

**SOCIAL SERVICES AND WELL-BEING (WALES) ACT**  
**Child and Adult Practice Review Training**

# Training Guide

March 2018



*Getting in on the Act*

## 1.0 Who is it for?

The training material supports those involved in conducting child and adult practice reviews.

The materials can be used for the following main purposes:

- Delivering training to new reviewers or other key roles.
- Refreshing the learning of existing reviewers or other key roles, as part of their Continuing Professional Development.

## 2.0 What does it include?

Materials are available to download from the [Information and Learning Hub](#) in Welsh and English. The following materials, as well as this guide, are available:

### Handouts

From the guidance, volumes 2 and 3:

Figure 1 Safeguarding Board infrastructure

Figure 2 Flowchart of child practice review process (page 29, Volume 2, guidance)

Figure 2 Flowchart of adult practice review process (page 29, Volume 2, guidance)

Annex 1 (2) Child Practice Review Report Template

Annex 2 Terms of Reference – an exemplar

Practice Examples (use regional if available), including:

- Genogram Template (Gwynedd)
- Suggested Agenda for First Review Panel Meeting (NWSB)
- Timeline/Agency Analysis Template (NWSB) – the guidance does not provide a template
- Child/Adult Practice Reviews – What is a Practitioner Learning Event? (Briefing Note, NWSB)
- Role Description for Panel Representative (NWSB)
- Role Description for Chair of Review (NWSB)
- Role Description for Independent Reviewer (NWSB)
- Role Profile – Review Panel Chairperson (WBSAB)
- Role Profile – Practice Review Panel Member (WBSAB)
- Practice Review Panel Member Checklist (WBSAB)

## 3.0 How to use the materials

### 3.1 Training transfer

Training is only successful when it is transferred into practice and has an impact on people's experience and outcomes.



There are four main factors involved in changing practice through training (*Training transfer: Getting learning into practice*, Research in Practice, 2012):

The **design and delivery** of the programme – how well learning is delivered and how this addresses the need to transfer this learning into practice.

**Individual characteristics** – how relevant learning is for people and their motivation to transfer this learning into practice.

**Workplace factors** – how managers and peers support transfer of learning into practice, and what opportunities there are to use this.

**Subject climate** – how far the organisational culture, structures and attitudes encourage transfer of learning into practice.

These factors are enabled in this module in the following ways:

- Design and delivery – the materials include preparation and follow-up; there are a range of activities to support practice.
- Individual characteristics – participants complete a learning needs analysis to identify their individual needs before and after the module, and they complete an action plan to enable use of learning.
- Workplace factors – the authorised officers' process includes the Local Authority nominating and following up with authorised officers; action plans identify support to carry out actions.

- Subject climate – this module forms part of wider work by the Care Council Wales to implement the *Social Services and Well-being (Wales) Act 2014 (SSWBA)*; this is referenced throughout the training module.

### 3.2 How to use the training materials

The training materials can be adapted, altered and amended. They are designed to be flexible and user-friendly. However, they are also intended to promote consistency in learning, particularly with regard to knowledge about the Act and the related Codes of Practice. The materials have also been quality assured and tested.

### 3.3 Facilitator person specification

If you are delivering training to authorised officers then you will need a high level of knowledge about the following areas:

- *Social Services and Well-being (Wales) Act 2014: Working Together to Safeguard People, Volume 2 – Child Practice Reviews*
- *Social Services and Well-being (Wales) Act 2014: Working Together to Safeguard People, Volume 3 – Adult Practice Reviews*
- *Protecting Children in Wales – Child Practice Reviews: Guide for Organising and Facilitating Learning Events* (Welsh Government, 2012)
- *Working Together to Safeguard People* statutory guidance – other codes of practice and statutory guidance related to the Act
- Care Council for Wales Learning Resources on the Act, in particular on safeguarding and advocacy
- Human rights
- *Code of Professional Practice for Social Care Professionals* (Care Council for Wales, 2015)
- *National Occupational Standards for Social Work* (Care Council for Wales, revised 2011)
- The policies and procedures of the organisation(s) you are delivering in.

You will need a high level of skills in:

- delivering adult learning programmes
- facilitating learning for experienced professionals
- supporting continuing, self-directed learning
- delivering complex information
- facilitation of group work.

You will need strong values in:

- promoting wellbeing
- promoting human rights
- partnership working.

### 3.4 Training delivery

Delegates will be required to undertake the following pre-course tasks:

Familiarise themselves with the guidance:

- Social Services and Well-being (Wales) Act 2014: *Working Together to Safeguard People, Volume 2 – Child Practice Reviews*
- Social Services and Well-being (Wales) Act 2014: *Working Together to Safeguard People, Volume 3 – Adult Practice Reviews*
- *Protecting Children in Wales – Child Practice Reviews: Guide for Organising and Facilitating Learning Events* (Welsh Government, 2012)

## 4.0 Facilitators/trainers' notes

### 4.1 Selection of facilitators/trainers

This is a two-day training package facilitated originally by two trainers, one focusing on practice and the other on the wider legislative, policy and theory context.

Trainers should have a combination of practice experience in both adult and children's services.

Materials can be adapted dependent on the delegates, their experience in this area and their expectations.

### 4.2 Introduction (can be modified according to audience and expectations)

Explain that the facilitator's role is to facilitate, and you, the delegates, hold the expertise.

Acknowledge time commitment (two days) and aspirations to be as interactive as possible.

Manage expectations in that all challenges highlighted in the day might not be resolved today, but that those challenges can be taken forward elsewhere.

Acknowledge delegates as experienced practitioners who have the transferable skills necessary to undertake a review.

Discuss who is in the room and highlight the importance of various professional groups, roles etc; ie, representatives from regional safeguarding boards, multi-agency representation (acknowledge importance of this in context of review), legal advisers, board business managers or business unit staff.

Highlight that the ultimate responsibility is to the subject of the review.

Note that the previous SCR framework focused on **WHAT** had happened where the review almost became an end in itself with momentum and capacity difficult to sustain.

Whereas today the framework whilst establishing and acknowledging the what, focuses more on the **WHY** and **HOW**, to better facilitate learning across the partnerships.

Remind delegates that the practice review guidance notes that the review framework is based on:

- **Collective endeavour** – other agencies have their learning and reporting systems eg, the National Patient Safety Agency (NPSA) clinical **incident reporting** mechanism with the need identified for further work on **incident analysis** in order to ensure a prospective as well as a retrospective consideration of risk.
- **The premise that better understanding** leads to competent and confident multi-agency practice.
- **The premise of strengthening agency accountability** including in relation to the provision of support and resources for staff, which is increasingly difficult in a period of austerity.
- **The premise of a fair and just culture** – identifying and appreciating the impact of the event on everyone including professionals and the need to ensure a safe environment for reflection, challenge and change.
- **The premise of a streamlined, flexible and proportionate approach** – with a six-month timescale set from the point of referral to the respective Adult or Child Review group. **THIS DOES NOT MEAN A LIGHT TOUCH APPROACH.**

Outline Safeguarding Boards' strengthened quality assurance role and reference their respective first annual reports covering 2016-2017.

Note that there is evidence that learning identified through reviews undertaken is being applied in practice, including (use relevant regional examples gleaned from Business Plans and Annual Reports to add to the examples below):

- the implementation of the Multi-Agency Pre-Birth Pathway and Safeguarding Children with Disabilities policies; the Self-Neglect and Escalating Professionals' Concerns protocols by the North Wales Safeguarding Board
- the development of the MASH; prevention of suicide and self-harm and safeguarding children looked after as identified priorities and managing adult large-scale safeguarding investigations by Cwm Tâf
- the use of a Multi-Agency Professional Forum (MAPF) to consider child sexual exploitation by Cardiff and the Vale.

Highlight emerging themes in both adult and children's services and relevant legislation; for example (you will need to update with any more recent work):

- Post *Well-being Act* with the emergence of the concept of an adult at risk (section 126) expanding the definition of a vulnerable adult.
- The legal duty to report both an adult and a child 'at risk' (*SSWBA*, section 128 and section 130 respectively).
- The *Modern Slavery Act 2015*.
- The *Serious Crimes Act 2015*; specifically reference the 'controlling and coercive behaviour' offence (section 76); the 'sexual communication with a child' offence; the strengthening of the protection of vulnerable children; the recognition of the psychological aspect as well as the physical aspect of child cruelty and the moderation of the *Sexual Offences Act* language (deletion of the term 'child prostitution').

- Self-neglect refer to Preston-Shoot, 2016; vulnerability of self-funding residents refer to Manthorpe, 2016.
- The provision of social care within the context of austerity as considered by the 2016-17 Safeguarding Leadership across Wales initiative by the National Board.
- Adverse Childhood Experiences (ACEs) in the Welsh adult population and their impact on health and wellbeing across the life course (Bellis MA et al, 2015).
- Sexual exploitation (Jay report, 2014), which led to the CSSIW-related inspection. Reference *Joint SCR* in Newcastle (Spicer D et al, 2018) which reflects need to work across adult and children's services.
- Comparative analysis of Welsh and English review models (Kingston and Eost-Telling, 2018). Concluded that the Welsh model has clarity of purpose and that the Learning Event is instrumental in this. Another positive was that the model used only trained reviewers. The one deficit highlighted was the need to supplement the Timelines with chronologies and more analysis.

## **5.0 PowerPoint materials day one**

This section contains PowerPoint slides and notes to support learning sessions.

### **DAY ONE**

#### **5.1 Learning objectives**

## Learning Objectives



- To consider the role of the Review Process in safeguarding individuals in the context of the SSWBA(W) Act 2014
- To consider the role of the reviewer and to equip the reviewer to undertake a review
- To consider the aspects of the review process
- To consider the opportunities and the challenges
- To consider the role of the Reviewer, the Chair, Review Panel and members, Board and its subgroups in undertaking effective reviews

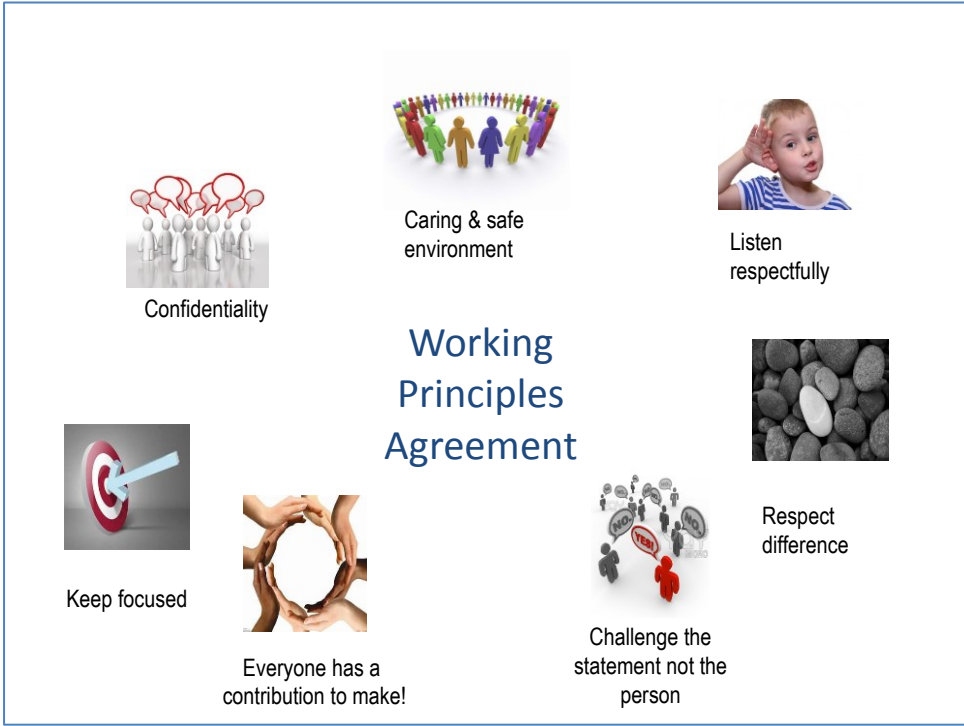
### 5.1.1 Facilitator notes

This slide sets out the learning objectives and introduces what participants have signed up to. The idea is to create an expectation of ownership and contribution.

## 5.2 Working Principles Agreement



**Working Principles Agreement**



Confidentiality

Caring & safe environment

Listen respectfully

Keep focused

Everyone has a contribution to make!

