Action Plan Closure report	
Action plan title	YL Safeguarding Adults Review Action Plan
Plan start date	Jan 2022
Plan closure date	June 2023
Report author	Chair, PSAB Quality Assurance subgroup

Background and context

The YL Safeguarding Adults Review (SAR) was published in November 2021. YL was a young woman in her early twenties who had a history of mental illness and a diagnosis of Emotionally Unstable Personality Disorder. YL was also the mother of a young child. When her mental health began to deteriorate, she was placed in temporary accommodation due to the perceived risk to her child. YL's self-harming behaviour began to escalate, and she tragically took her own life some months later.

Summary of findings from the SAR

The SAR was conducted by an independent reviewer and the key findings were:

1. The multiagency partnership did not always work in partnership effectively.
2. Appropriate assessments were not always completed so needs were not always identified, or risks mitigated.
3. Support was not always provided to meet identified need.
4. The voice of the adult was not always heard.
5. Safeguarding practice was not always optimal.

Recommendations from SAR

The Board accepted the findings of the review, and a multi-agency workshop was held with senior managers from partner agencies to develop an action plan. Actions planned or underway include:

- Update and promote the Family Approach guidance and resources.

- Develop guidance on supporting people who are or may become homeless including the 'Duty to refer'
- Ensure that the findings inform service development and the implementation of the Community Mental Health Framework
- Develop training and materials for staff on Emotionally Unstable Personality Disorder (EUPD)
- Review discharge-planning to ensure care and support needs are assessed as part of the discharge plan.
- Develop a referral pathway to ensure early consideration is given to the care and support needs of adults at risk placed in temporary accommodation.
- Build relationships between Children's Social Care and Mental Health services.
- Develop understanding of the Care Act 2014 and services for carers among Children's Social Workers.

The action plan was monitored by the Quality Assurance subgroup.

Key actions taken:

1. Duty to refer training provided and well attended.
2. Audit of discharge practice completed.
3. EUPD training delivered to a range of staff across the city, well attended and well received.
4. Revision of the Family Approach policy commissioned across the 4 Safeguarding Adults Boards/Safeguarding Children Partnerships in Hampshire. Work is expected to be completed by the autumn.
5. Adult Social Care and Housing colleagues worked together to improve communication and the referral pathway for adults in need of housing who also may have care and support needs.
6. Presentation to Childrens Social Care on Care Act 2014
7. Senior Adult Mental Health commissioners made aware of the findings of this review.

Outcomes

1. The duty to refer training has increased raised awareness of the need to refer homeless adults for housing advice and support.
2. The EUPD training has increased the knowledge of staff in the city of EUPD and the impact it can have on people who are living with EUPD.
3. The audit of discharge practice highlighted that there were some areas, of practice that needed to be improved. A follow up audit is planned in 6 months to assess if actions taken to improve practice have been successful.
4. Referral process between housing and social care colleagues has improved.
5. Family Safeguarding Service now in place in Childrens Social Care, and there is greater awareness of the Care Act 2014 and when to refer. This will be further strengthened when the Family Approach guidance is re-launched later in the year.

The Quality Assurance subgroup are aware that some of the action planning undertaken did not consider how impact/outcomes would be measure. This is a

priority area of work, and the chair will ensure that this is built into future action planning.

Next steps:

The Quality Assurance subgroup are recommending the closure of this action plan and the endorsement of the follow up actions. These actions will be monitored through the Quality Assurance subgroup and reported into the PSAB via the Quality Assurance subgroup quarterly report.

1. Follow up with Portsmouth Hospitals University NHS Trust ref EUPD training.
2. Complete a further review of discharge practice within Adult Mental Health.
3. Launch the Family Approach Gudiance.
4. Develop a methodology for testing impact and evidencing outcomes.