Derbyshire Safeguarding Adults Board Quality Assessment Framework

This Quality Assessment Framework has been developed by Derbyshire Safeguarding Adults Board to benchmark Safeguarding adults practice within Derbyshire. It will ensure that the same standards are applied by DSAB when evaluating Safeguarding practice across partner organisations and to help target specific areas where practice requires improvement. It will also help identify good and outstanding practice that can be shared by partner organisations. These standards should be viewed and incorporate where possible Standards for Safeguarding Adults 2017 (Local Government Association).

RAG	Grading	Outcome	Description
	Outstanding Practice in Adult Safeguarding	Outstanding multiagency practice. The person who was supported had their needs and wellbeing kept at the centre of all decision making. Outcomes for the adult at risk of neglect or abuse exceeded what would reasonably be expected. The person's life was improved from the safeguarding process.	• **Practice:** High quality practice that substantially and/or consistently exceeds expectation. Regular review, specific outcomes, and clear safety planning are evident. Practice guidance has been followed • **Making Safeguarding Personal:** Making Safeguarding Personal is at the heart of practice. Communication with the adult is well considered, person centered tools reasonable adjustments have been made, person centered practice and use of available resource to maximise the adults safety are at the central to interventions • **Outcomes:** Outcomes reduce or remove risk and are considered positive by the adult and professionals involved • **Mental Capacity Act**: Where possible outcomes were led by the adult. The Mental Capacity Act and best interests' decisions were used as appropriate. The adult was involved as much as possible in all aspects of Safeguarding decision making. MCA policies and procedures were followed • **Creative approach:** Evidence of creative and innovative approach to meeting needs and resolving concerns. Evidence based research, learning and enquiry are clear from written records and feedback • **Professional curiosity:** Professional curiosity has helped ensure work is completed in a timely and holistic way • **Multi-agency Working:** Outstanding multiagency working has taken place with a clear understanding of roles and responsibilities. There is evidence of multiagency meetings and actions • **Professional Relationship:** Professionals were persistent and pro-active in understanding, engaging, protecting, and

			supporting the adult • **Communication:** Communication is proactive and tailored to the person's needs. Communication aids have been used where necessary for the adult to understand the Safeguarding • **Management Oversight:** Clear managerial oversight where managers are aware of the Safeguarding and support and guidance are given • **Supervision:** Effective, regular and reflective safeguarding supervision which is provides opportunity to sustain and support high quality frontline practice. • **Evidence Based Decision Making:** Evidence based decision making which reflects an excellent understanding and analysis of the adults' needs, circumstances and history and uses information gathered from multiple sources • **Risk Management and Planning:** Evidence based practice that is both innovative and transformative. Actions that are time specific are taken to reduce and remove risk. Risk management is central to next steps discussions and discussions with the adult • **Future needs addressed:** Potential future issues and needs have been assessed, anticipated and addressed • **Recording:** Recording is proportionate, clear and accurate. DSAB and organisational practice guidance is followed. Legal literacy is evident during application of statutory process. • **Policy and Procedures:** Safeguarding policy and procedures have been followed. This includes application of S.42. DSAB Safeguarding Practice Guidance has been followed. This includes appropriate alerts, multi-agency meetings, safety plans and
	Good Practice in Adult Safeguarding	Safeguarding that is delivered in time that is proportionate for need and includes effective multi agency practice. Adults are protected and receive help necessary to support them to live safely and receive required care	• **Practice:** Practice that meets expected standards within safeguarding adults • **Making Safeguarding Personal:** Support is appropriately person centered and inclusive. Making Safeguarding Personal Tools, or other communication support including advocacy or interpreters has been used when necessary • **Outcomes:** To support positive outcomes risk and need are well understood, managed and regularly reviewed. Needs are met and/or concerns resolved • **Mental Capacity Act**: Where possible outcomes were led by the adult. • **Creative approach:** Evidence of an approach where creativity has been used at times and this has been successful in