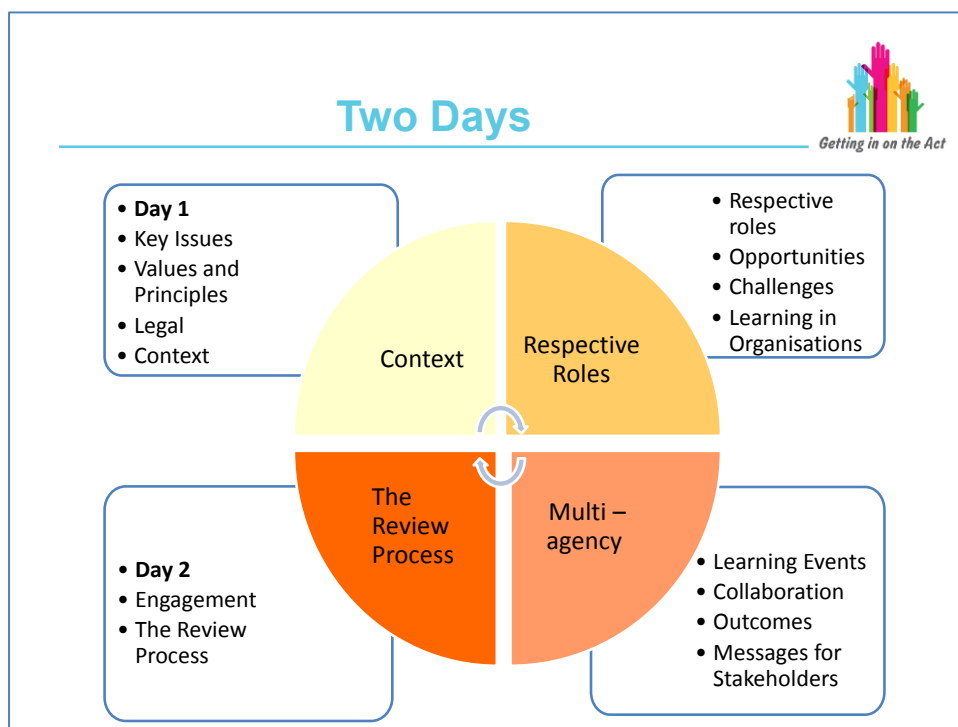
Challenge the statement not the person

Respect difference

**5.2.1 Facilitator notes**

This slide sets ground rules/ways of working. Note this mirrors the need for ground rules within the review process (as per the ‘Good Practice Role Exemplars’).

## 5.3 Setting the scene



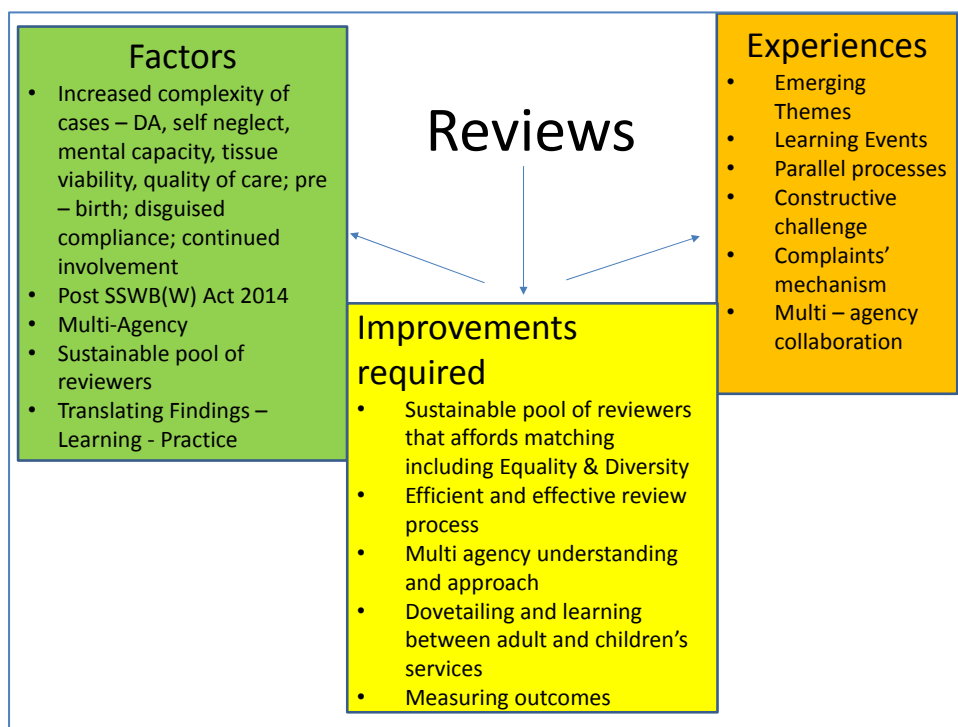
### Introductions

- Role & Organisation
  - Key issues for the two days training
- Getting in on the Act**

#### 5.3.1 Facilitator notes

These two slides outline the nature of the two days, and lead into initial introductions where people are invited to say who they are, their role and their organisation. As well as sharing their key issues or hopes for the training.

## 5.4 Reviews



### 5.4.1 Facilitator notes

The review provides an opportunity to bring together relevant factors, pertinent experiences and improvements needed.

Also note:

- variance in use of Multi-Agency Professional Forum
- parallel processes eg, police investigation or criminal proceedings (2014 guidance) and impact on review including convening of Learning Event
- publication – increased transparency
- engagement with subject and family
- the role of complaints.

## 5.5 Values

### Activity: The values that drive the practice review process



#### 5.5.1 Facilitator notes

Choose to use either of the following activities at the values slide above or the overarching principles slide below.

##### Activity Choice One:

Working in small groups, delegates identify the values which they think they use in the practice review process. As each group feeds back, explore as a whole group whether other participants share this view. Collect the feedback on flipchart and refer to it where relevant in the rest of the training.

In the feedback, explore what sort of values they are eg,

- Transactional v transformational.
- Related to professional codes of practice.
- How values can be measured.
- Where they see differences between agencies.
- How they respond to value conflicts between agencies.
- How they relate to the values and principles which underpin legislation. An example using the *Social Services and Well-being (Wales) Act 2014* is shown in the next slide.

##### Activity Choice Two:

Each group explores the five principles and identifies which one is integrated most and least into the practice review process. Groups feed this back and discuss it as a whole group. Process the feedback to identify where there is consensus or disagreement.

Explore if there is any conflict identified in how they are used in the practice review process:


- Are there any conflicts or similarities in the way different agencies use the principles?
- Are there any examples where agencies identify barriers to effective use of a principle in the practice review process?
- Are there any good practice examples of the principles being used in the practice review process?

## The Social Services and Well-Being (Wales) Act 2014 overarching duties and principles



- Well being
  - Active Offer
  - Voice and control
  - Multi agency working
  - Prevention and early intervention
  - Co production
- 
- How would you use (and balance) them in practice review process?
  - Identify minimal and maximal use


## 5.6 Principles



concept rule  
ethics direction honesty  
principle  
management integrity  
culture

Getting in on the Act

# Principles



## Principles



- professionals in all services working with children and families in the local area are given the assistance they need so they can undertake the complex and difficult work of protecting children with confidence and competence
- organizational cultures, and the processes that underpin the culture, are experienced as fair and just, and promote supportive management and work environments for professionals
- a positive shared learning culture is an essential requirement for achieving effective multi - agency practice

### 5.6.1 Facilitator notes

These principles are taken from part 3 of the guidance. Groups can explore three principles and agree which are the most implemented or least implemented.

- My agency uses these principles in its day-to-day practice.
- There is a wide interpretation as to how these principles are used in practice.
- We are not resourced effectively to deliver these principles in practice.

- We always/rarely review these principles in the practice review process.
- The guidance is evidence-based.

## Principles (Continued)



A culture of transparency is created that

- provides regular opportunities to address multi-agency collaboration and practice, and multi-agency learning, reflection and development
- has processes for learning and reviewing that are flexible and proportionate and are open to professional and public challenge
- engages with children and families in individual cases and takes account of their wishes and views

## Principles(continued)



- provides accountability and reassurance to children, families and the wider public
- identifies promptly the need for systemic or professional changes and ensures timely action is taken
- shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally and nationally
- the work of learning, reviewing and improving local multi-agency child protection policy and practice is audited and evaluated for its effectiveness

## 5.7 Overview of law, policy and practice



### 5.7.1 Facilitator notes

It is assumed that participants have read the guidance and this section should be delivered so that it prompts discussion around key parts of the guidance.

Where participants identify areas of the guidance which they think are not being adhered to locally, they can take these issues up with their agency or the Board.

Where relevant, use some of the following prompts to promote discussion:

- Do all agencies use the guidance in the same way?
- Is it clear/unclear at this point in relation to specific slides?
- What would need to change for this part of the guidance to be implemented effectively?
- Have you identified the resources needed to implement the guidance on each part of the practice review process eg, commissioning external reviewer/engagement/Learning Event/other?

Whilst working through the slides, write any key issues on the flipchart. These can then be referred to throughout the rest of the training.



## UK Context



- Practice Reviews (Wales)
- Serious Case Reviews (England)
- Case Management Review (Northern Ireland)
- Significant Case Review (Scotland)
- In Wales they aim to ensure that relevant agencies learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children and adults.

### 5.7.2 Facilitator notes

Outline different contexts and ask participants for any experiences of differences between the countries.

If cross-border issues do not come up, raise this as a discussion point.

Working in small groups, delegates discuss what they identify as key lessons from key reviews/local reviews and how they can put this into practice. They then feed this back to the whole room. Collect on flipchart and put up in the room.



### 5.7.3 Facilitator notes

Outline that this section explores the guidance, which derives from Part 7 of the *Social Services and Well-being (Wales) Act 2014*.

The following slides show the content of the guidance. Identify any sections which have questions for you or where you think there will be lack of clarity. These will be listed on the flipchart.



## Legislative Frameworks

- The Social Services and Well-being (Wales) Act 2014
- Serious Crime Act 2015
- Data Protection Act 1998
- The Public Interest Disclosure Act 1998
- Equality Act 2010
- Care Standards Act 2000
- Mental Capacity Act 2005
- Mental Health Act 1983 revision 2007
- Safeguarding of Vulnerable Groups Act 2006
- Domestic Abuse & Sexual Violence (Wales) Act 2014
- The Human Rights Act 1998
- The Children Act 1989

### 5.7.4 Facilitator notes

Outline relevant legislation and ask if any additional legislation. Respond to queries around links between legislation.

## 5.8 Practice reviews

### Practice Reviews (1)



- Introduction
- Principles
- Learning & Reviewing framework
- Multi agency professional forums

### Practice Reviews (2)



- Concise adult practice reviews
- Extended adult practice reviews
- Multi agency professional forum
- Applying PR to historic abuse
- Appendices

#### 5.8.1 Facilitator notes

Briefly cover what is in the guidance.

## Implications for the other Board members



- Establishing child/adult practice reviews and ensuring they are effectively managed.
- Contributing to the reviews and providing professional challenge.
- Identifying strategic implications for improving systems and practice in individual agencies or on an inter-agency basis.
- Signing off the final report and action plan when a review has been completed.
- Publishing the child/adult practice review report.
- Implementing and auditing changes in local policy, systems and practice to identify what difference they have made

### 5.8.2 Facilitator notes

Outline role of Boards in achieving improvement in safeguarding policy, systems and practice and their responsibilities.

Highlight that to achieve this Boards need to be well led, committed and supported by all Partners, as well as engaging effectively with organisations not represented on the Board but who have a role in working with children, families and adults.

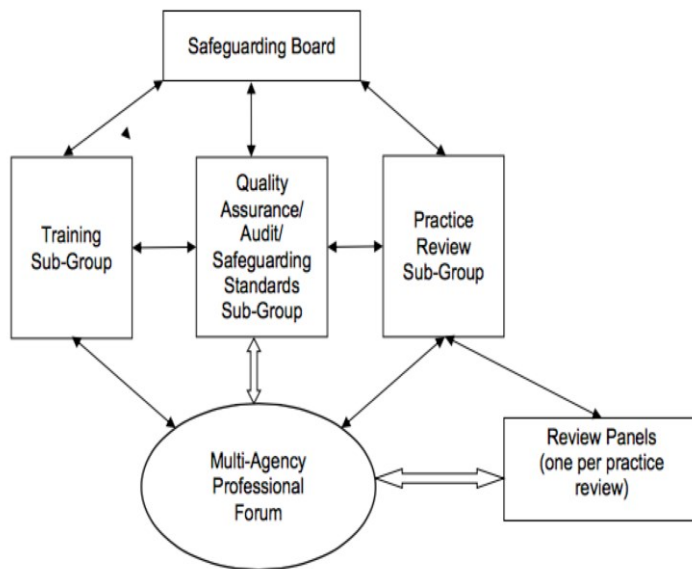
Note the need for Boards to be:

- learning-focused
- outcomes-focused
- encouraging and supportive
- maintaining close oversight and understanding of practice.

Address that the role of Boards in approving practice review reports is important, to ensure right levels of support and challenges, as well as ensuring learning is taken forward.

Board structures, including subgroups or committees, will need to reflect the core business of the Board, ensuring appropriate cross-representation, and coordinated workstreams.

