Report on SAB Learning Event held on 26 November 2018

1. Introduction

1.1 The Richmond and Wandsworth Safeguarding Adults Board (RWSAB) held its first learning event on 26 November 2018. It was well attended by 28 representatives from the partnership. The purpose of the session was to discuss and share information on safeguarding and learning from Safeguarding Adult Reviews (SARS).

1.2 In addition to the presentation and group discussions, there were displays showcasing the work of the Richmond Community Forum with the Metropolitan police on scams (see here), information about HRCH's excellent mental capacity act video (see here), the annual report (here) and other SAB pamphlets and information on how to enrol for the e-learning packages (here).

2. Objectives of the session

- To introduce the new SAB chair.
- To showcase some of the available learning material available to SAB partners.
- Discuss key themes emerging from SARs.
- To introduce and discuss the idea of Live Case Review to measure outcomes from SARs/other cases.
- To feedback on effectiveness of the session.

3. Programme

Time	Activity
09.00 - 09.30	Registration and refreshments, and viewing displays
09.30 – 09.40	Welcome
09.40 – 10.00	Chairs introductory comments
10.00 – 10.20	Overview of SARS and Learning
10.20 – 10.45	Group discussion – SARS
10.45 – 11.00	Group discussion – 7-Minute learning
11.00 – 11.20	Break and continue viewing displays
11.20 – 12.00	Group Discussion – Live case review
12.00 – 12.15	Evaluation and closure

Time	Activity
12.15 – 12.30	Networking and viewing displays

4. Presentations

4.1 The slide pack used on the day is available on the website.

5. Overview on SARS

5.1 RWSAB and (its predecessors) have received 27 SAR referrals, agreed 9 referrals met the criteria for a SAR and have completed 7 SARS, since 2014.

5.2 Themes arising from SARS.

Thematic area	Issues
Quality of direct practice with the person	Absence or adequacy of risk assessment.
	Personalisation and choice prioritised without taking account of other factors such as escalating risks.
Organisational factors	Lack of clear responsibilities when working with people in transition from children to adult's services i.e. 18 to 23 years-old.
	Poor record keeping with key documentation absent or unclear as well as failure to consult records.
	Resource constraints including lack of finance, lack of available specialist provision, lack of appropriate professionals and lack of time.
Inter-professional and interagency collaboration	Work conducted in multiple parallel lines with absence of multi-agency work or multi-agency risk assessment.
	Lack of clarity on the risk and intervention thresholds within different organisations.
	System failures in cross boundary and out of area communication and identification of responsibility.

Full details are in the slide pack above.

6. Summary of group discussion on SARS

6.1 How is learning from SARs or SAR reports shared in your organisations?

- Staff discussion groups.
- Team meetings.
- Workshops with partners and providers.
- Internal bulletins and newsletters.
- Formal governance such as Fatal Fire (London Fire Brigade) the CCG Quality Committee or organisations internal safeguarding committee.

- Incorporating learning themes into training for staff, some of which may be mandatory.
- Using learning to change and update procedures and guidance.
- Making use of the 7-minute briefings for staff.

6.2 How can the sharing of learning be improved across the partnership?

- Practitioners learning events at end of SAR, as was done with Mr X.
- Utilising 7-minute briefings widely.
- Incorporating learning into established training.
- Promoting understanding of the importance of information sharing across partner organisations.
- Better joint working between adults and children and improve feedback loop between agencies.
- Promoting awareness of themes in the community.

6.3 What actions can the SAB take to support you embed the learnings from SARs?

- Formal structured learning events.
- Complete 7-minute briefing for all SARs and increase the reach of these.
- Better use of technology e.g. use of webinars, conference calls, etc.
- Improve monitoring of action plans.
- Introduce a multiagency Quality Assurance process to ensure changes have been sustained.

7. 7-minute learning

7.1 7-minute briefings are based on a technique borrowed from the FBI. Research suggests that seven minutes is an ideal timespan to concentrate and learning is more memorable as it is simple and not clouded by other issues and pressures. Their brief duration should also mean that they hold people's attention, as well as giving managers something to share with their staff. Clearly such short briefings will not have all the answers, but it is hoped that they will act as a catalyst to help teams and their managers to reflect on their practice and systems. The SAB intends to compete these after all SARs as a way of disseminating the learning.

8. Summary of group discussion on 7-minute learning

8.1 What are the key learnings for your organisation?

- Importance of robust and clear pathways and processes.
- The importance of joint working, particularly in transitions and where there are multiple agencies involved in a person's care and support it is vital to have a clear lead professional to co-ordinate activities and facilitate sharing of information.
- Making use of every contact with the person to holistically review the situation and the risks.
- Recognition of the increased risk at peak times e.g. holiday periods.
- 'Triggers' need to be recognised in between formal assessments.
- Importance of good, effective information sharing between agencies.
- The need for a bespoke pathway and way of working with young people in transition up to the age of 23.

8.2 How can/do you use the 7-minute learning tool?

- In team meetings
- In governance meetings.
- In small professional development groups.

- Practitioner forum
- Workshop with clinicians.
- Incorporate in training.
- During supervision.

