JOINT INSPECTION OF **ADULT SUPPORT AND PROTECTION**

Shetland Partnership March 2023

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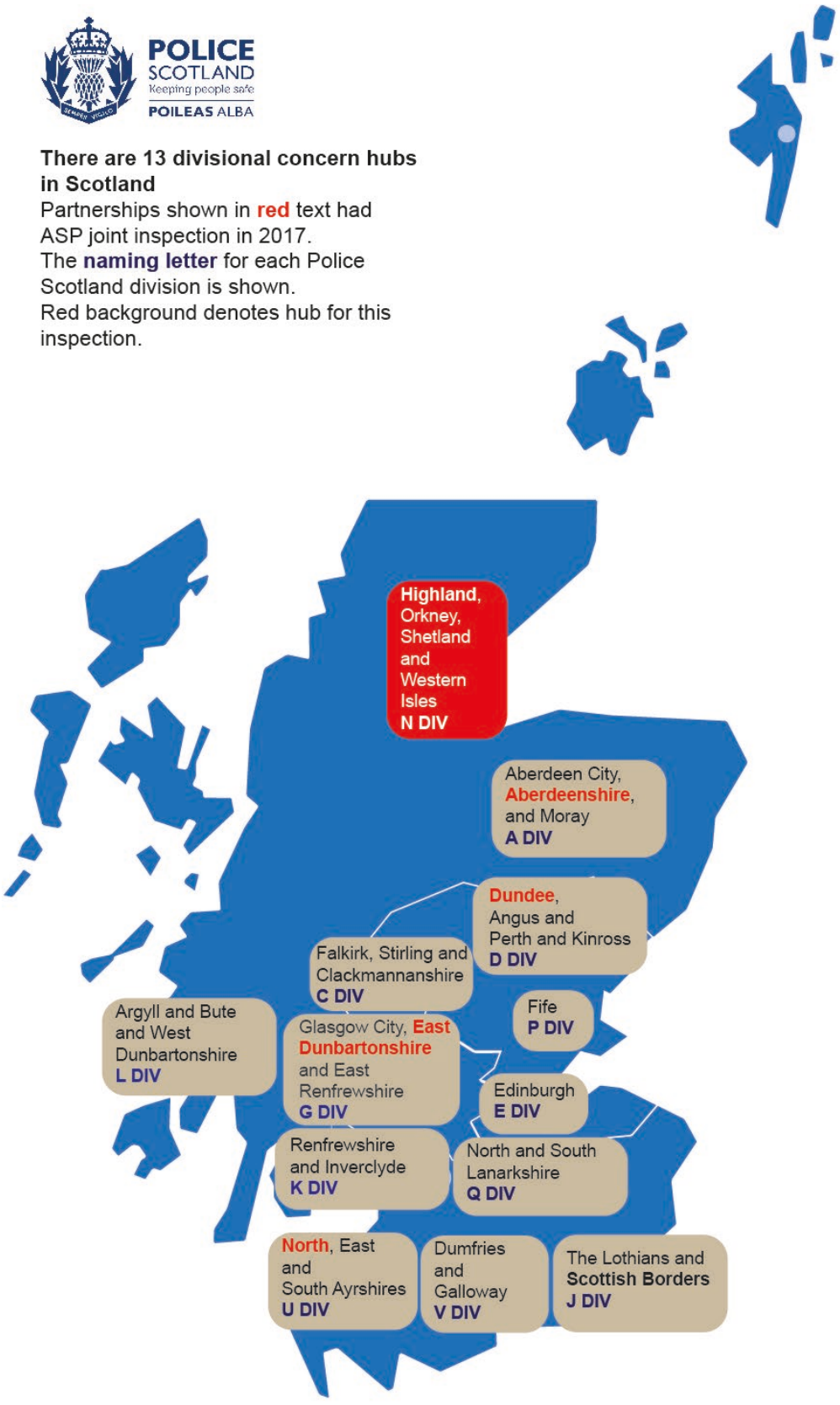
Map showing divisional concern hubs



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

The joint inspection of the Shetland partnership took place between October 2022 and March 2023. We scrutinised the records of adults at risk of harm for a two-year period, 24 October 2020 to 24 October 2022. The Shetland 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 Shetland 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.

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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?

