JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION: REVIEW OF PROGRESS

In the Orkney Islands Partnership Area

Published January 2025

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Background

Joint inspection partners

In June 2023 Scottish Ministers requested that the Care Inspectorate lead the progress reviews of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. These relate to six partnerships across Scotland where important areas of weakness outweighed strengths in our phase 1 inspection programme between 2020 and 2023.

Joint inspection focus

The purpose of these six joint inspection team progress reviews is to provide assurance about the extent to which improvement has progressed in each of these partnership[1] areas.

Updated code of practice

The updated code of practice for the Adult Support and Protection (Scotland) Act 2007 was published in July 2022. Partnerships should have implemented the new code of practice guidance for the cases scrutinised in this progress review.

Joint review methodology

The methodology for these six progress reviews includes:

The **analysis of supporting documentary evidence** and a focussed position statement submitted by each partnership. This evidence relates specifically to areas for improvement identified in the phase 1 inspection reports.

Scrutiny of health, police, and social work records of adults at risk of harm. We read the records of 11 adults at risk of harm whose adult support and protection journey progressed to an inquiry with investigative powers and beyond.

Staff focus groups – We met with 34 members of staff from the Orkney Islands partnership area to discuss improvements they had made to the delivery of key process, and strategic leadership for adult support and protection. Staff included multi-agency frontline staff, middle managers and strategic managers.

[1] https://www.careinspectorate.com/images/Adult_Support_and_Protection/New_links/1._Definition_of_adult_protection_partnership.pdf

Quality indicators

Our quality indicators for these joint reviews are on the Care Inspectorate's website.[2] We have used the same quality indicators that were used in the phase 1 inspection.

Standard terms applied to the sample of records we read.

All – 100%

Almost all – 80% - 99%

Most – 60% - 79%

Just over half – 51% - 59%

Half – 50%

Just under half – 40% - 49%

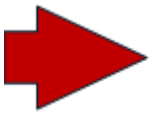
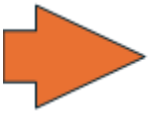
Some – 20% - 39%

Few – 1% - 19%

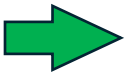
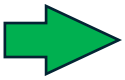
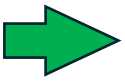
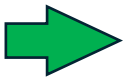
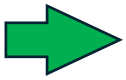
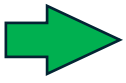
[2] https://www.careinspectorate.com/images/Adult_Support_and_Protection/4.__Adult_support_and_protection_-_quality_indicator_framework.pdf

Progress

Priority areas for improvement were identified in the phase 1 inspection. To indicate progress, we have used RAG rated arrow indicators. In our determinations we have included the principles of a RADAR model (Results, Approach, Deployment, Assessment and Refinement) that helped us to identify how effectively and efficiently partnerships approached their improvement work. What we mean by these is set out in the key below.

	Minimal progress	**Improvement is minimal**. The partnership's overall approach to improvement is not comprehensive or put into practice. It's deployment and implementation are limited. It has not embedded improvements or they are still at the planning stage. It does not communicate improvements effectively and they are not well understood by staff. It does not assess and review the effectiveness of its improvement progress.
	Some progress	**Evidence of some improvement**. The partnership's approach to improvement is moderate. Its implementation and deployment of improvements are structured. It is beginning to embed improvements in practice. It communicates improvements partially and staff understand them reasonably well. It has limited measures to evaluate and review impact and outcomes for adults at risk of harm. It periodically assesses and reviews its improvement methodology.
	Significant progress	**Significant improvement**. The partnership's approach to improvement is comprehensive and embedded. Its deployment of improvements is well structured, implemented and effective. It communicates improvements purposefully, and staff understand them fully. It has effective measures to evaluate and review impact and outcomes for adults at risk of harm. It continually assesses and refines its improvement methodology.

