Council of the Isles of Scilly assessment

How we assess local authorities.

Assessment published: Friday 19 September

About the Council of the Isles of Scilly

Demographics

The Isles of Scilly local authority covers a group of five islands 28 miles off the South West coast of England, nearest to Cornwall, with a population of 2,229. Most residents live on St Mary's, with small populations on four other islands which connect to each other by boat or helicopter. The four 'off-islands' are Tresco, St Martins, Bryher and St Agnes. It has an Index of Multiple Deprivation score of 2 (10 is the most deprived) and it is ranked 136 out of 153 local authorities, with 1 being the most deprived and 153 being the least deprived.

The proportion of people aged 18-64 is 56.53%, which is lower than the national average (60.51%). There are fewer people aged 0-17 (16.33%) than the national average (20.80%) and they have the highest proportion nationally of people aged 65 and over (27.14%, national average: 18.69%). The majority of people (97.52%) are White (national average, 81.05%) and the largest minority ethnic group is Mixed or Multiple. (1.1%, national average: 2.96%).

Isles of Scilly local authority is located within the Cornwall and Isles of Scilly Integrated Care System which serves a combined population of 582,782. It has a shared Safeguarding Adults Board and until recently had a shared Health and Wellbeing Board and shares a Director of Public Health.

It is a unitary authority and has a committee system of democratic governance comprising 16 independent elected members. There is no party affiliation or groups within the council, however there is an Adult Services lead member. The local authority received an 'Inadequate' Ofsted rating following the last inspection of its children's services in July 2023. A monitoring visit in February 2025 showed progress was being made. The interim Director of Childrens Services was also acting as an interim Director of Adult Services (DASS) at the time of our assessment.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£6,416,000.00**. Its actual spend for that year was **£9,704.000.00**, which was **£3,288.00 more** than estimated.
- The local authority estimated that it would spend **£1,058,000.00** of its total budget on adult social care in 2023/24. Its actual spend was **£1,702,000.00**, which is £**644,000.00 more** than estimated.
- In 2023/24, **17.54%** of the budget was spent on adult social care.

- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **15** people were accessing long-term adult social care support, and approximately **10** people were accessing short-term adult social care support in 2023/24. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall Summary

Local Authority rating and quality statement scores

Good: Evidence shows a good standard 70%

Summary of people's experiences

People's experiences in the local authority were generally good. Assessments, reviews, safeguarding and care were experienced without delay and people had a very person-centred, supportive service owing to the nature of the small population on the islands and close-knit nature of the community. Efforts were made to meet people's needs early before they escalated into more serious concerns and although there was a lack of choice because of the small and remoteness of the islands, staff and services were flexible and creative with partners to meet people's needs and wishes.

The local authority delivered care and support through strong partnership with their health and care partners and there was a good level of Voluntary, Community and Social Enterprise (VCSE) sector support on the main island. We heard about confidentiality being a constant challenge for staff and partners, because people generally knew each other and would approach staff informally to discuss people's care. Transport to off-islands and the mainland for services was a key challenge and availability was affected by changing seasons and daily weather conditions. To tackle this the local authority had enabled digital solutions and had further plans to allow people to stay on-island for consultations wherever possible.

Summary of strengths, areas for development and next steps

The Isles of Scilly is the smallest local authority in England and has the most ageing population. They are island communities and people generally wished to stay on-island for care. Some off-islands had extremely small populations. The local authority did not have national data to compare it to others in its performance.

There were no waits for assessment and reviews and people were treated fairly and in a person-centred way. There was lots of work to support people to live healthier lives, and there was a good impact of reablement and intermediate care. There were no waits for care services and arrangements for out-of-hours services were effective.

There was a low uptake of direct payments by older people, however some effective work had taken place on off-islands to employ local personal assistants. People generally wanted to stay at home on off-islands and remain independent and this could cause some issues with equity of provision. The local authority had worked with partners to improve virtual and digital solutions to allow people to avoid travelling to the English mainland and also remain at home with a virtual ward arrangement. Staff also offered weekly drop-in services on off-islands to stay in touch with anyone needing care and support or advice and this allowed staff to address needs early.

Staff and partners worked flexibly and creatively as one team, often sharing roles under supervision of each other to fulfil tasks. The multi-disciplinary team worked well as the central organising method to coordinate care and safeguard people. The partnership used the Better Care Fund and integration effectively to meet people's needs. However, we found a better strategic oversight of the islands' needs through a specific Joint Strategic Needs Assessment and a Health and Wellbeing Strategy, would allow for better proactive planning for the needs of the population. Public Health insights specific to the Isles of Scilly would also be helpful in terms of being able to systematically understand unmet needs.

Effective partnerships meant systems were safe and there were tried and tested contingency arrangements. Safeguarding was well organised and because training was shared and because of the MDT approach, safeguarding was everybody's business. There were no waits for safeguarding or Deprivation of Liberty Safeguards (DoLS) decisions.

There had been significant senior leadership changes with new people in roles. Despite this, partners reported strong relationships. The strategic framework was also patchy with some strategies and plans but we found this could be strengthened. There were plans to make strategies specific to the Islands and the local authority had recently decided to host its own Health and Wellbeing Board, but this had not yet been actioned. Understanding data and performance was also challenging, given the small population, and this was an area the local authority wanted to improve.

There was evidence of joint training being available for staff, carers and partners, with plans for apprenticeships opportunities for social workers. The local authority had invited external partners to support improvement activities, such as to quality assure case files and providing feedback to staff in a 1:1. Staff felt supported and had good relationships with senior leaders and there was evidence of improvement work having taken place since a Local Government Association (LGA) peer review. Leaders said there had been

significant changes over the last 4 years with more improvements planned over the next 2 years.

Theme 1: How the local authority works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score:

3 - Evidence shows a good standard

What people expect:

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment:

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

Staff and leaders consistently described assessment and care planning as rooted in person-centred, strengths-based principles. The 'Three Conversations' approach played a central role, supporting early engagement and promoting independence. Impact was evident. For example, the support offered at regular drop-ins helped a person regain stability and greater wellbeing. We also heard about a person maintaining autonomy and remaining at home following support. However, feedback from people painted a mixed picture. Some people said they had person-centred and strengths-based approaches and this was evident in records we reviewed. Other records focused more on needs than capabilities and could have been more strengths-based.

Multidisciplinary teams (MDTs) were convened daily, enabling quick, holistic responses. This close coordination, along with responsive access systems, like the dedicated adult social care phone line and an improved electronic recording system, helped ensure timely assessment and support. Staff highlighted the benefits of working on the islands, where small caseloads allowed for deeper relationships with people and partners and more

flexible, integrated delivery. Even areas relying on commissioned services, such as occupational therapy assessments, showed coordinated action and continuity.

The overall process framework supported coordinated and well-planned care across agencies. Rapid initial responses were built into the assessment process and supported by structured pathways from referral to review. The electronic recording system, introduced in January 2025, further helped to streamline work and enabled timely action, especially in urgent cases. The “Front Door” approach supported assessments at initial contact while also accommodating a wide variety of needs. This meant people received proportionate assessments at the right time to meet their needs.

Partners said there had been improvements to the assessment process in recent years and described collaborative work with the local authority and NHS primary care teams. However, they also said there had been historical barriers, for example people had avoided a dementia diagnosis due to a perceived lack of available support.

While person-centred and strengths-based care was embedded in ethos and process and demonstrated by staff in practice, experiences sometimes varied for those receiving support. Systems for assessment with partners were in place to deliver coordinated care.

Timeliness of assessments, care planning and reviews

Assessments and care planning arrangements were generally timely and up to date. People said they typically experienced annual reviews. Assessments were also completed promptly when a person’s care setting changed suggesting there was an effective system for managing transitions in care.

Partners said support was allocated effectively and people benefited from a diverse experience within teams. There were no waiting lists and response times were excellent, with contact typically being made within one to two days after receiving a referral. Reviews were up to date, with consistent efforts to maintain continuity. Assessments respected people’s mental capacity and supported decision-making. Partners said occupational therapy (OT) assessments were completed swiftly with commissioned OT services enabling quick visits. Some partners said staff turnover among social workers had sometimes disrupted continuity and led to delays in communication, assessments, reviews, and the delivery of care.