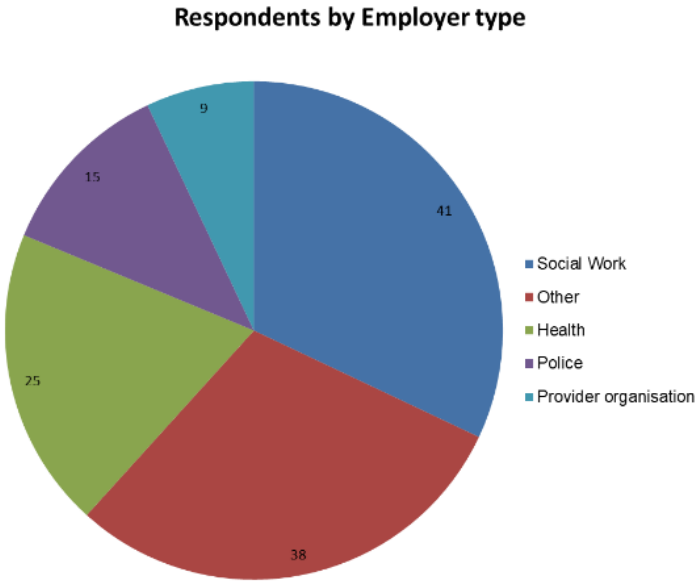
Joint inspection methodology

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.

One hundred and twenty-eight 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.

Staff survey



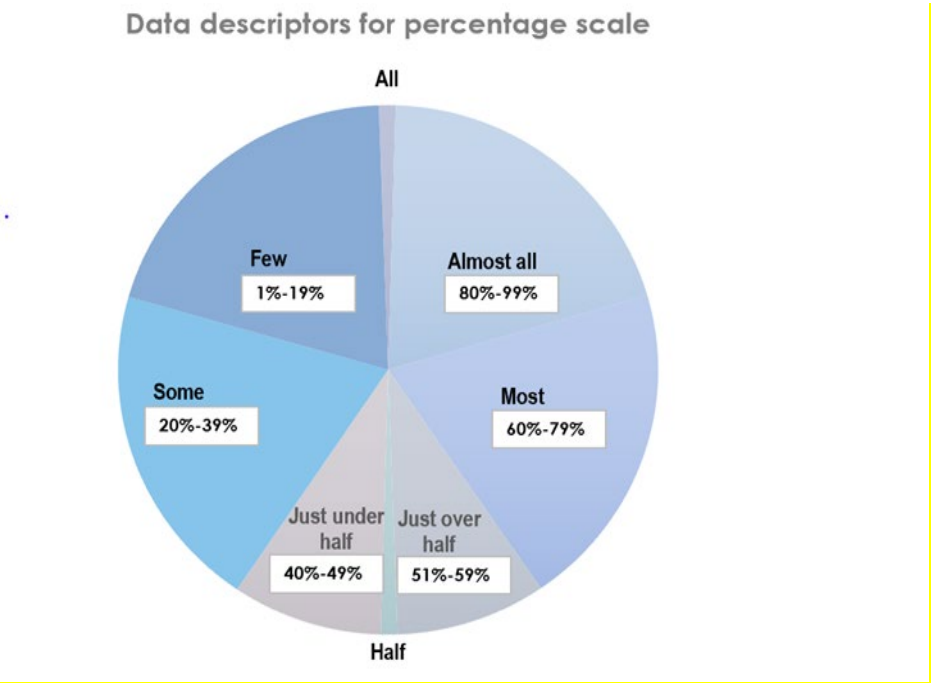
The scrutiny of social work records of adults at risk of harm. This involved the records of 37 adults at risk of harm who did not progress beyond adult support and protection inquiry stage.

The scrutiny of the health, police, and social work records of adults at risk of harm. This involved the records of 10 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 19 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 inquire case file template findings.



Summary – strengths and priority areas for improvement

Strengths

- Adults at risk of harm nearly always experienced improvements to their safety, health, and wellbeing. This was due to effective multi-agency working and interventions from partner agencies.

- The partnership had strong investigation and case conference processes in place for assessing and managing risks for adults at risk of harm. These led to improved outcomes for adults at risk of harm.

- Partners worked collaboratively with the third and independent sector to share information and support adults at risk of harm.

- Processes for addressing financial harm were effective and resulted in positive outcomes. The partnership raised awareness of scams and provided a variety of support for adults at risk of financial abuse.