**Fig. 1: Potential Safeguarding Board infrastructure of sub-groups supporting the learning and reviewing framework**



### 5.8.3 Facilitator notes

Identify this as a possible model and reflect that it shows the complexity of the Safeguarding Board task. Explore any local or regional variation with participants.

## Multi Agency professional Forums



- Case learning
- Dissemination of new learning and findings

### 5.8.4 Facilitator notes

Brief slide on the role of Multi-Agency Professional Forums.

## Concise practice reviews (1)



- Criteria
- Process for undertaking a concise review (Para 6.3 to 6.11)
- Where more than one board is involved
- Where more than one board in different counties is involved
- Parallel reviews of practices are involved
- Concurrent police investigations or judicial proceedings
- Relationships with other formal staff processes
- More than one index adult subject to review
- Recommendations to the chair of the board

## Concise practice reviews (2)



- Terms of reference
- Review panel
- Timelines and genogram
- Commissioning the reviewer
- Engagement of individuals and family members in the review process
- Learning event
- Adult practice review report
- Presentation of the report to the board
- Action plan

## Extended practice reviews (1)



- Criteria
- Process (Para 7.3 to 7.11)
- Where more than one board is involved
- Where more than one board in different counties is involved
- Parallel reviews of practices are involved
- Concurrent police investigations or judicial proceedings
- Relationships with other formal staff processes
- More than one index adult subject to review
- Recommendations to the chair of the board

## Extended adult practice reviews (2)



- Terms of reference
- Additional issues to be addressed by the extended review
- Review panel
- Timeline and Genogram
- Commissioning the reviewers
- Learning event
- Adult practice review report
- Presentation of the report to the board
- Action plan

### 5.8.5 Facilitator notes

The preceding four slides can be moved through quickly, as they provide a small amount of detail which will be explored in more detail in later sessions. They are optional and can be removed.

## Activity: Ten top tips on organising a practice review



### 5.8.6 Facilitator notes

Top Ten Tips: In small groups, participants to identify their top tips for organising a practice review.

Capture feedback and put on flipchart with each group identifying a Top Tip. This is then processed until it amounts to ten Top Tips. Ensure that all participants support the Top Tips which are identified. Final Top Ten to be written up and circulated to participants post course.

## Statutory Framework- Domestic Homicide Review



DHR's were established on a statutory basis under section 9(3) of the Domestic violence, Crime and Victims Act (2004). Came in force April 2011, a DHR should be taken forward when:

- Death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by-
  - a person to whom s/he was related or with who s/he had been having an intimate personal relationship or
  - A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.



## Alternative processes



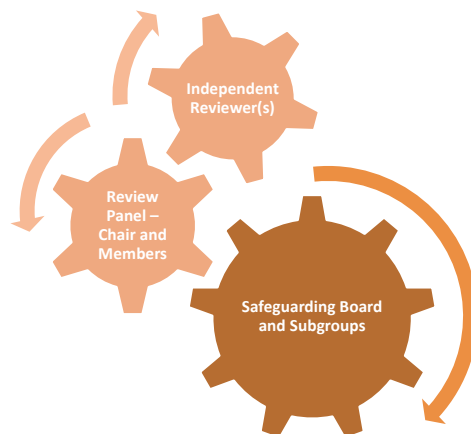
- Links to Police investigations
- Judicial proceedings
- Formal staff processes

### 5.8.7 Facilitator notes

Use these two slides for discussion on parallel processes and relationships between the processes. Collect feedback on flipchart.

### 5.9 Efficient and effective review: respective roles

## Efficient and Effective Review – Respective Roles



### 5.9.1 Facilitator notes

This section deals primarily with the **roles** of the Review Panel, Review Panel Members, Review Chair and the Independent Reviewer rather than the review process which is covered in detail on Day Two.

Activities should be selected dependent on the audience and the aims of the training, and options include:

- Consider the role description pro formas and consider:
  - any required amendments/additions
  - whether they would sign up to the role (WBSB checklist is particularly useful in this regard).
- Three or four groups reflecting Panel Member, Chair and Reviewer (Safeguarding Board optional dependent on audience) to consider their expectations of the other roles in enabling them to undertake their role ie, the Reviewer group sets out its expectations of the Panel Member, Chair and others.
- From the point of view of your ascribed role how can you ensure an effective and efficient review?

## Role of the Review Panel



- Monitor and review criteria and Terms of Reference (TOR)
- Agreed commissioning arrangements for external independent reviewers including safe recruitment practice
- Commissioning the reviewer(s) including matching considerations including Equality & Diversity
- Critical role in managing and reviewing process and in ensuring that learning is drawn from the case
- Ownership of review and action plan to facilitate acceptance at Board
- Commitment and consistency of membership
- Representation from adult services / children's services

### 5.9.2 Facilitator notes

Note that the criteria for the review are determined in the Adult or Child Practice Review Group before the setting up of a Review Panel but that the Review Panel should keep the criteria in mind as subsequent information may suggest that the status of the review should be changed; for example, from Concise to Extended.

Highlight that feedback suggests that the criteria in relation to child practice reviews are clearer than for adult practice reviews. Outline possible reasons for this, including:

- Reviews in relation to children are better established.

- Multi-agency mechanism Procedural Response to Unexpected Deaths in Children (PRUDIC) is a mechanism which logically directs a referral to the Child Review Group for consideration. There is no corresponding multi-agency forum in adult services.
- Regional variance in the number of adult practice reviews conducted and may be due to the use of the parallel health process Serious Untoward Incident (SUI) as an alternative to the review process.

Note that the guidance refers to the role of the Review Panel in appointing a reviewer, whereas practice is more usually that the CPR Group do (check case with delegates).

Ensure outline the importance of matching the reviewer in terms of Equality and Diversity, as well as area of expertise and considerations that are needed in respect of joint reviewers.

Reference to the Research in Practice 'Evidence Matters Tool 14: Areas of Expertise' is relevant here as is the reference in the guidance to relevant organisations; namely, Africa Unite against Child Abuse (AFRUCA) and Advice after Fatal Domestic Abuse.

The guidance refers to the good practice of ensuring adult services representation on child practice review panels and vice versa as a standard practice.

## Role of the Review Panel Members



- Sufficient mandate and status within the agency / organisation
- Link between panel member and Safeguarding Board member
- Panel members responsible for ensuring timely and fit for purpose timelines and agency analyses undertaken by managers who understand the service but have no operational responsibility for the case.
- Responsibility for ensuring that LE attendees are prepared and supported by their agency
- Guidance
  - Annex 2 TOR includes section on Review Panel's tasks
  - Vol. 2: 6.20 – 6.21; 7.24; Vol. 3: 6.19 – 6.20; 7.22

### 5.9.3 Facilitator notes

Cross-reference to the 'Good Practice Panel Member Role' pro-forma.

Begin to consider the role of the Timeline and Agency Analysis. This provides the evidential basis for the review and foundation for a robust, defensible report. Currently there is no suggested format in the guidance. Discuss provision in regions.

Begin to consider the central role of the Learning Event and the responsibility that Review Panel members have for preparing practitioners who will be involved.

## Review Pathways (Review Panel and Member)



- | • POSITIVE OUTCOME  | • LIMITED OUTCOME  |
|---|--|
| <ul style="list-style-type: none"><li>• All relevant cases identified</li><li>• Reviewer includes Equality &amp; Diversity</li><li>• Appropriate designation of review and TOR</li><li>• Review process including Board facilitated</li><li>• Fit for purpose AA and agency commitment /input</li><li>• LE attendees prepared and supported by agency</li><li>• Dovetailing adult and children considerations</li></ul> | <ul style="list-style-type: none"><li>• Inconsistency of attendance / membership reduces learning and ownership</li><li>• Lack of analysis impairs learning</li><li>• Unprepared and unsupported LE attendees</li><li>• Difficulties at Board</li><li>• Lost opportunity for dovetailing adult and children considerations</li></ul> |

### 5.9.4 Facilitator notes

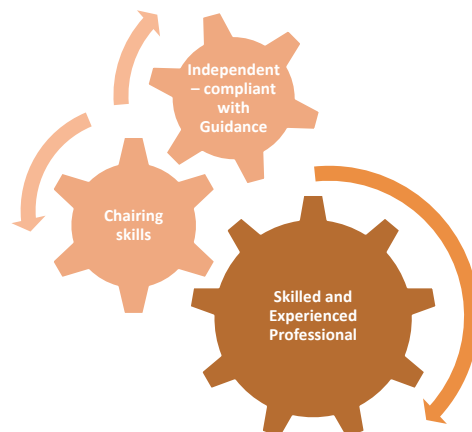
Summarise pathways to positive and limited outcomes in terms of achieving objective of learning. Emphasise the importance of ensuring that all incremental steps are managed carefully in order to optimise learning.

## Role of the Review Panel Chair



- Independent and compliant with the Guidance requirements
- General Chairing Skills
  - Building effective group relationships
  - Managing group dynamics and stages
  - Constructive challenge
  - Conflict resolution

## Key components of effective chairing



## Role of the Review Panel Chair



- Skilled professional with sufficient experience to:
  - Provide constructive multi agency challenge and rigour to the review process and utilise escalation processes
  - Ensure that information is shared, considered and analysed appropriately
  - Enable members to make informed decisions
  - Manage risk effectively and protect children and vulnerable adults by appropriate referral of safeguarding and personnel concerns
  - Not be judgemental and remain objective throughout
  - Maintain momentum
  - Identify the need for specific expertise and input including legal advice

## Review Pathways (Panel Chair)



- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• <b>POSITIVE OUTCOME</b><ul style="list-style-type: none"><li>• Effective panel meetings and momentum maintained</li><li>• Deficits / challenges are addressed</li><li>• Timely and effective progress</li></ul></li></ul> | <ul style="list-style-type: none"><li>• <b>LIMITED OUTCOME</b><ul style="list-style-type: none"><li>• Focus of the review, and on the review is distorted</li><li>• Momentum is stalled and process becomes protracted</li></ul></li></ul> |
|---|--|

### 5.9.5 Facilitator notes

This section outlines the critical role of the Chair in the process.

Importance of active listening and reflection.

Reference 'building effective group relationships stages in group dynamics' model from the *Learning Event Good Practice Guide* (2013).

The Chair has an important safeguarding role in identifying early lessons that require early remedy in terms of unsafe practice and professional competence.

## Role of the Safeguarding Board



- Guidance:
  - Vol.2 /3: 4.1 – 4.44)
  - Annex 2 TOR includes section on the tasks of the Board
  - Figure 5.1 – sub groups supporting learning & reviewing framework
- Necessary balance between support and robust challenge
- Focus on learning and outcomes - 'take findings into action' (Wirtz et al 2011)
- Co-ordinated processes and work programmes across subgroups
- Clear multi agency accountability and governance
- Commitment from member agencies
- Strong leadership
- Dovetailing between adult and children services

## Review Pathways (Safeguarding Board)



- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• <b>POSITIVE OUTCOME</b><ul style="list-style-type: none"><li>• Robust Constructive Challenge</li><li>• Ownership of process, review recommendations, action plan and implementation of learning</li><li>• Efficient and effective subgroups with TOR and work programmes to apply learning into practice</li><li>• Improved outcomes</li></ul></li></ul> | <ul style="list-style-type: none"><li>• <b>LIMITED OUTCOME</b><ul style="list-style-type: none"><li>• Defensible member agencies blocks learning</li><li>• Learning lost in cyclical transmission between the groups</li><li>• Recommendations not translated into practice</li><li>• Opportunities for safeguarding individuals lost or limited</li><li>• Review an end in itself</li></ul></li></ul> |
|--|--|

### 5.9.6 Facilitator notes

Consider the role of the Safeguarding Board and test out the understanding of the Board's remit and function including the changes brought about by the *Well-being Act*.

The Board commissions the report. Whose report is it? What is the relationship between the Board and practitioners? Consider the multi-agency aspect and the role and function of the subgroups in applying lessons learnt to practice.

Make reference to Complaints process as it is intended to be limited to the matters that arise in the multi-agency review process rather than the original case.

Action Plan: Reviewer will have limited involvement in the Action Plan but it is essential that recommendations are SMART as the Action Plan is built from these. Note *NISB Annual Report (2016-2017)* which outlines risks of producing too many recommendations and policies as a response to failures. Discussed more on Day Two.

## Reviewer – Skills and Expertise



- Guidance:
  - Vol. 2: 6.28 6.30; Vol. 3: 7.31 – 7.33
  - Reviewer Declaration / Statement in Review Report Template Annex 1.2
- Confident and competent professional – skills and expertise in relevant practice areas
- Balance between accepting challenge and maintaining courage of their convictions
- Providing constructive challenge
- Focus on the subject of the review
- Due regard and respect to family members etc...

### 5.9.7 Facilitator notes

This section focuses on reviewer role, skills and expertise.