Overview of progress made in the Orkney Islands Partnership

Priority areas for improvement from Phase 1 in April 2023		Progress	Progress review findings in January 2025
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.		Significant progress made.
2	Risk assessment, chronologies, investigations, and protection planning all require immediate improvement.		Significant progress made.
3	Change and improvement following the independently commissioned review by the partnership in 2021 needs to be accelerated. Adult support and protection should be a critical improvement priority for strategic leaders across the partnership.		Significant progress made.
4	The partnership's strategic oversight of progress should be strengthened. Effective governance and quality assurance arrangements are needed to support improvements in practice.		Significant progress made.
5	The involvement of adults at risk of harm at all stages of the adult support and protection process should be improved.		Significant progress made.
6	Strategic planning and decision-making should be informed by the lived experience of adults at risk of harm and their unpaid carers.		Significant progress made.
Significant progress		**Some progress**	**Minimal progress**

Progress on priority areas for improvement

Key processes priority area for improvement 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

The partnership operated a public protection committee (OPPC) which was multi-agency and fulfilled the joint role of child and adult protection committee. The OPPC introduced a new procedure in 2023, detailing adult support and protection processes and providing clarity for staff on the partnership's practice expectations. The procedure was comprehensive and relevant to all partnership staff. It included good guidance notes and supporting appendices. The procedure was not entirely in line with the new code of practice requirements. However, all activity was overseen by a manager/council officer and a council officer undertook all investigation activity. The partnership advised the procedure was to be reviewed as part of a stepped approach toward fully adopting the revised code of practice. This was to be based on a strategic assessment of increased staff awareness, confidence, skills and knowledge in the required aspects of practice. Case review of progress indicated the partnership had made significant improvement in this regard and was ahead of schedule. The partnership had introduced other, wider procedures to support adults at risk of harm. These included a useful self-neglect and hoarding protocol and toolkit, a preventative multi-agency risk management procedure, a separate and clear financial harm procedure, helpful chronology template and guidance, and an innovative placement stability procedure. This enabled the adult to remain living in a registered care setting where there was a risk of placement breakdown, which could lead to the adult being placed out with Orkney. This would have a determinantal effect upon the adult and their family.

The refreshed adult support and protection procedures offered clear guidance stating all cases progressing beyond inquiry should have a chronology completed. This was to inform case conference discussions and consideration of risk. This set out the purpose and importance of chronologies in supporting risk assessment and management. It was multi-agency, trauma informed, and used RAG rating to show protective factors, increased risk and actual harm. Overall, the guidance was clear, and the template was helpfully being embedded into the electronic database. Staff acknowledged the significant culture change with chronologies and described them as integral to risk assessment.

Risk assessment was also a strong feature throughout the new procedures and guidance. There was a helpful risk assessment framework to support staff identify and understand the likelihood and impact of harm. Helpfully, some templates were embedded in the electronic system which increased their visibility and quality within process recording.

Monthly development sessions with social work staff were facilitated by a service manager throughout 2024 and focussed on adult support and protection procedures and practice. This impacted positively on practice. Frontline practitioners stated they were much more engaged in adult support and protection work. They found the new procedure useful and described their team and service managers as accessible and supportive. They positively described team manager oversight of council officer, and where appropriate, second worker activity, and supervision discussions. Social work staff viewed supervision positively in terms of sharing and improving practice.

The NHS public protection lead provided health staff with guidance as required. Police staff were clearly and positively involved in adult support and protection and described the processes as effective following submission of a concern. The police concern hub facilitated useful and effective multi-agency weekly meetings to review vulnerable person database referrals (iVPDs), which had also enhanced interagency working relationships. In addition to this, the police had dedicated staff to attend interagency referral discussions (IRD), and internal recording was good. There was effective interagency communication, a supportive culture and increased confidence in making referrals.

Over the last three years adult support and protection referrals had doubled. A very positive referral and feedback culture supported the formal processes. This had strengthened the cycle of engagement, as multi-agency staff understood why previous referrals had not been taken forward. Formal training and informal information sessions that included service providers, supplemented this approach. Feedback from those attending was positive.

In summary, the partnership had implemented refreshed procedures and guidance that were the drivers for significant progress in the delivery of competent and effective adult support and protection key processes. They were well shared, embedded, understood and overseen.