- Business continuity arrangements for adult support and protection during the Covid-19 pandemic were well organised. Despite staff shortages, the partnership ensured the needs of adults at risk of harm were a priority.

- The strategic leadership team promoted audit activity to identify key priorities for adult support and protection performance and improvement activity.

Priority areas for improvement

- The screening and triaging arrangements for adult support and protection referrals should be reviewed to ensure consistent decision making at this key stage.

- Duty to inquire processes were inconsistently applied and recorded. The partnership should take steps to improve in this area.

- The Shetland public protection committee's vision and strategic business plan should be updated and more focussed on adult support and protection.

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

Key messages

- The partnership improved the quality of information recorded in chronologies through effective training and guidance.
- The quality of most risk assessments was good. Protection plans demonstrated partners worked collaboratively at all stages.
- Adult support and protection investigations and case conferences were carried out promptly and to a high standard. Adults at risk of harm and relevant others, including unpaid carers, were included at key stages.
- Capacity assessments and medical examinations were requested when required and carried out promptly for adults at risk of harm. This impacted positively on outcomes for adults at risk of harm.
- Screening, triage, and inquiry activity relating to adult support and protection concerns were inconsistently applied. Processes should be strengthened to better record, mitigate risk, and promote effective use of procedures including existing templates.
- Health staff were not consistently used as second workers in investigations when required.

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

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns.

All adult support and protection referrals received by the partnership were screened and triaged by the duty social work team. This work was overseen by a senior team member. The quality of the screening and handling of referrals was good or better in just over half of cases. This required improvement to promote more effective management of referrals. Almost all staff said they were supported to raise concerns and understood the adult support and protection referral pathway. Most staff said they were given timely feedback from social work after submitting a referral. While this was encouraging, health staff were less positive about receiving feedback.

The duty social work team participated in a fortnightly multi-agency meeting with staff from the Police Scotland divisional concern hub and health colleagues. The primary purpose of this meeting was to share information and discuss adult concern reports generated by the police that did not meet the threshold for adult support and protection. While this was a sound arrangement, some concerns would be routed back to the duty social work team as adult support and protection referrals. On occasions this was not required as concerns had been followed up in the interim. These added to the high number of adult support and protection referrals that required to be screened placing pressure on staff.

Initial inquiries into concerns about adults at risk of harm

Adult support and protection practice in the Shetland Islands was underpinned by the Shetland interagency adult protection procedures (2020). The procedures were well designed and included a range of standard forms and templates.

Adult support and protection inquiries were almost always managed in line with the principles of the Adult Support and Protection (Scotland) Act 2007. Nearly all staff who completed our survey were aware of the three-point criteria and how it applied to adults at risk of harm. While the three-point criteria had been applied in principle to almost all adult support and protection initial inquiries, it was not always well recorded.

Almost all initial inquiries evidenced effective communication between partners, management oversight, and decision-making processes. Interagency referral discussions were also convened by partners when decisions about the immediate management of risk required additional information.

Interagency referral discussions and the multi-agency meetings promoted shared operational involvement and wider collaborative discussion about adult support and protection concerns.

Police Scotland's divisional concern hub raised the most adult support and protection referrals and passed information to social work services timeously except in a few cases.

When adult support and protection referrals were received by social work, initial inquiries were almost always initiated quickly. A few inquiries were delayed which led to missed opportunities for early interventions to mitigate risks.

The recording of duty to inquire processes was not consistent. Social work staff did not always use the duty to inquire form set out in the procedures. This variation meant it was not always clear when the referral was made. In addition, it was difficult to determine the inquiry progress and reasons for no further action.

Chronologies

Chronologies for adults at risk of harm are an important element of risk assessment and risk management. The partnership had effective processes in place for recording and analysing risk and significant events for the adults at risk of harm. Seven out of nine adults at risk of harm who required a chronology had one and the quality of information recorded was described as good in four. This included examples of detailed summaries of events and how risks were managed. This supported the assessment and management of risk. The partnership continued to develop guidance and staff training to improve the quality and effectiveness of chronologies for adults at risk of harm.

