

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

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

Dumfries and Galloway Partnership November 2021

Contents

	2
Joint inspection of adult support and protection in the Dumfries and Galloway partnership	4
Summary – strengths and priority areas for improvement	7
How good were the partnership’s key processes to keep adults at risk of harm safe, protected and supported?	8
Investigation and risk management	10
Collaborative working to keep adults at risk of harm safe, protected and supported	14
Key adult support and protection practices	17
How good was the partnership’s strategic leadership for adult support and protection?	20
Next steps	25
Appendix 1 – core data set	26

Map showing divisional concern hubs



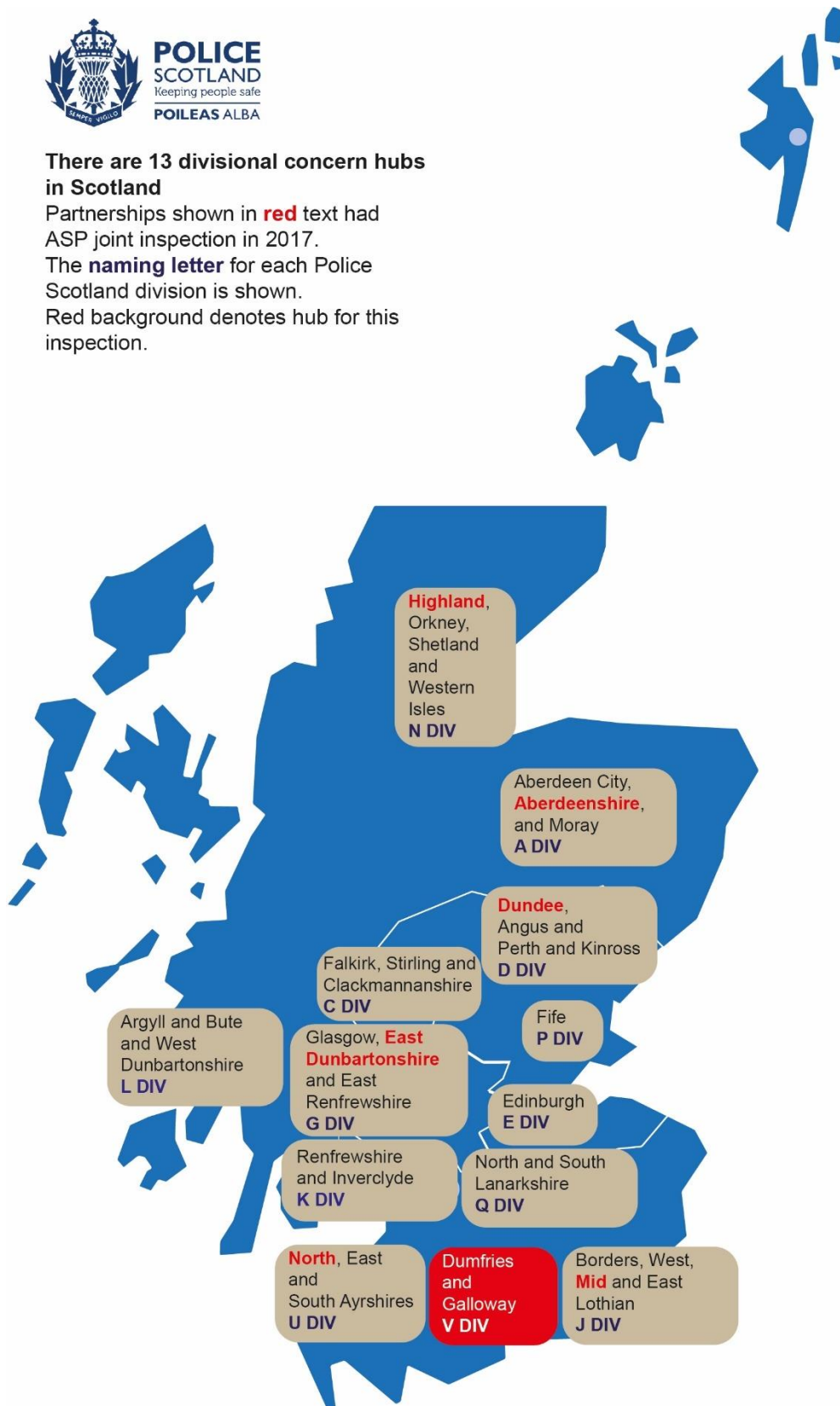
POLICE
SCOTLAND
Keeping people safe
POILEAS ALBA

There are 13 divisional concern hubs in Scotland

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

The **naming letter** for each Police Scotland division is shown.

Red background denotes hub for this inspection.



Joint inspection of adult support and protection in the Dumfries and Galloway partnership

Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead these joint inspections of adult support and protection in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland.

The joint inspection focus

Building on the 2017-2018 inspections, this is one of 26 adult support and protection inspections to be completed between 2020 and 2023. They aim to provide timely national assurance about individual local partnership¹ areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. Both the findings from these 26 inspections and the previous inspection work we undertook in 2017- 2018 will inform a report to the Scottish Government giving our overall findings. This will shape the development of the remit and scope of further scrutiny and/or improvement activity to be undertaken. The focus of this inspection was on whether adults at risk of harm in the Dumfries and Galloway area were safe, protected and supported.