Internal process documentation showed assessments were undertaken without delays or waiting lists. Initial contact was made within seven days of referral, and assessments were typically completed within 28 days. Staff said the electronic recording system, introduced in January 2025, had helped to improve pathways.

Assessment and care planning for unpaid carers, child’s carers and child carers

Many people said that they felt listened to and understood during assessments and appreciated having an allocated worker and access to equipment. Records we reviewed reflected good practices by identifying unpaid carers, acknowledging their distinct needs, and exploring how their role impacted daily life. For example, one demonstrated clear understanding of an unpaid carer’s responsibilities and the implications if support was lacking. Some people reported inconsistencies in unpaid carers assessment and reviews.

In particular, reviews were not always conducted within two years and a minority shared they were either unaware of their entitlement or unsure if an assessment had been offered. Therefore, while assessments were often carried out, the process may not have been systematically applied or clearly communicated in every case.

Staff acknowledged that carers assessments were generally quick, although delays could arise. Partners feedback reinforced a generally responsive picture. They said carers were typically contacted the same day and assessments were completed within seven days, they credited small caseloads and an in-house support service for the responsiveness. The absence of waiting lists for carers assessments, and the ability to act immediately in emergencies through the carers emergency card scheme, indicated a well-resourced and supportive system. Training opportunities for unpaid carers both in person and online, further strengthened the support offered, for example safeguarding training. The local authority's policy documentation showed the process for when an unpaid carer was identified: an assessment and support plan were completed, with pathways into carers support groups and, where appropriate, referral to Young Carers services via Children's Social Care.

Help for people to meet their non-eligible care and support needs

Overall, people were offered help, advice, and information about accessing services and support even when their care and support needs were not deemed eligible under the Care Act.

Staff and leaders described a practice of signposting and face-to-face engagement, citing drop-in sessions across the different islands and proactive outreach via leaflet campaigns and social media. These gave people regular opportunities to speak with social care professionals about their situation, whether or not they qualified for formal support. There was an emphasis on staff doing 'contact assessments' which captured the work offered around everyday help such as reading bills or fixing household items.

Data showed people were directed to relevant assistance. For example, between October 2024 and March 2025, 40 applications were submitted for Household Support Funding, and people were signposted to additional resources. Staff described support that extended beyond eligibility. For example, changing lightbulbs, helping with bins, and connecting people with informal community support.

Voluntary, Community and Social Enterprise (VCSE) partners supported non-eligible support. The memory café, community transport ("Buzz a bus"), and informal social activities like the 'men's shed' created space for people to engage and connect with others, many of whom were not formally supported by adult social care. These were well regarded, particularly for individuals with dementia or social isolation, and helped meet needs in a non-statutory and wellbeing-focussed way.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. In September 2024 the local authority commenced the redesign and development of a revised 'front-door' process which involved moving between electronic recording systems. The local authority process showed it was designed to work

on a preventative, strengths-based and a ‘3 conversations’ approach. Eligibility was assessed using this approach, looking at what was important to the person, balanced with the eligibility criteria.

There was one appeal recorded in 2024 which had been reviewed with an independent assessment completed. Other appeals had been progressed through the complaints process.

Financial assessment and charging policy for care and support

The local authority’s framework for assessing and charging adults for care and support was transparent and consistently applied. However, some feedback also revealed occasional gaps in clarity for individuals receiving support, particularly around funding eligibility.

Financial assessments were carried out annually, or sooner if a person’s funds dropped below the eligibility threshold. This approach allowed for flexibility in responding to changing financial circumstances, ensuring timely consideration of funding options, including support from health or education services where needed. Additionally, Continuing Health Care assessments were conducted through the multi-disciplinary team (MDT) for individuals requiring high levels of support or end-of-life care, reflecting an integrated funding model.

The electronic recording systems supported consistent delivery. Financial assessments were linked directly to care planning: when a care and support plan identified required services like home care or care home provision, an assessment was triggered. Local authority performance data supported this, with no recorded waiting times or waiting lists for financial assessments.

Staff said financial assessments were completed swiftly, particularly when required in emergency situations. For example, one assessment was completed shortly after urgent care was provided over the Christmas period.

One unpaid carer expressed uncertainty over the funding arrangements for their parent’s care, including what financial contribution would be required. This reflected a need to ensure financial implications were consistently explained in a way that was understandable and accessible to carers and service users, particularly at points of assessment or service transition.

Provision of independent advocacy

There was evidence that independent advocacy support was available, and in some cases timely and responsive, helping people participate more fully in care assessments and planning. Partners said there were mixed referral practices from staff, with some regularly referring people for advocacy, demonstrating a strong understanding of when support was necessary, whilst other staff did not.

Leaders said the local authority had a formal contract with an advocacy provider, and staff within care homes were also seen as trusted professionals who could offer informal support. Processes supported this and detailed how people with sensory needs or had English as a second language received specific support. Independent Mental Capacity

Advocate (IMCA) services were available for people requiring support related to capacity decisions.

Supporting people to lead healthier lives

Score:

3 - Evidence shows a good standard

What people expect:

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment:

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The local authority had taken meaningful action to promote independence and prevent, delay, or reduce the need for care and support, working closely with people, unpaid carers, partners, and the wider community. People told us they felt the support they received, such as respite arrangements and direct payments, helped them maintain their own independence. For instance, a carer described being able to walk their dog and go to work, while another had a direct payment for support which gave them time away from their caring role. Records we reviewed showed how training and social connections enabled both carers and cared-for individuals to remain at home for longer.

People said that while they generally experienced positive outcomes, there were areas where improvements could be made. Some carers had not received one-off payments. Others mentioned their wellbeing didn’t noticeably improve until the cared-for person entered residential care, and some expressed frustration over the quality of equipment provision.

Staff and leaders consistently spoke about a dedication and a necessity to provide a preventative, early-intervention approach. Examples included providing weekly drop-ins with each member of the team having an off-island to support, outreach via Meals on Wheels, the integration of digital tools for remote consultations, and commissioning the “Buzz-a-Bus” transport service to reduce isolation. Staff described capturing the varied work done by staff through the newly introduced contact assessment, which also allowed them to better identify individuals not receiving formal support but who still needed help.

Partners said they strongly supported the local authority’s preventative efforts. One highlighted a volunteer-led befriending and shopping service, funded via the Better Care

Fund, had a direct impact in helping people stay independent and delayed the need for formal care. Other partners described how local charity shops and a community café promoted wellbeing through social connection and ensuring people had a meal. Some partners said the local authority's preventative work needed to help more people stay in their homes rather than moving into residential care.

Partners said the local authority's commissioning of community transport helped reduce isolation while enabling people to attend appointments and engage socially. Other partners highlighted collaborative initiatives, such as the "Dementia Together" umbrella partnership, had strengthened support and improved people's navigation of care.

National figures from the Adult Social Care Outcomes Framework (ASCOF 2024) showed that 100% of people receiving short-term support no longer required ongoing care while the national average was 79.39%.

Provision and impact of intermediate care and reablement services

The local authority worked collaboratively with partners to deliver intermediate care and reablement services.

Most people said reablement support helped them return home with greater independence. Records we reviewed showed a period of reablement enabled a person to manage successfully at home with the support of their unpaid carer. Similarly, another person receiving intermediate care spoke positively about the telecare and occupational therapy support that formed part of their reablement package. However, one person said the bed-based intermediate care did not always promote independence effectively and extended stays could lead to increased dependency.

Partners described the challenges inherent in hospital discharge and providing support to go home from mainland hospital settings to the islands in the local authority. They also described challenges with delivering a "home-first" approach, citing logistical issues such as weather impacting transport options such as helicopter or boat travel, but said that remote working and staff integration were helping. Partners indicated a shift toward more home-based intermediate care, moving away from bed-based models, and planned to introduce digital tools to support assessments locally, reducing the need for transfers to the mainland. Virtual wards were already in place to support people to stay at home or return home earlier than would be possible otherwise.

Partners said there were plans in place to strengthen the reablement offer. A dedicated reablement gym was being developed to serve both inpatients and the wider community on the Cornwall mainland. The local authority was working with partners to create a new in-house service to replace Park House (the local authority's in-house care home and reablement site) and construction was underway. This intended to place the community hospital on the same site as the in-house care home, which also provided the bed-based reablement and intermediate care offer.

