Learning and Recommendations from Scrutiny Review of Safe & Well (SAW)

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Original Purpose of Scrutiny Review of SAW

- As a result of the withdrawal from the non injury falls response contracts (Coventry, Dudley, Wolverhampton):-
- Impact on SAW for at risk individuals
- Analysis of SAW referral pathways identified that all 3 falls services are referring high risk individuals for SAW
- Broadened scope as agreed in May 2022

Methodology

The proposed methodology for the review was to facilitate 4 themed, focused and interactive workshops aligned to the purpose of the review and these were:-

1. risk stratification including referrals and relationships with partners
2. record keeping
3. delivery including training and development,
4. performance management, quality assurance and evaluation

Interdependencies identified between them = more appropriate to hold one event – round robin participation across the themes.

Workshop held 7/7/22 with a Microsoft Form questionnaire for those unable to attend.

Learning – Risk Stratification

- Varying levels of understanding about risk stratification
- There are low and no risk referrals in the system
- Need to be proportionate in responding to the risk at referral
- Complex Needs Officer referrals are often in appropriate
- Limited understanding about resources to support delivery of SAW and work with partners
- Trying to manage too many pathways – quantity rather than quality
- WMFS hold all the risk once referrals made by partners
- Limited opportunity for feedback to partners
- No revisit programme for high risk individuals
- Appointments not being made in a timely manner or prioritising those at high risk
- No process to record resources and effort applied to manage and review SAW referral pathways

Learning Record Keeping

- Limitations of Activity Assistant (AA)– legacy system & not mobile 1st
- Duplication of recording – paper based notes followed by entry to AA
- Limited understanding of how PowerBi can support SAW
- Nervousness about information gathering and sharing – linked to understanding of policy
- Restrictions in AA to provide further contextual information
- Not person centred records based on address not person(s)
- Limited understanding of why records are created – linked to understanding of how risk is stratified and what creates risk
- Quality assurance highlights opportunities to improve record keeping

Learning Training & Development

- Comprehensive guidance and resources are available on MESH
- Operations are supported through face to face and virtual engagement
- Prevention survey highlighted MESH is the place people go to for guidance however, review highlighted this isn't always the case
- More training for record keeping, softer communication skills, signposting and referrals
- elearn does not always provide quality training
- National training package would be an advantage

Learning – Performance Mgmt, Quality Assurance & Evaluation

- HMICFRS identified delivery based on resources rather than risk
- SAW priorities changed as a result of HMICFRS feedback 4.8.22
- Target driven culture with a focus on quantity rather than quality
- Good work and reduction of risk through SAW should be recognised
- Awareness of quality assurance, people do not routinely receive feedback
- Little knowledge of PowerBi and the service user feedback survey data – people don't understand the impact of a good SAW

Learning from COVID

- Mixed views about the use of remote SAW (RSAW) – how it can be incorporated into a proportionate suite of interventions for lower risk referrals

Learning – Culture & Equity

- Performance managed differently in different commands
- There is a target driven culture that drives performance on quality rather than quality
- Limitations of current systems, processes and knowledge can create barriers which hold people back from performing at a high level
- Good work and risk mitigation actions are not always celebrated
- Not everyone is comfortable in asking sensitive questions
- Everyone's learning styles are different, and the current opportunities for learning and development for SAW may not suit everyone's needs e.g. considerations for neurodiversity
- People do not believe they have the softer skills to be able to communicate with SAW service users in a person centred way
- There is limited opportunity to learn from good practice and areas highlighted for improvement

Recommendation 1

Continue to develop and implement the Tymly system and supporting automated business processes which already includes the following functionality :-