The joint inspection of the Dumfries and Galloway partnership took place between August and November 2021.

The Dumfries and Galloway partnership and all others across Scotland faced the unprecedented challenge of recovery and remobilisation after 20 months of the Covid-19 pandemic. We appreciate the Dumfries and Galloway partnership's co-operation and support for the joint inspection of adult support and protection at this difficult time.

Quality indicators

Our quality indicators² for these joint inspections are on the Care Inspectorate's website.

1

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

2

<https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf>

Progress statements

To provide Scottish Ministers with timely high-level information, this joint inspection report includes a statement about the partnership's progress in relation to our two key questions.

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

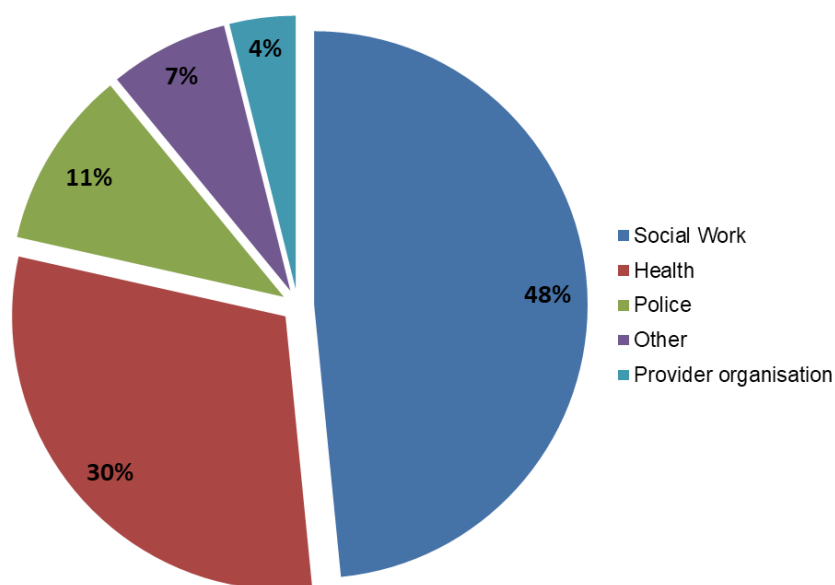
Joint inspection methodology

In line with the targeted nature of our inspection programme, the methodology for this inspection included four proportionate scrutiny activities.

The analysis of supporting documentary evidence and a position statement submitted by the partnership.

Staff survey. Two hundred and fifty-six staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

Respondents by Employer type

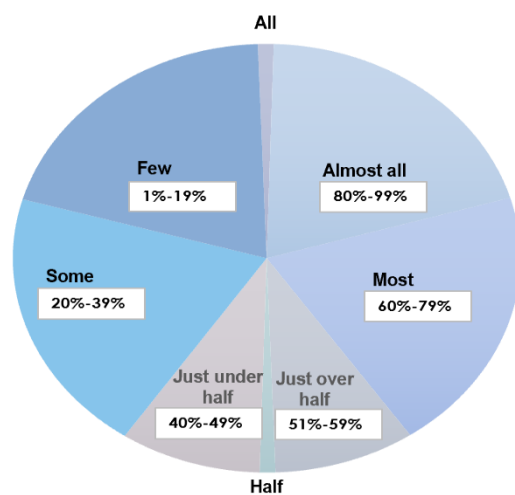


The scrutiny of the health, police, and social work records of adults of risk of harm. This involved the records of 50 adults at risk of harm where their adult protection journey progressed to at least the investigation stage. It also involved the scrutiny of recordings of 40 adult protection initial inquiry episodes where the partnership had taken no further action, in respect of further adult protection activity, beyond the duty to inquire stage.

Staff focus groups. We carried out two focus group and met with twenty-two members of staff from across the partnership to discuss the impact of the Covid-19 pandemic on adult support and protection and adults at risk of harm. This also provided us with an opportunity to discuss how well the partnership had implemented the Covid-19 national adult support and protection guidance.

Standard terms for percentage ranges

Data descriptors for percentage scale



Summary – strengths and priority areas for improvement

Strengths

- The partnership achieved good outcomes for almost all adults at risk of harm, including during the period of Covid-19 restrictions.
- The partnership had made a sound decision to focus on adult support and protection early screening/triage and duty to inquire arrangements. The well-resourced multi-agency safeguarding hub provided a robust platform from which to take forward adult support and protection work.
- Adult support and protection investigations and risk assessments were collaborative and undertaken to a high standard. The rolling risk assessment and use of a risk matrix contributed to high quality work.
- The partnership's chief officer group and public protection committee worked well together to provide a clear vision and ensure adult support and protection remained a strategic priority prior to and during Covid-19.
- There was a clear collaborative ethos across the partnership including frontline staff, and across the leadership team including the statutory, third and independent sector organisations.

Priority areas for improvement

- Key process timescales were inconsistently met. This resulted in poor outcomes for a small, but significant number of adults at risk of harm.
- Medical examinations should be completed in line with the needs of the adult at risk of harm.
- The partnership should implement means to ensure frontline staff are more directly involved in self-evaluation and improvement activity.