Risk assessments

The partnership had effective processes in place for recording the risks for adults at risk of harm. Eight out of nine adults who required a risk assessment had one with all evaluated as good or better. Risk assessments were developed timeously and demonstrated the ongoing involvement of relevant professionals. Information recorded in risk assessments was mostly comprehensive. Standard risk assessment templates were not always used leading to some inconsistencies in the recording processes for some. Importantly, this meant not all risk assessments were as clear as they could have been. The partnership revised their risk assessment template which aimed to improve this. It was too early for us to determine if this was positively impacting on the issue.

Full investigations

Commendably, adult support and protection investigation processes were a strength of the partnership. All relevant partners were involved which promoted effective communication and management of risk.

A full investigation was carried out for nine out of 10 adults at risk of harm. All required a second worker, and one was deployed in eight out of nine cases. Two adults at risk of harm would have benefitted from a health professional as the second worker. More work was needed to strengthen this important health role in protection work.

When investigations were conducted, they were carried out timeously. The quality of investigations was rated good or better in eight out of nine cases. Positively, all investigations appropriately determined if the adult was at risk of harm.

Adult protection case conferences

Case conferences are important as they provide the opportunity for all relevant agencies to collaborate and share information. Case conferences were convened for every adult at risk of harm who required one. They effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported in six out of seven instances. Relevant professionals were routinely invited to attend case conferences and attended most of the time. Health representatives were invited to attend all cases conferences and always did so. Police provided valuable contributions and attended nearly every time they were invited.

Five out of seven adults at risk of harm were invited to attend their case conference and almost all attended. The reasons for not inviting the adult at risk were inconsistently recorded. Where appropriate, family members or unpaid carers were also invited to attend and attended on all occasions. Adults at risk of harm were well represented at case conference even when they chose not to attend.

Six out of seven case conferences were rated good or better. All case conferences effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected and supported.

Adult protection plans / risk management plans

The partnership promoted the effective use of protection plans which had a positive impact on managing risks. Protection plans were required for nine out of 10 adults at risk of harm and were in place for eight. The quality of information in these protection plans was good or better in all cases. All plans demonstrated the positive contribution of services working with the adult at risk to keep them safe.

Adult protection review case conferences

Review case conferences were required for six adults at risk of harm and were convened nearly every time. Where they were convened, the timing was in keeping with the needs of the adult at risk of harm. All review case conferences effectively determined what was required to minimise risks for the adult at risk of harm.

Implementation / effectiveness of adult protection plans

Protection planning arrangements were effective in identifying and addressing risks. All services supporting the adult at risk of harm contributed to protection plans. Where appropriate, the views of unpaid carers and families' views were also considered. Protection plans provided clear information about the management of risk but did not always align with the adult's risk assessment when they should have. Most of the information shared at interagency referral discussion meetings was well recorded in the protection plan.

Large-scale investigations

The partnership had not conducted any large-scale investigations prior to our inspection. Large-scale investigation planning meetings were appropriately held to consider whether a large-scale investigation was required. These meetings effectively promoted collaborative decision-making and assessment of risk. The partnership proactively sought guidance from another partnership and the Care Inspectorate to support development of their large-scale investigation procedure.

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

Overall effectiveness of collaborative working

Collaboration was a strength of the partnership particularly from investigation stage onwards. This was evident between statutory agencies and with providers. Information was appropriately shared when required to ensure that adults at risk of harm were supported and protected. Adults at risk of harm, relevant family members and unpaid carers were positively included in decisions about care and support most of the time.

Plans to raise awareness amongst staff working with adults at risk of harm were at an early stage. Adult support and protection procedures were under review to bring them in line with the most recent national guidance. Almost all staff said they had a sufficient understanding of other agencies' roles in adult support and protection. A similar proportion said they were supported to work collaboratively to achieve positive outcomes for adults at risk of harm.

Health involvement in adult support and protection

Health services made a positive contribution to the assessment, support, and protection arrangements for adults at risk of harm.

Some health staff did not receive regular supervision that supported their adult support and protection practice. Most health staff said they participated in regular multi-agency training, but importantly some did not. The NHS board had clear arrangements in place for single agency staff training.

Health services were well represented and played key roles at adult support and protection decision-making meetings. This included adult protection case conferences and multi-agency meetings.

NHS Shetland had a specialist protection post that worked collaboratively with the divisional concern hub and social work staff to share information and coordinate support for adults at risk of harm. Nine out of 10 records contained information relating to adult support and protection interventions provided by health services. The quality of information recorded in health records was good. Almost all staff said they had access to systems that allowed for accurate recording of adult at risk concerns.