Note previous discussion at 5.9.2.



## Reviewer – Skills and Expertise



- Understanding and proficiency in Multi–Agency Partnership Working
- Joint Reviewer role
- Structured Professional Judgement
- Evidence informed practice
- Reflection in action / reflection on action
- Analytical
- Critical Thinker
- Hypothesis / Confirmation Bias

## Reviewer – Skills and Expertise



- Analogy with role as professional
  - Assessing / analysing agencies' application of these aspects in the context of casework with the subject of the review
  - Utilising these aspects him / herself in role of the reviewer when undertaking this assessment / analysis of agency practice
  - Utilising these aspects him / herself in role of the reviewer in relation to the review process

## Review Pathways (Reviewer)

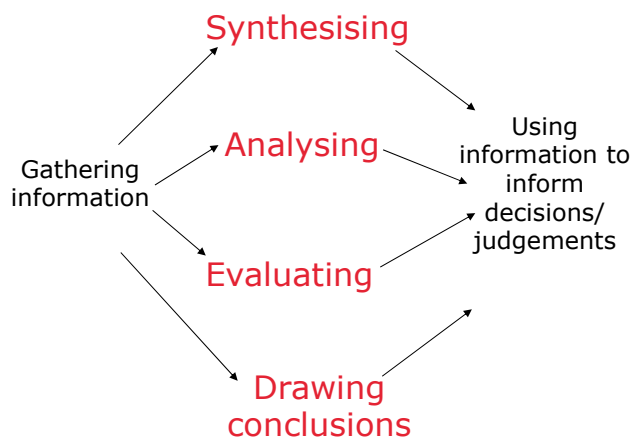


- **POSITIVE OUTCOME**
  - Subject's 'direct testimony' is evident
  - Thoughtful and analytical consideration
  - Fully informed review
  - SMART Recommendations
- **LIMITED OUTCOME**
  - Subject's 'direct testimony' is not reflected
  - Collation of information
  - Limited confidence in the review

### 5.9.8 Facilitator notes

Discuss these in detail, seek additional skills from groups, include role of supervision to support.

## Analysis and Critical Thinking



## Analysis and critical thinking shows your reasoning



*Child protection work makes heavy demands on reasoning skills. With an issue as important as children's welfare, it is vital to have the best standard of thinking that is humanly possible. Mistakes are costly to the child and family.'*

(Munro E (2008) *Effective Child Protection*. London: Sage Publications)

- Calder & Archer

Critical thinking is associated with reasoning, which includes:

- Having reasons for what we believe and do, and being aware of what they are
- Critically evaluating our own beliefs and actions
- Being able to present to others the reasons for our beliefs and actions
- (Cottrell S (2005) *Critical Thinking Skills: Developing effective analysis and argument*. Basingstoke: Palgrave Macmillan)
- <https://www.scie.org.uk/children/safeguarding/case-reviews/quality-markers/running/13-analysis.asp>

### 5.9.9 Facilitator notes

Draw on research in terms of analysis and critical thinking, highlight its importance in this context.

These resources are relevant here: [https://socialcare.wales/cms\\_assets/file-uploads/Evidence-Matters-in-Family-Justice-Tools.pdf](https://socialcare.wales/cms_assets/file-uploads/Evidence-Matters-in-Family-Justice-Tools.pdf) and <https://www.scie.org.uk/children/safeguarding/case-reviews/quality-markers/>.

## Analysis, intuition, critical thinking



- > **Analysis**
  - The strength of analytical thinking
- > **Intuition**
  - A way of thinking
- > **Critical thinking**
  - > Weighing up the different options
  
- > **Hypothesising**
  - > Trying out different interpretations
  - > Giving different meaning to data and to the story
  - > Thinking about a range of possible ways of explaining what might be going on

### 5.9.10 Facilitator notes

Explain that the strength of analytical thinking is that, used properly, it is rigorous, systematic and methodical. Highlight its importance in this context.

Analysis is about breaking something down into its constituent parts and exploring the relationship between them. It involves working systematically through often complex information and making sense of it.

Intuition operates at the level of the subconscious. It is about using your 'gut reaction' or feelings to shape the questions you ask of yourself and of the situation, pursuing and testing hunches.

The Munro review emphasises the importance of intuition, and of reflection, to use intuition well.

Critical thinking, cite Turney et al (2011), being clear and explicit about why one interpretation/option might be chosen and explaining why.

Note risk of hypothesis/confirmation bias. Highlight need to test hypotheses with others.

Cite Calder (2016) analysis and intuition are complementary rather than competing concepts.

## Reflection-in-action



This describes the way a competent practitioner is able:

- To think on their feet
- Use learning from previous situations
- Apply it to the current situation

### Reflection-on-action

The reflective practitioner is able to:

- Look back on what they did
- Think about how it went
- Consider how it might have been done differently

### 5.9.11 Facilitator notes

Note differences between reflection-in-action and reflection-on-action.

## Multi Agency



- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743862/pdf/v013p00242.pdf>
- Analysis of clinical incidents: a window on the system not a search for root causes C A Vincent
- NSPCC Police: learning from serious case reviews  
Summary of risk factors and learning for improved police practice nspcc.org.uk
- Jackie Ann Farquharson (2016) 'Referrals to the police of vulnerable adult abuse' The Journal of Adult Protection Vol 18 Issue 2 pp 119 - 127

## Essential infrastructure for structured professional judgment



- › Structured professional judgment accepted by social workers, managers and legal representatives
- › More use of standardised measures in practice and in supervision
- › Support for partnership working with families
- › Support for action when goals not reached
- › High quality training, CPD and supervision
- › Regular service audits of decision-making processes

### 5.9.12 Facilitator notes

Reinforce the multi-agency nature of the review remit and process, referencing respective agencies' methods of working with risk and internal processes for organisational learning.

Ask the group what infrastructure they have to support structured professional judgment.

**Early afternoon workshop sessions can be inserted into this section, or held separately. Please see document 'Emerging Themes, Opportunities and Challenges Workshops' for training notes.**

## 5.10 Learning in organisations



### 5.10.1 Facilitator notes

In framing the session, outline key ideas:

- Blame is not helpful for good learning.
- The words we use have an emotional context.
- Learning from 'success' is as important as learning from 'failure'.
- We need to think about Senge's work on the learning organisation – perhaps it's more about learning in organisations: <http://infed.org/mobi/the-learning-organization/>.

The session also considers the role of Black Box thinking in organisations. Summary can be found at <https://www.samuelthomasd Davies.com/book-summaries/business/black-box-thinking>.

Trainers are encouraged to read the book before delivering this session.

Useful guidance on organisational change can be found at <https://academiwales.gov.wales/Repository/resource/adc1c84d-46bc-4a86-a0e3-b23170286bf0/en>.

Remind participants that this session will be quite pacy. There will be an activity at the end of the session to support participants to agree the areas they focus on in their practice. It is suggested that at the end of the session participants choose a technique between Day One and Day Two and explore how these can be used in practice.

Take participants through the positive psychology of exploring success before failure and its impacts: <https://academiwales.gov.wales/Repository/resource/be67e554-eebf-42d0-b79b-69781e6f0236/en>.

Remind delegates it's a chance for people to think and reflect about how they would like to change the practice review process.

## Activity



Let's identify some ways we can show success in safeguarding



### 5.10.2 Facilitator notes

Working in small groups, delegates identify the successes of their safeguarding practice and feed back. Record on flipchart.

Trainer to facilitate a discussion which explores:

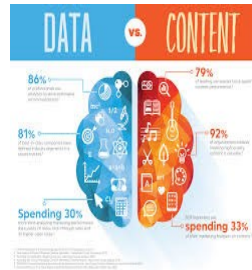
- How did that feel?
- Is it different to conversations you normally have about safeguarding?
- What could be the learning about discussing your successes in safeguarding?



## When things go wrong



- We can either blame or we can learn
- We can respond by thinking fast or thinking slow
- We can skim in our day to day work?
- We can move into learnt helplessness



We can react with our right brain or our left brain

### 5.10.3 Facilitator notes

Remind participants we can be guided by right or left side of brain which is influenced by how mindful we are as an organisation.

Ask participants for examples of right- and left-brain thinking they see in the safeguarding process.

How mindful  
is your  
organisation  
?



### 5.10.4 Facilitator notes

Explore the following points from the group supporting participants to identify examples of where this works in practice.

- When do people have time to reflect?

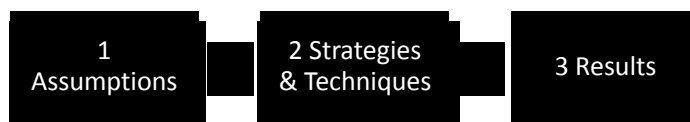
- What does a mindful organisation look like?
- Do you understand the stress signature of your organisation?
- Is it contributing to success or failure for your organisation?
- Are you clear about the links between stress and performance in your organisation?
- What is the relationship like in your organisation between failure-success-risk?
- How is success celebrated in your organisation?

Trainer can share some examples of mindfulness resources in this section.

## Single loop V Double loop learning



Single loop learning explores the relationship between 3 and 2 . It is process driven



Double loop learning focuses on the broader context of change for organisations .

It explores the relationship between 3 ,2 and 1. It focusses on continuous improvement.

### 5.10.5 Facilitator notes

Outline concepts of single loop and double loop learning.

Double loop learning is more helpful in the context of safeguarding.

Activity: In pairs, delegates explore which sort of learning they can see within their organisations and with Partners. Ask delegates to consider if one form of learning is more helpful than another. Is there a way of synergising learning?

## Black Box thinking is about



- “[Black Box Thinking] is about the willingness and tenacity to investigate the lessons that often exist when we fail, but which we rarely exploit.” Furthermore, “It is about creating systems and cultures that enable organizations to learn from errors, rather than **being** threatened by them.”



## He Argues...



- The single greatest obstacle to progress is failing to learn from mistakes
- A cornerstone to success is a progressive attitude to failure
- ‘Only by redefining failure will we unleash progress, creativity and resilience’
- ‘When we are confronted with evidence that challenges our deeply held beliefs we are more likely to reframe the evidence than we are to alter our beliefs’
- ‘Marginal gains is not about making small changes and hoping they fly. Rather it is about breaking down a big problem into small parts in order to rigorously establish what works and what doesn’t’

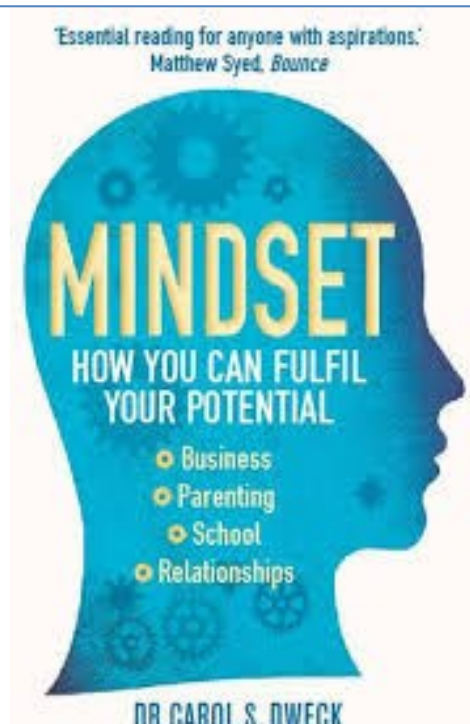
56

### 5.10.6 Facilitator notes

Matthew Syed argues the points above.

Ask the participants which (if any) of the quotes do they agree with? If no access to voting system, use the old-fashioned way eg, show of hands. Explore which idea resonates most for participants and which is the most challenging.

# Fixed v Growth Mindset



## 5.10.7 Facilitator notes

Introduce Dweck's thinking and explore once the slide has been introduced how this can be applied to safeguarding.

Is having a fixed mindset an issue in failure in safeguarding?