The Better Care Fund was used to deliver reablement services both in the community and at Park House, with adult social care taking the lead through multidisciplinary assessments to ensure joined-up care. National data indicated 1.33% of people aged 65+ received reablement or rehabilitation following hospital discharge while the national average was 3% (ASCOF, 2024). Yet the outcomes were strong, with 91% of individuals remaining at

home 91 days after discharge, outperforming the national benchmark of 83.7%. This suggests that while reablement services were not accessed as widely, those who did benefit from support received effective care that helped sustain independence.

Access to equipment and home adaptations

Access to equipment and home adaptations in the local authority was generally effective and person-centred, with many people reporting timely support. But geographical constraints mean that some requests, particularly for more complex or bespoke adaptations, can take longer to fulfil.

People said that they were generally supported with adaptations and equipment, and many gave positive feedback. One carer, for example, described how equipment provided for a partially sighted family member made a meaningful difference to their ability to live safely at home. Others spoke of receiving grab rails and other devices quickly, especially when the items were already available on the island. Some also reflected well-planned provision following assessments.

Staff and leaders acknowledged both successes and limitations. They said that because of the local authority's small population, adaptations like rails or ramps could be completed faster than on the mainland. However, they also highlighted challenges with traditional housing not being well suited for modern adaptation. They said their geography created challenges in sourcing materials, builders, and specialist occupational therapists. One staff member said tech-enabled support, like telecare or medication prompts, were available, well used and especially valued on the off-islands to reassure isolated residents.

Healthwatch said they received positive feedback about equipment provision, and about the local authority's collaboration with organisations to provide equipment and adaptations. The local authority also said they worked with physiotherapists, OT assistants, and had a 'Tech Champion' to identify tailored solutions. Staff highlighted some barriers, including difficulty securing complex adaptations through Disabled Facilities Grants (DFG) and occasional digital connectivity issues.

Process data showed that the local authority generally responded quickly. The waiting list size and its median, and maximum waiting times were all reported as 0 from 2024-2025. Referrals for equipment were usually made within one week and fulfilled in one to two weeks.

Provision of accessible information and advice

People were generally able to access information and advice about their rights under the Care Act and ways to meet their care and support needs, including for unpaid carers and individuals arranging their own support.

People said they had received guidance and signposting from Adult Social Care, particularly during assessment or planning processes. They were provided with information about social care services, the complaints process, and financial support options. Unpaid carers also received advice; in one example, support was given with an application for financial support and staff provided details about the carers emergency card. Others said they were informed about carer support groups.

Staff said they offered accessible, tailored advice across the islands. Drop-in sessions at local hubs, including libraries and off-island community venues, helped raise awareness about safeguarding, benefits, and carers' rights. They also emphasised the importance of building personal relationships, often relying on face-to-face communication to improve trust and support. Staff and partners said information was available in multiple formats, phone, email, in-person, and there were annual tenant visits to proactively identify social care support needs in housing services.

Partners said information was widely circulated online and within community spaces. Social media platforms were one way information was shared, but partners said for those digitally excluded, informal communication through church groups or community cafés helped keep people informed. Others said they had developed information cards for seasonal workers which summarised available services, and they worked alongside employers and police to improve awareness around wellbeing.

Direct payments

The local authority did use direct payments to support choice and independence, however people said they didn't always receive the necessary information or support to use them effectively. Staff said they were offered routinely, but partners and carers highlighted a need for clearer, more proactive support to ensure people feel empowered in managing their care.

People told us that direct payments were helpful in some cases, for example one person highlighted how access to a live-in carer funded through direct payments supported them to remain at home and helpfully reduced the number of people visiting them. Another example showed direct payments were used to fund a personal assistant but came with no signposting or advice on how to manage this arrangement, around contracts or payroll. Most unpaid carers said they were not receiving direct payments or weren't aware of the option.

Staff said they routinely offered direct payments when support needs were identified during assessments and that this option was documented clearly on the local authority's website. There were people living on off-islands using direct payments to source support from people locally. However, staff also said there was some reluctance among people to employ support locally due to familiarity in small communities. Leaders also noted that although the direct payment process was available, uptake was low especially among older adults. Processes were in place to support timely access, staff said once a budget was agreed, direct payments were initiated promptly.

The proportion of people requiring support receiving direct payments was 9.09%, significantly below the England average of 25.48%. While uptake among working-age adults (18–64) was 100%, it was 0% for those aged 65 and over. Carer uptake was recorded at 23.08%. The local authority reported only four people were actively using direct payments at the time of submission, and just two people had discontinued using them, both following a transition into nursing care.

Equity in experience and outcomes

Score:

2 - Evidence shows some shortfalls

What people expect:

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment:

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority had a working knowledge of its population profile, with evidence of both informal intelligence and engagement helping it to identify and respond to inequalities, although there were areas for improvement in data use and outreach.

Staff and leaders said they knew their communities well and consistently referenced the local authority's close-knit nature. They described specific groups such as people with hearing loss or members of the farming community, older populations and those with complex needs, while also recognising the diversity among visitors and residents including people who are Lesbian Gay Bisexual Transgender Queer and others (LGBTQ+), people from ethnic minority groups and those working in care roles. Leaders and staff said drop-in sessions and frequent local community events help to highlight emerging needs. Leaders also said staff were trained in equality, diversity and inclusion practices, and made person-centred decisions when planning care.

Partners said the local authority was responsive to groups facing accessibility barriers. Healthwatch said off-island residents were recognised by the local authority as seldom-heard. We heard about the creation of "Soup drop-ins" to build relationships and hear concerns from the community. Other partners described how the local authority's rurality meant transport issues and funding constraints could restrict access to dementia support for people in the area. The community was interconnected and well known to the local authority, however challenges in equity existed particularly relating to geography, occupation and the seasonal workforce.

Partners and leaders said the local authority was addressing risks like fuel poverty, social isolation, and winter hardship. Staff used hardship funds after the Covid-19 pandemic to reach more people, including those who didn't typically engage with formal services. Other

partners said the seasonal rhythm of the islands presented challenges, for example the boat to the mainland operated less out of peak tourist season, but fewer tourists meant there were opportunities for more social connection in winter months.

However, the local authority acknowledged gaps in fully understanding inequalities and said they needed to improve analysis and collaboration with public health teams. While data on age, deprivation, and health was available, it wasn't clear how these insights were used to shape strategy or measure impact. For example, the local authority's self-assessment identified the need to bridge inequalities more effectively, and staff said improving access to specialist services, especially on smaller islands, was still a challenge.

People said that being part of a small community meant their circumstances were often known and supported. Staff said they worked hard to recognise emerging risks and provide targeted interventions. Partners said the local authority had made meaningful efforts to engage vulnerable groups, though they also suggested practical barriers could still limit inclusion.

Inclusion and accessibility arrangements

The local authority had mechanisms in place to support inclusion and accessibility for many individuals, including access to interpreters and specific formats. People said they felt well supported in some areas, and staff said they proactively respond to emerging needs, but some partners said certain groups may still be overlooked.

The local authority had taken steps to put inclusion and accessibility arrangements in place, allowing people to engage with services in ways that suited their individual needs, including provision for British Sign Language (BSL), interpreter services, and digital support.

People and staff said that practical adaptations had helped to improve access, particularly for those in remote areas. For example, partners reported that services were delivered via telephone or video to reduce barriers for off-island residents. Drop-in sessions at the library and digital skills classes helped to bridge access for people who were less confident using technology, with free tablet loans to support digital inclusion.

Staff said where communication needs were greater, such as people who were deaf/blind or those who spoke English as a second language, the local authority contacted external partners on the mainland to arrange interpreters or advocacy services. This included access to BSL interpretation and there was acknowledgement the offer for sign language users was limited. One example demonstrated the local authority engaged with a specific organisation to support people directly, when they had a communication need unique to them, recognising their risk of isolation.

Leaders and staff said that inclusion was regularly reviewed and personalised, particularly in response to unique challenges posed by the islands' geography and cultural profile. They described the population as mostly white and middle-class, but growing in diversity due to visitors and seasonal workers. Protected characteristics such as LGBTQ+ identities and disability were acknowledged, and services such as Pride events and adjustments to travel arrangements (e.g. boat passes for off-island residents) demonstrated inclusive practices. Partners said that efforts to engage with seldom-heard groups were evolving.