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

Key messages

- All referrals were processed through an effective single access point that appropriately categorised them according to risk and level of concern.
- The multi-agency safeguarding hub promoted effective collaboration at the inquiry stage. The quality of conversations and inquiry work was mostly of a high standard.
- The partnership's approach to investigations and risk assessments was thorough. Risk assessments were commenced early and continued to be developed throughout the adult support and protection journey.
- The partnership achieved safety improvements for almost all adults at risk of harm, including across the period of Covid-19 restrictions.
- Some investigations took too long to complete, and the gap between investigations being concluded and the initial case conference was also too long. In a small yet significant number of cases, this meant adults at risk of harm missed the opportunity to have the support of a formally implemented protection plan, leading to poor outcomes.
- The partnership should explore ways to better support the attendance and participation of health staff at case conferences.

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

Initial inquiries into concerns about an adult at risk of harm

Screening and triaging of adult protection concerns

The partnership had a well-established process for screening and triaging adult protection referrals. All referrals were processed through an effective single access point that appropriately categorised them according to risk and level of concern. High-risk concerns were directed to the Multi-Agency Safeguarding Hub (MASH) to be progressed under adult support and protection (ASP). There were clear protocols in place to ensure that referrals that did not meet these criteria were directed to the appropriate agency for additional support or closed as appropriate.

Almost all staff reported that the process of making an adult protection referral to social work was clear and well understood. There was a high level of confidence that the partnership dealt with initial adult at risk of harm concerns effectively.

Initial inquiries into concerns about adults at risk of harm

Following a multi-agency case file audit in February 2019, the partnership had revised the duty to inquire (DTI) process to develop a more consistent approach. Leaders had focussed much of their attention on improving the front door arrangements and clear progress had been made to develop a more succinct process, where all initial inquiries were processed by the MASH. Most inquiries were processed within the partnership's key timescales and in keeping with needs of the adult at risk of harm.

All adult protection referrals were handled in line with the principles of the Adult Support and Protection (Scotland) Act 2007 and staff had applied the three-point test correctly in almost all initial inquiry episodes. However, this was not always clearly recorded in the referral documentation. There was evidence of communication between ASP partners in almost all initial inquiries and communication was good or better in almost all cases.

The MASH processed all duty to inquire activity and there was evidence that they provided good oversight in almost all of the duty to inquire episodes that we reviewed. The templates for recording inquiries were well designed. Forms were clear and concise which aided the governing process. The various agencies forming the MASH collaborated well and effectively governed decisions about whether to proceed to adult support and protection investigation.

Adult initial referral discussions (AIRDS) were embedded into key processes, to consider particularly complex cases referred to the MASH. Where we saw them applied, they were highly effective in determining the next steps. While this was positive, they were not being used as often as they should have been, limiting their benefit and impact.

The timescales for progressing inquiries were not always met. Some were not progressed within a timescale that met the needs of the individual. The partnership recognised this as an area of improvement, and further audit work was planned later this year to address this critical area of practice.

Investigation and risk management

Chronologies

Almost all adults at risk of harm had a chronology of key events, and staff were confident that these chronologies were an essential element of risk assessment and risk management.

The quality of chronologies was good or better in just over half of cases. Records included a 'concern history' as well as a 'record of contact and discussions'. Both provided useful background information regarding the adult protection referral, including a history of risk to the adult and any previous health and social care interventions. The information provided was used to effectively inform the decisions on how the adult protection episode would proceed.

The few chronologies that were rated as weak or unsatisfactory lacked sufficient information about key events in the life of the adult at risk of harm, were not up to date, limited to social work interventions, and lacked review and analysis. The partnership should develop a standard template for recording adult protection chronologies, which covers all key areas, and can be applied consistently to inform the ASP process.

Risk assessments

Following an evaluation of the adult support and protection risk assessment process in September 2019, the partnership was in the process of replacing their current risk matrix tool with another. Staff across the partnership had been trained in the use of the new risk assessment in March 2021. Results from initial tests of change were positive and further pilot work was planned before full implementation.

Using the standard matrix framework to assess risk, as part of the adult support and protection process, ensured that the partnership's approach was consistent. Almost all adults at risk of harm had a completed risk assessment within their records, which was appropriately informed by multi-agency partners and completed timeously.

The partnership had a dynamic approach to risk assessment, which commenced at the duty to inquire stage and was carried through to investigations. This strengthened the assessment and planning process and ensured that there was a direct link between agreed outcomes and risk.

The quality of risk assessments was good or better in almost all cases. Assessments were comprehensive and had a good level of analysis of risk and protective factors. Use of a risk matrix further strengthened the effectiveness of risk assessments.

Almost all staff were confident that the partnership's risk assessments included the relevant analysis of risk. The partnership performed strongly in this area of practice.

Full investigations

Adult support and protection investigations were appropriately undertaken in almost all instances. All investigations were appropriately led by a council officer and, in almost all cases the relevant people were involved, and the investigation effectively determined if the adult was at risk of harm. The quality of investigations was rated as good or better in almost all cases.

Second workers were deployed appropriately in almost all cases. In the small number of cases where the second worker should have been a suitable health professional, this happened in most instances. This indicated close collaboration amongst key professionals.