Interventions provided by acute and community care services were rated good or better in the cases that applied. Three adults at risk of harm required a medical examination, and every time health services responded promptly. Overall, health services made a positive contribution to improved outcomes for adults at risk of harm.

Capacity and assessment of capacity

Capacity assessment processes were timely, competent, and effectively delivered. When social work requested an assessment of an adult at risk of harms capacity, it was carried out timeously by an appropriate health professional. The effectiveness of this work was important to the positive outcomes of adults at risk of harm across the Shetland Islands.

Police involvement in adult support and protection

Contacts made to the police about adults at risk of harm in three out of four incidents were effectively assessed by control room staff for threat, harm, risk, investigative potential, vulnerabilities and engagement required (THRIVE). Two out of five records had an accurate STORM Disposal Code (record of incident type). There was an opportunity to improve STORM Disposal Code recording.

In all cases, the initial attending officers' actions were evaluated as good or better. There were relevant interventions initiated in support of adults at risk of harm. There was diligent practice and engagement with relevant partners when determining an appropriate and proportionate response. Officer assessment of risk of harm, vulnerability and wellbeing was accurate and informative in all cases. The wishes and feelings of the adult were always appropriately considered and properly recorded.

Where adult concerns were raised, officers did so promptly in six out of seven occasions, using the interim vulnerable person's database. Frontline supervisory input was evident in six out of seven cases, with the supervisors' contributions rated good or better in five out of six cases.

Divisional concern hub staff's research and assessment was rated good or better in six out of seven cases. Consideration of adversities and protective factors was strong. This allowed for the accurate and timely exchange of information on risk and vulnerability with colleagues. The use of the interim vulnerable person's database to record retrospective referrals and relevant information shared by partners was identified as good practice.

The divisional concern hub should always initiate the escalation protocol review where required following a series of adult concern episodes over a short period. While the need for them was recorded, opportunities remained for the police to be more proactive in initiating a proportionate multi agency/single agency intervention in support of the adult at risk. The divisional concern hub also needed to develop single agency response plans demonstrating evidence of input and oversight from the local area command team.

The police administered and chaired the partnership's interagency referral discussions. Case file numbers limited our ability to understand the impact of this approach.

Officers also participated in a fortnightly partner meeting to consider and manage police generated adult concern referrals with involvement in the group facilitated by hub staff. Improved information pathways would add further value to these arrangements to help ensure that all appropriate adult support and protection related information was effectively disseminated. The police attended five out of six case conferences when invited, when they positively contributed to discussions and decisions.

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 Shetland public protection committee worked collaboratively with the third and independent sector to develop support groups for adults at risk of harm, families, and unpaid carers. The Shetland public protection committee welcomed active representatives from various partner agencies and third sector providers. The third and independent sector made a significant contribution to our staff survey. Responses were mostly positive although some said they were not always given timely feedback from social work on actions they had taken in response to protection concerns they raised. Adult support and protection training was available to all staff working in the partnership which helped to ensure staff were appropriately skilled. Some staff working in the independent and third sector said they were not involved in evaluating the adult support and protection work they undertook. This needs reviewed to strengthen this important relationship.

Key adult support and protection practices

Information sharing

Almost all staff were confident escalating matters about adults at risk of harm and knew where to get advice if they were unclear about an adult at risk of harm concern. All the adult support and protection records demonstrated partners were sharing information. The quality of information sharing and collaboration between partner agencies was good or better in almost all cases.

Social work records were often very detailed and included a high volume of additional information which was not necessary. This made accurately determining the risks difficult in some cases.

Management oversight and governance

Oversight of practice and evidence of supervision was apparent in eight out of 10 records. The level of recording for these records was also appropriate. Seven of these cases evidenced exercise of governance. While information recording processes were effective across the partnership, social work staff did not consistently record information on the templates available. Social work managers should aim to address this. Positively all police and health records demonstrated oversight had taken place.

Involvement and support for adults at risk of harm

The partnership sought the views of the adult at risk of harm throughout all inquiry and investigation work. Adults at risk of harm were included in decisions made at case conference and in protection planning. The effectiveness of the support was good or better for nine out of 10 adults at risk of harm. Partners, including those services providing care and support, understood the needs of the adult at risk and worked in partnership to ensure information was shared with the adult when required.