Key processes priority area for improvement 2

Risk assessment, chronologies, investigations, and protection planning all require immediate improvement.

Risk assessments

The presence and quality of risk assessments had improved considerably. In the 2023 inspection, just over half of adults at risk had a risk assessment with only some being good or better in quality. In the 2024 progress review almost all adults at risk of harm who should have had a risk assessment had one, and the quality of most risk assessments was good or better. This indicated significant progress had been made since the last inspection. Risk assessments also demonstrated key strengths in that

they were multi-agency and timely. Overall, these improvements clearly evidenced that the changes needed since the last inspection were comprehensively met.

Chronologies

Positively, the presence of chronologies in the adult at risk of harm's record had increased within the almost all categories. In terms of quality, this had improved significantly. In 2023 just under half were good or better in quality and most were weak or unsatisfactory. In 2024, all chronologies were adequate or better in quality, with the majority of these being good or better. Positively, there was some reference to broader life events and their impact upon the person. Further enhancing this element would benefit the partnership.

Investigations

In our progress review we found similarities with the last inspection, in that almost all investigations involved the appropriate parties. Positively, most were timely, and the presence and quality of investigations had significantly improved. In our 2023 inspection most adults at risk had an investigation that effectively determined if they were at risk of harm. This had improved to almost all in our 2024 review of progress. Almost all adults at risk of harm had a formally recorded investigation within their records, which effectively determined risk in all cases. In our 2023 inspection only some investigations were good or better in terms of quality, where as our progress review found most were good or better. In addition to this, a council officer was always involved and there was a second worker in almost all cases where required. Enhancing the availability of health staff as second workers was needed.

Protection Planning

There was an overall improvement in the presence and effectiveness of initial case conferences, with the quality being good or better in all cases. However, the consistency of attendance from health and police, and timeliness had decreased. Review case conferences were convened when required and effectively determined what needed to be done to ensure the adult at risk of harm was safe, protected, and supported. These factors were reflected in the high quality of protection planning, including at case conferences. In our 2023 inspection, just under half of adults had a protection plan with only some being good or better in quality. In our 2024 review of progress, their presence had greatly improved with almost all adults at risk of harm having one where required. All plans were up to date, and most were good or better in terms of quality, another marked improvement.

In summary, the partnership made significant progress in these priority areas for improvement. The refreshed procedures, guidance tools and templates had combined well to support staff. This was demonstrated by the consistency and quality of critical adult support and protection work. The partnership clearly prioritised and oversaw the necessary improvement in the delivery of key processes. A team or service manager clearly supported practice. The partnership's approach should further enhance the improvements made going forward.

Strategic leadership priority area for improvement 3

Change and improvement following the independently commissioned review by the partnership in 2021 needs to be accelerated. Adult support and protection should be a critical improvement priority for strategic leaders across the partnership

A great deal of strategic improvement work was undertaken since our last inspection, and although no formal vision statement had been agreed or promoted, a strong adult support and protection ethos was evident across the partnership. Staff shared this view. Leaders were developing a strategic vision based upon outputs from the chief officers group development day. There was a plan to embed this in their 2025-2030 strategic plan. They operated under the national 'act against harm' strapline as an appropriate interim arrangement.

The chief officers group development day positively included the third sector and service managers. This strengthened relationships and increased senior manager visibility within the partnership. Third sector representation within focus groups demonstrated that they were clearly part of the partnership, with representation at the Orkney public protection committee (OPPC). They understood the agenda and contributed positively to the support and protection of adults.

Strategic leaders were therefore effectively engaged with the adult protection improvement agenda and demonstrated knowledge, commitment and enthusiasm to drive and support improvement work. Commendably the partnership increased its strategic capacity by introducing two new posts, a lead officer for public protection and a public protection training and development officer. This was in addition to the valuable use of an independent social work consultant. NHS Orkney supported the agenda through their senior managers and their public protection lead nurse. A social work service manager, supported by a team manager, had also been remitted to focus upon adult support and protection. All these measures combined, had positively impacted upon the quality of practice.