Some investigations were not completed within a timescale in keeping with the needs of the adult at risk of harm, and in just over half of those cases, the delay was more than one month. Whilst most adults at risk of harm were well supported during the delayed period, reaching a timely conclusion would have been more beneficial. The partnership had identified this as an area for improvement. More work needed to be done to address this important aspect of adult support and protection activity.

Adult protection case conferences

Case conferences were convened for almost all adults at risk of harm who required one. In most cases, where a case conference was not convened when it should have been, the reasons for this were clear and unavoidable.

There were a few cases where case conferences were not convened because of delays in the preceding key process, as reported above. In a few cases, other significant events occurred in the life of the adult at risk during the delay period, that meant a case conference was no longer appropriate. This had significant consequences for a small, but notable number of adults at risk of harm and should be addressed as an area for improvement.

The partnership convened case conferences that focused on the needs of the adult at risk of harm, and this was a view supported by frontline staff. Adults at risk of harm were invited to attend case conferences in almost all cases, and unpaid carers were invited to attend on all occasions where it was appropriate. All adults at risk of harm were effectively supported to participate in the case conference in all instances. In just under half of cases, the adult at risk of harm had been invited to attend the case conference but did not attend. The main reason recorded in the record was that the adult chose not to attend.

Where the partnership convened a case conference, almost all of the relevant professionals were invited to attend. However, in just over half of the case conferences reviewed, the relevant people did not attend. In most instances, it was a representative from health who did not attend. This was an area for improvement.

In almost all cases, case conferences effectively determined what needed to be done to ensure that the adult risk of harm was safe and the minute of the conference was circulated to all the relevant people. However, just under half of case conferences were not completed timeously. Just over half of those delayed were by more than two weeks, with the remainder by more than one month. This was an area of improvement for the partnership, to ensure that all case conferences were completed within a timescale appropriate to the needs of the adult at risk of harm.

Adult protection plans / risk management plans

Most adults at risk of harm who required a risk management plan had one. In almost all cases, these plans were up to date and collaboration between multi-agency partners was clearly evident.

Just over half of the partnership's risk management/protection plans were rated as good or better. In some cases, protection plans would have benefited from pulling through the analysis from the risk assessments more consistently. Protection plans accurately captured all the risks identified through the ASP processes and clearly identified what needed to be done to ensure that the adults at risk of harm were safe and protected. Protection plans that were developed following case conference reflected a collaborative approach to keeping the adult at risk of harm safe, and the roles of multi-agency partners in doing so were clear.

Adult protection review case conferences

Adult protection review case conferences were carried out for all adults at risk of harm who required one. In almost all cases, protection plans were completed timeously, and on every occasion, we concluded that they had effectively determined what was required to keep the adult at risk of harm safe and protected.

Implementation / effectiveness of adult protection plans

Staff were encouraged to start protection planning early in the ASP process. An interim protection plan was initiated at the duty to inquire stage and extended into the investigation process. This ensured that the identified risk could be addressed early and safeguards could be put in place to ensure that the adult at risk of harm, and where appropriate their family, were safe and protected. However, this was work in progress and implementation of the interim plans was not yet fully embedded.

Protection planning was more developed following case conference. The views of adults at risk of harm - or where appropriate their representatives - were always considered in the planning, implementation, and review of adult protection plans. Feedback from staff regarding protection plans was positive. Most staff were confident that the adults at risk of harm or their representatives were involved in developing their protection plans.

For those individuals who had complex needs and were hard to reach, adult protection plans were useful in safeguarding the needs of the adult at risk of harm and their family. However, not all of these cases were progressed to case conference which made protection planning for these individuals very challenging. Some of these adults would have clearly benefited from a more formal multi-agency discussion framework to address the level of risk and promote a multi-agency approach to keep them safe.

Large-scale investigations

The partnership had completed one large-scale investigation within a local care home in the last two years. The large-scale investigation was undertaken timeously, and in line with the partnership's comprehensive guidance for completing large-scale investigations.

The process of large-scale investigations was inclusive. The views of service users within the care home and the families of the adults at risk of harm were considered as part of the investigation. It was clear that multi-agency partners had worked collaboratively and involved relevant, wider adult protection partners, including the Care Inspectorate to investigate adult protection concerns within this care home.

Large-scale investigation core and oversight groups were established promptly, and overall, there was good governance of the large-scale investigation process. The large-scale investigation effectively determined that no further action was warranted. However, some important areas for development were identified, and improvement work had been linked to ongoing care assurance work within the Care Home Oversight Group.

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

Overall effectiveness of collaborative working

Multi-agency partners worked collaboratively to keep adults at risk of harm safe in Dumfries and Galloway. This was supported by almost all staff who completed our survey.

The single access point and multi-agency safeguarding hub ensured that all the relevant multi-agency staff were involved in the adult support and protection process from the onset and continued to work together to achieve positive outcomes for adults at risk of harm. Information sharing and collaboration between relevant agencies was strong and rated positively in all instances.

Adult support and protection practice was informed by the West of Scotland Inter-Agency Adult Support and Protection Practice guidance. This provided clear guidance for staff about the action to be taken by the key agencies when harm was identified. However, the guidance on key process timescales was confusing and the indicative timescales were not clear. The partnership acknowledged that this was an area for improvement and needed to be addressed. This would support staff in their understanding of the guidance and what is required of them in order to complete key processes in a timely way.

