the two adult protection cases that progressed to this stage, only one review case conference was convened. It was not held in a timescale in line with the adult at risk of harm's needs and was ineffective in assessing and managing risk.

Implementation / effectiveness of adult protection plans.

There was no evidence protection plans were implemented following case conference.

Despite this, most staff were confident about outcomes and adults at risk of harm getting the support to remain safe and supported. This was mostly because of care management and not adult support and protection processes. Eleven from 18 adults at risk of harm were identified as requiring additional support. Three adults refused support and eight adults were provided with support. The effectiveness of the support was good or better for two out of eight adults at risk of harm.

Large-scale investigations

The partnership had an interagency procedure for large-scale investigations of adults at risk of harm in managed care settings in their guidance. These had not been updated with reference to the revised codes of practice (2022).

The partnership conducted one large-scale investigation during the last two years. It did not carry this out in line with procedure. While there was a multi-agency meeting it was not clear if this corresponded with the interagency referral discussion stage, as defined in the large-scale investigation procedures. Recording was limited and police were not involved in any stage of the process. Positively, this meeting did agree a protection plan to manage risk, allocated tasks to further assess and formally activated the large-scale investigation process.

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

Overall effectiveness of collaborative working

The partnership operated a weekly multi-agency meeting to consider police referrals. This was a positive initiative that required further development, but it did support the triaging process. Most staff from across agencies were confident in the referral pathway to social work.

Collaboration between the key agencies at investigation stage and beyond was less evident. The police should have been involved in more investigations and health staff should have been deployed more routinely as second workers in investigations.

Health involvement in adult support and protection

Health staff were less positive about outcomes for adults at risk of harm than the other key partners. Health staff reported a good understanding of their role and responsibilities under the legislation. Health referrals were notable within the inquiries we considered.

In January 2022, health involvement in adult protection was strengthened by reconfigured structures to an NHS Western Isles public protection arrangement. This supported involvement and leadership in the recently established adult protection committee subgroups. Health also led the care home oversight group, established in response to the covid pandemic. This group continued to have good oversight on a range of matters including adult support and protection in care homes. The public protection service was actively raising awareness of adult support and protection across health services.

Operational health involvement was more variable. Medical examinations were required in five out of 15 cases, but only completed in one. This negatively impacted on the effective risk assessment of complex situations. More positively, health was involved in the investigation process for those that took place. Collaboration by health and contribution to positive outcomes for adults at risk of harm was rated good or better for four out of nine cases.

Capacity and assessment of capacity

Acute NHS services participated well in adults with incapacity training, with work ongoing through the 'discharge without delay' programme. A range of professional and clinical leads were involved as part of the programme and this proved to be useful for information sharing, including relevance to adult support and protection. The partnership facilitated internal discussions amongst health professionals to consider the process of accessing assessments of capacity, and how this would better support adult support and protection processes.

We did not read any records that evidenced the positive measures had an impact on practice.

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 (THRIVE). All cases had an accurate STORM Disposal Code (record of incident type).

In eight out of 10 cases the initial attending officers' actions were evaluated as good or better, with relevant interventions delivered in support of adults at risk of harm. There was evidence of effective practice and meaningful contribution to community response. Officer assessment of risk of harm, vulnerability and wellbeing was accurate and informative in all 10 cases. The wishes and feelings of the adult were always appropriately considered and properly recorded.

Where adult concerns were referred, officers did so efficiently and promptly in nine out of 10 cases, using the interim vulnerable persons database (iVPD). Frontline supervisory input was evident in seven out of 10 cases and the contribution rated good or better in five out of seven cases.

Divisional concern hub staff actions/records were good or better in eight out of 10 cases. There was evidence of strong staff contribution to adult support and protection arrangements, including diligent assessment and research. Additional input to iVPD chronology was a reoccurring feature and viewed as adding value to the police records. Eight out of 10 cases showed a resilience matrix, with all eight recording a relevant narrative of police concerns. The referral was shared swiftly with partners in eight from 10 cases.

The police administered and chaired the partnership's interagency referral discussion meetings. The low number of cases we read limited our ability to understand the impact of this approach. Officers also participated in the partnership's weekly multi-agency meeting to consider and manage police generated adult concern referrals with involvement in the group facilitated by hub staff. Opportunities remained to improve information pathways to ensure that all appropriate adult support and protection related information was disseminated across relevant police officers and staff.

Police were not invited by social work to any case conferences convened during the two-year inspection time frame. There were occasions where officer involvement would have added value to case conference proceedings.