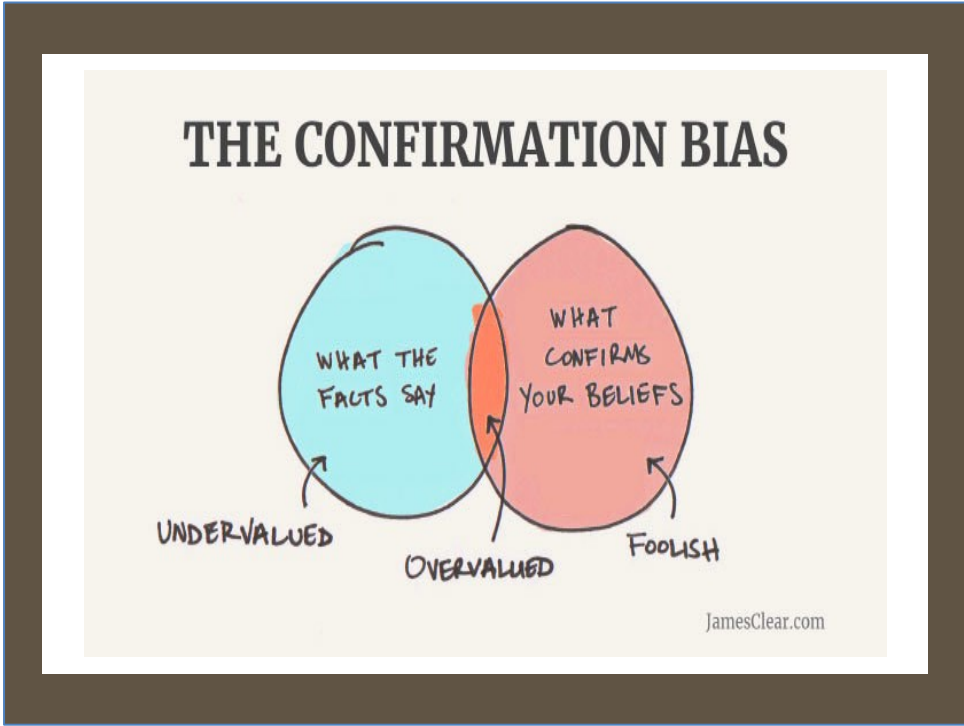
<https://alexvermeer.com/why-your-mindset-important/>.

Outline the Fixed v Growth mindset as being at extreme ends of the spectrum.

Highlight how the mindset can fluctuate in different areas.

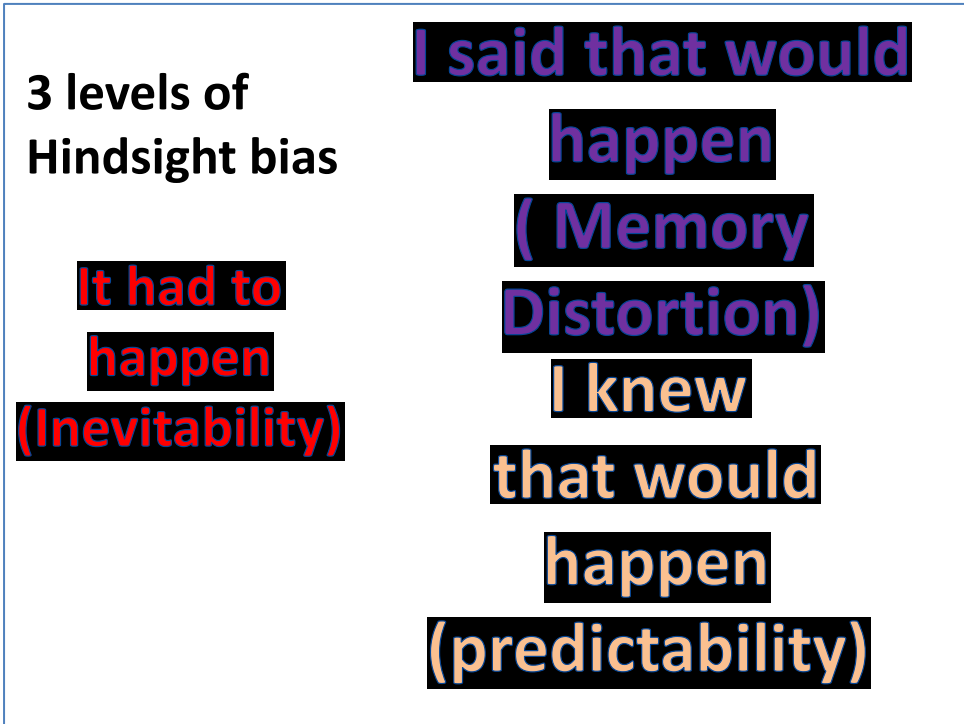
Outline how the mindset impacts behaviour. If it is helpful, select vignettes from <https://alexvermeer.com/why-your-mindset-important/>.

Dweck argues that those with a growth mindset can manage more complex problems eg, in safeguarding, those with a growth mindset will be better at working across boundaries and with complexity.



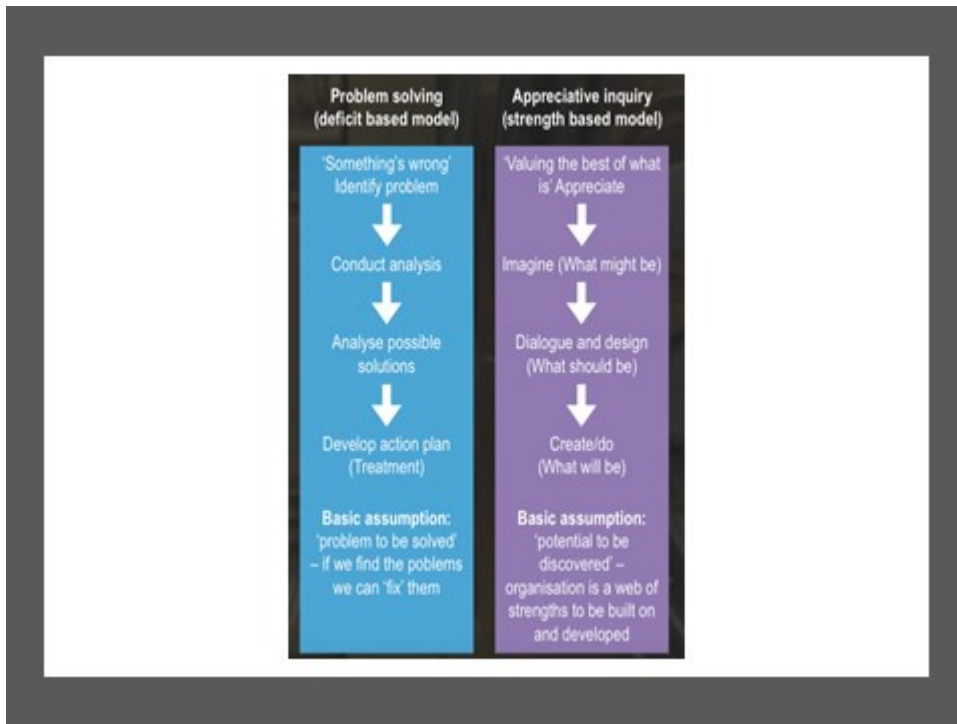
**5.10.8 Facilitator notes**

Frameworks such as the Gibbs reflective cycle and effective supervision are essential in the process.



**5.10.9 Facilitator notes**

Ask participants which example of hindsight bias they see the most of. Ask are there any examples of how these biases have been addressed if they come up in the practice review process?



  
*Getting in on the Act*

### Appreciative Inquiry in child protection - identifying and promoting good practice and creating a learning culture: Practice Tool (2014)

PRACTICE TOOLS AND GUIDES  
PUBLISHED: NOV 2014  
AUTHOR: CLAUDIA MARTINS

This Practice Tool provides a starting point for practitioners, managers, supervisors and LSCBs in understanding Appreciative Inquiry and its potential as a tool in service evaluation and promoting and implementing service improvement. The purpose of this toolkit is to explain what Appreciative Inquiry is and to support practitioners and managers to use it as a method for evidence-gathering, analysis and action planning.

Number of pages: 12



### Appreciative Inquiry in Safeguarding Adults: Practice Tool (2015)

PRACTICE TOOLS AND GUIDES  
PUBLISHED: SEP 2015  
AUTHOR: RESEARCH IN PRACTICE FOR ADULTS

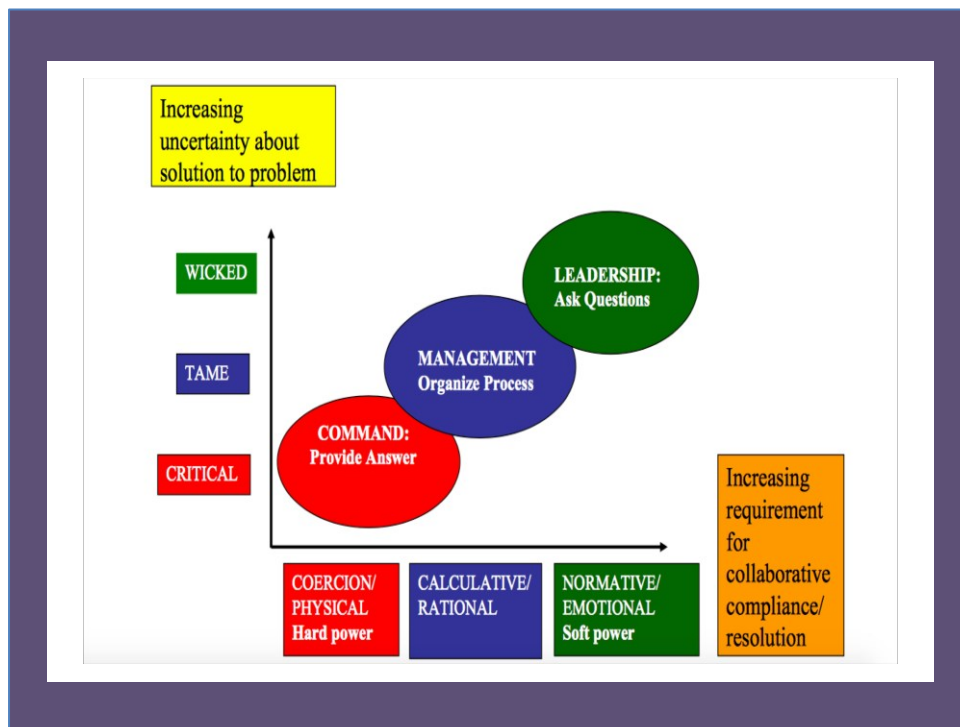
**Please note that this has not been updated since it was published.**

Appreciative Inquiry is a method to help you analyse situations, make decisions and formulate action plans for change. This tool is a great starting point for practitioners, managers, supervisors and Safeguarding Adult Boards who want to understand more about Appreciative Inquiry and how it can be used to evaluate and improve safeguarding services.



### 5.10.10 Facilitator notes

Highlight the benefits of an Appreciative Inquiry approach to safeguarding and the benefits of this methodology in a review.

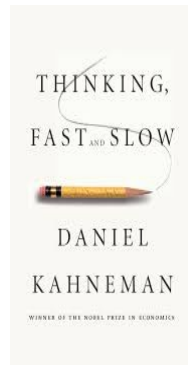


### 5.10.11 Facilitator notes

Using this approach by Keith Grint, we can explore the relationship between the strategy adopted and the outcome achieved. Grint argues that there is often a mismatch – this could explain where we rely on process and not professional practice which relies on evidence base. The initial part of safeguarding should be seen as critical as it is about immediate protection; however, this can become command and control in the latter part of the safeguarding process. Again this relies on good reflection by the practitioner and manager. It could be argued that unless there is an immediate risk, then safeguarding should rely on more slow thinking.

More information can be found about his approach at <http://leadershipforchange.org.uk/wp-content/uploads/Keith-Grint-Wicked-Problems-handout.pdf>.

- System 1 :  
Fast &  
Intuitive
- System 2  
Smart &  
Slow



#### 5.10.12 Facilitator notes

Introduce the concept and then ask participants where they see different forms of thinking being used in the safeguarding process.

Summary from <https://paulminors.com/wp-content/uploads/2014/07/Thinking-Fast-and-Slow.pdf>.

### Safeguarding relies upon

- Good assessment, information sharing and review of information
- Accessing good supervision
- Early intervention and support
- Following local multi-agency procedures
- Effective partnership working
- Good risk management and review
- Working within Legal Frameworks
- Good Record Keeping Standards

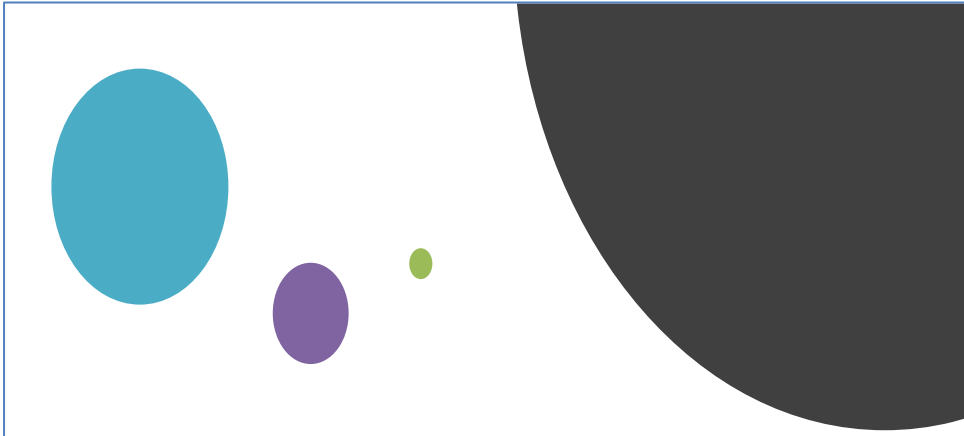




- Do we need to think differently about our Safeguarding practice?
- If we celebrate what we do well we can make learning easier in the Safeguarding process

#### **5.10.13 Facilitator notes**

Ask delegates to explore the question.