Health involvement in adult support and protection

There was a dedicated team of healthcare staff who were part of the multi-agency safeguarding hub. This promoted active collaboration with staff from other agencies, to ensure that adults at risk of harm in Dumfries and Galloway were safe and protected.

From the staff survey, health staff were generally positive about their role in relation to adult support and protection. Staff were confident about what to do when they had concerns about an adult at risk of harm and similarly about raising or escalating adult protection concerns appropriately.

The quality of record keeping in relation to adult support and protection in the health records was rated as good or better in almost all cases, and in all cases, health professionals had contributed positively to improved outcomes for the adult at risk of harm.

We reviewed the records of some adults, who were re-admitted to hospital with a health condition which may have been related to their risk of harm. In most instances, the interventions from hospital services to keep the adult safe were rated positively. This was also the case when adults at risk of harm were subject to repeat referrals for community health services.

Interventions to keep those adults at risk of harm, who frequently presented to emergency departments, safe and protected, were rated less positively in a few cases. This should be reviewed by the partnership and improvements made to ensure that adults at risk of harm are safe and supported in all health and social care settings.

Medical examinations were only completed in just over half of the cases where one should have been carried out. The two primary reasons for this were refusal to cooperate by the adult at risk of harm and a lack of coordination by professionals. This area needed to be strengthened.

In a few but significant number of cases, health staff had not attended case conference, despite being invited. The reasons for not attending were not always clear. The partnership should explore this and ensure that action is taken to support health staff to effectively contribute to case conferences as appropriate.

Police involvement in adult support and protection

Almost all contacts made to the police about adults at risk of harm were effectively assessed by officers and staff for threat of harm, risk, investigative opportunity and vulnerability (THRIVE). Most cases had an accurate STORM disposal code (record of incident type).

Most initial attending officers' actions were good or better. Their assessment of risk of harm, vulnerability and wellbeing was accurate and informative in almost all records, and the wishes and feelings of the adult were considered and recorded in most instances. Officers engaged directly with partners to secure swift and appropriate interventions. On all occasions where adult concerns were identified, referrals were made promptly through use of the interim vulnerable persons database (IVPD).

In a few cases, the attending officers dealt with the criminal activity of a third party but did not recognise the associated impact on the adult at risk of harm. Supervisory oversight was present and considered good or better in most cases. In a few instances there was a notable absence of oversight, including in more complex cases where supervisory input to assessment and management of risk would have been expected.

The divisional concern hub recorded the triage process to prioritise risk in almost all cases. Records almost always contained an appropriately detailed resilience matrix, with evidence of good research, assessment and input by staff. Just over half of the cases referenced an Inter-Agency Referral Discussion. The police link to the MASH was well-established and effective.

Where the escalation protocol was initiated (following repeat police involvement) there was evidence of it being used to good effect. On occasions Police Scotland's own guidance regarding escalation thresholds was not followed. There were also instances where it may have been appropriate to consider and record single agency police actions beyond referring to the MASH.

The divisional concern hub actions and records were good or better in almost all cases, and very good or better in just under half. Police almost always attended case conferences, when invited. The contribution of officers was viewed as being good or better in just over half of these instances.

Third sector and independent sector provider involvement

The third sector played a key role in adult support and protection and had direct links to the single access point. Their contribution to keeping adults at risk of harm safe and protected was evident, particularly when they required additional support. Support was often signposted to third sector and independent sector services.

All staff from these sectors were confident about their role in supporting adults at risk of harm, and almost all felt supported to work collaboratively. Third and independent sector staff raised adult protection concerns appropriately, and in almost all cases they attended cases conferences when they were invited and played key protection support roles.

Key adult support and protection practices

Information sharing

Adult protection partners were sharing information appropriately and effectively in almost all cases. The multi-agency hub promoted effective information sharing between staff from the statutory agencies, and strong links had been established with wider adult support and protection partners. This was working well.

Management oversight and governance

Management oversight of adult support and protection was strong in Dumfries and Galloway. On almost every occasion, there was evidence of exercise of governance in the adult protection records, and the level of recording was appropriate and in keeping with needs of the adult at risk of harm.

Almost all social work records demonstrated that discussions had taken place between the case worker and their manager, and most line managers were periodically reading the records. Evidence of management oversight was also apparent in most police records.

It is recognised that management oversight in health records is not typical in clinical practice, however, there was evidence of management oversight in most of the health records that we reviewed.

Involvement and support for adults at risk of harm

The partnership involved adults at risk of harm and unpaid carers in all aspects of adult support and protection effectively. In almost all instances, adults at risk of harm were appropriately supported throughout their adult protection journey and the level of support offered was effective.

Independent advocacy

Most adults at risk of harm were offered independent advocacy, however, only some of those offered actually accepted and received the service. The reasons for not receiving this support were not always clearly documented. The partnership would benefit from exploring why so few adults at risk of harm accepted the support offered.

Where advocacy was accepted it was almost always timely, making a positive difference in all cases. Where face-to-face engagement was not appropriate (due to the restrictions of the Covid-19 pandemic) advocacy was often facilitated through telephone contact, and other digital solutions where it was appropriate to do so.

Capacity and assessment of capacity

Where there were concerns about capacity, almost all adults had an appropriate request to health for an assessment. Subsequently, where these requests were made, almost all adults had their capacity assessed by a health professional in a timely manner and in keeping with their needs.