			meeting outcomes. • **Professional curiosity:** A degree of professional curiosity has been used including in gathering information from other agencies. • **Multi-agency Working:** Agencies are working effectively together or agencies are holding each other accountable through contact that is as urgent as is required, and when necessary professional challenge and escalation are evidenced. All agencies are sufficiently involved and understand their role • **Professional Relationships:** Positive relationships between professionals and the adult are clearly evidence. These relationships are a catalyst for change • **Communication:** Communication is effective and supports involvement with the adult. • **Management Oversight:** Evidence of managerial oversight and where necessary involvement to support keeping adults safe • **Supervision:** Regular and structured supervision is supporting frontline practice. This is delivered in line with individual organisational expectations • **Evidence Based Decision Making:** Conclusions and decision making are evidence based and analysis and findings in relation to significant harm are clear • **Risk Management and Planning:** Assessments are completed quickly and efficiently with in a time frame that keeps them safe. Risk and protective factors are identified and appropriate action is taken to safeguard adults • **Future needs addressed:** Future needs are identified clearly, and some planning has taken place to ensure future risk is minimised and anticipated • **Recording:** Up-to-date and accurate records, as specified in individual organisational policy and procedures and Safeguarding policy • **Policy and Procedures:** Safeguarding policy and procedures have been followed. Procedures and actions have been completed as expected with little deviation
	Satisfactory Practice in Adult Safeguarding	Meets minimum statutory requirements set out in guidance. Insufficient assurance that agencies are working together to provide good protection, help and care for adults.	• **Practice:** Minimum statutory requirements are met, and the adult has been protected through enquiries. However, practice has not been efficient, person centered and there is not assurance agencies are working together sufficiently • **Making Safeguarding Personal:** Adults have some involvement. Though this is not

			seen as sufficient to empower them to lead their Safeguarding. This is not seen as sufficient inline with good practice and Making Safeguarding Personal policy • **Outcomes:** Risk and needs are understood. The adult may not have always been involved as much as possible. Outcomes are positive and minimise risk • **Mental Capacity Act**: Adults and where appropriate their representative. Consent has been sort as appropriate unless not possible due to nature of abuse as highlighted in DSAB Practice Guidance. • **Creative approach:** Practitioners have shown limited creativity though policy and procedure in their approach to safeguarding has been broadly followed • **Professional curiosity:** Limited professional curiosity has been used including in gathering information from other agencies. This may have impacted the degree to which the person has been protected • **Multi-agency Working:** Working together effectively enough and/or holding each other accountable through appropriate challenge and escalation • **Professional Relationships:** Some evidence of positive relationships supporting positive outcomes. Workers are professional • **Management Oversight:** Evidence of some management oversight and guidance during the safeguarding process. Evidence of authorisation for actions as required in line with policy • **Supervision:** Supervision is not consistent and does not fully evaluate the Safeguarding. Supervision has taken place. • **Evidence Based Decision Making:** Conclusions and decision making are evidence based and analysis and findings in relation to significant harm are clear • **Risk Management and Planning:** Assessments are completed in timeframes agreed and necessary to reduce risk. Risk and protective factors identified and action is taken to safeguard adults • **Future needs addressed:** Though the safeguarding enquiry has highlighted abuse and reduced and/or eliminated abuse. Future needs are not always identified and planned for. • **Recording: Is accurate and reflects what happened.** It is not in depth and though all information is available it has not always been recorded in the correct

			place. • **Policy and Procedures:** Policies and procedures have been followed to the extent to which they reflect statutory duty
	Inadequate Practice in Adult Safeguarding	Insufficient evidence of following statutory procedures under the Care Act 2014 and associated safeguarding guidance. Failures or serious failures leave adults harmed or at risk of harm.	• **Practice:** Insufficient evidence of compliance with minimum standards • **Making Safeguarding Personal:** The adult has not been sufficiently involved in the Safeguarding responses from professionals • **Outcomes:** Responses are not timely or effective and potentially leave the adult at risk of harm • **Mental Capacity Act**: The Mental Capacity Act 2005 has not been applied as directed in law. Mental Capacity assessments may not of been completed or maybe of poor quality • **Creative approach:** The approach to Safeguarding has not been creative or innovative • **Professional curiosity:** Insufficient professional curiosity means information to support decision making is not available. Safeguarding action has not explored options • **Multi-agency Working:** Poor multiagency working where other agencies are not sufficiently involved. There is no evidence of timely or appropriate professional challenge and multiagency meetings • **Professional Relationships:** Lack of professional relationships impact Safeguarding outcomes • **Management Oversight:** Lack of managerial oversight and lack of organizational support for front line workers • **Supervision:** Safeguarding supervision did not take place • **Evidence Based Decision Making:** Quality of decision-making, assessments and planning is poor • **Risk Management and Planning:** Risk is not appropriately assessed for or planned • **Future needs addressed:** Future needs are not explored or addressed sufficiently • **Recording:** Recording is poor. Hard to follow and no completed as specified in practice guidance. • **Policy and Procedures:** Safeguarding policies and procedures have not been followed and this has affected outcomes and prevented effective risk management