Independent advocacy

The partnership had a short-term arrangement in place to provide statutory independent advocacy. This was delivered through a remote (telephone and online) contact model based in England. In six out of 10 cases the adult at risk of harm should have been offered independent advocacy but were not. Only one adult at risk of harm accepted the offer of advocacy and received it. That said, staff indicated that overall, the remote support received from the advocacy provider was helpful.

The contract for independent advocacy provision was due to end in September 2023. The partnership was planning to re-tender for this provision and had contingency measures in place.

Financial harm and alleged perpetrators of all types of harm

Collaborative approaches were in place to help tackle financial harm across the Shetland Islands. The financial harm sub-committee worked closely with the community and representatives from local projects to raise awareness of financial harm.

Commendably, the partnership always took action to stop the financial harm. The quality of interventions to stop financial harm were almost always good or better.

In seven out of 10 cases there was an alleged perpetrator of harm, the perpetrator in all cases was known to the partnership. Action against the alleged perpetrator was taken by the partnership when appropriate and interventions were good or better for six adults.

Safety outcomes for adults at risk of harm

Some early adult support and protection work needed to be improved. Beyond that there were effective processes in place which led to improved outcomes for nine out of 10 adults. Good multi-agency working was the main reason for improved outcomes for adults who required support and protection. Half of the cases we read required ongoing health and social care support to keep them safe and protected beyond adult support and protection interventions. All of them received very good support from partner agencies and the third and independent sector. This had a positive impact on their longer-term safety, health, and wellbeing.

Adult support and protection training

The Shetland public protection committee's training strategy was jointly developed to support the needs of all staff working with both children and adults. The strategy provided general information about public protection training available to staff groups. It lacked direction to specific training, and the training delivery methods. Uptake rates for specific training were not clear. Training to support early interventions such as trauma informed practice and distress brief interventions were not included in the strategy. A gap existed in terms of how the committee planned and evaluated the public protection learning and development needs of the workforce in the Shetland Islands.

The partnership recognised that staff shortages during the Covid-19 pandemic had negative impact on the delivery of training and attendance. Important steps were taken by the partnership to ensure most of the training delivered was available online. The training sub-committee had developed a programme of training to promote learning and development and had begun to introduce more face-to-face training recently. Strategic leaders were committed to securing financial support to further extend and promote learning. Almost all staff said they were confident they received the right level of mandatory adult support and protection training.

Staff who had attended training said it supported them to understand risks in the context of adult support and protection. Police Scotland offered training and guidance around preventing financial harm to all staff, unpaid carers and local support groups.

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

Key messages

- Leaders oversaw the delivery of competent, effective, and collaborative adult support and protection work in most areas of practice.
- Strategic leaders promoted collaborative working and proactively sought external support and learning opportunities. This contributed to improved outcomes for adults at risk of harm.
- The partnership was actively raising the profile of adult support and protection in the community through public awareness events and social opportunities to share information.
- The partnership carried out audits to identify the quality of work and the strength of key processes. Outcomes from these audits prompted improvements including how risks were managed.
- The partnership did not have a clear vision for adult support and protection.
- The Shetland public protection business plan had minimal focus on adult support and protection. Improvement actions identified from adult support and protection quality assurance work were not included. The partnership should develop an adult support and protection improvement plan linked to multi-agency self-evaluation and quality assurance activity.
- Adults at risk of harm and unpaid carers were not represented on the public protection committee or sub-committees. This should be addressed to ensure the lived experience of adults and unpaid carers enhances strategic decision making.

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

Vision and strategy

The overarching Shetland Partnership Plan 2018-2028 included a shared vision for all communities within the Shetland Islands. The plan included four strategic priorities. The partnership cited the 'people' priority as key to its adult support and protection objectives. The partnership had not articulated a specific vision for adult support and protection.

In 2019 the health and social care partnership merged its adult and child protection committees into the Shetland public protection committee. The committee had not developed a strategy to support the delivery of adult support and protection. It had produced an annual business plan, but this had minimal focus on adult support and protection.