**Activity**

So how can this theory be used in the review process ?

**5.10.14 Facilitator notes**

If some themes have arisen in the discussion, ask different groups to apply the learning from this section to those problems. Alternatively, explore general points raised by participants.

**5.11 Concluding session**



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**Day One review and evaluation**

## What did I get from today ?



- So what was your lightbulb moment?

### 5.11.1 Facilitator notes

Hand out post-its to participants – ask them to write one idea they identified as important or things they want to explore further. Trainer to group ideas which can then be written up and briefly discussed.

Trainer to make links with key issues from this morning – ticking off issues addressed today and issues to be carried forward to Day Two. These can be marked using coloured marker pens.

## Before next time



- Reflect on the learning from today and consider what would support you in your role as reviewer and what you or your local area needs to:
  - Start doing
  - Continue doing
  - Stop doing

In order to support effective practice reviews

### 5.11.2 Facilitator notes

Opportunity to set task for Day Two. Check out whether meeting objectives in order that this can be remedied if appropriate on Day Two.

Ensure people complete evaluations.

## DAY TWO

### 6.0 Welcome back to Day Two

## Activity



- Reintroduce self
- Something you remember from day one



5

#### 6.1.1 Facilitator notes

Provide the opportunity for people to feed back on their 'homework' from Day One, and remind delegates of the purpose and aims for Day Two.

Highlight any reviews, research or other publications that may have been published since Day One.

## Engagement

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### 6.1.2 Facilitator notes

Introduce section exploring models of engagement and their application to the practice review process, as well as exploring how service user engagement can be improved in the process.

Whole group activity: What does engagement in the practice review process mean for you? (Capture on flipchart.)

Prompts:

- Link with culture of organisation.
- Attitude to risk.
- How is effective engagement measured in the process?
- NB negotiate with the group which are the most relevant activities. This will depend on the points which are raised within the discussion.

## The guidance says



- “Engages with children and families in individual cases and takes account of their wishes and views’ Page 3 of the guidance
- “Reviews should illuminate the past to make the future safer”, and ensure that they, “articulate the life through the eyes of the victim” (p.6 para 7).
- To seek contribution to the review from the individual/s and appropriate family members and keep them informed of key aspects of process ‘ template 1 , Page 34 of the guidance

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### 6.1.3 Facilitator notes

Any reflections from the group on this?

## Think about



- How much understanding do you have about the principles of engagement – is this common to all review team?
- Do you draw upon advice from relevant others e.g. advocacy providers?
- Describe the values of the team in relation to engagement – e.g. minimal or maximal
- What are the drivers /counter drivers within your agency /partnership?
- For drivers how have you deepened these?
- For counter drivers how have you addressed them ?

8

## Direct Testimony and 'Voice' of Review Subject



- Is there a sense of the subject at all times?
- Some panels ensure a photo of the subject is visible at meetings
- Is the subject's 'direct testimony' explicitly portrayed in the review?
- Main responsibility towards the subject of the review
- "Reviews should illuminate the past to make the future safer"  
... "articulate the life through the eyes of the victim"  
(DHR HO Guidance p.6)
- Muldaly, N & Goddard C (2006) The Truth is Longer than a Lie: Children's experiences of Abuse and Professional Intervention JKP

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### 6.1.4 Facilitator notes

Any experience or examples of good ways to ensure a sense of the subject at all times, or to ensure direct testimony is in there?

## Engagement of Family Members



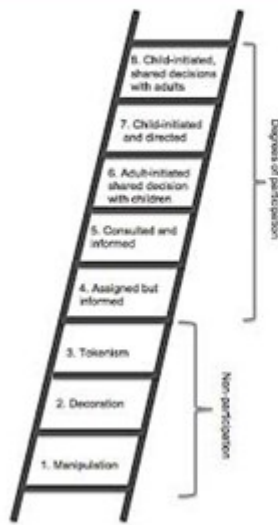
- Ensuring that their perspectives and views inform the review process
- Creative ways of ensuring that their experience informs learning / learning event
- Reviewer has critical role
- Careful arrangements for explain the process at the beginning of the review, for sharing the findings at the conclusion of the report and reflecting their comments in the final report
- Children's Commissioner's 2016 interest in this area
- Equality & Diversity
- Reviewer has critical role in balancing the engagement of family members with the primary responsibility to the subject of the Review particularly when there is conflict or dissonance

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### 6.1.5 Facilitator notes

Provide some examples of engaging family members. Elicit discussion around the balance of the family members and the subject of the review.

# Models of engagement



Arnstein (1969) Ladder of citizen participation

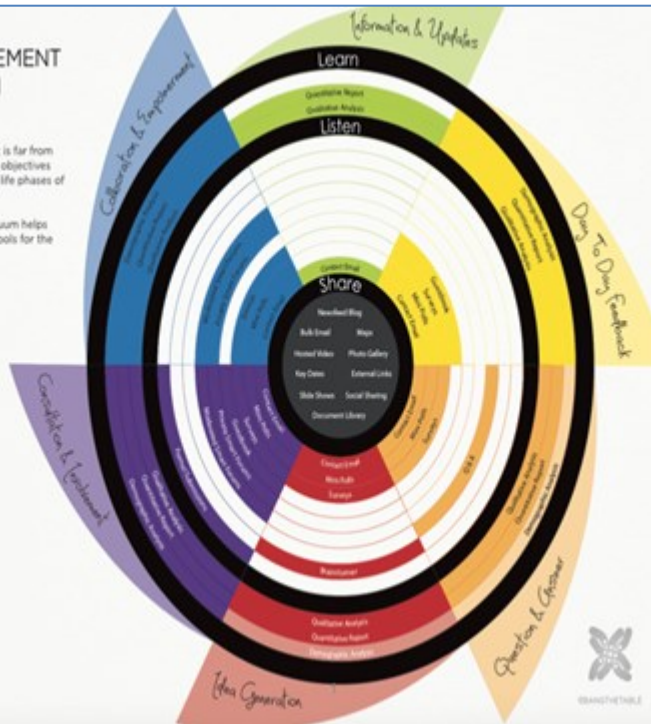


George Julian  
University of Gloucestershire

## THE ENGAGEMENT CONTINUUM

Community engagement is far from static. Your engagement objectives evolve through time and life phases of the project.

The Engagement Continuum helps you to choose the best tools for the job.





Cael Iais Cael dewis Having a voice Having a choice		Safonau Cyfranogiad Cenedlaethol dros Blant a Phobl Ifanc Children and Young People's National Participation Standards	
<b>Mae hyn yn golygu:</b>	<b>Byddwn ni:</b>	<b>This means:</b>	<b>We will:</b>
<ul style="list-style-type: none"> <li>The person will have a say about what happens to them.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>You have the right to information that is easy to understand and allows you to make an informed decision.</li> </ul>	<ul style="list-style-type: none"> <li>Provide information that is good quality, clear and accessible.</li> <li>Inform you about what is going to happen and let you know what difference your treatment could make.</li> </ul>
<ul style="list-style-type: none"> <li>The person will have a say about what happens to them.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>You have the right to choose to be involved and work on things that are important to you.</li> </ul>	<ul style="list-style-type: none"> <li>Give you enough support and time to choose if you want to get involved.</li> </ul>
<ul style="list-style-type: none"> <li>The person will be able to make their own choices.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>Children and young people are all different and have the right to be treated fairly.</li> </ul>	<ul style="list-style-type: none"> <li>Challenge discrimination.</li> <li>Provide a range of opportunities and support to meet the needs of children and young people.</li> </ul>
<ul style="list-style-type: none"> <li>The person will be able to make their own choices.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>You have the right to have a say. Your opinions are important and will be respected.</li> </ul>	<ul style="list-style-type: none"> <li>Listen to your views, experiences and ideas and take you seriously.</li> <li>Work with you on things you say are important.</li> <li>Value what you have to offer.</li> </ul>
<ul style="list-style-type: none"> <li>The person will be able to make their own choices.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>You have the right to learn and be the best you can be.</li> <li>You will have opportunities to work with others and make a difference.</li> <li>We want you to be involved in positive experiences.</li> </ul>	<ul style="list-style-type: none"> <li>Work with you in safe, fun and enjoyable ways.</li> <li>Make the most of what you know and do things that build your confidence and skills.</li> </ul>
<ul style="list-style-type: none"> <li>The person will be able to make their own choices.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>You have the right to know what differences you have made and how your ideas have been listened to.</li> </ul>	<ul style="list-style-type: none"> <li>Always ensure you have feedback in an agreed time.</li> <li>Tell you how your ideas have been used and why.</li> <li>Tell you what happens next.</li> </ul>
<ul style="list-style-type: none"> <li>The person will be able to make their own choices.</li> <li>The person will be able to make their own choices.</li> </ul>	<ul style="list-style-type: none"> <li>We will be able to make our own choices.</li> <li>We will be able to make our own choices.</li> </ul>	<ul style="list-style-type: none"> <li>Those who make decisions that affect children and young people should put children's rights at the centre of everything they do.</li> </ul>	<ul style="list-style-type: none"> <li>Work with you and learn how we can do things better.</li> <li>Ensure your ideas make a difference to the way we make plans and decisions.</li> </ul>



Getting in on the Act

## Activity



Getting in on the Act

In small groups using a model apply it to the practice review process.

You are asked to map the process against the model.

## Review activity



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### 6.1.6 Facilitator notes

This set of slides looks at models of engagement.

Theorists such as Hart and Arnstein have developed models of citizen engagement based on the ladder of participation. In Wales we also have the participation standards.

Hart's work focuses on participation of children, whereas Arnstein's original work relates to adults.

Introduce the ladders and get the group to map the models against the engagement process. If delegates have conducted or been involved in a review they could map this example to the ladders.

When feeding back, elicit discussion about the difference between participation and engagement, or are they the same?

Reference the national participation standards for children and young people.

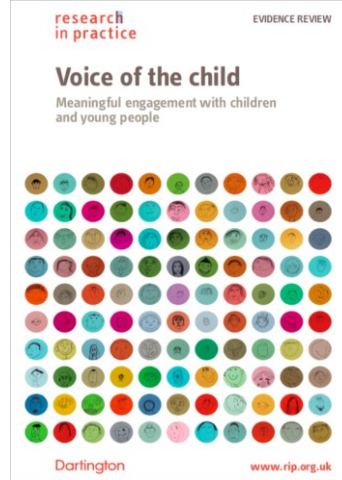
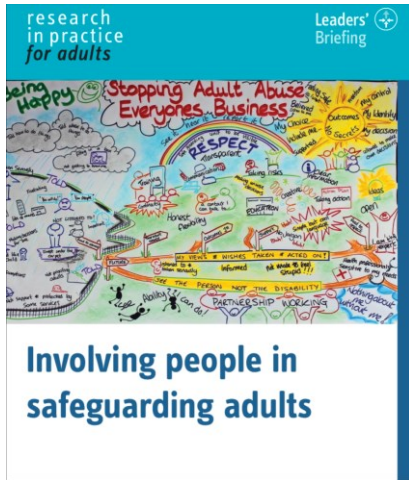
### 6.1.7 Facilitator notes

Review activity. Return to the flipchart captured in 6.1.2.

Whole group activity: What does engagement in the practice review process mean for you? (Capture on flipchart.)

Reintroduce their earlier feedback and ask them to indicate whether they still agree with what was said.

# Resources



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## 6.1.8 Facilitator notes

Introduce resources to support engagement and invite delegates to share resources that they use.

Examples of Resources – opportunity to discuss ones valued locally or regionally (emphasis on multi-agency). Reference may be made to Mudaly N and Goddard C (2006):

*The title for this book came from a 12-year-old girl... that's always the problem with these people, they don't want to believe the truth, they just want to believe the easiest side, the side that is... the simplest, basically... They don't want to hear the truth because the truth is so much harder to understand and so much longer than a lie about the truth.*

## The Review Process



- Guidance:
  - “The overall purpose of the review system is to promote a positive culture of multi-agency child protection learning and review in the local area”.
  - Vol. 2: 6.7 – 6.12 (Concise); 7.5 – 7.13 (Extended);
  - Vol. 3: 6.7 – 6.11
  - Flowchart Figure 2 p.29

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### 6.1.9 Facilitator notes

This section provides an overview of the review process.

Delegates will need the following resources:

- Figure 2 Flowchart
- Annex 1 (2) Practice Review Template
- Annex 2 TOR Exemplar
- First Review Panel Agenda Template
- Any examples of Learning Event materials that delegates have provided in advance

There is a section that considers the Learning Event. This can either be delivered as a separate workshop or incorporated into the whole day.