They said people who didn’t use the internet were kept informed through community networks.

Local authority documentation also showed it used varied communication methods including face-to-face contact, digital platforms, easy-read formats, and interpreter services, to improve accessibility.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score:

3 - Evidence shows a good standard

What people expect:

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment:

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority actively engaged with local people and stakeholders to better understand the care and support needs of its population, particularly those most at risk of poor outcomes, such as older adults, people with protected characteristics and unpaid carers. While they made use of national and local data, such as the Joint Strategic Needs Assessment (JSNA), feedback suggested there was room to strengthen how these insights were embedded in planning and service delivery.

People said the Isles of Scilly's close-knit community allowed emerging needs to be noticed and responded to quickly. Staff told us they worked with local residents and professionals through drop-in sessions, safeguarding partnerships, and community events. This included outreach to rural populations and hard-to-reach groups, such as veterans, those on off-islands, and those experiencing fuel poverty or isolation during winter. Partners said they collaborated with the authority to gather local intelligence and adapt models of care based on demographic trends.

Partners acknowledged the local authority's strengths in knowing its community, but some said data could be better used to identify gaps in services. They highlighted a reliance on community organisations to raise and notify the local authority about emerging needs.

Other partners said while service availability was sufficient, there was still a lack of choice that could affect people's experiences.

Local authority documentation showed their use of demographic data. The JSNA outlined projected increases in dementia, hearing loss, and sight loss. It also highlighted health inequalities, such as higher levels of suicide and self-harm linked to isolation and deprivation. The Better Care Fund identified an ageing population—with over 25% aged 65 or older which had meant investment in wellbeing activities, social connection, and independence. Local Insight reports compiled by an external research, data and neighbourhood analysis organisation, were used by the authority to understand community-specific data on age, housing, health, and vulnerability.

The local authority's Market Position Statement and self-assessment demonstrated understanding of rising support needs, limited housing, and workforce shortages. Planning for future demand included housing development surveys, service adaptation for complex conditions, and digital innovation. The JSNA and the Health and Wellbeing Strategy were shared with Cornwall at the time of the assessment. Plans were active to separate this so the local authority had its own JSNA and Health and Wellbeing Strategy which aimed to improve their understanding of local needs.

Market shaping and commissioning to meet local needs

People said they had access to a varied range of local support services designed to meet their needs in safe and flexible ways. Services such as Park House were consistently mentioned, offering respite care, intermediate care, and day support for people and carers. Some individuals shared positive experiences, particularly those who benefited from using personal assistants supported by direct payments, which allowed for more personalised care arrangements. However, there were mixed views on access and staffing, some carers said respite was difficult to arrange without relying on existing packages or family, and a reliance on agency workers at Park House. While people appreciated the familiarity of local services, some said choice was limited and more diversity in provision would help.

Partners said the local authority had made strong strides in tailoring services to the island’s unique needs and praised its creative use of limited resources. One described flexible respite models using hospital beds, residential settings, and overnight at-home support, enabling quick responses in emergencies. Others recognised that co-produced initiatives like subsidised transport through the ‘Buzza Bus’ and boat travel subsidies allowed residents to access care more easily, especially from off-islands. Others acknowledged commissioning of innovative models such as “Dementia Together,” although they noted difficulties in transport constraints and funding limitations. Overall, partners supported the local authority’s integrated commissioning agenda and said it aligned well with broader public health goals, housing needs, and preventative strategies.

Staff said the local authority was committed to commissioning services that prioritise independence, wellbeing, and outcomes. Social care teams took pride in small caseloads, enabling time to build trusting relationships and provide support that was truly person-centred. Senior leaders said services were run in-house for stability and acknowledged the lack of a care market reduced choice. Commissioning strategies were described as outcome-focused, with outdated models phased out in favour of integrated care pathways. For instance, the new health and social care facility, co-developed with NHS partners, was

described as a transformative investment that would deliver residential beds, outpatient services, mobile diagnostics, and a unified workforce. Staff also said the local authority worked collaboratively with the Health and Wellbeing Board (HWB) and Integrated Care System (ICS) to align priorities and jointly develop policies, such as age-friendly housing and accessible transport.

The local authority's approach to commissioning also included a focus on housing with support options. Staff explained that, due to local geography and workforce challenges, traditional development models were not viable and required more tailored planning. Staff said surveys had identified 135 homes were needed by 2030, and the local authority was proactively planning new builds and repurposing existing facilities, such as the transformation of Park House into staff housing and supported accommodation after the integrated facility opens. These strategies were aligned with the local authority's corporate plan commitments to retain on-island residential care and promote independent living.

In relation to unpaid carers, all stakeholder groups noted the importance of flexible support. Staff gave examples of personalised plans and direct payments, and shared an example where transport, respite, and social contact were combined to support both the unpaid carer and cared-for person. Partners said carers could generally access support easily and quickly and praised the local authority's emergency response arrangements. People acknowledged receipt of one-off payments and some training opportunities, though some said they lacked clear guidance on how to manage direct payments or arrange formal support.

Commissioning arrangements were described by both staff and partners as supportive of new and innovative care models. Examples included encouraging community members to become personal assistants, especially on off-islands, using digital solutions to reduce travel barriers, and piloting integrated team-based care. Staff said commissioning decisions were informed by national and local data, including the Joint Strategic Needs Assessment, Local Insight reports, and community feedback gathered through drop-ins and informal contacts. These inputs helped shape small-scale service innovations and ensure planning was tailored to local challenges and the needs of the population.

Ensuring sufficient capacity in local services to meet demand

Processes in the local authority broadly supported the availability and accessibility of care and support. Feedback from people, staff, and partners described a responsive system shaped by the island's geography, workforce constraints, and infrastructure limitations, but also one that was evolving to meet current and future demand.

People shared that care was generally available when needed and appreciated how the local authority tailored services to the community's specific context. People said there was good support offered in Park House although some mentioned there was a reliance on agency staff. People spoke positively about telecare, occupational therapy, and advice received through drop-in sessions, which helped address practical needs like bathing and mobility. However, some said that the quality of services could be compromised by limited staffing and housing shortages.

Staff described care as safe, flexible, and largely free from delays. Residential, respite, intermediate, and reablement services were delivered at Park House and in people's

homes, with effective coordination between health and social care. No waiting lists were recorded for home care or residential placements. Intermediate care was increasingly provided in people's homes, supported by the virtual ward model, with trained staff using digital diagnostics and accessing consultant input usually within 12 hours.

Staff and leaders said where there was pressure on services, it was not from waiting times but from increasing complexity of need. In response, staff were supported through extensive training, apprenticeships, and recruitment strategies, including housing provision for care workers following challenges experienced during the pandemic. Personal assistants on off-islands were described as valued members of the wider care team, improving reach and choice in remote areas.

Partners praised the Local authority's resilience, recognising strong leadership and inter-agency collaboration in maintaining services. Partners pointed to the social impact of limited access and local deprivation and agreed the new integrated care facility would be a pivotal development, improving recruitment and service integration. Staff and leaders also confirmed ongoing efforts to deliver more accessible homes, supported by a large landowner and targeted planning, including 135 new units identified for development by 2030.

Specialist services, such as nursing homes and supported living, were not available locally, though Park House flexibly delivered nursing care through partnership with the hospital (eg. with staff visiting the care home to provide nursing tasks). Out-of-area placements were rare and when used, carefully managed. Only two individuals were placed outside the islands, both for highly complex needs. These placements were reviewed annually with families and providers.

Unpaid carers benefitted from flexible respite care in planned and emergency scenarios. Park House provided a dedicated respite bed, and unpaid carers could access support via hospital coordination or overnight care at home. An example showed how a personalised plan enabled one carer to take respite, with transport and familiar surroundings helping maintain continuity of care. Partners confirmed services effectively supported carers to take a break, remain well and able to continue caring.

The local authority had tackled challenging geographic barriers by recruiting and training personal assistants, offering free safeguarding and manual handling courses. Five local carers, three on one island and two on another, were supporting care delivery in areas which were remote and enabling people to remain at home.