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

The Shetland public protection committee and chief officers' group hosted focussed meetings four times a year to discuss and evaluate public protection arrangements. This included review of adult support and protection practice, quality assurance and improvement outcomes. Attendance and representation at these meetings were not optimum and the structure of agendas required improvement to ensure consistency in sharing and recording discussions. The Shetland public protection committee and chief officers' group oversaw the quality assurance processes and resulting key performance outcomes. This ensured strategic leads were informed of the operational and strategic improvement activity. Strategic oversight and governance could be strengthened further with, increased attendance, and enhanced recording of decisions.

The Shetland public protection committee was strategically aligned to the health and social care partnership's multi-agency public protection arrangements including the Shetland domestic abuse partnership. A variety of sub-committees sat beneath and were shared by these groups. These included the quality assurance, financial harm, community protection and digital safety. This fostered good cross cutting work and benefitted adult support and protection. Strategic leaders had reached out to other partnerships to learn and strengthen their quality assurance processes.

The partnership's two-year public protection business plan included eight key public protection priorities for improvement. The public protection priorities were appropriately focussed on health and wellbeing priorities. Some priority timescales set out in the plan were on schedule, others were behind. Progress indicators for all priorities were described as 'likely to meet target' making it difficult to evaluate progress.

The business plan lacked detail about targeted adult support and protection interventions, outcomes, and impact.

Improvement actions arising from adult support and protection audits were not included. The business plan did not provide an accurate measure of adult support and protection improvement progress.

Most staff were confident in strategic leadership and the capacity in services to meet the needs of adults at risk of harm. There was also confidence amongst most staff that local leaders understood the quality of work delivered by front line services and felt valued for the work they did reflecting a supportive culture promoted by strategic leaders.

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

Promoting the participation and involvement of adults at risk of harm and unpaid carers at a strategic level was a partnership priority. The Shetland public protection committee was at the early stage of developing a new public communication strategy. This should be implemented promptly to strengthen this commitment.

Adults at risk of harm and unpaid carers were involved in some service specific activity and community awareness raising events about harm. These were arranged by the Shetland public protection committee and provided ideal opportunities for raising awareness of safety and prevention of harm as well as gathering feedback about the effectiveness of services.

Adults at risk of harm and unpaid carers were not represented on the Shetland public protection committee. This meant the voice of people with lived experience was limited in informing strategic decision making. This should be addressed in line with national adult protection committee guidance.

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

The strategic leadership team oversaw the effective delivery of adult support and protection at an operational level. Strong collaborative working in adult support and protection, particularly from investigation stage onwards evidenced this. The partnership proactively identified approaches and implemented strategies to develop and improve practice.

Almost all staff said they were supported to work collaboratively to achieve positive outcomes for adults at risk of harm. Staff commended the strategic leadership, particularly how well services were delivered during the Covid-19 pandemic. Staff understood each other's roles.

Some staff felt that the continued use of mainly online meetings reduced opportunities for information sharing and wider discussions. Staff acknowledged the lack of consistency in recording information using standard recording templates and agreed it was an area needing improvement. The partnership's quality assurance sub-committee had identified information recording to be an area for improvement.

Partners worked collaboratively to ensure information about additional risks for adults at risk of harm were shared. Examples of this included the multi-agency meetings and the introduction of a 'Cuckooing Framework' to support interventions to minimise risks associated with drug dealing.

The partnership developed a case file audit tool which they used to evaluate key areas of practice including how well risks were managed for adults at risk of harm in the Shetland Islands.

Supportive contributions from services including the police, health, the Scottish Fire and Rescue Service and housing for adults at risk of harm were evident. They all submitted concerns, but often they related to welfare, as opposed to protection issues. Some adult concern referrals prompted unnecessary adult support and protection activity. This contributed to increased workload. Health services expertise needed to be used where necessary to better support the adults needs at key stages of the investigation.

Quality assurance, self-evaluation and improvement activity

The adult protection quality assurance sub-committee was the vehicle for driving improvement work forward. It met quarterly to plan and discuss outcomes of the quality assurance work being carried out in the partnership. The group recently concluded that while progress had been made in this area of practice more work was needed to develop the framework further.

The Shetland public protection committee biennial report 2020-2022 provided evidence of the partnership's quality assurance and multi-agency (social work and NHS Shetland) self-evaluation approach and findings. Aspects of police involvement with the adult at risk of harm, as detailed in social work records, were also included in the review. Case studies in the report offered useful examples of how adults at risk of harm had been supported by services.