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

Third sector and independent sector provider involvement

The partnership strengthened its relationship with the third and independent sector in response to the pandemic. This was positive and included business continuity planning and allocation of the additional funding from Scottish Government to support the management of risk so service provision could be prioritised.

The Western Isles community care forum, representing the third and independent sector and carers had representation at the adult protection committee. The partnership stated they plan to further engage this sector in the work of the adult protection committee.

Staff from providers responding to our survey felt supported to make adult support and protection referrals but were less confident they were handled efficiently.

Key adult support and protection practices

Information sharing

All key partners shared appropriate information. For health and police this was evidenced in all investigations, for social work this was evidenced in all but two investigations. There were opportunities to improve the quality of the information shared to further inform risk assessment, support, and protection planning.

Information was shared via the weekly multi-agency meeting but records of this were not available. Guidance and operational protocols were currently ineffective in supporting decision making.

Just over half of all staff survey respondents agreed that they received timely feedback from referrals indicating more work needed done to improve in this area of practice.

Management oversight and governance

Social work records were not adequately maintained in seven out of 18 cases. Management oversight was lacking and 10 out of 18 social work records. These records had no evidence of discussions from supervision or of the manager periodically reading the record. Police records showed stronger performance in this area of practice. Evidence of exercise of governance was less apparent in health records. This is not necessarily a deficit due to the types of health records scrutinised.

Involvement and support for adults at risk of harm

Involvement and consultation with the adult at risk of harm at the inquiry and investigation stage was evident for most adults at risk of harm. The staff had addressed potential barriers in 12 out of 16 cases.

The effectiveness of support was variable and less positive for six out of nine adults at risk of harm that received it. Support for the adult at risk of harm was inconsistent and needed strengthened.

Unpaid carers were more appropriately involved and consulted in the adult support and protection process.

Independent advocacy

Independent advocacy was available to adults at risk of harm. Following the increased use of technology which supported remote contact, the level of engagement achieved by advocacy services had increased.

Eleven out of 15 adults at risk of harm who should have been offered advocacy were offered it. In two of these cases advocacy was accepted and received. Where advocacy was accepted by an adult at risk of harm, support was delivered quickly and made a positive contribution.

There was a strategic advocacy planning group responsible for ensuring that local services were accessible and coordinated across the population groups. Future service specification was under consideration.

Financial harm and alleged perpetrators of all types of harm

The partnership did not have a specific protocol or group to respond to financial harm, although they did consider financial harm reports at the adult protection committee. There was evidence of early collaborative work with the development of the Supporting Service User's in Managing their Finances Policy Statement and Procedure Handbook (2022). This draft procedure had limited reference to the Adult Support and Protection (Scotland) Act 2007, thus limiting its potential impact.

Where financial harm was identified, the partnership effectively acted most of the time. From the 18 cases, the partnership worked with the alleged perpetrator in five of the six cases where it was appropriate. The quality of this intervention was good or better for two of the five cases.

Safety outcomes for adults at risk of harm

Across key agencies there was confidence that adult support and protection intervention contributed to positive outcomes for adults at risk of harm.

There was evidence of positive outcomes for adults at risk of harm for 14 out of 18 adults at risk of harm. This was mainly due to multi-agency working and not adherence to adult support and protection processes. Poor outcomes were identified for four adults at risk of harm. This was mainly due to the individual being unable or unwilling to engage.

Adult support and protection training

The Covid-19 pandemic impacted training and planned development work was paused. To reignite this important agenda the partnership established a multi-agency learning and development subgroup in October 2022. This group developed a Western Isles learning and development strategy including adult support and protection. This draft document was comprehensive but had not yet been implemented.

Training delivered over the past two years included bespoke sessions, on-line modules, and training on hoarding. Half of all staff reported they had access to multi-agency training and development and were positive about specific adult support and protection training. Almost all staff who responded in the survey reported they had improved knowledge, skills and understanding of risk following participation in training.

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

Key messages

- The partnership managed the challenges of the pandemic well.
- The recent reconfiguration by NHS Western Isles to a public protection service strengthened health involvement in adult support and protection strategic leadership.
- Since May 2022, the adult protection committee established subgroups to support improvement.
- The improvement actions from previous audits were not embedded in the adult protection committees' improvement plan, nor had they been implemented.
- Critical weaknesses in governance had resulted in deficits in key processes not being identified or improved.
- Strategic oversight of adult support and protection lacked rigour, detail, and process. This limited the partnership's ability to drive improvement work forward.
- Adults with lived experience were not strategically involved. Feedback from them was not evident in the strategic adult support and protection committee.
- Collaborative working within adult support and protection practice in the Western Isles was ineffective and did not support the effective delivery of key processes.