Ensuring quality of local services

There were established arrangements for monitoring the quality and impact of commissioned care and support services, but there was some mixed feedback from people and partners.

People said that their experiences with care quality were mixed. One person said their relative had received poor standards of care. Although another person shared that while the overall care was caring and respectful, with good relationships formed, the quality depended heavily on which individual staff member delivered the care. They felt the service could be rushed at times and lacked continuity.

Partners said that they submitted regular monitoring data to the local authority, such as monthly reports for commissioned services. Some partners said there were missed opportunities in this process for reflection and service improvement. Staff and process evidence confirmed formal arrangements for quality monitoring were in place. The local authority said commissioned services were subject to an annual quality visit by social care professionals, and that the same improvement process applied across all adult social care work. Contracts, such as the concessionary transport service “Buzza Bus” commissioned were reviewed regularly and re-awarded based on performance outcomes.

People said the adult social care workforce had built meaningful relationships with them and many care staff provided respectful, person-centred support. However, they also noted variability in service quality depending on which individual was delivering care. For example, some shared concerns about rushed home visits and inconsistent experiences, while others spoke positively about staff attitudes and engagement.

Ensuring local services are sustainable

Staff said that recruitment was an ongoing challenge but acknowledged the significant steps the local authority had taken to address this. Posters placed across the community helped recruit five private individuals to offer care, increasing choice and capacity. They also highlighted the impact of housing shortages for staff in the past. In response, the local authority had allocated seven properties specifically for adult social care staff and declared a housing crisis in 2022, which triggered partnership work with the largest landowner to increase suitable housing supply.

Partners said there was a stable adult social care workforce, with staff often working in the sector for more than three years. However, recruitment risks and pressure from national labour market conditions, including pay competition and relatively high housing costs, remained areas of concern.

The local authority conducted annual reviews of social care charges and completed a Fair Cost of Care exercise to better understand service demand, delivery costs, and sustainability. Two micro-provider contracts in homecare were ceased, both of which were absorbed by the local authority’s in-house team with no delays in service delivery.

They also maintained workforce stability through enhanced training and a ‘market forces supplement’. This was an additional payment intended to address recruitment and retention challenges where market rates don’t meet the high costs of delivery. The supplement recognised the financial pressures of working in the local authority. Staff were employed under national “green book” pay scales, helping ensure wages were competitive and transparent. In line with their Strategic Workforce Plan 2023–2026, the local authority aimed to be a modern employer.

The local authority sustained its care services by proactively investing in training, housing, fair pay, and local recruitment. People said they valued relationships with staff, although service consistency could be improved. Staff said they felt supported and recognised and partners highlighted a largely stable workforce, despite recruitment and housing remaining central to long-term viability. The local authority’s planning and financial practices, especially its Fair Cost of Care approach and strategic workforce mapping, suggest it had

a clear understanding of local trading and workforce conditions and was committed to maintaining service quality.

Partnerships and communities

Score:

3 - Evidence shows a good standard

What people expect:

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority demonstrated a strong and evolving commitment to working collaboratively with partners to align strategic priorities, integrate aspects of care and support, and develop new operating models that meet people's needs.

People said they could clearly see the benefits of integrated care in practice. One person shared a positive experience where a person stayed at Park House instead of being hospitalised. They highlighted the effectiveness of the multi-disciplinary team (MDT) approach, noting how health professionals were accessible quickly and easily, which made a tangible difference in the person's care.

Staff said partnership working was not only embedded but strengthening. Leaders described an ambition for a "one-workforce" identity, even if staff are employed by different organisations. Leaders said the relationship they had with the hospital trust was excellent, and spoke about integrated work between pharmacy, primary care, and social care as exciting and future focused. Staff also spoke about strong collaboration with public health, housing, community nursing, and mental health services. Daily and weekly MDTs are used to coordinate care and share information effectively. Partners confirmed positive strategic and operational relationships and said there had been improvements in communication and joint safeguarding arrangements.

Partners said they felt included and supported in collaborative efforts. Some partners reported regular formal and informal contact with the local authority, describing it as responsive and accessible. They confirmed that the local authority holds MDT meetings to identify and support vulnerable individuals, even when that support needs to come from mainland services. Some partners said that while partnerships weren't formally structured, collaboration often took the form of informal relationships, with mutual respect and awareness of community projects like a charity shop or a community cafe.

The local authority's self-assessment outlined strategic objectives which committed to combining health and care services on the islands. This included the development of a new integrated health and social care facility, co-funded with health partners, that will bring together residential care, home care services, maternity, minor injuries, outpatients, and respite care into one shared location. The project also aimed to develop a co-produced model of care, with streamlined working between providers. Partnership links with Cornwall Local authority and the acute hospital trust underpinned arrangements for outpatient and emergency care, bridging the gap between local and mainland services.

Arrangements to support effective partnership working

The local authority had clear arrangements in place for governance, monitoring, quality assurance, and joint funding mechanisms, including strong use of the Better Care Fund (BCF). These systems were actively used to support service integration, strategic alignment, and improved outcomes for people. Although some feedback suggested areas where cross-agency work could continue to improve.

Staff said the governance structure was built on strong multi-agency collaboration. Weekly and daily multidisciplinary team (MDT) meetings were routinely described as the backbone of service coordination. These meetings brought together adult social care, GPs, pharmacists, ambulance services, mental health teams, social prescribers, and community nurses to manage people's care collaboratively. Staff said the reinstatement of these MDTs was extremely useful for managing both community and hospital-based needs. Leaders said the integrated health and care project, launched in 2018 and given renewed investment in 2024, underscored their commitment to joined-up, accountable systems, combining governance with funding and service redesign.

Leaders also described other formal partnerships such as 'Safer Scilly' and the 'Community Drugs Partnership', which involve housing, education, police, fire services, and safeguarding teams. These groups operate under clear terms of reference and escalation agreements, allowing shared ownership of risk and responsibility. The local authority's work with the Health and Wellbeing Board and Cornwall Local authority was also described as supportive and strategically aligned, particularly around public health and housing needs, although work was underway to establish the local authority's own Health and Wellbeing Board in order to give more focus to the area's needs.

Partners said the local authority was accessible, responsive, and open to collaborative review. We heard about both formal and informal communication routes and staff and partners confirmed vulnerable people were routinely discussed during MDTs and this worked extremely well. Partners praised the partnership with health colleagues for identifying and referring unpaid carers but acknowledged more could be done for young carers. Partners confirmed that recent rapid reviews of complex cases involved roundtable decision-making with shared ownership and that every voice was actively heard.

Staff said pooled funding arrangements were being used strategically. The Better Care Fund had been invested to sustain staffing for residential and home care, develop preventative services, and enhance partnership training. It was also used to fund an independent volunteer coordination service through Healthwatch. Training for social prescribers and the development of an island-based public health function were also supported through BCF allocations, enabling a more localised and integrated response.

Process evidence confirmed governance arrangements included regular contract reviews, embedded escalation pathways, and cross-sector representation in safeguarding and strategic planning. The self-assessment and Community Drugs Partnership documentation outlined clear roles, responsibilities, and meeting schedules. Strategic objectives in the Corporate Plan include the integration of care services, and partner agencies were visibly involved in service design and workforce planning.

However, some staff and partners said integration still had room to grow. While the partnership model was generally praised, some partners said operational practices differed between organisations, and some staff felt uneasy with the pace of change. Confidentiality was also noted as a challenge within the small population, and leaders said that while incident-led responses were strong, strategic coordination for broader issues like domestic abuse could be better structured.

Impact of partnership working

Staff said partnership working was integral to service delivery, with daily multidisciplinary team (MDT) meetings being the central approach. These meetings, bringing together adult social care, health, community nurses, ambulance services, pharmacists, social prescribers, and GPs, were widely described as the most useful tool for managing health and social care needs across the islands. Between March and mid-June 2025, 30 MDT meetings took place, addressing the needs of 21 individuals. Staff also reported monthly workshops to support service development and regular use of IT (information technology) conferencing to coordinate care, even though data systems remained separate.