Financial harm and perpetrators of all types of harm

Financial harm was reported in some of the records that we read. In almost all instances, multi-agency partners worked effectively to stop financial abuse when it occurred. On the few occasions that they did not, this was largely due to the adult at risk choosing not to engage with the process.

Where the partnership undertook work with alleged perpetrators who were known to them, this was appropriate, and we rated the quality of this work as effective in all instances.

Safety outcomes for adults at risk of harm

The partnership achieved safety improvements for almost all adults at risk of harm, including across the period of Covid-19 restrictions. This was primarily due to multi-agency working, with the contribution of the various adult support and protection partnership agencies a key factor in the delivery of positive outcomes for adults at risk of harm.

Most staff completing the survey thought that adults at risk of harm experienced a safer quality of life from the support they received. Almost all adults at risk of harm who needed additional support received it.

Despite the partnership's coordinated response to recognised adult protection concerns, there were a few instances where delays in delivering key processes had a significant impact. A small, yet significant number of adults at risk of harm missed the opportunity to have the support of a formally implemented protection plan. This resulted in poor outcomes.

Adult support and protection training

The partnership had a three-year training and development strategy in place. Whilst the Covid-19 pandemic had impacted on implementation, the partnership was working hard to address this. A dedicated public protection post had been created to drive this work forward.

Most staff who responded to our survey were confident that the partnership provided the right level of mandatory ASP training for all staff groups. In addition, almost all staff felt that this training equipped them with the knowledge and skills to undertake their roles effectively. Those who received council officer training, felt that it underpinned their understanding of ASP legislation.

Staff responses were less positive regarding participation in multi-agency training and development opportunities and whether this had strengthened their contribution to joint working in adult support and protection.

At the height of the pandemic, the partnership had made the decision to pause all training in the interests of safety. Whilst this was necessary due to pressure on services, frontline staff who participated in our focus group also reported that this had adversely affected them and there was a gap in essential learning. The partnership's leadership team acknowledged this and reported that a training needs assessment, which had been paused due the pandemic, was now progressing. The partnership should address any gaps identified and determine the specific action required to ensure that the training needs of staff are met.

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

Key messages

- The partnership's vision and key priorities for adult support and protection were clearly laid out.
- The partnership had committed additional resources and made several key appointments to strengthen the multi-agency safeguarding hub.
- The partnership's leadership had worked collaboratively to ensure that adult support and protection was a priority and governed progress well during the Covid-19 pandemic.
- Most staff felt appropriately supported to undertake adult support and protection work, and felt safe and protected doing so during the restricted period.
- The partnership should consider how it involves staff more directly in quality assurance and improvement work. This will increase their level of involvement and their understanding of change and improvement activity.
- The partnership should more effectively govern progress of areas of improvement identified through self-evaluation activity.

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

Vision and strategy

The partnership's vision and key priorities for adult support and protection were clearly laid out in the comprehensive Public Protection Strategic Plan, 2020 - 2023. The role of the public protection committee in implementing and delivering this plan was defined in the public protection constitution, 2020 and they were doing so effectively. Most staff reported that they had a good understanding of the vision.

Leaders demonstrated a strong commitment to working collaboratively and supporting their staff to deliver shared priorities. This collaboration was evident in how staff worked well together to deliver positive outcomes for adults at risk of harm.

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

The chief officers' group - public protection had an overall lead role for all public protection. The partnership had a public protection committee which reported directly to chief officers' group - public protection on adult protection, as well as child protection and violence against women and girls.

All statutory partners were appropriately represented at both the chief officers' group and public protection committees. The groups met regularly and attendance at meetings was consistently good. The partnership had reconfigured the strategic planning and delivery groups to take into account the impact of the Covid-19 pandemic and were delivering a collaborative response. This included a revision of the public protection constitution and enhanced governance and oversight to ensure that public protection, including adult support and protection, remained a priority despite the challenges.

A range of sub-committees had been developed to support the functions of the public protection committee and the partnership had recently added a sub-committee to monitor initial and significant case reviews. This was positive and provided a strong foundation for the partnership to support collaborative learning and ensure that review findings were contributing to improvement in adult support and protection practice.

The partnership had made several appointments across partner agencies to strengthen the MASH, this included additional resources for social work, police, and key appointments to enhance the health contribution to adult support and protection. These appointments demonstrated the partnership's commitment to partnership working and provided a good foundation to strengthen the governance of adult support and protection.

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

Leaders had instilled a collaborative ethos across the partnership. They collectively recognised the contribution of frontline staff towards keeping adults at risk of harm safe and protected, particularly during the restricted period due to the Covid-19 pandemic.

Leaders had initiated a rapid response to address pressure on the system due to the pandemic and made key investments in the MASH, which included a dedicated health public protection team. This ensured that the partnership continued to deliver effective adult support and protection work, despite an increase in referrals and investigations. Staff were positive in their views about the leadership provided by the public protection committee.

Despite the challenges brought on by the Covid-19 pandemic, leaders demonstrated innovation by developing a range of initiatives to improve practice during the restricted period. This included implementing a reflective learning tool, to promote learning amongst multi agency staff following significant events, and the development of the home teams model. The home teams model aimed to strengthen early intervention across all community health and social care interventions, including more effective support for adults at risk of harm, who may not meet the adult support and protection criteria but were still at significant risk.