- Improvement of administration, communication, and onward referral tasks through automated processes
- Prioritises appointments for those most at risk
- Triages lower risk to proportionate interventions
- Broadens the data collection to include all risk and vulnerability
- Eliminates the need for paper records
- Records risk and vulnerability at an individual and household level
- Multiple search options including name and DOB
- Mandatory answer requirements for key questions
- Information buttons embedded in the record that provide guidance and support conversations about risk and vulnerability
- Triages CNO case referrals
- Introduces revisit scheduling based on risk remaining after SAW
- Supports two way referral processes into and from SAW
- Self-service for referring partners to obtain feedback on their referrals compliant with GDPR and enables ‘sharing ownership of risk’
- Performance management is based on the work done to reduce risk and vulnerability i.e. the impact of the SAW

Recommendation 2

Continue to review, improve, update, and raise awareness of the guidance, and support available on MESH. This should include:-

- Quality assurance and evaluation
- Good practice for information sharing
- Purpose and use of the Organisational Performance PowerBi dashboard for SAW
- Links to relevant organisational policies

Where elearn is the learning tool, consider how this can facilitate shared group rather than individual input to enhance understanding and knowledge.

Recommendation 3

Identify, develop, and implement solutions to address the training gaps identified in paragraph 4.3 of the report and detailed below:-

- Record keeping
- Softer skills for communicating in a ‘person centred’ way risk stratification and links between fire and health inequality
- Need for further support / training to be able to signpost for further support

Consideration should be given to the role that development plans for trainee firefighters, firefighters, supervisory and middle managers has within this.

Recommendations 4 & 5

Recommendation 4

Explore the option to quality assure SAW delivery alongside the current quality assurance of records through ‘observed practice’ in the form of ‘standardised assessments’

Recommendation 5

Continue with the implementation of RSAW as a means of providing SAW to those who are identified as low risk at the point of referral. Ensure that there is a clear escalation process to SAW where risk identified at RSAW requires this.

Recommendation 6

To enhance risk stratification and opportunities to improve delivery, explore and implement opportunities for raising awareness of the learning from:-

- Serious incident reviews to increase awareness of those in our communities who are overrepresented, and therefore at risk of being a serious or fatal casualty in an accidental dwelling fire.
- Station Prevention Evaluation sessions

Consideration should be given to the use of Organisational Intelligence debriefs and the role that the prevention teams, and operational middle and supervisory managers have for this.

Recommendation 7

The organisation has an independent internal Service Peer Assessment process(SPA). The purpose of which is to enable feedback, check understanding and application of processes and policy.

Consider how this process can evidence:-

- Levels of understanding and application of current processes and policy
- Improvement in understanding and application of new systems and processes as the recommendations from this review are implemented.

Recommendations 8 & 9

Recommendation 8

To support the recent changes in SAW priorities, consider the benefits of the creation and publication of good practice guidance for operational middle and supervisory managers to support them to monitor and manage performance and quality assurance. This should include consideration of the benefits of the introduction of buddy schemes and champions to support delivery.

Recommendation 9

To support the provision of a consistent and national approach to SAW and continue to implement the 8 core components of the NFCC Person Centred Framework for Home Fire Safety Visits including the:-

- Standardised data set
- Training package
- Evaluation framework

Recommendation 10

Continue to develop the SAW Membership arrangements and onboard partners who work with service users that the CRMP identifies as being at risk and vulnerable to fire in order to:-

- Improve performance management of referral pathways through the provision of resources for partners to identify risk and refer to WMFS for SAW
- Enhance data sharing arrangements with SAW partners in line with GDPR
- Enable sharing of risk for services users with referring partners
- Create opportunity for 2 way referrals into SAW and from SAW for ongoing support
- Enable feedback and data sharing between partners to evidence the impact that SAW has on reducing risk and vulnerability to fire and improving health, wellbeing and quality of life
- Improve partner engagement in the Serious Incident Review process and the implementation of the learning that results.

Next Steps

If the recommendations in this report are agreed, the next steps are to create the action plan with milestones and to agree dates for progress reports to be brought to Scrutiny Committee.

Our Vision

Making the West Midlands Safer, Stronger, and Healthier

Community Risk Management Plan

Our Plan

Community Risk Reduction

Enabling Services

People

Value (£)

WHY

WHAT

HOW

WEST MIDLANDS FIRE SERVICE