Staff described how integration had improved over time, with gaps that previously existed in communication now being addressed. Partners said the current models of care and relationship-building had reduced fragmentation. Others spoke of co-leading the development of an integrated workforce model and embedding skills gap analysis to strengthen joint delivery. On an operational level, creative arrangements, such as sourcing carers and meal deliveries on the Tresco island estate, showed how flexible, asset-based partnerships supported sustainable solutions. Community safety partnerships and refreshed working groups on antisocial behaviour also indicated a move toward more outcomes-focused joint planning.

People said the impact of partnership working could be felt in practical terms. People reported benefits from swift access to health professionals through integrated arrangements at Park House, especially where hospital admissions had been avoided. We heard one MDT meeting led to coordinated support including home adaptations, fire safety advice, and ongoing dialysis care that allowed an individual to remain at home with support from multiple agencies, including support from the hospital handyman.

Partners said relationships with the local authority were generally positive and collaborative and described strong engagement from older people, though expressed concern that younger voices might not be well represented. Partnership working was well established and embedded across health, social care, housing, and the VCSE sector. Staff said integration and MDT processes were effective and responsive and people said they saw benefits in terms of coordinated support and improved outcomes.

Working with voluntary and charity sector groups

The local authority worked collaboratively with the VCSE sector to understand and respond to people's needs, though the scope of voluntary involvement was limited due to the island's small population.

People said they benefited from voluntary sector involvement in connecting with their community. In documents we reviewed there was clear partnership working with people supported to undertake physical activity with 'Active Scilly'. People were also signposted to groups such as the memory café and reading clubs through the local library, reflecting integration between statutory and voluntary services to improve wellbeing and inclusion.

Staff said they actively engaged volunteers in delivering services, particularly in roles like Meals on Wheels, which was coordinated by social workers and the on-island hospital. Staff said volunteers were also trained in manual handling to better support people informally, even in very small communities. Leaders said the close-knit nature of the island meant older residents were looked after well within communities, but they acknowledged the VCSE sector was limited in scale.

Staff described "Community Days," which had evolved from Community Voice forums. These events brought together agencies like Healthwatch and Citizens Advice Bureau alongside health partners to share information and hear concerns from people. They were designed to make engagement easier for the public while strengthening cross-sector collaboration. Leaders and partners said these relationships extended beyond the island, and that informal networks and external partnerships were vital to maintaining services.

Partners said they had generally positive relationships with the local authority reporting good working links, though there were occasional issues in directly reaching individual staff. Healthwatch provided formal and informal feedback about community needs. Staff and partners confirmed links with VCSE support groups for people with dementia and learning disabilities but noted these networks were not widespread and sometimes relied on connections to mainland services, where transport presented additional challenges.

Processes and documentation confirmed strategic efforts to engage the VCSE sector. The self-assessment recognised a lack of alternative organisations on the islands but demonstrated efforts to compensate through volunteer recruitment and partnerships with Healthwatch to host drop-in sessions and facilitate engagement. The local authority also used Community Voice forums to bring issues and coordinate VCSE responses.

The local authority worked creatively and collaboratively with the VCSE sector to identify and meet people's needs. People said they benefitted from VCSE support and signposting, staff said they relied on volunteers to deliver key services and coordinate community engagement, and partners said relationships were strong.

Theme 3: How the local authority ensures safety within the system

This theme includes these quality statements:

- *Safe pathways, systems and transitions*
- *Safeguarding*

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score:

3 - Evidence shows a good standard

What people expect:

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

Staff said that multidisciplinary team (MDT) meetings played a central role in safeguarding and risk management. One example involved a person initially known to the ambulance service for frequent falls, being referred through the MDT process, which enabled a holistic plan involving grab rails, food deliveries, and health monitoring. Staff also described out-of-hours arrangements, with social workers rotating to ensure consistent coverage, supporting people in crisis late at night or during weekends.

Partners highlighted how safety procedures adapted to seasonal changes. For example during summer, when the population quadrupled due to tourism, robust emergency plans were activated via multi-agency coordination. In mental health crises, the police station was used as a temporary safe space, backed by a rota system that ensured someone is always available until a person could be securely transported to the mainland. Where transport wasn't immediately possible, for example with ferry restrictions or unsuitability for

air transfer, staff said a commissioned boat was used to safely relocate a person in need of secure mental health support.

Partners said they valued the integrated team, which they felt were best placed to deliver safe and personalised care. They confirmed strong collaborative working, though some raised concerns about the impact of confidentiality in such a close-knit setting, particularly when people were flown off the islands for acute care. Despite this, they were reassured by the presence of proactive monitoring and shared accountability.

Process evidence supported the emphasis on safety. The upcoming integrated health and social care facility aimed to enable more coordinated and digitally-enabled care, including remote testing and monitoring, reducing the need to travel off-island and mitigating risks related to delayed appointments or disrupted transport. This new model reinforced the local authority's commitment to delivering safe care locally and effectively.

Safety during transitions

People said they felt involved and supported during transition planning. For example, records we reviewed showed Care Act assessments were used proactively to develop a transitions plan, identifying long-term options and keeping both the person and their family at the centre. In another case, a person was supported to return to a placement in another local authority through collaboration between social workers in both places, demonstrating continuity of support across locations. Staff described a culture of responsiveness and flexibility, noting that integrated working had helped to ensure safe step-down care and avoided abrupt service changes.

Staff said transitions, particularly from children's to adult services, were underpinned by a structured approach. This included a dedicated transitions pathway that started around age 14, encouraging early planning with families, housing, and lifelong learning providers. Staff said they had joint visits between adult and children's services and tailored support for individuals preparing to move into supported living.

Transition pathways were clearly documented, with specific procedures for young people with special educational needs and disabilities (SEND) and for those moving between services or into placements due to changing needs. The local authority had responded to four instances in the past year, ensuring alternative arrangements when support could no longer be sustained at home. Drug and alcohol services also included transitional support from adolescence into adulthood.

In the context of hospital discharge and return from mainland treatment, the local authority used the Discharge to Assess model, guided by weekly MDT meetings to plan safe reablement, intermediate care, or placements. Staff said these meetings allowed for rapid coordination and helped determine which professionals needed to be involved. The implementation of the new electronic recording system was seen as a further enabler in streamlining work and improving oversight during transitions.

Mental health transitions were managed through a well-defined local procedure, which recognised the logistical challenges of the islands. The procedure outlined multi-agency roles in coordinating Mental Health Act assessments, identifying safe places, and arranging transportation when mainland admission was required. Staff and partners said where hospital admission wasn't immediately possible, a person's home or the community

hospital could be used temporarily as a place of safety. Partners confirmed that MDT approaches help step-up and step-down care appropriately.

Partners said they appreciated coordinated support during transitions, though some also highlighted challenges. Poor transport links placed challenges on hospital discharge, particularly when flights were cancelled or weather delays occurred. People sometimes returned home alone following surgery, facing steps, luggage, and anxiety with little visible coordination. They felt communication between the local authority and mainland health services could improve this experience for people.

Contingency planning

Due to the remote geography, unpredictable weather, and limited infrastructure, the local authority had developed tailored processes to ensure services remain safe, responsive, and coordinated during emergencies or service disruptions.

Staff said out-of-hours support was robust and well-organised. All urgent calls were directed through Park House, with social workers rotating on-call duties to ensure coverage at all times. Park House was used flexibly to provide emergency bed space, and staff said they had always met people's needs effectively, with no cases of people not being able to access the service, demonstrating confidence in the system's capacity to respond quickly.

Process evidence confirmed the existence of formal contingency plans across health and social care settings. For example, a multi-professional coordination model was in place involving GPs, physical and mental health services inpatient services, and the residential and home care provided in the local authority. Contingency protocols were co-developed with clinicians and managers to support care across five islands. These plans covered complications such as medical evacuations, service disruptions, and travel delays caused by geography and adverse weather. The Park House Care Home Contingency Plan outlined specific risks, escalation procedures, and actions to maintain operations during disruption. This included continuity of care for residents and those receiving services from the home care team.

In the event of a broader emergency or service failure, adult social care was designated as the lead coordinator, with staff trained to act quickly and allocate resources appropriately. There was also a Local Resilience Forum Cascade Plan, a coordinated document between Devon, Cornwall, and Isles of Scilly local authorities, which was designed to support a joint response to major incidents. It included procedures for triggering pre-event assessments, initiating teleconferences between partner agencies, and sharing critical information across organisations. Contingency systems were embedded in the island's multi-agency operations, ensuring that risk was managed across clinical, community, and social care settings.