The partnership produced and implemented an impressive range of procedures to improve process and practice. A project board effectively oversaw developments to the electronic social work record, including ongoing work to embed the chronology template. Our review of progress indicated that these measures were effective and impactful regarding the quality of adult support and protection work being undertaken.

Dedicated council officer and wider adult support and protection training had been rolled out since our last inspection in 2023. Newly qualified social work staff were being well supported and prepared for the council officer role. In our 2024 review there was also a clear training plan for social work staff. Non–social work frontline managers were invited to the council officer training that increased awareness and skills more widely, enabling them to offer informed support to their staff around adult protection decision making. Additional bite-size training was delivered for non-social work staff. Online training was available to health staff and more in-depth training had been developed for accident and emergency staff. In addition to this, the partnership had provided training for students undertaking the HNC social care as part of their core curriculum.

To summarise, the partnership had made significant progress regarding the pace of change. Strong collaboration was undertaken, and clear progress was evident. Adult support and protection was a priority across the partnership. A clear vision statement would further support this. Subsequent investment dedicated to driving change and improvement activity was provided by leaders to support the transformational work. A project board brought together those with an understanding of practitioner needs and those with the technical skills to aid system development. This improved the quality of case recording within social work case file records.

Strategic leadership priority area for improvement 4

The partnership's strategic oversight of progress should be strengthened. Effective governance and quality assurance arrangements are needed to support improvements in practice.

The partnership recently commissioned external biannual audits that were robust and informative. This provided strategic leaders with independent assurance and helpfully highlighted areas requiring an improvement focus. Within social work, a biannual supervision audit tool was introduced to assist practitioners, and their managers consider practice issues and development. Subsequent data was escalated to relevant strategic groups for consideration and assured the partnership they were operating according to guidance.

The partnership conducted an online council officer survey as part of their wider strategy to encourage reflective learning. The survey supported practitioners to reflect on their skills, knowledge and confidence in relation to adult support and protection practice. They were also asked to consider the adult support and protection managerial supports available to them. The results informed service improvement through the Orkney public protection committee and social work senior management team. The partnership planned to re-run the survey in April 2025.

The strategic leadership team demonstrated a knowledge of, and commitment to, the adult support and protection agenda. Leaders met formally and informally about adult support and protection to develop their thinking. This highlighted a positive level of interest and curiosity within the leadership group. Additionally, there was a specific service manager with responsibility for adult support and protection operational development and management, who sat on the OPPC. This had clearly been impactful upon the development of process and practice.

NHS Orkney and police leaders used the NHS public protection accountability and assurance framework as part of their strategic self-evaluation. Integration joint board representatives received monthly briefings, and they monitored the agenda and provided effective oversight.

To inform the partnership's oversight role, they ensured it had representation on key national groups and development forums. It also usefully considered the issues highlighted in other work streams such as suicide prevention.

The national minimum dataset and local data was used to assist effective governance by the OPPC. The regular collection and analysis of this data assisted the partnership to identify the positive impact of policy developments such as their self - neglect and hoarding policy. Data was also gathered to measure the impact of the financial harm procedures.

In summary, there was significant progress in strategic leaders approach to oversight. This included consideration of self-evaluation findings, external and single agency audits, learning reviews and case conference evaluations. This work included all core partnership agencies. Findings were discussed in the context of the improvement plan and assisted the identification of thematic trends and areas for improvement. The OPPC used the last inspection report and data from their commissioned audits, to identify areas of improvement which were clear in the improvement plan. Examples included, the consistent offer of advocacy, council officer training and clarifying when risk assessments and chronologies should be conducted. These were all addressed through written guidance, training and briefing sessions and were evident within case file reading. The Orkney public protection committee and chief officers group had clearly monitored the improvement plan closely since the last inspection. Staff acknowledged the culture shift in terms of the approach to improve professional practice, and the impact was supported by the positive case file reading results. Together, these indicated strong strategic oversight and governance.