Begin with the flowchart and talk through the process, this works well if you reproduce the flowchart on a flipchart - you can do this either 'live' or prepare a flipchart.

Remind delegates that the purpose of the review is to promote learning and that anything that hinders that needs to be addressed.

## Criteria & Designation of Review



- Concise CPR Vol. 2: 3.4 – 3.11
- Extended CPR Vol. 2: 3.12 – 3.17
- MAPF Vol. 2: 3.3 'examine case practice'
- Vol. 3: MAPF 3.3
- Vol.3: Concise Review 3.4 – 3.11
- Vol.3: Extended Review 3.12 – 3.17
- Vol. 2; Vol. 3 Annex 3 Historic, organised or multiple abuse

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## Criteria & Designation of Review



- Member agencies' commitment to identify and refer appropriate cases
- Rigorous and robust referral systems
- Re-designation as necessary
- Learning opportunities afforded by MAPF
- Historic, organised or multiple – CSE, residential establishments, specific cohort

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### 6.1.10 Facilitator notes

Encourage discussions – are the criteria equally clear and understood in relation to children and adult reviews? If there is disparity, why is this (PRUDIC/SUI) and how can this be reconciled?

You may want to ask what circumstances may be appropriate for a Multi-Agency Professional Forum.

## Terms of Reference



- Living document to be revised as necessary
- Sets parameters and manages expectations
- Reflects specific aspects e.g. historic, organised or multiple abuse
- Facilitates Chair's role in constructive challenge including conflict of interest
- Ensures proper focus and mandate
- Mechanism for redress – complaints' process?
- Guidance:
  - Vol. 2: 6.17 – 6.19; Vol. 3: 6.16 – 6.18
  - Annex 2 Exemplar

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### 6.1.11 Facilitator notes

Highlight the important role of the TOR, providing mandate and remit for the review. It also includes the role of the family in determining the expectations of the process.

Includes clarification of the complaints process in this context; that it relates to the review and not to the original circumstances.

## Parallel Reviews



- Vol. 2: 6.7 - 6.12 (Concise) = Vol. 2: 7.8 – 7.13 (Extended)
- Vol.3: 6.7 – 6.10; 7.7 – 7.10
- Inquest; Criminal Investigations; IPCC investigations; judicial proceedings; Competence to practice; DHR; Prisons & Probation; HIW; Serious Untowards Incident.
- CPS and ACPO Guidance on simultaneous processes including sharing information (Vol.2: p.13)

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### 6.1.12 Facilitator notes

Police investigations and criminal proceedings can have an impact on reviews and may introduce delay.

Highlight importance of identifying these at early stage (which is why they are standing item on the first Review Panel meeting agenda). Give examples of why this is important. For example:

- A Learning Event may put witnesses into contact with each other. Therefore, provision would be made to avoid this.
- Materials generated by the review may be useful and of interest to criminal investigators.

'Chapter 4: Serious Case Reviews (SCRs) or Welsh Child Practice Reviews (CPRs)', *A Guide for the Police, Crown Prosecution Service (CPS) and Local Safeguarding Children's Boards (LSCBs)* (2014).

(The National Policing (formerly ACPO) Child Death Working Group and CPS)  
<https://www.cps.gov.uk/legal-guidance/serious-case-review>.

## Direct Testimony and 'Voice' of Subject



- Human Rights Act 1998
- Mental Capacity Act 2005
- UNCRC Article 12
- UN Principles for Older Persons
- Is there a sense of the subject at all times?
- Some panels ensure a photo of the subject is visible at meetings
- Is the subject's 'direct testimony' explicitly portrayed in the review?
- Main responsibility towards the subject of the review
- "Reviews should illuminate the past to make the future safer" ...  
"articulate the life through the eyes of the victim"  
(DHR HO Guidance p.6)
- Muldaly, N & Goddard C (2006) The Truth is Longer than a Lie:  
Children's experiences of Abuse and Professional Intervention JKP

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## Direct Testimony and 'Voice' of Subject – Review Pathways



### POSITIVE OUTCOME

- The subject remains the focus
- Experience of the subject is validated
- Review is fully informed
- Learning is robust and valid

### LIMITED OUTCOME

- Subject is not the focus of the review / process
- Replicates and devalues the subject's experience
- Review is not fully informed
- Learning is limited

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### 6.1.13 Facilitator notes

Acknowledge this is a recap from earlier discussions. Important to note that the subject of the review may have died and so would be unable to contribute. How can we ensure the subject remains the focus?

Home Office DHR guidance has useful resources on this.



## Engagement of Family Members



- Ensuring that their perspectives and views inform the review process and are reflected in the report
- Creative ways of ensuring that their experience informs learning / learning event
- Reviewer has critical role including Equality & Diversity
- Three main engagement points
- Children's Commissioner's 2016 interest in this area
- Fine balance
- Vol. 2: 6.31 -6.36; Vol. 3: 6.30 – 6.35

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## Engagement of Family Members – Review Pathways



### POSITIVE OUTCOME

- Appropriate balance achieved
- Affords due regard to significant others
- Review is fully informed

### LIMITED OUTCOME

- Due regard not given
- Review is not fully informed
- Over identification may deflect from the subject of the review and distort learning
- Process is deflected and becomes a means of achieving 'redress'

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### 6.1.14 Facilitator notes

The first Review Panel Meeting will identify the ways in which family members will be involved.

Usually a meeting with identified family members and significant others will take place at the beginning of the review, and sometimes a second meeting before the Learning Event to glean their views (especially if this is not appropriate at the first meeting). A meeting with family members will also take place to share conclusions prior to publication.

Views should be included in the report, including any disagreement. Reference the Children's Commissioner's recommendations in 2016 that there should be increased transparency to family members in the review process.

Highlight importance of recognising the risk of re-traumatising family members. What support contingencies are in place? Note that the review process complements the individual agency/organisation's duty of care towards staff; it does not replace them.

Questions for discussion:

When we involve family members, how do we ensure that we afford them proper regard, without detracting from the subject? (Add this if you feel there is additional discussion to be had in addition to that at 6.1.5.)

How do we involve those who may have contributed to harm as a means of increasing understanding about not only what happened but why and how?

## Genogram



- Vol. 2: 6.24; 7.27
- Vol. 3:6.23; 7.25
- Genogram should be available at panel meetings and or reference at all stages of the review report.
- Useful in complex cases
- Facilitates understanding of family dynamics
- Not to be included in the published report.
- Good Practice Example

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### 6.1.15 Facilitator notes

The guidance refers to the use of a genogram. Share good practice examples of genograms.

## Timeline



- Timeline of 12 months – to be extended in exceptional circumstances including extended reviews to a maximum of 2 years
- May be extended to include decisions and action(s) following the incident
- There is no suggested individual agency timeline template in the Guidance
- Evidential basis for the review and lessons to be learnt

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## Merged Timeline



- Merged timeline of significant events from the individual agencies' timelines
- Annex 1 – 3 Summary Timeline Template – anonymised to be included with the published report
- Board arrangements for merged timeline process

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## Timeline - pathways



### POSITIVE OUTCOME

- Robust evidential basis for the review report
- Provides coherent narrative and facilitates analysis
- Facilitates single and multi-agency understanding
- Holistic consideration

### LIMITED OUTCOME

- Fragmented consideration
- Single agency dimension
- Incoherent narrative
- Inhibits analysis

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## Agency Analysis (AA)



- Guidance (Vol.2: 6.23, 7.26; Vol. 3: 6.22; 7.24) refers to brief analysis.
- Setting out context; issues and /or events.
- Is the AA comprehensive and analytical?
- There is no suggested AA template in the Guidance.
- Evidential basis for the review and lessons to be learnt.
- Role of the Review Panel Member in ensuring that the AA is fit for purpose

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### 6.1.16 Facilitator notes

You can revisit material from Day One at this section.

Highlight there is currently no suggested template for the Timeline and there may be regional variation. Ask delegates about their templates. Do they have a separate Agency Analysis template or does it feature as a column in the Timeline?

Discuss distinction between a Timeline and a Chronology. Review Panel members have critical role in ensuring the Timeline provided is fit for purpose and evidence-informed.

Consider the practicalities of a merged Timeline. There are examples of Community Safety Partnerships working with Safeguarding Boards, and in some regions police analysts undertaking the tasks.

Who undertakes the analysis? Is it the reviewer or the panel?

The merged Timeline should be visible at the Learning Event and presented in an easy-to-understand format.

The proposed Learning Event model in the guidance suggests that attendees should consider the Timeline in multi-agency pairs and focus on what isn't contained as well as what is.

Consider the emotional impact of the Timeline (and photos of the subject) on practitioners and others attending the Learning Event.

Suggested activities:

- 1) As a Review Panel member/reviewer, how are you going to ensure that the Timeline and Agency Analysis are fit for purpose and provide the evidential basis for a robust report?
- 2) Provide a set of value statements in relation to the value statements (see bullet points below). Assign delegates to be in groups 'in agreement', 'neutral', 'against' or 'moderating'. Each group should then discuss the statement in relation to their designation, not their own view (this avoids people becoming entrenched in personal views) and then feed back to the group on each statement.
  - Family members should be able to influence the Terms of Reference.
  - The reviewer should interview all staff.
  - Member agencies can nominate deputies to sit on the Review Panel.
  - The review process should provide a mechanism for redress for family members.
  - The reviewer should change the report if asked.
  - Advocates should always be appointed.
  - Family members should attend the Learning Event.
  - Not all reports should be published.
  - One member-agency should direct and dominate the review panel.

## Report and Outline Action Plan



- Report– Vol. 2: 6.41 – 6.45, 7.39 – 7.43; Template Annex1.2
- Succinct and focused on improving practice
- To include the circumstances of the review, the practice and organisational learning, effective and improvements needed
- Ongoing process of refining and synthesising and ongoing analysis
- Synthesise and collate the learning to date for panel discussion
- Actions should be specific, workable and affordable and have clearly defined intended outcomes

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### 6.1.17 Facilitator notes

Review material from Day One.

Have a discussion around ownership of the report.

When writing recommendations, the reviewer should emphasise that they will need to be translated into SMART.

## Presentation to the Board



- Guidance Vol.2: 6.46, 7.44 – 7.48
- Once agreed by Panel the anonymised draft review report including anonymised summary timeline, identified learning and an outline action plan will be presented to the Board by the Panel Chair and Reviewer(s)
- Reviewer to present the timeline and practice organisational issues arising from the Review
- The role of the Board is to engage and contribute to the analysis, to provide appropriate challenge and to ensure that learning is turned into action
- Identify additional learning or strategic actions to be in the final review

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## Presentation to the Board



- Review Panel and Reviewer to complete the review report to reflect any further learning
- Board accepts the review report and accepts responsibility for the Action Plan
- Chair of the Board to submit the review report to WG and NISB at least two weeks before publication
- Finalised practice review to be published on the Board website for a minimum of 12 weeks and may be available on request subsequently
- Important link between Review Panel member and Board representative – liaison and mandate to ensure shared understanding and early indication of any difficulties arising from any of the review findings

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### 6.1.18 Facilitator notes

Presentation of the Board provides the opportunity to develop a shared understanding of the report.

Elicit discussion around considerations of asking a reviewer to change their report.

Agree publishing arrangements and appropriate communications strategy. Discuss whether not publishing is ever an option.

## Action Plan



- Review Panel and Review prepare Outline Action Plan to reflect the single / multi-agency learning from the review report
- Actions should be outcome focused, SMART, and demonstrate how they will achieve intended outcomes
- Finalised Action Plan to be completed within 4 weeks of presentation to the Board
- The Chair to sign off for partner agencies
- To be sent to the WG for information

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## Ongoing monitoring of the Action Plan



- Vol. 2: 6.54; 7.51 -7.55
- Reviewed and monitored by Review sub- group and reported to the Board
- Wide dissemination of Review and Action Plan within and across agencies
- Action plans should lead to improvements and audit is required to quantify achieving intended outcomes
- Reviewer may be requested to undertake staff events
- On completion of the Action Plan to be signed off by the Board and a report to WG evidencing improvements in practice / achieving intended outcomes
- Other Sub groups – Training and Audit to action any related action points
- Themed learning within and across regional safeguarding boards
- Dovetailing between children and adult themes

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## Action Plan



- Action Plan is not an end in itself
- Outline Action Plan – reflect learning including good practice, 'outcome focussed and indicate how actions are intended to make a difference to local systems and child protection practice'
- 'Means by which recommendations / learning points are translated into workable actions and followed through' (Brandon et al 2011)
- 'Take findings into action' (Wirtz et al 2011)

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## SMART Action Plans



- “The results suggest that CDRTs are doing a better job of ‘assessing the problem’ than in ‘proposing solutions’ – CDRT reports often do not address follow up of their written recommendations’ SG
- Tension between quick ways to audit learning and more considered responses and deeper learning
- ‘Breaking down recommendations into achievable actions has resulted in a further proliferation of tasks to be followed through’
- Procedural compliance vs professional judgement – conducive to measurement?
- ‘Those recommendations that were easy to implement rarely addressed complex matters of professional judgement’. (Brandon et al 2011)
- <http://www.safeguardingchildren.co.uk/safeguarding-news/outcome-focused-problem-solving-making-serious-case-reviews-work/> Grint 2005

38

## SMART Action Plans



- Specific – breaking down into discrete actions, clearly identified outcome
- Measurable – how much, how many – training events, policies etc... can be quantified, more difficult to quantify impact in terms of follow on outcomes
- Achievable / appropriate – delegated responsibility for action completion, ownership and commitment critical
- Relevant / realistic – risk of potentially inappropriate or irrelevant actions on the basis of a single case
- Timely – realistic timescale – priority rating

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## SMART Action Plans



- How can we ensure that learning points are translated into specific actions with measurable outcomes?
- How can we ensure that this 'knowledge to action' is viewed as a central part of the review process?
- How do we audit and evaluate the action plan in relation to whether the intended outcomes are realised?
- How do we future proof the action plan?
- What is the role of the:
  - Reviewer?
  - CPR Panel?
  - CPR group and other subgroups?
  - Board?