Safeguarding

Score:

3 - Evidence shows a good standard

What people expect:

I feel safe and am supported to understand and manage any risks.

The local authority commitment:

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

Staff and leaders said that safeguarding was treated as a priority and integrated into daily practice. Leaders confirmed increased safeguarding activity over recent years, with changes made at the safeguarding partnership board cascaded across teams. Political leaders also took an active role in public engagement and awareness-raising, using accessible language, such as "areas of concern", to help the community feel comfortable speaking up.

Partners described the safeguarding system as straightforward, which they viewed as an advantage for making timely decisions. They praised leaders for providing strong representation on safeguarding and for leading quality improvement efforts. Multi-disciplinary team (MDT) meetings were described as a core safeguarding tool that enabled prompt responses, collaboration, and redesign of processes when needed, for example, working with police and local authority colleagues on high-risk cases.

Staff shared examples of embedding safeguarding in local delivery, such as providing private personal carers on St Martins island with safeguarding, handling, and care legislation training. Police and social care staff collaborated through domestic abuse groups and a flexible Mini-MASH (multi-agency safeguarding hub) system was tailored for the islands and worked well. Out-of-hours support was coordinated through Park House, ensuring continuous cover. Streamlined referral routes had been created, including a single email and phone number for safeguarding concerns, a public-facing website with updated contact details, and drop-in sessions for community engagement. The local authority's safeguarding pathway guided practitioners from initial concern through to closure, centering on the individual's outcomes and wellbeing. A multi-agency review of

safeguarding thresholds led to a training session proposed for local MDTs to further strengthen referral accuracy.

Processes reflected a well-structured safeguarding framework. The local authority participated in various Safeguarding Adults Board (SAB) subgroups, including learning and development, Safeguarding Adults Reviews (SARs), and quality assurance, although maintaining this representation was a challenge because of small numbers of staff. The SAB was shared with Cornwall local authority. The annual SAB report showed the board was independently chaired and recently underwent a Local Government Association (LGA) peer review.

Responding to local safeguarding risks and issues

The local authority demonstrated a strong understanding of safeguarding risks and worked effectively with partners to prevent abuse and neglect. Staff, leaders, and partners consistently highlighted a proactive and responsive safeguarding culture.

Staff described how most concerns were identified and addressed early due to well-established relationships, resulting in fewer escalated cases. Partners said that while formal safeguarding referrals and reviews were relatively low, this reflected early intervention and effective coordination.

The local authority participated actively in regional safeguarding partnerships. Leaders were visible to partners and attended the SAB executive board and chaired the quality improvement group. Staff contributed to subgroups focused on learning and development, Safeguarding Adults Reviews (SARs), and quality assurance, although maintaining full representation had been challenging due to low numbers of staff. Specific training initiatives were developed in response to learning from SARs, including improvements to the application of the Mental Capacity Act following review findings.

Learning from SARs was distributed across the system. Although the local authority had not conducted any formal SARs during the reporting period, the local authority accessed and implemented regional learning. This included issuing “7-minute briefings”, participating in quarterly SAB newsletters, and organising practitioner events. A quarterly performance report was submitted to the SAB, and partners said no significant concerns were raised in relation to local safeguarding data.

The SAB's 2024–2027 Strategic Plan identified priority risks including self-neglect, unpaid carers, mental health and wellbeing, safeguarding culture, and transitions into adulthood. Staff confirmed these priorities were embedded in day-to-day operations, supported by community engagement, drop-in sessions, and simplified referral pathways. Safeguarding awareness was promoted locally through accessible language.

Partners said the local authority was responsive and willing to collaborate, particularly with Cornwall local authority in complex cases. Some partners said there may be low referral rates for safeguarding and carers assessments.

Responding to concerns and undertaking Section 42 enquiries

People said safeguarding concerns were addressed quickly and felt the local authority was responsive. People also said they were kept informed throughout the process and described the system as easy to navigate once engaged.

Staff said there was clarity about what constituted a Section 42 concern and when an enquiry was required. A Section 42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. They explained all safeguarding referrals were triaged immediately, and where necessary, Section 42 enquiries were initiated without delay. Leaders oversaw safeguarding processes, with decisions made collaboratively through a streamlined front-door system using a single contact number and email. Staff said they acted straight away on any safeguarding concern, conducting enquiries only when appropriate and completing them within the required timescales. They noted awareness-raising had increased referrals in recent years, and many did not result in formal enquiries which reflected a strengthened safeguarding culture.

Staff also said the “mini-MASH” and integrated MDT working with partners enabled timely identification of cases meeting the Section 42 threshold. Staff confirmed that safeguarding was a core function embedded within everyday practice and that the mechanisms to escalate concerns, either formally or through professional dialogue, were well understood across services. While safeguarding pathways could feel challenging at times due to geographic constraints, staff said the system allowed them to work through complex scenarios effectively.

Partners said there was shared understanding and confidence in safeguarding thresholds and processes. They confirmed the SAB functioned well, learning was communicated, and actions were taken based on reviews and feedback. Healthwatch had been commissioned to gather experiences, and partners said this led to a more person-centred approach in how safeguarding concerns were addressed and was based on people’s expectations and outcomes.

Processes showed the local authority allocated all safeguarding referrals and Section 42 enquiries within 24 hours, reflecting consistency and efficiency. The safeguarding pathway outlined the full enquiry process, from initial concern to closure, with an emphasis on gathering feedback from the individual at each stage. Action plans were developed in response to learning from SAB subgroups, and thematic issues, such as poor application of the Mental Capacity Act, resulted in specific training and improvement efforts.

People said the system felt responsive, staff said they applied Section 42 thresholds clearly and acted swiftly, and partners said learning and collaboration supported best practice. The processes in place confirmed that safeguarding enquiries were managed consistently, person-centred outcomes were prioritised, and multi-agency cooperation strengthened the overall system.

Making safeguarding personal

Safeguarding was largely made personal by the local authority, with a commitment to tailoring processes around people’s needs and desired outcomes, though there remained room to improve how feedback from service users was consistently captured and used to inform practice.

People said safeguarding experiences were increasingly shaped around their preferences. Partners said the approach to managing safeguarding concerns had evolved to become

co-produced, focusing on what mattered most to individuals at risk and outcomes were discussed with the person involved in the enquiry.

Staff said they acted quickly when safeguarding concerns were raised and were able to resolve issues in ways that maintained independence and dignity for the individual. The safeguarding triage process included initial decision-making without always requiring formal investigations, depending on the wishes and needs of the person. Social workers described strong, trusting relationships with people and said they addressed risks swiftly, often working with the individual to avoid disruption or unnecessary escalation. Staff also noted the increase in safeguarding referrals over the past two years reflected greater community confidence and awareness, even if many did not meet the full threshold for enquiry.

Partners said the safeguarding adults board supported a personalised safeguarding culture. Some partners said while more could have been done to ensure advocacy referrals were made consistently, they were informed throughout the process. They confirmed the SAB shared lessons learned across agencies. Partners also said safeguarding was embedded within the local authority's practice and that efforts were made to make it personal, even in complex or multi-agency cases.

Processes showed safeguarding pathways guided practitioners to involve individuals throughout each stage of the enquiry, including gathering feedback on whether their outcomes had been met. However, the adult social care self-assessment acknowledged that further development was needed in systematically capturing service user feedback related to safeguarding.

Theme 4: Leadership

This theme includes these quality statements:

- *Governance, management and sustainability*
- *Learning, improvement and innovation*

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score:

2 - Evidence shows some shortfalls

The local authority commitment:

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

Staff said governance mechanisms were well embedded. Fortnightly meetings with elected members, biannual scrutiny sessions, and monthly reports to the local authority chair contributed to visibility and oversight. Councillors played an active role in challenging risks and offering constructive feedback. Staff also highlighted strong multi-agency relationships and data monitoring, enabled by leaders chairing the safeguarding quality group and also by keeping local authority data distinct from Cornwall. Partners welcomed the decision to separate from Cornwall's Health and Wellbeing Board, they felt this would ensure local needs were better represented. Leaders said there was some limited capacity and system strain due to ongoing change, however.