Strategic leadership priority area for improvement 5

The involvement of adults at risk of harm at all stages of the adult support and protection process should be improved

Since the last inspection, adult support and protection procedures had been amended to clearly include the stated requirements for involving the adult at risk of harm when conducting an interview. New easy read leaflets for adults at risk of harm were in use and file reading highlighted good use of formal notification letters to adults about adult support and protection processes. Adults were invited to case conference when appropriate and when they were not, appropriate and relevant reasons for this were recorded in the minutes. The partnership also deployed a feedback survey which included gaining the adults views post case conference, which was informative. There was consistent consideration of adults' views throughout the entire adult support and protection process.

Independent advocacy was re-commissioned, and the service provider reported increased engagement, receipt of timely information and the positive nature of meetings they attended. Partnership staff were confident in this important service and were very positive about adults experience of receiving advocacy. Case conferences were offered on a face to face or virtual basis. When virtual, social workers attended the persons home with a laptop. It was noted by advocacy this had a positive impact in terms of providing an informal opportunity for the person to discuss the meeting with the social worker prior to commencement. These factors represented a wider approach which successfully obtained and considered the views of adults at risk of harm to inform a high level of support throughout the process, which was trauma informed. Partnership staff sought and took account of adults views in almost all investigations and case conferences, and in all protection plans. This was in addition to the positive feedback received through the post case conference survey.

In summary, the partnership took multiple measures to strengthen this area of practice since the last inspection. The procedures laid out engagement expectations, leaflets supported this, and process feedback was embedded into key elements of practice. Changes to practice were adopted, driven by this feedback. Our 2024 review of progress found that almost all adults at risk of harm were well supported. Positively, the quality of the support all adults at risk of harm received was good or better. These factors indicated significant improvement with regard to the involvement of adults in the process.

Strategic leadership priority area for improvement 6

Strategic planning and decision-making should be informed by the lived experience of adults at risk of harm and their unpaid carers.

There was a strong commitment to involve adults at risk of harm and their unpaid carers within the Orkney public protection committee. A strategic manager provided relevant feedback from the carers strategy group. The representation of unpaid carers was described as a work in progress, with plans for a representative to commence sitting on the committee or relevant subgroup in 2025.

The partnership introduced the innovative sharing of lived experience accounts to assist their understanding of the process and to inform further improvement planning. These included a reflective summary by a service manager to aid strategic discussion.

A case conference feedback form was used effectively to gather the views of individuals, unpaid carers and professionals. A formal report was submitted to the Orkney public protection committee (OPPC) with analysis of feedback. Findings for adults at risk of harm and unpaid carers were similar. They both said they were able to speak up, were listened to and treated with respect throughout adult support and protection processes.

The OPPC actioned the report recommendations and made improvements. For example, they reduced the number of people attending case conferences and gave guidance to staff to turn off their cameras in virtual meetings. This evidenced that the OPPC oversaw this feedback and were willing to make impactful changes at a strategic and operational level. The OPPC minutes clearly noted the consideration of the feedback data and the planned presentation of a report detailing feedback received and actions taken over a six-month period.

The OPPC considered the issues around direct involvement of those with lived experience at committee level, and other ways in which they could share their experiences. However, given the remote rural nature of the islands, maintaining anonymity was a notable issue. The partnership therefore developed the use of lived experience accounts to reflect a person's experience to the OPPC and the chief officers group. These personal accounts included reflection from the service around practice challenges and improvements. Some of these points were evident in case file reading and supporting documents. However, this approach would be strengthened through more formal tracking of the issues and how they have been addressed. Importantly, this model avoids the person themselves having to attend formal meetings or their identity being shared.

Advocacy services attended the chief officers development day. The partnership planned to work closely with advocacy in 2025 to support the lived experience agenda.

In summary, since the 2023 inspection there had been significant progress supported by two key elements. Firstly, the development of a case conference survey which included adults and their carers. Secondly the development of an approach that delivered accounts of lived experience to the OPPC and the chief officers group. The partnership's improvement plan stated these were now a quarterly feature of the OPPC. The culmination of strategic and practice-based engagement of those with lived experience, placed the partnership in a strong position in terms of informing their strategic decision making.