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 had an established public protection continuous improvement vision that all agencies in the Western Isles were committed to. Although clearly set out, just over half of staff understood the vision. There was not an overall strategic plan developed by the adult protection committee to support delivery of adult support and protection.

There were opportunities to strengthen practice and achieve the vision by developing both the improvement plan and the numerous key documents in draft form. The progress of the improvement plan was last updated in December 2022 and included an outline of key actions and intended outcomes that were RAG (Red, Amber, Green) rated. This plan had been in place since March 2021, and while some actions had commenced, some were still to be progressed. No actions were complete.

While there were clear challenges for the partnership, leadership of adult support and protection by the adult protection committee was considered effective by most staff survey respondents.

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

The convener for the adult protection committee was appointed in November 2021. This reinvigorated the work of the committee initially, but critical improvement to structures and processes for reporting had not yet been fully embedded. The adult protection committee was quorate and had representation from all the key agencies.

In 2022 the adult protection committee established two multi-agency subgroups to support the delivery of the improvement plan. Prior to this the committee did not have subgroups in place, which significantly weakened governance and impeded improvement activity. Both subgroups had developed terms of reference, draft development frameworks and reported progress to the committee. This work was much needed, but it was too soon to measure its impact.

The committee had relevant reports from the established two subgroups, chair, and lead from social work. While there was a nominated lead from health and police, reports were only provided by social work. There were no reports from other key agencies or other relevant organisations making it difficult to assess the strength of joint working arrangements. Performance data was basic and there was a lack of oversight of decisions taken at previous meetings to ensure they had been actioned and progress made. Overall, the lack of an effective governance structure and process for strategic delivery of adult support and protection was a crucial weakness.

The adult protection committee reported regularly to the chief officer group on public protection matters. Written and verbal updates were provided by the convener on relevant adult protection issues but focused on national issues rather than the work of the committee. There were no clear decisions or actions communicated by the chief officer's group to the adult protection committee. The chief officer group did not operate a risk register. This was a critical area for improvement given the weaknesses in key processes, and the chief officer group's lack of adult support and protection oversight. Strategic oversight of adult support and protection lacked rigour, detail, and process. More positively, the chief officer group monitored vacancies and demand on social work and health services and took steps to address identified pressures. They prioritised budgets to ensure resources met demand resulting in additional resource being provided to the social work frontline.

NHS Western Isles had recently developed a public protection executive group to support the implementation of the public protection accountability framework. A positive development was remodelling work within NHS Western Isles to create a public protection service that included adult support and protection. The lead protection nurse also chaired one of the adult support and protection subgroups which supported cross over activity.

In response to the Covid-19 pandemic, meetings for the adult protection committee moved online. The partnership also implemented a business continuity plan including formal structures that supported vulnerable adults.

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

The partnership did not have representation from adults with lived experience on the adult protection committee. It did have representation from an unpaid carer's organisation and the advocacy service. The partnership did not gather feedback strategically or operationally from adults with lived experience or their unpaid carers. The partnership had committed to develop trauma-informed approaches and planned to engage in training in this area. Improved engagement with people who have lived experience is essential.

The partnership undertook awareness raising to highlight concerns such as scams and updates to the code of practice. The partnership, as part of their improvement plan, included the development of a communications strategy as a core function of the adult protection committee.

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

In response to the pandemic the partnership had established a multi-agency care home oversight group that considered adult support and protection. The partnership also engaged with services and advocacy to respond to the wider system pressures and prioritise services for those that most required them. During this period the adult protection committee and partnership delivered services and met virtually to share information, plan, and monitor their response. Each agency had its own approach to ensuring the wellbeing of their workforce and there was a helpful focus on managing off duty to ensure rest periods were sufficient.

The partnership stated it had a strong collaborative ethos and whenever possible adopted a multi-agency approach. However, in practice, operational and strategic collaboration did not support the effective delivery of adult support and protection. Operationally information was being effectively shared, but this did not lead to the competent delivery of key processes. Multi-agency procedures did not support effective delivery of practice and processes were poorly adhered to. This resulted in many areas of adult support and protection practice that required to be significantly improved. The lack of rigor and competent strategic collaboration resulted in ineffective oversight and governance of practice. While there had been recent initiatives, many measures were in draft and should have been embedded earlier.