8.3 What can the SAB do to improve these tools?

- Alert to be sent to all partners when a SAR is published.
- Do 7-minute briefing for all completed SARs.
- Ensure anonymity of providers.
- Keep working neutral to avoid blaming.
- Review website to ensure it is easy to find.
- Present cases into themes and agencies – so it is clear what cases are relevant to your service.

9. Live case review

9.1 Purpose of live case review

- Act proactively before harm occurs.
- To obtain assurance that changes made in the system have been sustained.

9.2 Type of live care reviews

- A case is selected at random and reviewed based on the circumstances, which highlight a repeat issue of concern.
- A case is referred to the SAR sub-group for consideration and similar live cases are identified and reviewed (whether or not the original referral fits the full SAR criteria or whether or not a SAR is commissioned).
- Learning is identified through a SAR and circulated. Similar cases are later identified and reviewed to confirm (or not) whether the learning has translated into practice.

10. Summary of group discussions – Live case review

10.1 What is your view of live case review as a mechanism for testing changes made in the system as a result of learning from SARs?

- Good to get assurance through pressure-testing system based on “matched” profile. Identify gaps in more time.
- Help to drill information down to front line staff.
- Good to get SU feedback as well as review of documents.
- Makes sense and is proactive.
- Should be augmented by live multi-agency case audit.
- Probation and Children’s social care use this system – group looks at cases then comes together to discuss.
- Resources across partners may be a limitation.

10.2 In what ways could live case reviews help your organisation and the SAB to ensure that safeguarding practice is effective?

- Need an agreed process for this (could learn from health SI’s and 72-hour reports).
- Could inform cases for audit (re-emerging themes).
- Would form part of each organisation quality assurance.

10.3 What would be an effective way for the SAB to introduce live case reviews?

- Trial live case review before implemented widely.
- Clear definition methodology, including where it feeds information in each organisation's governance.
- Might take time to get agreement; a good time to introduce these reviews, as organisations have recently undergone changes.
- Important to agree and define the governance arrangements and who would be involved.
- Important to clarity what happens if failings are identified and how improvement actions would be managed and monitored.
- Focus on top 3 SAR concerns.
- Needs to 'work' for the partners/agencies and 'Buy in' would be key.
- Presenting it as a supportive offer.
- Define SAB's role in the feedback mechanism.

11. Next Steps

- Workshop report to be complied and distributed
- SAB Executive to consider the workshop finding at the next meeting
- SAB to introduce 7-minute briefings to improve sharing learning from SARS.
- SAB to discuss and agree a mechanism for introducing live case reviews.

12. Attendance

Name	Organisation
Adela Kacsprzak	National Probation Service, Wandsworth
Andy Cane	London Fire Service - Richmond
Beverley Baldwin	South West London & St George's Mental Health Trust
Bill Turner	St George's Hospital
Colleen Bowen	Health Watch Wandsworth
Colette Cashell	Chelsea and Westminster Hospital NHS Foundation Trust
Derek Oliver	Assistant Director of Adult Social Services, Richmond & Wandsworth Councils
Eglionna Treanor	Carers Centre, Wandsworth
Jessica El-Kaddah	Safeguarding Adults Coordinator
John Snelgrove	London Fire Service, Wandsworth
Julie Hesketh	Director of Quality & Governance, Wandsworth & Merton CCG
Kate Buck	Safeguarding Adults Coordinator, Richmond & Wandsworth Councils
Kathryn Williamson	Richmond Council for Voluntary Services
Lynn Wild	Head of Safeguarding and Professional Standards, Richmond and Wandsworth Councils
Mike Derry	HealthWatch – Richmond

Name	Organisation
Rachel Field	Wandsworth Council
Phillip Smith	Training and Development Manager, Richmond & Wandsworth Councils
Richard Neville	Independent Chair, RWSAB
Sandie Cox	HRCH
Sarah Gallimore	Chelsea and Westminster
Sarah Loades	CCG, Richmond & Kingston
Shannon Katiyo	Consultant in Public Health - Adults, Social Care and Health Care
Susan Ashbourne	Safeguarding Lead, Richmond Wellbeing Service
Suzana Karakashi	Wandle Housing Association
Trish Stewart	Central London Community Healthcare NHS Trust
Virindar Basi	Safeguarding Adults Service Manager, Richmond and Wandsworth Councils
Julie Carpenter	London Ambulance Service
Les Jackson	Crime Prevention, Met police

Apologies

Name	Organisation
Cassie Newman	Community Rehabilitation Company, Wandsworth
Clinton Beale	London Ambulance Service
Di Manning	Head of Commissioning
Donna Johnson	Alzheimer's Society, Wandsworth
Donna Lamb	HRCH
Elisabeth Major	SCB Manager & Professional Advisor, Richmond & Kingston
Fergus Keegan	Director of Quality and Safeguarding Lead, Kingston and Richmond CCG
Gill Ford	Richmond Council
Himayun Baksh	St Georges Hospital NHS Trust
Marino Latour	CCG, Merton and Wandsworth
Natalie Gourgaud	CQC
Owain Richards	South West London Metropolitan Police Safeguarding BCU
Patrick Bull	South West London & St George's Mental Health Trust
Rachel Corry	Age UK, Wandsworth
Rajinder Khakh	Merton and Wandsworth CCG
Sarah Cook	Health Watch Wandsworth
Su Fitzgerald	Your Health Care – Richmond
Vik Seenayah	Community Rehabilitation Company