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### 6.1.19 Facilitator notes

Activity considering the role of the Reviewer, the Panel, the Board and other groups/subgroups.

## Review Activity



This activity reviews dilemmas in the Practice Review Process

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### 6.1.20 Facilitator notes

Draw on key themes highlighted in the review process section, and review any key issues as a group. You may have resolved issues as you went, in which case you can leave this activity.

## 7.0 Learning Event

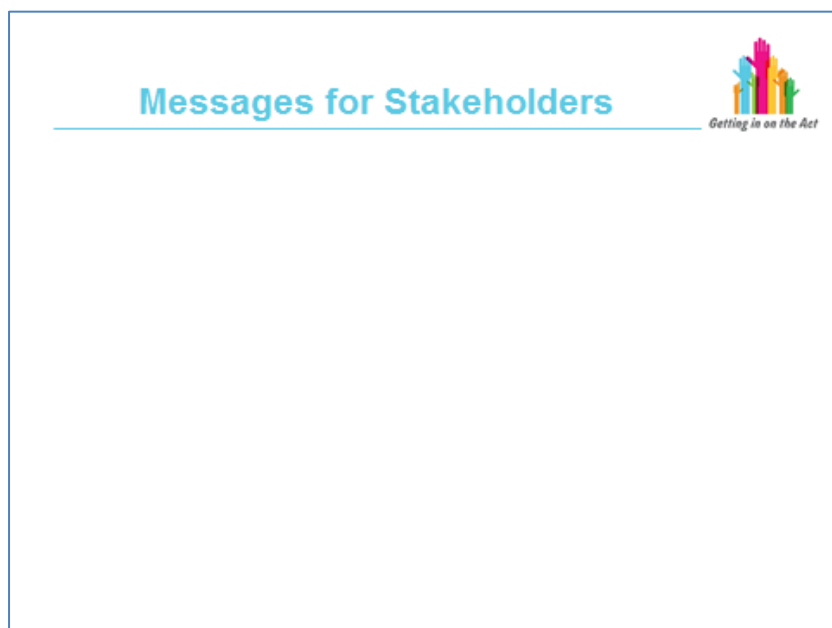
The Learning Event material can either be delivered as part of the whole day, or it can be delivered as a break out workshop.

Refer to the document 'Learning Event Workshop' for the notes on this section, should you be choosing to include it in the main programme.

## 8.0 Collaboration Workshop

If you elect to do the Learning Event section as a workshop you can have a parallel workshop on collaboration. Refer to the document 'Collaboration Workshop' for the notes for that workshop.

## 9.0 Messages for stakeholders



### 9.1.1 Facilitator notes

This is the penultimate session of Day Two, and is followed by the evaluation.

## We Want



- More of
- Less of

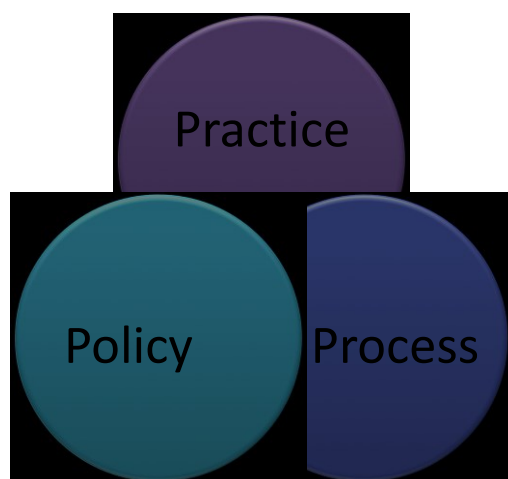
44

### 9.1.2 Facilitator notes

Thinking about all of the discussions across the two days, what are the things that we would like to see more of, and what would we like to see less of? What would we like to keep as it is?

This can be done using flipcharts and post-it notes, with people moving around the room to different sets of flipcharts headed up 'More of', 'Less of', 'Keep doing the same'.

## Messages for stakeholders



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### 9.1.3 Facilitator notes


Activity:

Allocate participants to Practice, Policy or Process groups.

Give ten minutes for them to discuss their P and identify the message for them. If you have time in the programme, rotate.

If you don't have time to rotate, then gather feedback from each group on whether they agree or disagree with that message. Use flipchart to gather feedback and ensure that it gets sent to relevant organisations/personnel post workshop.


All resource neutral changes are to be separately collected eg, these will be quick wins and we can get all to sign up to this.

  
*Getting in on the Act*

## My leadership and safeguarding

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- Participants will develop a tweet
  
- When leading Safeguarding I will .....



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### 9.1.4 Facilitator notes

Cards pre-prepared with a tweet symbol.

Reflect back to earlier sessions on framing things positively and the impact that this can have.

Participants can do 140 characters max.

This card is to be used in the evaluation activity which follows.

## Review and Evaluation Day 2

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### 9.1.5 Facilitator notes

Hand out evaluation forms.

Use tweet cards and ask people to put into self-addressed envelope, and they will be posted out after the course. Alternatively, gather the tweet cards, collate them and share them anonymously via email three weeks post course, for people to reflect on what they have done differently.

TOPIC	SLIDES	ACTIVITY/EXERCISE	OTHER MATERIALS	TIME
Pre-course task Familiarity with relevant guidance and in accordance with identified needs	1-2		<p>Social Services and Well-being (Wales) Act 2014: <i>Working Together to Safeguard People, Volume 2 – Child Practice Reviews</i></p> <p>Social Services and Well-being (Wales) Act 2014: <i>Working Together to Safeguard People, Volume 3 – Adult Practice Reviews</i></p> <p><i>Protecting Children in Wales - Child Practice Reviews: Guide for Organising and Facilitating Learning Events</i> (Welsh Government, 2012)</p> <p>Handouts as suggested in Trainers' Notes</p>	
Introduction	1-5		Informed discussion about key issues; values and principles exercise	9.30-10am
Values and principles	6-11	<p>Slides 6-7: Choice of two values and principles activities</p> <p>Slide 9: Principles line-up activity</p>	Trainers' Notes	10-10.50am
BREAK				10.50-11.05am
Overview of law, policy and practice	12-28	<p>Prompts and exercises detailed in Trainers' Notes</p> <p>Slide 26: Top Ten Tips identified. This to be</p>	Trainers' Notes	11.05-11.45am

		typed up and circulated to participants following the course.		
Efficient and effective reviews - respective roles – Review Panel Member and Chair; Reviewer	29-42	<ul style="list-style-type: none"> <li>• Consider the role description pro formas and consider: <ul style="list-style-type: none"> <li>○ any required amendments/additions</li> <li>○ whether they would sign up to the role (WBSB checklist is particularly useful in this regard)</li> </ul> </li> <li>• Three or four groups reflecting Panel Member, Chair and Reviewer (Safeguarding Board optional dependent on audience) to consider their expectations of the other roles in enabling them to undertake their role ie, the Reviewer group sets out its expectations of the Panel Member, Chair and others</li> <li>• From the point of view of your ascribed role how can you ensure an effective and efficient review?</li> <li>• What support do you need to undertake your role?</li> <li>• Top Ten Tips for a reviewer (either in this section or as above at slide 26)</li> </ul>	<ul style="list-style-type: none"> <li>• Role Description for Panel Representative (NWSB)</li> <li>• Role Description for Chair of Review (NWSB)</li> <li>• Role Description for Independent Reviewer (NWSB)</li> <li>• Role Profile – Review Panel Chairperson (WBSAB)</li> <li>• Role Profile – Practice Review Panel Member (WBSAB)</li> <li>• Practice Review Panel Member Checklist (WBSAB)</li> </ul>	11.45am-12.30pm



LUNCH				12.30-1.15pm
Role of the Reviewer continued – including the role of analysis	43-48		Trainers' Notes	1.15-2pm
Workshops		Choice of two workshops – 'Emerging themes, opportunities and challenges' – Adult (1) and Children (2)	Trainers' Notes	2-2.45pm
BREAK				2.45-3pm
Learning in organisations	49-64	Various – detailed in Trainers' Notes	Trainers' Notes	3-3.45pm
Concluding session and evaluation	65-67	Light-bulb moments	Trainers' Notes	3.45-4.15pm
<b>DAY TWO</b>				
Catch up and setting the scene	1-5		Trainers' Notes	9.30-10am
Engagement with subject (if possible) and family members	6-16		Trainers' Notes	10-11am
The actual review process	17-30	<ul style="list-style-type: none"> <li>Recommended values exercise (detailed in the Trainers' Notes)</li> <li>As a Review Panel member/reviewer, how are you going to ensure that the Timeline and Agency Analysis are fit for purpose and provide the evidential basis for a robust report?</li> <li>Develop Top Ten Tips for being a</li> </ul>	<p>Figure 1 Safeguarding Board infrastructure</p> <p>Figure 2 Flowchart of child practice review process (page 29, Volume 2, guidance)</p> <p>Figure 2 Flowchart of adult practice review process (page 29, Volume 2, guidance)</p> <p>Annex 1 (2) Child Practice Review</p>	11am-12.30pm

<p>Report, action plan and presentation to the Board</p>	<p>31-39</p>	<p>Reviewer</p> <ul style="list-style-type: none"> <li>• Consider what models of support would be essential for you as a reviewer</li> <li>• How can we develop a sustainable pool of reviewers?</li> <li>• As a Review Panel member/reviewer how are you going to ensure that the Timeline and Agency Analysis are fit for purpose and provide the evidential basis for a robust report?</li> </ul> <ul style="list-style-type: none"> <li>• How can we ensure that learning points are translated into specific actions with measurable outcomes?</li> <li>• How can we ensure that this 'knowledge to action' is viewed as a central part of the review process?</li> <li>• How do we audit and evaluate the action plan in relation to whether the intended outcomes are realised?</li> <li>• How do we futureproof the action</li> </ul>	<p>Report Template</p> <p>Annex 2 Terms of Reference – an exemplar</p> <p>Practice Examples:</p> <ul style="list-style-type: none"> <li>• Genogram Template (Gwynedd)</li> <li>• Suggested agenda for first Review Panel Meeting (NWSB)</li> <li>• Timeline/Agency Analysis Template (NWSB) – the guidance does not provide a template</li> <li>• Child/Adult Practice Reviews – What is a Practitioner Learning Event? (Briefing Note, NWSB)</li> </ul> <p>Day Two: Slide 39 and Trainers' Notes</p>	
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		<p>plan?</p> <ul style="list-style-type: none"> <li>• What is the role of the: <ul style="list-style-type: none"> <li>○ Reviewer?</li> <li>○ CPR Panel?</li> <li>○ CPR group and other subgroups?</li> <li>○ Board?</li> </ul> </li> </ul>		
LUNCH				12.30-1.15pm
Review process Continuation		Continued from above	Trainers' Notes	1.15-2pm
Choice of workshop Learning Event - How do we achieve 'Safety, openness and trust' and 'appropriate constructive questioning and challenge'? (Guidance, App 1), or Multi-agency collaboration or incorporate into Day Two			Trainers' Notes Action Plan Template <i>Protecting Children in Wales - Child Practice Reviews: Guide for Organising and Facilitating Learning Events</i> (Welsh Government, 2012)  Trainers' Notes	2-2.45pm

BREAK		Break		2.45-3pm
Collaboration (either as workshop choice as above or incorporated into Day Two)			Trainers' Notes	3-3.45pm if delivered sequentially to Learning Event section rather than concurrently
Messages from stakeholders		More/less of activity Tweet activity and various others	Trainers' Notes	3.45-4.15pm
Conclusion and evaluations				4.15pm

## References

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