The adult protection committee membership included appropriate membership from other relevant agencies such as the Scottish Fire and Rescue Service, attendance at committee was variable. It was unclear how the adult protection committee engaged with those that do not attend.

Quality assurance, self-evaluation, and improvement activity

In September 2021, there was a single agency social work audit of 18 cases that went to investigation between September 2019 to August 2021. The audit was undertaken by a small number of file readers which included social worker officers involved in adult support and protection processes. The audit tool was based on the previous Care Inspectorate inspection template. The audit findings were reported to the adult protection committee in July 2022 but were not yet embedded in the current improvement plan.

The audit identified similar areas for improvement as our inspection. Some immediate improvement actions were made to systems and the health and social care partnership were in the final stages of implementing a new social work recording system. Yet, more was needed to be done to ensure protection type risk was appropriately assessed at each stage of the process. Although many issues were identified because of this beneficial process, there was no improvement action plan arising from the audit, limiting the value of the work done so far.

The partnership did not have a multi-agency framework for self-evaluation or audit. It was indicated in the adult protection committee improvement plan and constituted subgroup for quality assurance that action would be taken to develop a plan. There was no mechanism for views from adults at risk of harm with lived experience, unpaid carers, or feedback from practitioners.

Initial case reviews and significant case reviews

The partnership did not have a local procedure for initial or significant case reviews. During the time period considered there were no reviews completed. The partnership mandated consideration for and of reviews from other areas to the recently established quality assurance subgroup. The partnership had considered learning from recently published reviews to support the reflection of practice in the local area.

Summary

The partnership had a vision and improvement plan to support the delivery of adult support and protection. However, the vision needed strengthened amongst staff, and the improvement plan did not take account of recent audit findings. The reinvigorated work of the adult protection committee was developing processes and structures that should have been long embedded. The reconfiguration by NHS Western Isles from a child protection service to a public protection service, extended the remit to include adult support and protection. This contributed positively to the strategic adult support and protection agenda.

The partnership had responded to the demands of the pandemic well. Yet, strategic leadership for adult support and protection was lacking. Governance frameworks had not identified the significant weaknesses present in practice. Collaborative working in adult support and protection, both operationally and strategically, was ineffective and did not support the effective delivery of key processes. Both the chief officers' group and adult protection committee required to significantly improve their communication and oversight arrangements.

Adult support and protection practice in Western Isles was underpinned by the Multi-agency Procedures and Guidelines (2016). This procedure was seven years old and did not support the effective delivery of adult support and protection processes. There were critical failings at each key stage of the adult support and protection process. In many instances social work, as the lead agency, did not evidence that they fulfilled their statutory duties. The processes for robust decision-making lacked system resilience, support, and effective management oversight.

Adults at risk of harm and their unpaid carer were insufficiently involved and engaged in operational practice and there were opportunities to further involve them in strategic adult support and protection.

Overall, there were many key areas for improvement identified across key processes and strategic leadership. These critically impacted on the experiences and outcomes for adults at risk of harm and need urgently addressed.

Next steps

We asked the Western Isles 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

- 92% 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
- 74% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 77% of episodes where the three-point criteria was applied correctly by the HSCP
- 69% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 8% less than one week, 25% one to two weeks, 25% two weeks to one month, 33% one to three months, 8% more than three months
- 90% of episodes evidenced management oversight of decision making
- 36% of episodes were rated good or better.

Staff survey results on initial inquiries

- 83% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 8% did not concur, 9% didn't know
- 70% 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, 24% didn't know
- 70% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 13% did not concur, 18% didn't know

Information sharing among partners for initial inquiries

- 85% of episodes evidenced communication among partners

Staff survey results about aspects of key processes

Involvement and support for adults at risk of harm

- 74% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 11% did not concur, 15% didn't know

Safety and additional support outcomes

- 62% concur adults subject to ASP, experience safer quality of life from the support they receive, 11% did not concur, 27% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 58% concur local leaders provide staff with clear vision for their adult support and protection work. 20% did not concur, 23% didn't know

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

- 64% concur local leadership of ASP across partnership is effective, 14% did not concur, 23% didn't know
- 61% concur I feel confident there is effective leadership from adult protection committee, 18% did not concur, 21% didn't know
- 41% concur local leaders work effectively to raise public awareness of ASP, 26% did not concur, 33% didn't know

Quality assurance, self-evaluation, and improvement activity

- 45% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 20% did not concur, 35% didn't know
- 45% concur ASP changes and developments are integrated and well managed across partnership, 15% did not concur, 39% didn't know