Partners said they were confident engaging with the local authority although staffing and leadership changes in adult social care had had some impact. Some partners said historic concerns around confidentiality had improved. Partners described elected members as helpful and receptive to them, and others said they remained confident in their ability to raise safeguarding concerns under the new leadership structure.

Processes showed mostly clear and effective governance arrangements. Councillors maintained close oversight, and staff and leaders met regularly with elected members to support transparency. The local authority's action plan aligned with Care Act duties, tracking progress against 13 objectives, with none rated as red.

Risk and quality systems were active. The adult social care risk register tracked amber-rated concerns such as staffing shortages, high care costs, and housing pressures, supported by mitigation plans. A quality improvement framework outlined staff responsibilities, and workforce plans included apprenticeships, career pathways, and preparation for the new integrated care facility opening in 2025.

Contract procedures supported legal and ethical commissioning, with clear standards and exemptions for statutory care placements. Staff surveys and strategic planning addressed leadership, wellbeing, and sustainability.

Efforts to improve people's experiences included regular engagement, co-production events, and a streamlined safeguarding referral system. The mini-MASH model and front-door access supported fast triage. However, leaders and staff acknowledged that service user feedback, particularly around safeguarding, still needed strengthening.

Strategic planning

People said they saw evidence of planning in action through targeted initiatives, like renovations at Park House, the carer support offer, and improvements to transport and technology-enabled care. Carers raised specific issues, such as reducing repetition in completing forms, access to specialist health input, and flexibility in respite, which fed into the draft Carers Strategy. However, some carers said they were contacted only sporadically or lacked consistent engagement, suggesting that feedback mechanisms were not yet fully embedded.

Staff said data collection and visibility had improved with the transition to a new electronic record system earlier in 2025. Monthly reporting of activity, including assessments, safeguarding referrals, and reviews, was shared with senior leaders, including the Chief Executive Officer of the local authority. Qualitative data was considered vital for understanding community needs, especially given the small population, and staff described using storytelling and case reflection over trend analysis due to small sample sizes. There were challenges for the local authority in understanding how services were performing compared to others, as benchmarking and performance tracking were difficult.

The intention to improve strategic planning was evident in the development of a local Health and Wellbeing Board, separate from Cornwall. Staff and leaders described ambitions to tackle long-standing health inequalities, such as access to medical transport, obesity, and rising long-term conditions among the local authority's ageing population. Plans were being developed to improve data access and protection, with recognition that small cohorts complicated traditional data analysis. Leaders were recruiting a strategic lead to focus on quality assurance and workforce development as part of a broader improvement journey. A Joint Strategic Needs Assessment and Health and Wellbeing strategy that focussed on the local authority, rather than shared with Cornwall, aimed to support far greater insight into the specific needs of the population and support strategic planning. A greater focus of public health insight into specific needs and populations would also benefit the strategic planning of the local authority.

Partners said the local authority worked well with partners to design an integrated health and social care campus that aimed to reduce costly 'fly-offs' to the mainland (where people were transported by helicopter or airplane in an emergency). Metrics were being

developed to track outcomes, such as hospital admission rates, reliance on off-island outpatient appointments, and use of digital care solutions. The adult social care team administered several key funding streams, including the Better Care Fund and Disabled Facilities Grant, suggesting active involvement in resource allocation aligned to strategic goals.

The 2025 Service Plan identified achievements and challenges while setting out six priority objectives. These included public health, service integration, and workforce development. The Integrated Care Programme incorporated person-centred planning, technology, and joint leadership structures, and the draft Carers Strategy showed a commitment to co-production. Policy alignment and governance were supported by specific systems to ensure legal compliance, and regular performance reports were used to inform planning and identify service pressures.

Information security

The local authority had arrangements in place to maintain the security and integrity of data, records, and systems, although these were evolving. Leaders said they were in a programme of work to refresh policies and practices around data protection.

Staff, leaders and partners said that maintaining confidentiality was a consistent challenge, particularly in a small community where residents often knew one another. They described their work on challenging a formerly fairly paternalistic culture and the continuous improvement work necessary to ensure confidentiality and formalise practice, whilst maintaining an approachable and compassionate service.

Processes confirmed that the local authority had transitioned between different electronic case recording systems recently, with continued implementation underway. Staff described the new system as more user friendly and said it improved productivity. Staff participated in the design of its workflows, particularly those linked to Care Act assessments and reviews, and leaders used the system to audit areas such as eligibility determinations. This contributed to a more robust foundation for record accuracy and compliance.

The local authority had also signed a formal data-sharing agreement with the acute NHS Trust as part of the integrated care programme. This agreement supported joint leadership and enabled better alignment across health and social care. Partners described a vision for a shared health and care system that would place people at the centre, allowing them to be active participants in managing their care.

Learning, improvement and innovation

Score:

3 - Evidence shows a good standard

The local authority commitment:

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

People said they felt increasingly involved through initiatives like the co-production of the carers strategy, which included drop-in coffee mornings and consultation events. Healthwatch confirmed that survey responses had influenced the development of carers groups and information packs.

Staff said the organisation had embraced a culture of change and learning, including the new recording system to improve case management, reporting, and auditing processes. Leaders drove reflective practice improvements by for example bringing in external audits specialists from Cornwall local authority and providing monthly guided conversations. Staff described regular training opportunities in safeguarding, Deprivation of Liberty Safeguards (DoLS), mental capacity, and domestic abuse. Training, such as on dementia and falls prevention were valued by staff as responsive to workforce and population needs.

Supervision was described as collaborative and person-centred. However there were no fixed intervals between supervisions, meaning this could be sporadic or delayed. There was also no mechanism for monitoring supervision which indicated an area for improvement to ensure supervision was consistent and high-quality. Small team sizes meant training attendance had to be staggered to ensure service continuity.

Partners said co-production had increased since a 2023 adult social care survey to people. Partners and Healthwatch reported meaningful involvement of people in developing the carers strategy. Other partners said they were occasionally consulted but not routinely involved in strategic co-production. However, they welcomed the local authority's intention to strengthen collaboration during upcoming contract reviews.

Progress following the 2024 LGA Peer Review was a key driver for change. Staff reported the review helped highlight areas needing attention, including safeguarding clarity for partners, transitions from children's services, service flexibility, and case file consistency. In response, the local authority improved safeguarding training across agencies, separated leadership roles to improve oversight, and committed to building capacity in quality assurance and workforce development. The review also prompted further development of

co-production, including a new local authority plan and engagement with people who use services.

Learning from feedback

People said their feedback was increasingly acknowledged, with some positive outcomes. On one occasion, a carer was changed immediately following a complaint, reflecting swift action. Others said they felt heard through surveys and drop-in forums. However, others reported that despite the local authority taking some action, they were not completely satisfied with the outcome. Healthwatch feedback showed improvements, including an increase from 11% positive comments in 2021 to 70% in 2023.

Staff said feedback was a regular part of service delivery. Welcome pack feedback forms were used to gather views on the quality of support. These were uploaded into a live database and discussed in team meetings and supervision as part of the Quality Improvement Process. Staff described reflective learning in response to complaints, including extra training on eligibility, capacity, and Care Act assessments following a formal concern.

Partners said the authority made visible efforts to capture and act on feedback and described meaningful consultation across the five islands during the new care model development, with public views influencing decisions like the naming of facilities and structure of service delivery. Healthwatch was commissioned twice, once for adult social care feedback and again for a broader community health survey and was integrated into governance through a steering group. They confirmed that feedback led to improvements like a centralised contact system, drop-in sessions, and better community-facing communication.

Process evidence supported the commitment to listening. The Quality Improvement Framework included service user feedback, reflective supervision, and external audits. Surveys were issued to all households across the islands, gathering both quantitative and qualitative data. Feedback forms were embedded at multiple service stages and used to inform practice improvements. Compliments were received and documented, though the volume of formal complaints was low, only one in the past 12 months. This complaint was fully investigated with procedural transparency, including updates at every stage and guidance on escalation to the Local Government and Social Care Ombudsman (LGSCO).

The local authority acknowledged its limits in drawing thematic learning from complaints due to low volumes and the size of its team. It had reverted to using the local authority's generic complaints pathway to safeguard independence and shared any future complaints would be assessed for external review if needed.