The findings from the social work case file reading audit identified how well risks were managed. The case file audit identified strengths in managing risks as well as some areas for improvement consistent with our inspection findings. This demonstrated robustness in the audit approach. While the actions taken following the audit provided some information to demonstrate how improvements will be met, a more detailed action plan had not been developed. Some staff were not aware of this audit and the outcomes.

The partnership had carried out a single agency social work adult support and protection audit in 2019 and 2020. In 2021, an interagency case file audit was also conducted to determine outcomes of adult support and protection key processes. The findings highlighted an increase in referrals over a three-year period. Screening, triage, and inquiry processes should be a priority area for improvement to ensure they meet the increased demands more effectively.

The partnership recognised there were staff shortages, particularly during the pandemic. This had a negative impact on the delivery of training and on attendance. The training sub-committee had since developed a programme of training to promote learning and development.

Staff we met were not aware of all the quality assurance work which had taken place. Similarly, less than half of the staff responding to our survey said they had been involved in evaluations of the adult support and protection work conducted in the partnership.

Initial case reviews and significant case reviews

There were no initial or significant case reviews or learning reviews for any adult support and protection cases completed. The chief officers' group had discussed the 2022 adult support and protection learning review guidance and were considering how to implement the national guidance in practice.

Summary

The partnership's key processes for adult support and protection were mostly effective. Critical elements of practice including investigations, assessment, and management of risks including case conference performance were strong. Improvement was needed at the screening, triage, and duty to inquire stages. This is important because it will improve how adults at risks of harm are protected from the outset.

Collaborative working arrangements at an operational level were commendable, although this did not always translate into accurate and consistent recording which undermined the good joint work done. Recording at the inquiry and investigation stage were not as strong as they could be.

Overall, strategic leadership was effective. However, the adult support and protection vision needed to be more specifically set out in key strategic policies. The partnership oversaw a mostly competent and effective adult protection approach. A strong culture of collaboration had been fostered amongst staff, who felt valued. There was evidence of some self-evaluation activity and audit work driving improvement, but it needed to be further developed. Quality assurance was focussed on key processes but was not sufficiently aligned to the public protection business plan. Meetings attended by chief officers' and the Shetland public protection committee generated discussions, but oversight could be strengthened to include discussion of adult support and protection outcomes.

An adult support and protection improvement plan was required, and more work was needed to include staff in self-evaluations of practice and performance. The partnership involved adults at risk of harm and unpaid carers at key stages of adult support and protection journey. The structure that supports adults at risk of harm and unpaid carers should be developed to demonstrate participation at all levels.

The plan for statutory independent advocacy was in place. A tendering process was planned to secure longer term arrangements. This was needed to ensure advocacy is available for adults at risk of harm.

Next steps

We asked the Shetland 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 processes

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

- 97% of initial inquiries were in line with the principles of the ASP Act
- 85% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 46% of episodes where the application of the three-point criteria was clearly recorded by the HSCP
- 89% of episodes where the three-point criteria was applied correctly by the HSCP
- 89% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 50% one to two weeks, 25% two weeks to one month, 25% more than three months
- 89% of episodes evidenced management oversight of decision making
- 51% of episodes were rated good or better.

Staff survey results on initial inquiries

- 95% concur they are aware of the three-point criteria and how it applies to adults at risk of harm, 2% did not concur, 3% didn't know
- 83% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 3% did not concur, 14% didn't know
- 85% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 6% did not concur, 9% didn't know

Information sharing among partners for initial inquiries

- 89% of episodes evidenced communication among partners

Staff survey results about aspects of key processes

Involvement and support for adults at risk of harm

- 86% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 5% did not concur, 9% didn't know

Safety and additional support outcomes

- 85% concur adults subject to ASP, experience safer quality of life from the support they receive, 3% did not concur, 12% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 74% concur local leaders provide staff with clear vision for their adult support and protection work. 10% did not concur, 16% didn't know

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

- 75% concur local leadership of ASP across partnership is effective, 4% did not concur, 21% didn't know
- 66% concur I feel confident there is effective leadership from adult protection committee, 6% did not concur, 27% didn't know
- 61% concur local leaders work effectively to raise public awareness of ASP, 9% did not concur, 30% didn't know

Quality assurance, self-evaluation, and improvement activity

- 63% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 7% did not concur, 30% didn't know
- 65% concur ASP changes and developments are integrated and well managed across partnership,5% did not concur, 30% didn't know