Learning On One Page (LOOP)

(Derby Safeguarding Adults Board (DSAB): Audit – Young Adults (18-24) - May 2024)

Description of Audit Context

Multi-agency case file audits on Young Adults (18–24-year-old) were carried out during June – October 2022, and it was agreed by the Quality Assurance (QA) Subgroup, in 2024, to revisit new cases that have been processed following April 2023 where the theme was on Young Adults (18–24-year-old). The aim of audits on a repeated theme was to establish if there had been an improvement in learning and practice.

Some of the learning themes identified from the audits carried out in 2023 were:

1) Delays in making safeguarding referrals due to consent, 2) need to make more advocacy referrals, 3) need for consistency in record keeping, 4) the need to have clear safety plan in place with the Adult/Representative saying what they want, and 5) Involvement of relevant agencies during information exchanges.

The DSAB completed a multi-agency audit in May 2024, reviewing ten case files where safeguarding concerns had been raised for individuals between the age of 18-24.

The recent multi-agencies case file audits were completed with support from a panel of practitioners who sit on the QA Subgroup. It was not possible to obtain feedback from adults as part of this audit.

Good practice

- In 100% of the cases audited, the appropriate referring process was used when making a safeguarding referral within appropriate referring timescales.
- In 100% of the cases, decision making was made in appropriate time with appropriate agencies contact about the decision.
- In 90% of the cases, information exchanges were carried out with all appropriate agencies.
- In 100% of the cases, the referring agency was provided with feedback, following the safeguarding referral.
- Generally, through most cases there was evidence of good information sharing between partner agencies.
- In 10% of the cases, it was identified that the referring agency made the decision to make the referrals in best interest even when the individual didn't consent to making the referral.
- In each case the views and wishes of the individuals were sought and their outcomes were actioned on.
- Next steps meeting was actioned immediately for 10% of the cases following the concerns raised.
- In 80% of the cases, ethnicity information was recorded on customer record.
- In 100% of the cases, a safety plan was put in place where what the Adult wanted to happen clearly was identified in the Safety Plan discussions?
- Positive working alongside Children Social care was identified in most cases, encouraging think family approach.

What didn't go so well?

- In 10% of the cases, more professional curiosity could have been utilised around ongoing risks and further safety planning.
- In 10% of the cases, all risk raised in initial referral should have been covered in the later safeguarding enquiry, even when further risks emerge.
- In 10% of the cases, it was identified that information exchange was not being carried out with the community safety team effectively.
- Consideration of advocacy services should have been given to 40% of the cases, and having more of a rationale of why advocacy support was not sought.
- Being clearer around considerations completed around an individual's capacity.
- Carers assessment would have been benefitted in 10% of the cases.
- 10% of the cases were not asked the four making safeguarding personal questions.

Any key themes?

- The use of having a Multi-Agency Safeguarding Hub (MASH) supports the positive safeguarding process, encouraging to use the Think Family approach.
- A common theme identified in most cases for Young Adults was around physical abuse and sexual exploitation.
- Use of advocacy services.
- Carrying out information exchanges with appropriate agencies.
- The use of capturing making safeguarding personal questions.
- The use of carers assessment.

Recommendations from DSAB

- To promote and raise the awareness of the use of independent advocacy services, especially where there are concerns around the Adult's capacity.
- Adult Social Care to consider all partner agencies during information exchanges to ensure all pieces of the jigsaw are collated.
- To ensure making safeguarding personal questions are captured and recorded during the closure stage.
- To ensure carers assessments are considered, where carers are identified.
- To look at training around physical abuse and sexual exploitations.