Quality assurance, self-evaluation and improvement activity

The partnership completed a multi-agency self-evaluation of adult support and protection processes biennially and single agency peer reviews were conducted by social work services bi-monthly. There was an established multi-agency template in place and audits were done in stages. For example, the focus of these audits between January and March 2021 was adult initial referral discussions.

Whilst these evaluations provided an effective platform to drive forward improvement, more needed to be done to evidence impact. The Covid-19 pandemic would have impacted on implementation of the recommendations identified in the last multi-agency audit. However, this was in 2019 and some improvements were yet to be implemented. The partnership's leadership should strengthen how they monitor and govern progress on recommendations and improvement actions identified through self-evaluation activity.

Staff views on the partnership's approach to self-evaluation were mixed, and only some felt that the leadership involved them in evaluating their own practice to inform improvement in adult support and protection work. The strategic leadership team should develop the role of staff in self-evaluation activity, to ensure that frontline staff are fully involved in driving change and improvement of ASP practices and feel that their contributions are of value.

The partnership was in the process of strengthening its performance framework, to include the production of live dashboards. This will be useful in providing more robust, measurable information to allow the public protection committee to monitor adult protection activity and inform improvement. The establishment of the home teams model was also expected to improve multi-agency planning.

Initial case reviews and significant case reviews

The partnership carried out five adult protection initial case reviews. These were conducted in line with the national interim guidance for initial and significant case reviews. All reviews were collaboratively conducted by a multi-agency case review group.

Whilst we considered the impact of the Covid-19 pandemic, there were significant delays between notification and convening of the initial case review panel.

A dedicated public protection sub-committee was responsible for overseeing progress on implementation of review findings. The partnership had developed an initial case review composite plan, which included the recommendations from three initial case reviews between February and May 2021. This allowed the partnership to develop an overview of important themes and learning from these reviews and provided a platform for them to address the areas of improvement identified.

Impact of Covid-19

The Covid-19 pandemic had placed pressure on the partnership's well-established systems and processes. One of the main challenges for the partnership was maintaining staff capacity to address adult support and protection referrals during the pandemic. Partnership leaders were working collaboratively to implement an effective response to these challenges.

Clear progress had been made to ensure that adult support and protection remained a priority despite the challenges. In half of the records we read, the adult protection concern had been raised during the restricted period. It was evident in almost all instances that multi-agency partners had worked collaboratively to deliver key adult protection processes effectively, and the adults at risk of harm were kept safe as a result of the partnership's interventions.

The pandemic had adversely affected adults at risk of harm and their carers. The associated restrictions of the pandemic, particularly the inability of family to visit their relatives in care settings, had played a part in the events leading up to the large-scale investigation described above. Partnership leaders had made considerable efforts to gather the views of adults at risk of harm and their carers to inform improvement. The smart survey developed, to gather service user feedback during the restricted period, was a good example of that. This work was effectively supported by a third sector body.

Most staff who responded to our survey, reported that they felt appropriately supported to undertake support and protection work, and that they felt safe and protected doing so during the restricted period. Where staff expressed a view about the partnership's leadership, feedback was positive in most cases. Partnership leaders were aware that staff had worked beyond the limits of their traditional roles to keep adults at risk of harm safe. Whilst progress had been made in response to the pandemic, more needed to be done to ensure that all staff, including those who worked in the third and independent sectors, were supported.

Summary

The Dumfries and Galloway partnership had a clear vision for adult support and protection, and the role of the public protection committee in delivering the partnership's key priorities was well defined. The partnership's leadership team was working collaboratively to deliver positive outcomes for adults at risk of harm. This was evident in the delivery of an effective response to the challenges associated with the Covid-19 pandemic. The chief officers' group and public protection committee worked closely together and there was good oversight and governance of adult support and protection issues. More work was needed to more effectively involve frontline staff in improvement work.

Considerable improvements had been made to the partnership's adult support and protection access arrangements and the partnership had prioritised and developed a process that effectively screened and triaged adult protection referrals. This was well established.

In addition, the MASH promoted collaborative delivery of adult support and protection duty to inquire processes for adults who met the three-point test and were at risk of harm. Communication, information sharing and the quality of work undertaken by this team was typically very good. However, adult support and protection key processes were not always completed in a timely manner.

The partnership's approach to risk assessments in particular was very strong. This enhanced the partnership's positive approach to investigation work and risk analysis. While analysis of risk was evident, this did not always pull through to risk management or protection plans. The quality of chronologies was mixed and more work was needed to ensure they consistently supported adult protection work more meaningfully.

Partnership staff worked collaboratively to deliver positive adult support and protection outcomes for adults at risk of harm and felt appropriately supported to do so.

We concluded the partnership's key processes and strategic leadership for adult support and protection were effective with clear strengths areas for improvement.

Next steps

We ask the Dumfries and Galloway partnership to prepare an improvement plan to address the priority areas for improvement (see priority areas for improvement we identify). The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland will monitor progress implementing this plan.