Summary of progress

Key processes progress including findings out with priority areas for improvement

New procedures and guidance were introduced in 2023 which had clearly supported practitioners to undertake their critical adult support and protection roles. These were supported by a range of new tools, templates, and protocols around specific areas of adult protection practice. Examples include financial harm, hoarding, and chronologies. In addition to this an interagency referral discussion process was in place and a comprehensive approach to reviewing all vulnerable person referrals (iVPDs) in weekly meetings with the police. This had created a strong collaborative approach to key processes.

These initiatives were supported by a training framework and a strong commitment from strategic and operational managers to improve practice. The impact of all these measures meant practitioners demonstrated a greater knowledge and confidence in their work, that we saw in our file reading. Overall, this showed considerable improvement in the quality of work. The presence and quality of chronologies, investigations and risk assessments had all improved alongside the staffs' understanding of their value.

The challenges of operating in a remote rural context were well understood. These mainly related to the availability of transport to remote areas and isles and the impact of bad weather. It may be useful to monitor these in order to understand their impact and the need for any further mitigations, including contingencies within the local procedure.

Adults at risk of harm involvement in key processes was much improved. Operational management and oversight had strengthened and was supportive and accessible. They effectively ensured that procedures were followed, and that high quality work was achieved.

Case conferences and review case conferences had improved in terms of presence and quality. More consistent attendance of police and health was needed, although case conferences always determined the required action, and their quality was good or better.

An area of focus moving forward, is the need to align procedures with the national code of practice. The extent of the partnership's progress indicates it may be able to take this step sooner than planned.

Encouragingly, there was a notable presence of adult protection recording in health records and the quality of this was good or better in just over half of instances. However, the level of oversight in the records had decreased notably and there were indicators that awareness raising, training and more formalised access to in person guidance would be beneficial for health practitioners.

Strategic leadership progress including findings out with priority areas for improvement

The Orkney public protection committee (OPPC) had promoted a more positive working culture in Orkney. The OPPC was delivering positive change and improvement in a way that was supported by staff, and as planned should now develop and promote the strategic vision. They oversaw the implementation of a range of linked supporting procedures and other initiatives that had improved practice. The culmination of the strategic decisions made, and work undertaken demonstrated significant progress across adult support and protection practice. The positive transformational work undertaken was effectively prioritised by the chief officers group. The pace of change was commendable. The OPPC and the chief officers group promoted the updated electronic systems and oversight board, updated training and introduced weekly iVPD meetings. All of which had a positive impact and strengthened operational management.

Positive key features of the strategic leadership of the OPPC, supported by chief officers, included deployment of self-evaluation, audit, case conference evaluations and effective consideration of their findings to drive improvement. The recruitment to two new posts (strategic and training) also represented significant and impactful investment in improvement. The OPPC used external audit which provided robust and objective assurance in terms of the partnership's own case file analysis findings.

The use of the case conference feedback form and lived experience accounts was firmly linked to strategic change and improvement. The partnership had also carefully considered the advantages and challenges of involving adults with lived experience in their committee. The committee was now well placed to consider building upon the work undertaken to establish regular contact with people with lived experience, to give feedback on the extent to which they feel better protected by the committee's activities.

In terms of raising community awareness, some activity was noted with local groups and there was a notable radio interview regarding hoarding. This was a strong attempt to engage the community in the adult support and protection agenda. The press release provided clear descriptions about the complexities of hoarding and the public's role in referring issues to the partnership.

Overall, the OPPC and wider partnership had invested significantly in making and supporting improvements around the adult support and protection agenda, which was clearly a priority for the partnership.

Next steps

The recently published multi-agency quality improvement framework for adult support and protection, should be considered by the Orkney public protection committee and wider partnership to strengthen self-evaluation. The Care Inspectorate link inspector will continue to engage with the partnership. We have shared the full record reading results with the partnership to inform future improvement work. The Care Inspectorate, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland would like to thank the Orkney Islands partnership for their engagement in the progress review.

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