Appendix 1 – core data set

Scrutiny of recordings results and staff survey results about initial inquiries – key process 1

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

- 100% of initial inquiries were in line with the principles of the ASP Act
- 65% of adult at risk of harm episodes were passed from the concern hub to the HSCP in good time
- 83% delay in the concern hub passing on concerns by less than one week, 17% were delayed by one to two weeks.
- 80% of episodes where the application of the three-point test was clearly recorded by the HSCP
- 93% of episodes where the three-point test was applied correctly by the HSCP
- 68% of episodes were progressed timeously by the HSCP
- Of those that were delayed, 54% less than one week, 31% one to two weeks, 8% two weeks to one month, 8% one to three months
- 95% of episodes evidenced management oversight of decision making
- 78% of episodes were rated good or better

Staff survey results on initial inquiries

- 86% concur that the partnership accurately screens initial adult at risk of harm concerns, 14% did not concur
- 84% concur they are aware of the three-point test and how it applies to adults at risk of harm, 8% did not concur, 9% didn't know
- 76% concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option, 9% did not concur, 15% didn't know
- 72% concur they are confident that the partnership deals with initial adult at risk of harm concerns effectively, 20% did not concur, 9% didn't know

Information sharing among partners for initial inquiries

- 98% of episodes evidenced communication among partners

File reading results 2: for 50 adults at risk of harm, staff survey results (purple)

Chronologies

- 90% of adults at risk of harm had a chronology
- 57% of chronologies were rated good or better, 42% adequate or worse
- 86% concur chronologies form an important feature of ASP investigation reports

Risk assessment and adult protection plans

- 98% of adults at risk of harm had a risk assessment
- 87% of risk assessments were rated good or better
- 67% of adults at risk of harm had a risk management / protection plan (when appropriate)
- 53% of protection plans were rated good or better, 47% were rated adequate or worse
- 82% concur that ASP investigation risk assessments include relevant analysis of risk, including risk / protective factors.

Full investigations

- 98% of investigations effectively determined if an adult was at risk of harm
- 67% of investigations were carried out timeously
- 81% of investigations were rated good or better

Adult protection case conferences

- 84% were convened when required
- 57% were convened timeously
- 86% were attended by the adult at risk of harm (when invited)
- Police attended 89%, health 67% (when invited)
- 85% of case conferences were rated good or better for quality
- 90% effectively determined actions to keep the adult safe
- 88% feel confident adults at risk of harm are appropriately supported to attend ASP initial case conferences

Adult protection review case conferences

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

Police involvement in adult support and protection

- 79% of adult protection concerns were sent to the HSCP in a timely manner
- 70% of inquiry officers' actions were rated good or better
- 84% of concern hub officers' actions were rated good or better

Health involvement in adult support and protection

- 78% good or better rating for the contribution of health professionals to improved safety and protection outcomes for adults at risk of harm
- 87% good or better rating for the quality of ASP recording in health records
- 76% rated good or better for quality information sharing and collaboration recorded in health records

File reading results 3: 50 adults at risk of harm and staff survey results (purple)

Information sharing

- 98% of cases evidenced partners sharing information
- 96% of those cases local authority staff shared information appropriately and effectively
- 84% of those cases police shared information appropriately and effectively
- 94% of those cases health staff shared information effectively

Management oversight and governance

- 72% of adults at risk of harm records were read by a line manager
- Evidence of governance shown in records - social work 94%, police 77%, health 61%

Involvement and support for adults at risk of harm

- 93% of adults at risk of harm had support throughout their adult protection journey
- 92% were rated good or better for overall quality of support to adult at risk of harm
- 77% concur adults at risk of harm are supported to participate meaningfully in ASP decisions that affect their lives, 8% did not concur, 15% didn't know

Independent advocacy

- 76% of adults at risk of harm were offered independent advocacy
- 29% of those offered, accepted and received advocacy
- 91% of adults at risk of harm who received advocacy got it timeously.
- 73% concur they are confident adults subject to ASP investigations have the opportunity to access independent advocacy

Capacity and assessments of capacity

- 91% of adults where there were concerns about capacity had a request to health for an assessment of capacity
- 90% of these adults had their capacity assessed by health
- 74% of capacity assessments done by health were done timeously

Financial harm and all perpetrators of harm

- 10% of adults at risk of harm were subject to financial harm
- 40% of partners' actions to stop financial harm were rated good or better
- 80% of partners' actions against known harm perpetrators were rated good or better

Safety and additional support outcomes

- 58% of adults at risk of harm had some improvement for safety and protection
- 93% of adults at risk of harm who needed additional support received it
- 70% concur adults subject to ASP, experience safer quality of life from the support they receive, 11% did not concur, 19% didn't know

Staff survey results about strategic leadership

Vision and strategy

- 57% concur local leaders provide staff with clear vision for their adult support and protection work. 16% did not concur, 27% didn't know

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

- 56% concur local leadership of ASP across partnership is effective, 13% did not concur, 31% didn't know
- 54% concur I feel confident there is effective leadership from adult protection committee, 10% did not concur, 36% didn't know
- 54% concur local leaders work effectively to raise public awareness of ASP, 12% did not concur, 35% didn't know

Quality assurance, self-evaluation, and improvement activity

- 49% concur leaders evaluate the impact of what we do, and this informs improvement of ASP work across adult services, 13% did not concur, 38% didn't know
- 48% concur ASP changes and developments are integrated and well managed across partnership, 14% did not concur, 37% didn't know